Working with you to make Sheffield HEALTHIER

NHS Sheffield Clinical Commissioning Group

Independent Hospital Services Review

Governing Body meeting

A

6 September 2018

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Purpose of Paper

In May, the Hospital Services Review (HSR) published its final report. Board, Governing Bodies and members of the public have now given their feedback on the recommendations in the report.

The feedback has been used to inform a Strategic Outline Case (SOC), which is the system's statement of intent around how it will take forward the recommendations of the HSR.

Key Issues

The SOC largely accepts the recommendations of the HSR, with two main changes:-

- It emphasises the transformation of the workforce more than the HSR did
- It outlines that the Clinical Working Groups on maternity and paediatrics will be asked to explore clinical models that could satisfy interdependencies between maternity and paediatrics, as a possible alternative to moving to a Standalone Midwifery Led Unit.

Is your report for Approval / Consideration / Noting

The Governing Body is asked to formally sign off the Strategic Outline Case and agree to its publication.

Recommendations / Action Required by Governing Body

The Governing Body is asked to:

- Formally sign off the Strategic Outline Case and agree to its publication, in line with their statutory responsibilities in relation to leadership of service change as described in NHS England's Guidance on Planning, Assuring and Delivering Service Change for Patients (2018).

Governing Body Assurance Framework

Which of the CCG's objectives does this paper support?
To ensure there is a sustainable, affordable healthcare system in Sheffield

Are there any Resource Implications (including Financial, Staffing etc)?

Not applicable at this stage

Have you carried out an Equality Impact Assessment and is it attached?
Please attach if completed. Please explain if not, why not Not applicable at this stage
Have you involved patients, carers and the public in the preparation of the report?
Wide public engagement including public meetings held as part of the Hospital Services Review. Full details are available on the Working Together website

Paper for
South Yorkshire and Bassetlaw, Wakefield, North Derbyshire and Hardwick CCG Governing Bodies
and SYB, Mid Yorkshire and Chesterfield Foundation Trust Boards
on the
Strategic Outline Case on Hospital Services
August 2018

1. Summary

In May, the Hospital Services Review (HSR) published its final report. Boards, Governing Bodies, and members of the public have now given their feedback on the recommendations in the report.

The feedback has been used to inform a Strategic Outline Case (SOC), which is the system's statement of intent around how it will take forward the recommendations of the HSR.

The SOC largely accepts the recommendations of the HSR, with two main changes:

- it emphasises the transformation of the workforce more than the HSR did
- it outlines that the Clinical Working Groups on maternity and paediatrics will be asked to explore clinical models that could satisfy interdependencies between maternity and paediatrics, as a possible alternative to moving to a Standalone Midwifery Led Unit.

CCG Governing Bodies are formally invited to sign off the Strategic Outline Case and agree to its publication, in line with their statutory responsibilities in relation to leadership of service change as described in NHS England's **Guidance on Planning, Assuring and Delivering Service Change for Patients (2018).**

Trust Boards are asked to confirm their agreement to the publication of the Strategic Outline Case.

2. Background: responses to the HSR

The final report of the independent Hospital Services Review was published on 9th May 2018.

Governing Bodies and Trust Boards, stakeholders and the public were invited to comment on the report by 12th July (this was not a formal public consultation). Responses were received from trusts and CCGs; 1 local authority; and 2 members of the public. All responses received as of 21st August are at Annex B.

The responses from the CCG Governing Bodies and Boards broadly supported the recommendations. Some points were raised which were addressed in the drafting of the SOC (section 3 below).

In July NHSE also provided input through Gateway 1 of the NHSE assurance process. NHSE approved the process thus far, and laid out the areas which will need further work if the system takes forward the recommendations.

3. The Strategic Outline Case

Up to May, the HSR was an independent review. The vehicle for the system to confirm its response to the recommendations, and publicly state its next steps, is the Strategic Outline Case (SOC).

Content of the SOC

The draft SOC lays out the overall direction for the SYB Integrated Care System (as SYB defined in the Sustainability and Transformation Plan) with Mid Yorkshire and North Derbyshire; the case for change; and the response to the HSR recommendations. The document says that the system will take forward work in three areas:

- **Shared working between acute providers**: through developing Hosted Networks and a system-wide Health and Care Institute, alongside an Innovation Hub
- **Service transformation**: building on and supporting the shift of activity out of hospital into the primary and community care sectors; and transforming workforce roles and clinical pathways
- **Reconfiguration**: modelling options for reconfiguration of maternity and paediatrics on 1-2 sites; considering moving to 3-4 sites for emergency GI bleeds out of hours; and looking at options to support stroke services on sites which only have an Acute Stroke Unit through joint working, while standardising access to e.g. Early Supported Discharge and stroke rehabilitation across the trusts.

The 5 trusts of SYB, plus Chesterfield Royal Hospital NHS Foundation Trust will participate in all of these workstreams. Mid Yorkshire Hospitals NHS Trust will consider whether they want to be part of the Hosted Networks and service transformation workstreams as these develop; they are not part of the reconfiguration workstream.

Changes between the HSR and the SOC

In response to the comments received, the following key changes have been made between the HSR and the SOC. A more detailed point by point response to each of the replies received is at Annex B.

- **A greater focus on transformation** has been introduced, in particular a stronger role for Clinical Working Groups in redesigning job roles and clinical pathways. This is now a workstream in its own right.
- **The timeline has been lengthened**, to allow more time to develop the transformation of the workforce roles before modelling reconfiguration, and to allow more time for Boards and Governing Bodies to engage.
- **On maternity and paediatrics**, several organisations raised concerns about interdependencies and Standalone Midwifery Led Units. The SOC says that the Clinical Working Groups will be asked to explore alternative ways of addressing interdependencies between maternity and paediatics, without moving to a SMLU. Any models which are proposed would be scrutinised by the Clinical Senate.
- **On elective services**, the HSR recommended that the next stage of work should look at some elective services. CEOs and AOs agreed that this should not be a part of the next stage of work on hospital services, although work on improving quality of elective services will continue through the elective workstrand.
- **In relation to Chesterfield**, the SOC makes it clearer that the SYB ICS will work with the Derbyshire STP in developing proposals and mitigations.
- **Where a reconfiguration option would result in some patients moving to trusts which are not within SYBND,** the SOC says that the team will do due diligence around any quality issues while the options are being modelled, and the quality implications will be assessed against the evaluation criterion on quality.
- **The data in the financial analysis** has been slightly updated. Some updated numbers on activity levels were provided by some trusts too late to be included in the HSR. They make

only a very marginal difference and do not change the decision making but in the interests of completeness they will be published alongside the SOC.

- **Local Authorities** requested that they should be more closely involved in the development of the next stage of work. This is being taken forward formally through the context of the wider ICS governance review. On an informal level, the hospital services team will engage more closely with Local Authority colleagues going forward.
- **Members of the public** raised a number of concerns. The detailed response to the points raised is at Annex B, and clarifications (e.g. around the intention to retain all existing A&Es, and to engage with transport organisations) have been provided in the SOC where possible.

CCG Governing Bodies are formally invited to sign off the Strategic Outline Case and agree to its publication, in line with their statutory responsibilities in relation to leadership of service change as described in NHS England's **Guidance on Planning, Assuring and Delivering Service Change for Patients (2018).**

Trust Boards are asked to confirm their agreement to the publication of the Strategic Outline Case.

Alexandra Norrish
Programme Director, Hospital Services Programme
24 August 2018

South Yorkshire and Bassetlaw, Mid Yorkshire and North Derbyshire: Hospital Services Programme

STRATEGIC OUTLINE BUSINESS CASE

August 24th 2018

CONTENTS

1 EXECUTIVE SUMMARY

Health and care organisations in South Yorkshire and Bassetlaw, Mid Yorkshire, and North Derbyshire (SYBMYND) have formed strong partnership working over a number of years with a reputation for delivering long term improvement to health and care for all of our local populations.

This joint working covers primary care, community care, mental health, acute and specialist care and our thinking starts with where people live, in their neighbourhoods, focussing on people being enabled and supported to stay well. Our ambition is to introduce new and improved services, to develop better coordination between those which already exists, to provide support for people who are at most risk and to adapt our workforce so that we are better meeting people's needs.

Prevention will be at the heart of everything we do, and investing in and reshaping primary and community services and integrating mental and physical health will ensure people are supported as close to home as possible. At the same time we have an ambition that everyone should have improved access to high quality care in hospitals and that no matter where people live they should receive the same standards of care. Key to this success will be developing innovative models of care building on the work of the Working Together Acute Care Vanguard.

Following the publication of the South Yorkshire and Bassetlaw system plan the South Yorkshire and Bassetlaw Health and Care Partnership, through its Partnership Board, voluntarily initiated an independent review of Hospital Services. The Hospital Services Review (HSR) was published in May 2018 and it made a number of recommendations including ways in which acute trusts could work together more effectively to meet the needs of patients and how services are designed across SYBMYND.

Partners, including all health commissioners and acute providers across SYBMYND, have now considered the report and provided feedback on its recommendations. The independent review together with its recommendations was well received and broad support was given from system partners to take the work to the next stage.

This Strategic Outline Case (SOC) describes how SYBMYND partners will take the review and its recommendations forward to support realisation of shared ambitions set out in the System Plan published in November 2016.

Below is a summary of the key recommendations which will be taken forward and which the system will build on in the next stage.

1.1 SHARED WORKING BETWEEN ACUTE PROVIDERS

- **Acute, community and primary care providers should continue to work together**, at Place level, to ensure that services are delivered as close to patients' homes as possible. This should be supported by standardisation of which services are being provided nearer to where people live rather than in acute hospitals.
- **The acute hospitals should work together more closely**. 'Hosted Networks' should be established, initially for the 5 services included in the Independent Review. They will drive collaboration, improve workforce planning development and deployment, standardise clinical protocols to improve outcomes, and identify and roll-out cost-effective quality-improving innovations across the system.

- **System partners should establish a Health and Care Institute and an Innovation Hub** to provide a system-wide central support for workforce and innovation across the system.

1.2 TRANSFORMATION OF SERVICES

- **Moving care into primary care and community care.** The individual Places within SYB and ND are developing an Out of Hospital Strategy to enable people and patients to be cared for outside a hospital setting where this is appropriate, and as close to home as possible. To support this, the Clinical Working Groups will work jointly with colleagues in primary care and community care to identify care pathways and services which could be delivered in non-acute settings.

- **Transformation of clinical models and workforce roles**. In order to ensure that we are making the best use of our staff, and providing care as efficiently as possible, we will ask the Clinical Working Groups to develop new workforce models and new clinical service models. The reconfiguration modelling will take account of these new clinical workforce and clinical service models, to ensure that reconfiguration options are fit for the future and sustainable.

1.3 RECONFIGURATION

- **District General Hospitals will be maintained in every place**, each with its own service portfolio comprising a core and specialist offer, working in a networked way across the region.
- **Providers and commissioners will consider consolidating** some services onto fewer sites, in order to improve the quality of care that can be provided to patients and make the best use of available workforce:
    - **All Emergency Departments** should remain open and continue to provide 24/7 care
    - **Paediatrics**: The system will consider the consolidation of full-time inpatient paediatric units from six sites onto four or five, maintaining part-time short stay paediatric assessment units in those places that consolidate their paediatric inpatient units.
    - **Maternity**: the system will consider service models that can support changes to the paediatric services available onsite. This should include the possibility of maintaining standalone Midwifery Led Units on sites which do not have inpatient paediatrics. However we will also look at other options that can address the interdependencies between inpatient paediatrics and obstetric services.
    - **Gastrointestinal bleeds**: Given the difficulty in sustaining out-of-hours rotas for GI bleeds, the system will model consolidating its services from five (currently not all full-time) rotas to three or four full-time out-of-hours rotas.
    - **Stroke**: Hospitals should adopt a paired approach to collaborative working to deliver stroke services, whereby sites with a combination of Hyper Acute Stroke Unit (HASU) and Acute Stroke Unit (ASU) services work with sites that have only ASU/in-patient rehabilitation services, to allow rotation of staff and exposure to more development opportunities.
- The system will establish a transport reference group with a remit to develop a system-wide transport strategy and the specific functions to support and deliver it

1.4 GOVERNANCE

- Commissioners, providers, NHS England and NHS Improvement and the Arms-length-Bodies have being developing a collaborative approach to shared working which they will build on. Commissioners and providers recognise that the current arrangements for decision making will need to evolve to support the scale of change that is included in this report.
- As the ICS develops, SYBMYND will review current governance arrangements in context of the existing legal framework and ensure these enable appropriate decision making to support the successful implementation of the recommendations in this report so that partners can improve outcomes and accessibility to services for people and patients.

This report sets out the case for change behind these agreed directions of travel, and how the system will take them forward.

2 STRATEGIC CONTEXT

2.1 VISION

This Strategic Outline Case recognises that South Yorkshire and Bassetlaw, Mid-Yorkshire and North Derbyshire (SYBMYND) are on a journey, which began several years ago with providers and commissioners choosing to work collaboratively, the publication of a system plan outlining the strategic ambition for health and care and which continues with the Hospital Service Review recommendations, We recognise that ways of working and approaches to collaboration will continue to evolve, as South Yorkshire and Bassetlaw (SYB) develops its role of becoming one of the first, and one of the largest, Integrated Care Systems (ICS) in the country.

Our vision focuses on people staying well in their own neighbourhoods, by integrating health and care services and developing a workforce that best meets people's needs.

The SYB ICS brings together commissioners, and acute, mental health, community, social care and primary care providers from our five places to work together to improve health and care services and outcomes to benefit our population.

Our vision for acute hospitals is to work together within networks rather than as individual, standalone providers. By working more closely together, we believe that we will provide better and more equitable care for our patients. We believe that we should have agreed standards and a shared way of doing things so that people can access the most appropriate care, no matter where they live.

In most cases, we anticipate that the majority of patients will continue to receive their care in their local hospital. We confirm our commitment to maintaining all of our local District General Hospitals.

Where patients have more complex needs, we anticipate they may access specialist care and treatment at another site within the network.

The networked approach will include Mid Yorkshire and Chesterfield hospitals, which are associate partners to the SYB ICS but have a long history of shared working with the SYB hospitals due to well established patient flows from the border areas of SYB.

2.2 INTEGRATED CARE SYSTEMS

Integrated Care Systems (ICSs) are systems in which NHS commissioners, providers, NHS England and NHS Improvement and other Arm's-Length-Bodies, working closely with GP networks, local authorities and other partners, agree to take shared responsibility (in ways that are consistent with their individual legal obligations) for how they use their collective resources to improve quality of care and health outcomes. ICSs are expected to make faster progress than other health systems in transforming the way care is delivered, to the benefit of the population they serve.

2.2.1 The SYB ICS

The SYB system is large and complex, comprising of five places: Barnsley, Bassetlaw, Doncaster, Rotherham and Sheffield. Within the SYB system are 208 GP practices, five local authorities, five clinical commissioning groups, five acute Foundation Trusts (two with integrated community services), four mental health providers and one ambulance service. The system is served by 72,000 staff and a health and care budget of £3.9bn each year. There are also two associate partner trusts: Chesterfield Royal Hospital NHS Foundation Trust and Mid Yorkshire Hospitals NHS Trust, and two associate CCGs: North Derbyshire CCG and Wakefield CCG.

2.2.2 The SYBMYND Collaborative

The five 'core trusts' are the members of the South Yorkshire and Bassetlaw Integrated Care System:

- Barnsley Hospital NHS Foundation Trust;

- Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust;
- Sheffield Teaching Hospitals NHS Foundation Trust;
- Sheffield Children's Hospital NHS Foundation Trust; and
- The Rotherham NHS Foundation Trust.

In addition to this, the neighbouring acute trust of Chesterfield Royal Hospital NHS Foundation Trust was fully included within the recommendations of the Review, and recommendations relating to shared working (though not to reconfiguration) also included the Mid Yorkshire Hospitals NHS Trust.

Their inclusion was due to a long history of joint working and clinical networks which support patient services, and the formal collaboration which has existed between the seven SYBMYND acute providers since 2014, when the Providers Working Together acute national Vanguard Programme was established.

However, going forward, work with Chesterfield will need to take account of Chesterfield's position within the Derbyshire Sustainability and Transformation Plan as well as its links to South Yorkshire and Bassetlaw.

2.3 The Hospital Services Review (HSR)

In 2017 the system commissioned a review of its acute services, recognising they faced significant sustainability challenges.

The HSR was undertaken over a 10-month period phased in three stages:

- June – August 2017: Identifying the services in scope for the Review
- September – December 2017: Detailed analysis of the issues facing the 5 core services
- January – May 2018: Development of options for the core services.

The Review was informed by a process of clinical engagement, through a series of Clinical Working Groups each of which met five times; and a public engagement programme which included both face to face and online communications. Concerted effort was made to engage seldom heard groups.

The Review team has published the notes of the clinical meetings, the reports of all the public engagement events, the findings of the Review and the detailed evidence for these at each stage of the Review. The reports and the supporting annexes can be found, along with the full set of Review documentation, at:

http://www.healthandcaretogethersyb.co.uk/index.php/what-we-do/working-together-future-proof-services/looking-at-hospital-services

This Strategic Outline Case outlines the system's agreed way forward following the receipt of the HSR recommendations. It draws on the HSR report, and on the responses to that Report (attached at **Annex A**).

3 CHALLENGES IN ACUTE SERVICES

A full case for change for the system is published as part of the HSR's website online. An updated analysis of the performance metrics of the Trusts in the system, and an overview of the challenges identified in the five services in scope of the review can be found in **Annex B – Case for Change.**

3.1 INTRODUCTION

The partners and associates of the South Yorkshire and Bassetlaw ICS commissioned the HSR in response to the challenges identified in the SYB Sustainability and Transformation Plan (STP) or System Plan.

SYBMYND has some of the best acute hospital services in the country, some of which have national and international reputations, including a specialist cancer centre, children's hospital and numerous high quality services in many locations. It also has one of the country's busiest accident and emergency departments. However, the system is under pressure from mounting demand and workforce pressures, both of which impact on the quality of care that patients receive. In addition there are inequalities of access and health outcomes across SYBMYND.

The current and future context will continue to challenge the system, as Trusts continue to respond to increasing demand and to national requirements around quality of care, equity of access and efficiency. The Review offered a unique opportunity to fundamentally change the way care is delivered in the system, and to consider options to transform the way trusts work together to sustain services.

Through tackling the challenges together, and considering the Report recommendations, SYBMYND aims to become one of the most innovative, safe, caring, responsive, effective, well led and efficient health and care systems in the country.

3.2 UNSUSTAINABLE SERVICES

The HSR spent the first three months of the Review assessing performance across all acute specialties in SYBMYND.

The findings of the assessment are published in the Stage 1A Report of the HSR, available at:

https://www.healthandcaretogethersyb.co.uk/application/files/7515/0903/4254/Hospital_Services_1a_Report.pdf

The HSR found that a number of acute services across SYBMYND were facing significant sustainability challenges. The HSR undertook a methodical prioritisation process to identify those services which were facing the most acute challenges, and from these it selected five significantly challenged services as the focus of the Review.

Details of how the services were identified are laid out in the 1A Report which is available on the website. In summary, the HSR considered a range of published metrics to provide an independent analysis; worked with Trusts to identify the services that they thought most unsustainable; and identified the level of interdependencies with other services.

The below table identifies the acute services identified as the most unsustainable. A high score indicates that not only was the service of high concern to individual Trusts across the system, but that this assessment was backed up by evidence, and that the service was critically interdependent in maintaining other hospital services.

Rank	Service	Independent analysis	Trust self-assessment	Degree of clinical co-dependencies	Sustainability Score
1	Emergency Medicine	13.6	16.0	16.0	15.2
2	Gastroenterology	10.8	13.0	15.0	12.9
3	Urology	13.5	12.0	13.0	12.8
4	Stroke - HASU	10.8	16.0	11.0	12.6
5	Critical Care	13.0	12.0	12.0	12.3
6	ENT	11.9	12.0	13.0	12.3
7	Cardiology	14.3	11.0	11.0	12.1
8	Radiology	11.8	12.0	12.0	11.9
9	Acute Medicine	11.2	11.0	12.0	11.4
10	Dermatology	14.3	18.0	0.0	10.8
11	Paediatric Medicine	9.4	11.0	11.0	10.5
12	Orthopaedics	14.3	8.0	8.0	10.1
13	Endoscopy	6.7	10.0	12.0	9.6
14	Ophthalmology	14.4	14.0	0.0	9.5
15	Neonatology	7.6	10.0	10.0	9.2

Table 1: Assessment of service sustainability. Services taken forward for inclusion in the Hospital Services Review are highlighted

In order to agree which of these very challenged services the Review should focus on, the HSR team invited input from the HSR Steering Group (including Medical Directors of all the trusts); patients and the public; and national organisations such as NHS England.

From the Steering Group, the following five services were identified for Review:

- Urgent and Emergency Care
- Acute Paediatrics (Care of the Acutely Ill Child)
- Maternity
- Stroke (the acute pathway, supporting HASU)
- Gastroenterology and Endoscopy

Four of these scored in the top fifteen most unsustainable services in SYBMYND (highlighted in orange in the table above). The fifth, maternity, was added because its interdependencies with paediatrics make it difficult to consider paediatrics in isolation, as well as its significance whilst considering the role of the District General Hospital (which was part of the HSR's terms of reference). Endoscopy and Gastroenterology were included together for the same reason.

3.3 The Main Challenges Facing the Five Core Services

The main challenges facing each of the five services were identified through the Clinical Working Groups, engagement with patients and the public, and performance and workforce data provided by the Trusts.

The main challenges that emerged in relation to the five services are as follows:

- **Workforce** – As is the case across the country, SYBMYND has a significant shortfall in the number of substantive staff in the system, with problems in both the recruitment and retention staff. The remaining workforce is therefore overstretched and there is a significant reliance on costly agency staff. Gaps in the workforce mean that staffing levels can fall below those required to provide a safe service for patients**.**
- **Unwarranted Clinical Variation** - Lack of standardised clinical protocols across the region means that patients with the same condition can receive different packages of care. This results in variation in clinical outcomes, both between and within Trusts. Reducing unwarranted variation is a key priority for the NHS nationally and was identified as a key challenge in the SYBMYND region.
- **Innovation** – Technology and digital infrastructure were flagged as being problematic. Outdated systems that were incompatible with one another, and slow adoption of new technologies across the region were hindering progress that could support the work of clinical healthcare staff.

Further detail on the challenges faced by the system and those faced by the five services in question is provided in **Annex B – Case for Change**.

A full report of the challenges identified by the HSR is available in the Stage 1B Report available at:

https://www.healthandcaretogethersyb.co.uk/application/files/9615/1809/8702/Hospital_Services_Review_1b_report.pdf

3.4 Future Work on Other Services

The five services identified above have formed the first wave of services. In the work over the next twelve months, neonatology will be included in the work on paediatrics because its interdependencies with maternity and paediatrics mean that it needs to be considered as part of any potential reconfiguration. In South Yorkshire and Bassetlaw and North Derbyshire, most neonatologists also work in paediatric units. This point has been raised frequently in feedback from stakeholders across the system including the maternity and paediatric Clinical Working Groups.

4 RECOMMENDATIONS OF THE HOSPITAL SERVICES REVIEW

4.1 THE RECOMMENDATIONS IN THE FINAL REPORT

Following as assessment of the sustainability of acute services in the SYBMYND, which involved significant clinical and public engagement throughout, the HSR made the following recommendations:

- **Acute, community and primary care providers should continue to work together**, at Place level, to ensure that services are delivered as close to patients' homes as possible. This should be supported by some standardisation across the acute services: there should be a defined range of services that will be moved out of an acute hospital setting, to be delivered in primary or community care, or patients' own homes.
- **All of the existing District General Hospitals should be maintained**, each with its own service portfolio, working in a networked way across the region.
- **The acute hospitals should work together more closely**. 'Hosted Networks' should be set up, initially for the 5 services included in the Review, with each capable provider taking the lead on one of the services. There will be three tiers of Hosted Networks. At the minimum, they will aim to drive collaboration and improve workforce planning, development and deployment; standardise clinical protocols to improve outcomes; and identify and roll-out cost-effective, quality-improving innovations across the system. For some specialties, the Host of the Hosted Network will co-ordinate capacity and workforce; and in the most developed model the Host may potentially support delivery of a service on other site(s).
- **System partners should establish a Health and Care Institute and an Innovation Hub** to provide a system-wide central support for workforce and innovation across the system. A Health and Care Institute should provide a central resource to support the recruitment, training and development of staff; the development of standardised clinical protocols; and the analysis and monitoring of trust performance, acting as a central intelligence function. An Innovation Hub should provide the capabilities to identify and roll-out cost-effective innovations across the system, working with local, regional and national partners.
- **Providers and commissioners should consider consolidating some services onto fewer sites**. Given the magnitude of the workforce challenge, both now and forecast in the do-nothing future scenario, collaborative working will not go far enough. As such, the HSR recommended that providers and commissioners should consider the consolidation of some services onto fewer sites, in order to make the most out of the available workforce and improve the quality of care that can be provided to patients.
    - **All Emergency Departments** should remain open and continue to provide 24/7 care
    - **Paediatrics**: The system should consider the consolidation of full-time inpatient paediatric units from six sites onto four or five, maintaining part-time short stay paediatric assessment units in those places that consolidate their paediatric inpatient units.
    - **Maternity**: The system should consider the consolidation of consultant-led birthing units from six sites onto four or five, maintaining standalone midwifery-led birthing units in those places that consolidate their CLU.
    - **Gastrointestinal bleeds**: Given the difficulty in sustaining out-of-hours rotas for GI bleeds, the system should consider consolidating its services from five (currently not all full-time) rotas to three or four full-time out-of-hours rotas.

- **Stroke**: Hospitals should adopt a paired approach to collaborative working to deliver stroke services, whereby sites with a combination of Hyper Acute Stroke Unit (HASU) and Acute Stroke Unit (ASU) services work with sites that have only ASU/in-patient rehabilitation services, to allow rotation of staff and exposure to more development opportunities.
- **Elective**: The system should develop models for the transformation and reconfiguration of elective services to support an improvement in quality of elective services, as well as to support changes to non-elective services, given unsustainability challenges in this area.

- **Access**: The system should establish a transport reference group with a remit to develop a system-wide transport strategy and the specific functions to support and deliver it
- **Governance**: Current arrangements between providers are unlikely to be fit for purpose when considering the scale of change that is included in this report. SYBMYND should review current governance arrangements and ensure these enable rapid decision making at pace to support the successful implementation of the recommendations in this report.

Full details of how the HSR developed these options are available in previous Stage 1A, Stage 1B and Stage 2 HSR Reports.

Final recommendations themselves can be found at:

https://www.healthandcaretogethersyb.co.uk/application/files/2515/2845/1016/25._HSR_Stage_2_Report.pdf

4.2 Responses to the HSR Recommendations

Since publication of the final HSR in May 2018, its recommendations have been shared with CCG Governing Bodies and Trust Boards. Public engagement has also been ongoing to inform the public of developments while continuing to capture their thoughts.

There was broad support for the findings and recommendations of the Review, and as such this Strategic Outline Case outlines the Governing Bodies' intention to take on board the recommendations and commit to further work on the sustainability of acute services.

The feedback received to the HSR proposals is detailed in **Annex A – Responses to Feedback**, along with detailed responses to the individual points raised. This document outlines the system's agreed way forward following the receipt of these responses.

5 THE AGREED WAY FORWARD

CCGs, Trusts, Local Authorities and members of the public have given responses to the HSR recommendations (see **Annex A – Responses to HSR Feedback)**, and as a system we have developed our agreed way forward.

Overall, the South Yorkshire and Bassetlaw Integrated Care System, with Mid Yorkshire and North Derbyshire, agrees with the recommendations of the HSR. However, as a health system, the most vital focus for us going forward will be around developing shared working across the trusts, and transforming services, including through developing new workforce models. Only when we have understood the impact of both of these things will we consider changing the configuration of our services.

5.1 SHARED WORKING BETWEEN ACUTE PROVIDERS

Going forward, the acute providers will work together closely. We will set up Hosted Networks, as well as an infrastructure of a Health and Care Institute to support a shared approach to workforce and innovation.

5.1.1 Hosted Networks

- The system will work to establish a set of Hosted Networks across the five specialities identified in the HSR.
- The approach to Hosted Networks will consist of three tiers of Hosted Networks, with increasing levels of collaboration:
    - A basic Hosted Network will be responsible for standardising the approach to workforce functions; reducing clinical variation through setting agreed protocols; and rollout of specific identified innovations. It will be backed by agreed delegated decision making powers, accountability and monitoring.
    - A Co-ordinated Delivery Network will have the functions of a basic Hosted Network, with the Host having an additional co-ordinating role in identifying shortfalls in capacity and staff, and allocating resources to meet demand.
    - A Single Service Model will be explored, for some trusts and some specialties, whereby the Host may play a role in supporting the delivery of services on other sites. This arrangement is unlikely to cover every site in the network and would only occur if the support was requested by the receiving site.
- It is recognised that services are continually developing and evolving. As such, whilst we will work with service providers to determine the most appropriate level of network for each specialty, we acknowledge that this is dynamic and may change over time.
- The first step will be to work with providers and commissioners to develop a central framework on the networks' purpose, function and form that can be tailored to each service. The framework will outline the proposed form of the Hosted Networks and the lines of accountability between the Hosted Network, member trusts and the ICS. This will also lay out the responsibilities of both Hosts, and network members. An implementation plan will be drawn up to support this.
- The programme will engage providers and commissioners in developing a robust approach to equitably assigning Host organisations for each of the Hosted Networks. This will include developing criteria around what a Host must be able to provide, and the requirements that it must meet, in order to be eligible to host a service. This will ensure that whilst lead roles

are shared across the system, all Hosts have the resources and ability to perform the role of Host.

- Engagement will also be conducted to ensure staff have the opportunity to get involved and shape ways of working across the various organisations.
- The development of Hosted Networks will be alongside that of the Health and Care Institute and Innovation Hub, which will provide centralised analytical and human resource expertise for the Hosted Networks.

5.1.2 Health and Care Institute & Innovation Hub

- We will progress the work to establish a Health and Care Institute and Innovation Hub to support the transformation themes: workforce, unwarranted clinical variation and innovation.
- We will engage with both NHS and non-NHS partners, such as local universities and industry, to develop the detail of the model.
- We will also consider funding implications and any interdependencies or overlap with other ICS workstreams.
- We will work with Health Education England to develop the workforce function of the Health and Care Institute. The approach to developing the Health and Care Institute and Innovation Hub should also include social care and the third sector to enable the appropriate innovation in care pathways.
- The Institute and Hub are likely to be one organisation, rather than two separate structures, but this will be agreed in work going forward

5.2 SERVICE TRANSFORMATION

We will ensure that services are working together as well as possible.

In order to do this, we will ensure that care takes place in the right place, and that only care which needs to happen in acute hospitals is provided there.

We will also look at ways in which we can use our existing workforce better, through different workforce models.

5.2.1 Moving care out of hospital into primary care and community care

The NHS England Five Year Forward View, and subsequently the Sustainability and Transformation Plans of both SYB and North Derbyshire (SYBND), have focused on the importance of ensuring that care is delivered in the right place. In many cases, patients are currently receiving care in acute hospitals where this could be better and more efficiently provided in primary or community care, or in their own homes.

The individual Places within SYBND are developing their own strategies for reducing admissions to hospital, and making sure that patients receive care outside hospital wherever possible. The six CCGs have agreed to develop this into a single strategy.

In order to support this, we will ask the Clinical Working Groups to look at care pathways, and identify from the services under review which would be better delivered in settings other than the acute settings. The CWGs will work with colleagues in primary care and community care to understand what workforce and investment in primary care and community care would be necessary to make this happen. The Clinical Working Groups have already had some discussions of this, and this will build on this work.

5.2.2 Transformation of clinical models and workforce roles

The HSR describes the need to develop new workforce roles, in particular the roles of the alternative professions, such as Physicians' Associates and Advanced Nurse Practitioners. The HSR envisages that developing the approach to these would be part of the role of the Hosted Networks.

Providers and commissioners, in responding to the HSR recommendations, have highlighted the importance of ensuring that we do not simply base reconfiguration options on current workforce models. Therefore, before we model the impact of reconfiguration on our workforce, we will ask the Clinical Working Groups to develop new workforce models and new clinical models to ensure that we are making the best use of our staff.

The reconfiguration modelling will take account of these transformed approaches to the workforce, to ensure that the reconfiguration options are based on the new approach rather than simply replicating the status quo.

5.3 RECONFIGURATION

The HSR proposed that, where transformation options do not go far enough, we should consider reconfiguring services.

Leaders in the healthcare organisations have agreed with the majority of the HSR proposals for further work. The exception is maternity, where a number of responses raised concerns about the sustainability of Standalone Midwifery Led Units. As a result, the work going forward will include SMLUs but will also investigate other ways to address the interdependencies with paediatrics.

South Yorkshire and Bassetlaw, with North Derbyshire (SYBND) [1], have agreed to model the following options:

5.3.1 Urgent and Emergency Care

One member of the public asked for confirmation that the system intends to retain all 6 Accident and Emergency departments, plus the paediatric A&E at Sheffield. We confirm that we will do this.

The South Yorkshire and Bassetlaw Integrated Care System, with North Derbyshire, agrees:

- We will retain all 6 accident and emergency (A&E) departments plus the paediatric emergency department at Sheffield Children's Hospital. This includes emergency departments staying open 24/7, with consultant coverage appropriate to the size of the unit, guided by Royal College of Emergency Medicine guidelines.
- We will consider what staff presence is appropriate in A&Es at different times of the day and explore how we can use staff in different ways. Alternative staff roles, such as advanced nurse or medical practitioners, or support from GPs, could help to address workforce challenges in our A&E departments.

[1] Note, Mid-Yorkshire has recent undergone reconfiguration with other trusts in its STP, as such is not a part of the reconfiguration proposals. Chesterfield is included within the scope of the reconfiguration proposals, but we will need to engage closely with Derbyshire commissioners to ensure consistency with the development of the Derbyshire Sustainability Plan, since Chesterfield sits within Derbyshire STP as well as having patient flows to SYB.

5.3.2 Care of the Acutely Ill Child

Some concerns were raised around whether Short Stay Paediatric Assessment Units (SSPAU) were an appropriate way forward for system partners.

This concern is noted, and it is important to reiterate that any proposals for reconfiguration will be developed in close collaboration with clinicians to ensure they meet safety and quality requirements.

However, clinical evidence supports the safety of SSPAUs as an alternative to full-time inpatient units, particularly when there is not enough activity or resource to sustain a full paediatric inpatient unit, assuming appropriate transfer protocols are in place for those patients requiring overnight care. The Royal College of Paediatrics and Child Health support such a care model, stating that for many patients they are a more appropriate care setting than an inpatient unit, and are being increasingly used to deliver high quality paediatric care[2].

The South Yorkshire and Bassetlaw Integrated Care System, with North Derbyshire, agrees:

- We will model the impact of changing one or two inpatient paediatric units (from the existing units in South Yorkshire and Bassetlaw and North Derbyshire) into SSPAUs.
- Where an SSPAU is proposed, we will ensure that it is supported by robust referral and patient transfer protocols to ensure children are able to access the care they need out-of-hours.
- If changes are being proposed to paediatrics services, this will be mirrored by appropriate changes to maternity and neonatology services on the site. We will continue to test out a range of models that meet the required interdependencies between obstetrics and paediatrics, and will assure the safety of any such models with the Clinical Senate.
- We will continue to model transformation options, such as using mid-grade staff, and advance nurse and medical practitioners in different ways, and changing job roles, to address workforce challenges.

5.3.3 Maternity

The HSR focused on being able to expand the choice of services available to women, and being able to deliver high quality care at each of these care settings, given the current and projected constraints on consultant and midwife numbers in the system.

The SYB system is working to deliver the recommendations of the Better Births report. This includes providing women with greater access to choice of where to have their babies, including home births and Midwifery Led Units.

The HSR recommended that the system should provide a MLU on every acute site, and that one or two sites should look at having Standalone Midwifery Led Units, supporting a a part-time Paediatric Assessment Unit, with obstetric, neonatology and specialist paediatric services being provided at another linked site. This is a model that is used in a number of places in the NHS.

Some respondents raised concerns about the safety and in particular the sustainability of Standalone Midwifery-Led Units (SMLUs). The hospital services programme will continue to work with local obstetricians, midwives, nurses, sonographers, neonatologists and other healthcare professionals in the development of any specific proposals in the next phase of work, and this will involve a thorough assessment of the clinical evidence on SMLUs.

[2] Royal College of Paediatrics and Child Health, Standards for Short-Stay Paediatric Assessment Units, March 2017.
Available at: https://www.rcpch.ac.uk/sites/default/files/SSPAU_College_Standards_21.03.2017_final.pdf

In addition, the maternity workstrand will be asked to explore alternative clinical models, both locally and internationally, which allow of greater flexibility around the co-location of maternity and paediatric services, recognising the clinical interdependency that exists between these and neonatology services. We will test out other models that might allow for obstetric-led services remaining on a site without 24/7 paediatrics being present, and vice versa.

Any such options will be developed in close collaboration with expert Clinical Working Groups and submitted to the Clinical Senate for scrutiny, to ensure that they are safe and appropriate.

The system partners will also seek to engage with mothers and women of child bearing age to understand their thoughts and concerns on how and where they would like to give birth.

The need to fully consider the interdependencies between maternity, neonatal and paediatric services was also flagged in responses from Boards and Governing Bodies. The system has agreed to add neonatologists to the Clinical Working Group on Care of the Acutely Ill Child, and to include neonatology in any reconfiguration modelling in order to address this.

The South Yorkshire and Bassetlaw Integrated Care System, with North Derbyshire, agrees:

- We will model the impact of a reduction in the number of obstetrics units by one or two units, from the existing units in South Yorkshire and Bassetlaw and North Derbyshire.
- We will engage with the public on their preferences for midwifery-led care and we will continue to work with clinicians to understand if SMLUs can be delivered safely and efficiently.
- For those Places which potentially would not have an obstetric unit, we will model the implications of offering choice through standalone midwifery-led units, supported by robust referral and patient transfer protocols if needed.
- We will also explore alternative clinical models. Traditionally, if changes to the maternity services are being proposed on a site, this would be mirrored by changes in paediatric services. However we will also continue to explore alternative models that might allow the interdependency between maternity and paediatrics to be satisfied in other ways, and will assure the safety of any such models with the Clinical Senate. We will also engage with the public around these to ensure that the implications of any proposals are clear and to hear and consider their feedback.
- We will include neonatology in the modelling moving forward and involve neonatologists fully in the acute sustainability programme through the Care of the Acutely Ill Child Clinical Working Group.
- We will continue to model transformation options, such as using mid-grade staff, and advance nurse and medical practitioners in different ways, and changing job roles, to address workforce challenges.

5.3.4 Gastroenterology

Maintaining the quality, safety and sustainability of services are all key criteria taken into consideration throughout the development of any options and their evaluation, and in depth site-specific modelling of options will be done to assess and evaluate future options before any are considered and taken further.

One respondent raised concerns about the safety implications of moving to full out of hours services on three or four sites; however, we note that the system does not currently provide out of hours services on all of these sites.

One respondent suggested that staff should move to the patient rather than vice versa. However, this was discussed in the Clinical Working Group and was thought to be a less safe option, given the

risk that a consultant called to an emergency on one site could not then support an emergency at another site.

The South Yorkshire and Bassetlaw Integrated Care System, with North Derbyshire, agrees:

- At present we do not have five full out-of-hours areas, therefore, going forward as a system we will model moving to three or four rotas, and engage with our clinicians to ensure the concerns raised above are covered.

5.3.5 Stroke

The HSR did not propose any reconfiguration proposals for stroke services, as changes were already underway through the work on hyper-acute stroke units. The South Yorkshire and Bassetlaw Integrated Care System, with North Derbyshire, agrees:

- We will further develop proposals for the collaborative working of stroke services through paired sites, between sites with a HASU and an ASU. Such a collaborative way of working could be supported through the stroke Hosted Network.
- We will develop standardised commissioning specifications for early supported discharge, inpatient rehabilitation, and transient ischaemic attack services.

5.4 Considerations in Relation to Reconfiguration

5.4.1 Sites in Scope

The HSR's reconfiguration recommendations were site agnostic, based on the collective availability of workforce and capacity across the South Yorkshire and Bassetlaw, and North Derbyshire (SDYBND) region relative to forecast activity levels and care quality requirements. Some organisations have wished to outline concerns about service change at an early stage.

At this point, the principles around potential reconfiguration require that all the possible options must be considered equally. As an immediate next step, we will lay out the approach that the system will take to defining the sites and options which will be modelled, in line with national guidance and statutory requirements around options development and options appraisal.

We confirm that the hospital sites included in the baseline for the reconfiguration modelling (i.e. sites where services might change) are:

- Barnsley Hospital
- Bassetlaw District General Hospital
- Chesterfield Royal Hospital
- Doncaster Royal Infirmary
- Northern General Hospital
- Royal Hallamshire Hospital
- Sheffield Children's Hospital
- Rotherham General Hospital.

The South Yorkshire and Bassetlaw Integrated Care System, with North Derbyshire, agrees:

- As a priority, the acute sustainability programme will work with CCGs, Trusts and Clinical Working Groups to develop site-specific reconfiguration options to be taken forward for more detailed modelling and analysis.

- As we take the work forward, all Trusts will be considered in the context of the site-specific modelling; and we have an open mind in relation to how they are included. The system may wish to designate some fixed points, based on permissible criteria and in line with guidance and precedent. There would be an agreed approach to determining any fixed points, with full engagement from system leaders, patients and the public.
- Refreshed hurdle and evaluation criteria will be used to assess these options to ensure that any proposals that are taken further meet robust quality and safety requirements, and provide equal access to care for patients across the region. We will engage with system leaders, patients and the public in refreshing and agreeing weightings for the evaluation criteria.
- We recognise the need to work closely with Derbyshire CCGs around the impact of any proposals affecting Chesterfield on the Derbyshire STP.

The options modelled will be in line with the approaches agreed above.

5.4.2 Trusts outside the ICS

It is possible that under some reconfiguration scenarios the nearest service for some of our patients will be outside of the SYBND footprint.

Sites that could potentially receive additional patients from the SYBND region include, but are not limited to:

- Calderdale Royal Hospital
- Dewsbury and District Hospital
- Huddersfield Royal Infirmary
- King's Mill Hospital
- Leeds General Infirmary
- Lincoln County Hospital
- Pinderfields Hospital
- Pontefract Hospital
- Scunthorpe General Hospital

In addition, some STPs outside SYBND are undertaking reconfigurations or service changes of their own, so some of the hospitals on our borders may be making changes which could themselves impact on the SYBND sites.

The system agrees the following:

Patients moving outside SYBND:

- We will model all the appropriate options, including those where patients might move to trusts outside SYBND.
- However, as we do this we will undertake due diligence around understanding any quality, safety and capacity issues at the potential receiving sites.
- In evaluating the options, one of the existing evaluation criteria is quality, and we will consider any implications of quality for patients receiving care from trusts outside SYBND. In the assessment of equalities, we will also consider the potential equality implications of

some patients receiving care at sites which are not signed up to the principles of the SYB Hosted Networks.

Proposed changes in neighbouring STPs

- The Review team is already in contact with the leads on reconfiguration in neighbouring STPs, and contacts with these leads will continue.
- As we develop the modelling for the SYBND reconfiguration options, we will include the implications of potential patient flows into SYBND caused by potential reconfigurations in our neighbouring health economies, where these are known.

5.4.3 Transport

Feedback from members of the public raised concerns around transport, and asked in particular that we ensure that we link to strategic planning around travel and transport across the footprint. We will invite the leads on transport issues in the key organisations responsible for designing transport across the region to our travel and transport group, so the transport strategy will be a focus going forward.

The South Yorkshire and Bassetlaw Integrated Care System, with Mid Yorkshire and North Derbyshire, agrees:

- We will model the potential impact on travel times due to reconfiguration. Within the travel time modelling we will look at blue-light emergency transport, and journeys through both private transport and public transport means.
- We will also conduct a postcode-level analysis to look at the impact on different socio-economic groups based on indices of deprivation data, to ensure that no groups are disproportionately affected by change.
- We will engage local partners to set up a strategic travel group as a priority. This group will comprise representation from local acute trusts, commissioning bodies, ambulance services (both Yorkshire and East Midlands Ambulance services), local authorities, patients and the public, and other relevant local travel and transport stakeholders (such as local public transport providers). The programme will engage this group regularly as options are developed and assessed. Clinical Working Groups will be engaged in a similar capacity to understand the safety implications of increased travel times in emergencies. In such a way the acute sustainability programme will ensure that options taken forward seek to minimise and mitigate any increase in travel. It will consider the issues around public transport, in both urban and rural areas.

5.4.4 Equalities and the Equalities Impact Assessment

Ensuring equitable access to high quality care has been raised as an issue by patients and the public, and is a priority for the programme. A core aim of the Review was to address health inequalities, and this will be at the heart of modelling, and assessing our options, going forward.

The South Yorkshire and Bassetlaw Integrated Care System, with Mid Yorkshire and North Derbyshire, agrees:

- We will ensure the completion of an equalities impact assessment to inform any future proposals.
- This will be supported by quantitative modelling that seeks to identify any potential impact on patients, broken down into demographic groups, to understand and assess the impact on different groups in society. We will look at the impact on the protected groups (as identified

in the Equalities Act), as well as issues around socioeconomic inequalities which we will identify through postcode analysis.

- The programme will continue to engage with a wide range of stakeholders, including a particular focus on seldom heard groups, to hear and understand their views and concerns to ensure that their feedback is taken into consideration.
- The evaluation of options against evaluation criteria will include an assessment of impact on equalities, through the access criterion, as well as the separate Equalities Impact Assessment.

5.4.5 Affordability

Financial analysis was undertaken to understand the cost-benefit and affordability of any of the high-level reconfiguration options. Consideration was made of both any impact on trust operating expenditure and any capital cost requirements. Transition costs were also taken into account. The financial impact of each option was considered as one of the evaluation criteria in the HSR, and will continue to be so in any future appraisal of site-specific options.

More detailed modelling to fully understand financial impacts on providers and commissioners of site-specific reconfiguration options will be conducted in the next phase of work.

One response from the public raised concern about the level of modelling done to date querying whether data from all trusts had been used in the modelling, and cited the 'limitations' section in the financial annex of the report. We confirm that data from all trusts (reference costs and STP forecasts) was used to inform the analysis that underpins the HSR. The 'limitations' point relates specifically to the fact that at the time of writing only Barnsley had contributed service line reporting (SLR) data; not all trusts collect SLR data. A detailed response to the concerns raised by the member of the public is provided in **Annex A – Responses to HSR Feedback**.

The financial analysis published alongside the HSR used the data available at the time that the modelling was developed. Several trusts made more detailed data on activity available shortly before publication, and this was used to update workforce projections. However the updated data was made available too late to be included in the capacity and financial data, so an updated analysis is attached as an Annex to this Strategic Outline Case in **Annex E – Addendum to HSR Financial Modelling**. The changes are marginal (the greatest change to cost implications in any scenario is £1.3m, with most changes being £0 to £300,000) so the updated data made no impact on the final recommendations.

5.4.5.1 Operating costs analysis

Baseline trust provider costs for 2021/22, before any configuration changes, were taken from STP (now ICS) plans, which included assumptions around the impact of cost improvement programmes (CIPs), out-of-hospital schemes, and other service changes.

Various financial impacts were analysed:

Workforce efficiencies were quantified, whereby savings could be realised from the reduction in locum usage, given the decreased requirement for certain groups of staff following consolidation. Another key source of workforce efficiencies was that it might be possible to increase service coverage with fewer additional full time equivalents, relative to the current configuration. Changes to service models might also result in financial impacts: for example, new delivery models such as urgent treatment centres could be used to take activity out of A&E. Shifting additional care out-of-hospital, where appropriate, was another driver of cost impact.

Fixed cost savings were quantified to recognise a partial offset for new build costs. This was linked to changes in bed capacity when any activity shift led to new build costs.

These reductions in operating expenditure were balanced against any increased capital expenditure, with the revenue cost of any required capex phased equally over a 10-year period. More detail on the approach to quantifying capital costs is set out below.

Future stages of modelling will use more accurate trust costing data and work with commissioners and providers to quantify any associated impact on operating income.

5.4.5.2 Capital costs analysis

Capital costs were quantified on the basis of requirements for additional bed build at sites receiving additional activity. If the receiving site has no spare space, the incoming bed would be by necessity a new build. If the receiving site has spare space but not in the same department, the spare bed would need to be refurbished, for c. 50% of new build cost. If the receiving site has spare space in the same department, the incoming bed could be accommodated for no cost.

6 CAPITAL FUNDING

As part of the national process for prioritising STP/ICS capital, the ICS has completed a draft Estate Strategy and associated capital bids which include a range of schemes designed to deliver clinical, estate, patient quality and experience and workforce benefits across the system as a whole; including identifying an estimated future capital requirement associated with the final report of the HSR published on 9 May 2018.

HSR modelling on capital costs focused on the cost of moving activity and associated bed build. However, more detailed modelling in the next phase of work may draw out more granular capital needs, such as for technology and digital infrastructure, costs of which were accounted for in the capital bid.

At the point at which the system was required to submit bids for the next five years, HSR had not yet been fully considered by the system, and this Strategic Outline Case was still in development. On the advice of NHS England, therefore, South Yorkshire and Bassetlaw included a placeholder bid for capital related to the HSR, using a mid-range scenario from the modelling undertaken from the HSR. This bid will, obviously, only be pursued in the event that the system agrees to take forward reconfiguration, following public involvement and, if needed, consultation, and therefore the capital is required.

The ICS's total capital bid is comprised of five component workstreams as follows. The HSR reconfiguration element is 1e below. Note that, rather than including either the highest or the lowest level of costs identified in the HSR modelling, the scenario used here is a middle range which involves changes to one large and one small site for maternity and paediatrics.

ICS Initiative/ Clinical Workstream	Physical assets obtained:	Phasing of workstreams:	Capital Required:
1a System Sustainability – Primary and Community investment	Creation of additional capacity for delivering primary and community care services, training and development	Phase 1: Primary Care, Community, Mental Health, Digital and Linked Acute schemes can be delivered ahead of the HSR Strategic investment. As schemes are worked up and where change is considered significant, the ICS would be subject to NHS assurance processes, including potential public consultation and we would carry out our statutory duties.	£57m
1b – System Sustainability – Mental Health Investment	Creation of community crisis centre and reprovision of co-located services into new community hubs		£43m
1c – System Sustainability – Digital Investment	Introduction of a single, SYB-wide shared digital platform across a number of key services		£35m
1d System Sustainability – Linked Acute Schemes	Range of updated and improved clinical facilities across all acute providers (including removal of Nightingale wards, co-location of emergency services and the expansion of critical diagnostic services and key acute services)		£71m

ICS Initiative/ Clinical Workstream	Physical assets obtained:	Phasing of workstreams:	Capital Required:
1e System Sustainability – Strategic elements of HSR	Reprovision of 208 new beds across existing sites, to support the reconfiguration of key acute services across the ICS (subject to consultation). The scenario of 208 beds was identified as a mid-point between the maximum and minimum scenarios identified within the Hospital Services Review. It is an indicative figure at this point.	Phase 2: the HSR implementation could be completed alongside the Phase 1 workstreams. As the scheme is subject to NHS assurance processes, including potential public consultation, it is anticipated that a number of the Phase 1 schemes would already be completed if the scheme went ahead.	£99m

In addition, two further capital bids have been submitted around ensuring the sustainability of facilities that support acute services at Doncaster and Bassetlaw Hospitals and an ICS-wide Cancer Strategy.

The Doncaster and Bassetlaw work predominantly looks at improvement of emergency care services and improvement of services at Doncaster Royal Infirmary. We will work with the Trust on any areas that might impact or be impacted by the hospital services workstream.

In relation to the ICS-wide Cancer Strategy, the capital bid would cover potential improvements to sites and facilities across South Yorkshire and Bassetlaw. As with the HSR, any changes would be subject to engagement and, if necessary consultation with the public.

7 NEXT STEPS

This Chapter outlines the next steps being undertaken by the system to deliver the recommendations of the HSR, as per the agreed way forward detailed earlier in this Strategic Outline Case.

7.1 SERVICE LEVEL COLLABORATION

Developing Hosted Networks:

- Agree a framework for all the Hosted Networks, at a system-wide level;
- Establish criteria as to what responsibilities a trust must be able to meet in order to be a host;
- Define the responsibilities of the Hosts and Members;
- Agree how this links to the ICS structures;
- Agree which trusts will lead on each of the Networks; and
- Establish the Hosted Networks

7.2 SYSTEM LEVEL COLLABORATIVE WORKING

Develop Institute of Health and Care: covering Workforce

- Agree the objectives, structures, funding and governance of the Institute; and
- Agree how it will relate to the trusts and how it will support the work of the Hosted Networks
- Establish the Institute of Health and Care

Develop Innovation Hub: covering Innovation

- Agree the geographical footprint of the innovation hub, who are its members, and how it relates to the Institute of Health and Care (whether it is part of the same organisation or a separate one);
- Agree the objectives, structures, funding and governance of the Institute; and
- Agree how it will relate to the trusts and how it will support the work of the Hosted Networks
- Establish the Innovation Hub

7.3 SERVICE TRANSFORMATION

Transformation of clinical models and workforce roles:

- Engage Clinical Working Groups and Health Education England, and other workforce committees, to develop new clinical models and new workforce models to ensure that we are making the best use of our staff; and
- Ensure that any reconfiguration modelling takes account of these new clinical models.

Supporting the out-of-hospital strategy:

- The strategy for Out of Hospital care is being developed in the ICS in partnership with its five places identifying pathways in the core acute areas which would shift into primary or

community care, and the workforce / capital / financial implications of this shift of activity whilst the acute sustainability work develops.

7.4 RECONFIGURATION

Develop specification for modelling:

- Develop the specification of what the modelling needs to be able to model for financial, activity, workforce and access data;
- Agree what data sources, at what levels, are required for this; and
- Agree how the modelling will relate to the requirements of the Equalities Impact Assessment.

Agree evaluation criteria:

- Refresh the existing evaluation criteria to ensure that they are still fit for purpose and to address any gaps; and
- Engage the public and stakeholders on the weighting of evaluation criteria

Agree shortlist of options to be modelled:

- Develop the shortlist of options around the modelling, including identifying any 'fixed points' i.e. sites or services which would self-evidently not change, and all the possible combinations of the remaining sites.
- Engage clinicians on the proposed shortlist of options for modelling; and
- Engage patients and the public on the proposed shortlist of options for modelling

Model shortlisted options:

- Collect the relevant data, build the model using information around the transformed workforce developed by the Clinical Working Groups, and run the agreed options through the model. This will be iterated multiple times to ensure that the data is genuinely robust and reliable.

Agree preferred option(s) to be considered for consultation:

- Evaluate the outcomes of the modelling against the evaluation criteria: this will need to involve patients and the public as well as stakeholders across the system; and
- Identify a shortlist of preferred option(s) which are likely to be included within the Pre-Consultation Business Case, based on the outcomes of the evaluation process

Produce Pre Consultation Business Case:

- Engage with the Joint Health Overview and Scrutiny Committee to confirm if any elements of the proposed changes require formal public consultation (see below);
- Draft Pre-Consultation Business Case;
- Submit to NHS England for assurance (see below)

7.5 PUBLIC CONSULTATION AND ENGAGEMENT

The development of the HSR has included a significant level of public and clinical engagement. Going forward, we will build on this to ensure that clinicians, members of staff, patients and the public have as many opportunities as possible to be involved.

Respondents acknowledged the engagement that had been done to date, with clinicians, nurses, midwives, other healthcare professionals, the public and patients. However, several respondents felt more should have been done. Some respondents felt that the HSR had not yet engaged sufficiently with local authorities, and specifically their elected members.

Engagement with seldom heard groups was acknowledged as positive of the work to date and the acute sustainability programme will continue to do so in any future phases of work.

Future next steps include:

- **A detailed Engagement Plan**, to include the approach to involvement, will be developed by the ICS Communications team, in collaboration with the PMO for the acute sustainability work. It will be shared with the SYB ICS Citizens' Panel and Joint Health Overview Scrutiny Committee for comment and signed off by the Sustainable Acute Services Steering Group, and by the Collaborative Partnership Board. This will ensure that patients and the public have their say on proposals at all stages of development and will seek to engage people from all areas of the region.

- **Clinicians**, other healthcare professionals and other staff groups within services will continue to be engaged through the reconstitution of the Clinical Working Groups (see below). These will meet on a regular, scheduled basis and will be a key forum in which the programme will shape and develop any options for modelling and evaluation, actively seeking their expertise in the subject and knowledge of SYBMYND and its population.

- **Engagement with patients and the public**: The approach will be outlined in the engagement strategy. In summary, the acute sustainability programme will continue to engage regularly through the ICS Citizen's Panel, CCG Engagement Groups (including Patient and Partnership Groups), provider Trust Engagement groups and other relevant forums, such as Healthwatch, voluntary sector groups, local Maternity Voices Partnerships.

  Several large engagement events will also be held throughout this next phase of the Review, which will be specific to this programme of work. As respondents have pointed out, as proposed modelling work progresses, the nature of engagement will become more specifically related to changes to individual sites and services, whereas it has tended thus far to relate to broader discussion of concepts. Involvement will be frequent and regular to ensure clarity and transparency around proposals as they develop. We will also build upon the learning from previous consultations undertaken by our and other systems, to ensure relevant experience informs our work.

- **On travel and transport**: a specific patient and public group will be convened to focus on the transport and travel implications of any service change proposals. This will support a clinical and operational group on transport and travel.

- **Engagement with Local Authorities**: Whilst the HSR engaged with the Joint Health Overview and Scrutiny Committee, and will continue to do so, the programme will seek to strengthen moving forward. The Review team will engage with Directors of Public Health and Health and Wellbeing Boards on the hospital services workstreams, such as working with them as the modelling is developed to ensure that population data is accurate. More generally, the system partners will engage with Local Authorities, including Leaders, around the development of shared working across the system.

- **Formal Public Consultation**: If required, a formal public consultation plan will be developed and published alongside any pre-consultation business case, detailing plans to consult with all of the stakeholders in the SYBMYND health economy. We will actively seek comment on proposals from commissioners, trusts, healthcare staff, patients and the public, local authorities and others in order to inform any service change decision.

7.6 ASSURANCE OF THE PROPOSALS

As well as significant engagement with system stakeholders, patients and the public, proposals will undergo regulatory assurance processes with national NHS bodies:

Clinical Senate sign-off of proposals:

- The North West Clinical Senate will be asked to formally review options which require clinical changes to ensure that they are robust

NHS England assurance of proposals:

- The system will submit all proposals to NHS England for formal assurance as required

7.7 GOVERNANCE

The HSR was an independent review. Therefore, while its governance aimed to ensure that all the member organisations were closely involved in and sighted on the work, its governance reflected its Terms of Reference.

Going forward, the HSR ceases to be an independent review, and will become one of the workstreams of the ICS. The name of the programme, and its governance, need to reflect this.

Going forward, the health and care economy as a whole is going to need to develop appropriate governance to support the ICS and its partners. This will need to respect the existing statutory framework, while allowing for streamlined decision making in the integrated structure.

The HSR made a recommendation around ensuring that the governance is appropriately streamlined going forward, within the current statutory framework:

"The current arrangements between providers are unlikely to be fit for purpose when considering the scale of change that is included in this report. SYBMYND should review current governance arrangements and ensure these enable rapid decision making at pace to support the successful implementation of the recommendations in this report"

One member of the public raised a question around whether the governance was appropriate, and cited the point made in the review about the current arrangements between providers. They also expressed a query about the maintenance of statutory duties and lines of accountability in the any arrangements. It should be clarified that all commissioners will retain and perform their statutory duties, with providers and associated bodies held to account through any contracts held with the CCG(s).

Going forward, the workstream taking forward the recommendations of the HSR will be known as the Hospital Services programme (subject to agreement from our Citizen's Panel and other public stakeholders that this phrase is easily understood).

The governance will continue to recognise the need to involve all trusts and CCGs, and other core stakeholders, and the need for strong leadership. All relevant organisations should continue to be equitably and appropriately represented in the governance of the programme.

The governance will be formally laid out in, and signed off as a part of the Terms of Reference for the sustainability of acute services work going forward. However in summary we propose the following arrangements.

Programme Governance:

- **A Hospital Services Steering Group.** Stakeholder organisations agreed (in the Joint Committee of Clinical Commissioning Groups (JCCCG) and Collaborative Partnership Board) that we should maintain and expand the HSR Steering Group. The Steering Group will be a dedicated clinical and operational group at executive level, which will oversee the

development of the hospital services work and be accountable for delivery of the work programme within organisations. It will play a key role in the evolution of Review process, including the development of reconfiguration options and robust evaluation and appraisal frameworks.

The Steering Group (SG) is likely to bring together Medical Directors and operations executives from acute trusts, CCG Accountable Officers, senior leads from the community and mental health trusts and the Yorkshire Ambulance Service, and NHS England.

Moving forward, it is proposed that there should be designated sub-committees under the SG, such as a strategic travel group and a data and modelling group. Respondents were keen to ensure that they were represented on these groups and the membership of these groups will be confirmed in the Terms of Reference.

- **Clinical Working Groups** (CWGs) will bring together clinicians, nurses, and operations directors, and other healthcare professionals from the acute trusts, to advise on the development and evaluation of any proposals. Community and mental health services, primary care and commissioning representatives will also sit on CWGs to ensure the perspectives of the different clinical sectors are heard.
- **The Collaborative Partnership Board** (CPB) will have formal oversight of the programme for the ICS.

Statutory and Delegated powers:

- **The Boards and Governing Bodies of the trusts and CCGs** will be responsible for formal sign-off of proposals, since at this point they are the organisations which are statutorily accountable. These groups include Non-Executive Directors.

  Ultimately, statutory powers around decision making on service change rest with the CCGs, who will sign off and lead any consultation on service change.

- **The Joint Committee of Clinical Commissioning Groups (JCCCG), Committees in Common (CIC) for the acute trusts, and the ICS Executive Steering Group** do not currently have any formal delegated powers around this workstream but will continue to oversee and advise on direction.

  However, as part of work to develop the Integrated Care System, we are seeking to develop the governance of the system, within the existing statutory framework. The arrangements above may therefore evolve during the course of the programme if any changes are agreed to the delegated powers of the JCCCG and CIC.

External scrutiny:

- **The Joint Health Oversight and Scrutiny Committee** (JHOSC) will continue to exercise its formal powers of scrutiny. Further governance arrangements involving Local Authorities may evolve.
- **NHS England**: The programme is committed to adhering to formal NHS England Gateway processes, and will undertake these in a managed and scheduled way. There will continue to be NHS England representation at SG. The ICS will also submit developing proposals to the Northern England Clinical Senate for feedback on emerging proposals at the appropriate time.

8 TIMELINE FOR DELIVERY

The following section lays out the timeline for delivery of the work programme above, as well as the proposed arrangements for public engagement and governance.

8.1 HIGH LEVEL TIMELINE

The next phase of work, including the development and evaluation of site-specific options, will commence in earnest in October. Engagement with staff, patients and the public will be ongoing throughout the timeframe of the review, with plans aiming to launch a formal consultation on detailed, developed options in the early autumn of 2019 (if required).

Both Trust Boards and CCG Governing Bodies flagged the timeline of the next stage of work as something on which they would like further assurance. Organisations emphasised that decisions on change need to be made and delivered with enough pace to not prolong uncertainty for staff, while allowing sufficient time to fully consider the implications for staff, patients, and the public.

8.1.1 Agreed way forward

The timeline for delivery will be partly dependent on external factors, over which the health system has limited control. However, the intention is that we should follow the following timeline for reconfiguration work:

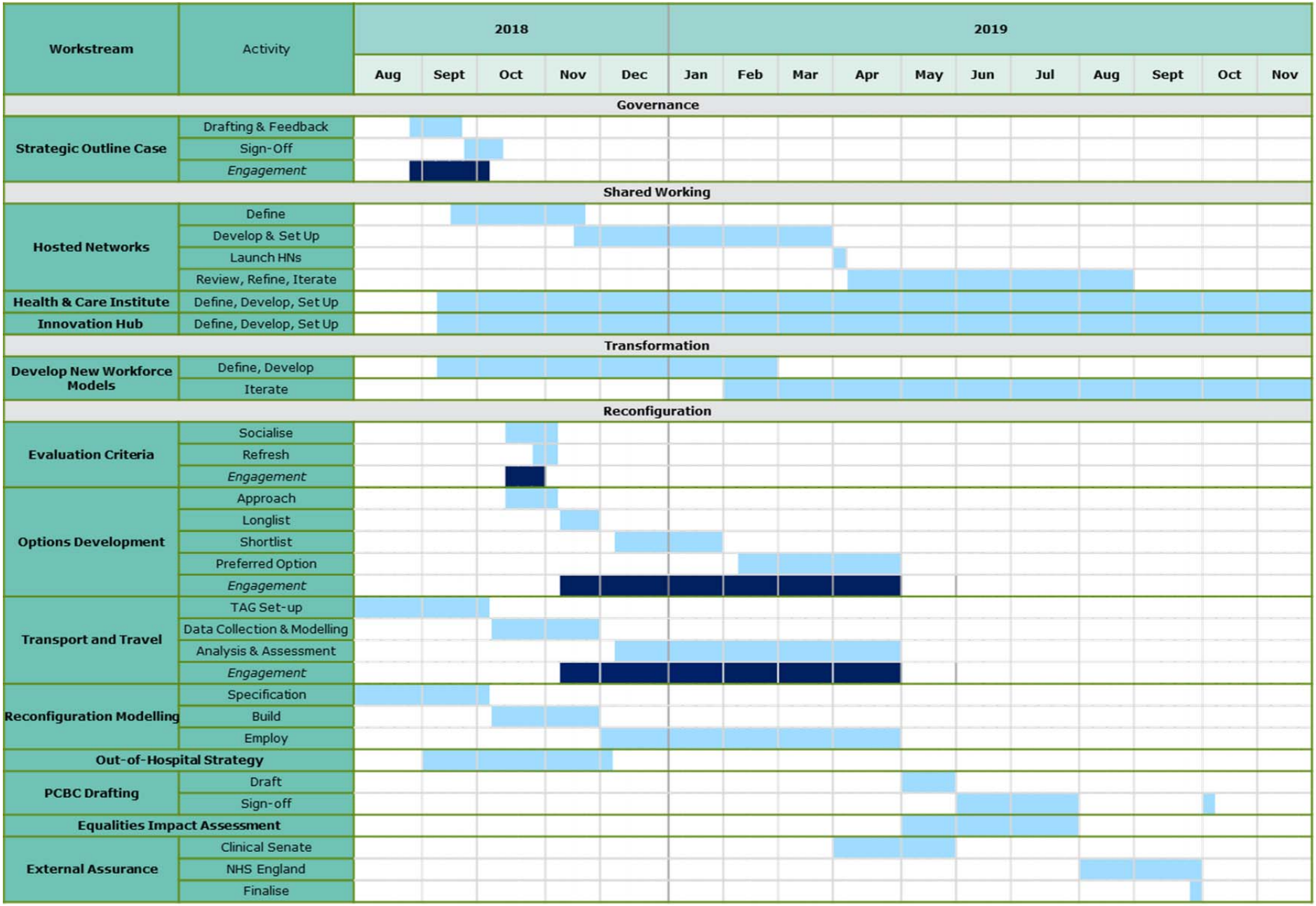
- September 2018: SOC discussed in public session at Trust Boards and CCG Governing Bodies. Governing Bodies sign off SOC under their statutory responsibilities for service change
- October 2018: Sign-off SOC at the Collaborative Partnership Board
- October – February 2018: prepare and model site-specific options; engagement with Clinical Senate and JHOSC, and ongoing public engagement
- February – October 2019: agree preferred option(s) for the pre consultation business case, if required, with public engagement; NHSE assurance process; engagement with JHOSC; draft PCBC;
- October 2019 –January 2020: public consultation on options, if required
- December 2020 onwards: Develop a Decision Making Business Case if required

Shared working plans for the establishment of Hosted Networks will be advanced alongside reconfiguration works, with a proposed timetable as follows:

- September – October 2018: Set up a programme to design and oversee implementation; agree the framework for a Level 1 network, its priorities and scope
- November – December 2018: Agree principles of engagement; appoint leads / hosts for the networks
- December 2018 – January 2019: Agree detailed requirements (including SLAs) of the leads / host
- February – March 2019: Design accountability framework; design governance and contractual arrangements
- 1st April 2019: Launch Hosted Networks

Alongside these streams of work there will be a parallel stream on transformation to develop new ways of working across the system, in conjunction with Health Education England, various groups of healthcare professionals, patients and the public.

An indicative timetable laying out the key milestones for the programme is detailed below.


Workstream
Activity
2018
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Aug
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Nov
Governance
Strategic Outline Case
Drafting & Feedback
Sign-Off
Engagement
Shared Working
Hosted Networks
Define
Develop & Set Up
Launch HNs
Review, Refine, Iterate
Health & Care Institute
Define, Develop, Set Up
Innovation Hub
Define, Develop, Set Up
Transformation
Develop New Workforce Models
Define, Develop
Iterate
Reconfiguration
Evaluation Criteria
Socialise
Refresh
Engagement
Options Development
Approach
Longlist
Shortlist
Preferred Option
Engagement
Transport and Travel
TAG Set-up
Data Collection & Modelling
Analysis & Assessment
Engagement
Reconfiguration Modelling
Specification
Build
Employ
Out-of-Hospital Strategy
PCBC Drafting
Draft
Sign-off
Equalities Impact Assessment
External Assurance
Clinical Senate
NHS England
Finalise

9 GLOSSARY

Term	Definition
A	
A&E	An accident and emergency department provides acute care for patients who arrive without prior appointment either by their own means or by ambulance and who have medical or surgical conditions that are likely to need hospital admission. They are typically open 24 hours a day, seven days a week.
Acute Care	Urgent short-term treatment - usually in a hospital - for patients with a new injury or illness or for patients with an existing condition that is worsening.
Acute Stroke Unit (ASU)	An acute neurological ward providing specialist services for people who have had a stroke. Patients are cared for in an intensive model of care with continuous monitoring and high nurse staffing levels. Typical length of stay may be up to 7 days. Patients are typically admitted to a Hyper-Acute Stroke Unit (HASU) for immediate emergency treatment before transfer for an ASU for ongoing care.
Acute Trust	NHS acute trusts manage hospitals. Some are regional or national centres for specialisms. Others are attached to universities and help to train clinicians. Some may also provide community services.
Advanced clinical practitioner (ACP)	An experienced, registered health and care practitioner with a Master's level award or equivalent that encompasses the four pillars of clinical practice, leadership and management, education and research, with demonstration of core capabilities and area specific clinical competence. ACPs undertake a level of practice characterised by a high degree of autonomy and complex decision making. Specific roles include Advanced Nurse Practitioner (ANP) and Advanced Therapy Practitioner (ATP). Delegating responsibilities to these roles reduces the burden on other clinicians.
Alternative workforce	This general term refers to roles for healthcare professionals that are 'non-traditional' and generally support or augment the work done by clinicians such as doctors and nurses. It encompasses Physician Associates, advanced clinical practitioners and support roles.
Antenatal Care	Care of women during pregnancy up to their going into labour by various healthcare professionals to ensure that mother and baby are as healthy as possible during pregnancy. This care also includes education, advice and support to make sure the mother is ready for labour.
C	
Care outside hospital	Care that takes place in a community setting. This could be a patient's home or community health centre.
Clinical Commissioning Groups (CCGs)	These are the health commissioning organisations that replaced primary care trusts (PCTs) in April 2013. CCGs are led by GPs and represent a group of GP practices in a certain area. They are responsible for purchasing healthcare services in both

	community and hospital settings.
Clinical governance	A framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.
Clinical interdependencies	Where some clinical services need other clinical services to be based on the same site for particular types of care to be successfully and safely delivered.
Clinical pathway	A clinical pathway is a template or blueprint for a plan of care for a specific speciality or condition. It is a guide to best practice treatment patterns, but does not replace the need for clinical judgement in meeting an individual's needs.
Clinical protocol	The detailed outline of the steps to be followed in the treatment of a patient with a particular condition.
Clinical Reference Group (CRG)	A group of clinicians and healthcare professionals convened to agree on and develop a specific clinical process, protocol or standard. The group is typically governed by a Terms of Reference and is part of a wider framework such as a Hosted Network.
Clinical Working Group (CWG)	A group comprised of clinicians, nurses, allied health professionals and other healthcare professionals from a specific service in the scope of the HSR. The primary purpose of the CWGs was to bring together members of staff from across SYB(MYND) to discuss service challenges, best practice and potential solutions, as well as to provide input and feedback into the review process.
Committees in Common (CiC)	A sub-committee of multiple committees with an agreed level of delegated decision-making rights on behalf of each committee. There must be clear terms of reference and reporting lines back to each committee.
Community Midwifery-led Unit / Birth Centre	A form of standalone midwifery-led unit providing prenatal, midwifery and postnatal services to predominantly low-risk mothers (see SMLU).
Community services	A wide range of non-emergency services provided closer to home at community facilities including local health centres and GP practices. Some may be provided by social care services.
Consultant-led obstetrics units	An obstetric unit with consultant presence, providing maternity and obstetric care to mothers, with the capacity to deal with a broader range of complications and conditions than a midwifery-led unit.
D	
District General Hospital (DGH)	Typically, the major healthcare facility in its locality with services that may include maternity, ED, acute medicine, surgery and a range of outpatient care. It may also provide some specialist facilities for care such as specialist surgery but does not cover all specialist services.
E	
Early supported discharge (ESD)	An intervention for adults after a stroke that allows their care to be transferred from an inpatient environment to a community setting. It enables people to continue their rehabilitation therapy at home, with the same intensity and expertise that they would

	receive in hospital.
Elective care	Treatment that is planned in advance because it does not involve a medical emergency.
Emergency care	Treatment for acute medical and surgical emergencies that may need admission to hospital. This includes severe pneumonia, diabetic coma, bleeding from the gut, complicated fractures that need surgery, and other serious illnesses.
Emergency Department	An acute hospital department responsible for the delivery of emergency medicine and care, providing treatment to patients arriving at hospital with an immediate care requirement. Accident and Emergency is a form of ED.
Engagement	The measurable degree of a stakeholder or patient's positive or negative involvement with the NHS, which influences their willingness to take part in NHS issues. In the context of the HSR, it refers to the involvement of different stakeholders to gather views, feedback and recommendations.
Evaluation criteria	A series of questions and factors to test options against to determine whether they are suitable and optimal for their intended purpose. Evaluation criteria have been agreed and used in the HSR to test service reconfiguration options.
F	
Facing the Future	*Facing the Future: Standards for children with ongoing health needs*[3] are a set of standards that focus on ensuring prompt and correct diagnosis, improving the long-term care and management of children in healthcare services. These standards were developed jointly by the Royal Colleges for Paediatrics and Child Health, General Practitioners, Nursing, Physicians and Psychiatrists.
Flexible working	The ability for clinicians and other healthcare professionals to work across multiple sites in networked system of care.
Foundation Trusts	NHS foundation trusts (FTs) are NHS organisations that run acute, community or mental health hospitals. They differ from non-foundation trusts in that they have greater financial autonomy and therefore more freedom to decide their own plans and the way local services are run. Foundation trusts have members and a council of governors.
Function	In the context of the HSR, 'function' refers to specific operational and management processes and is used as a generic term. It does not refer to statutory functions of NHS bodies (such as commissioners) unless explicitly stated.
H	
Hospital Services Review (HSR)	The programme to review the shape and nature of acute hospital services across SYB(MYND), culminating in this report. The HSR was commissioned by SYB commissioners on behalf of the partners in the SYB STP.
Hosted Network	A clinical network between acute trusts where a host trust provides leadership and coordination to support a system-wide approach to: workforce deployment and development; the adoption of standardised clinical guidelines; and the spread and

[3] Facing the Future, Royal College of Paediatric and Child Health, available online at https://www.rcpch.ac.uk/sites/default/files/page/Facing%20the%20Future%20Together%20for%20Child%20Health%20final%20web%20version.pdf

	adoption of innovation and best practice.
Hub	A setting for care outside hospital where patients are brought together for treatment also serving as a base for local healthcare teams. The services offered will vary depending on local needs and will range from bases for multidisciplinary teams to 'one-stop' centres for GP services, diagnostic and outpatient appointments.
Hyper Acute Stroke Unit (HASU)	Hospital wards that specialise in treating people who have had a stroke. A dedicated unit that gives all stroke patients access to the most up-to-date treatments and latest research breakthroughs during the first 72 hours after a stroke: swift action can reduce levels of disability and, in some cases, may even eradicate symptoms completely. Patients will typically be transported to a Hyper Acute Stoke Unit for initial emergency treatment before later being transferred to an ASU for ongoing care and therapy.
I	
Integrated Care System (ICS)	A partnership of NHS organisations, including providers and commissioners that collaborate to provide healthcare in a region in a close and coordinated manner. Member organisations take collective responsibility for managing resources, delivering NHS standards and improving the health of the population they serve.
J	
Joint Committee of Clinical Commissioning Groups (JCCCG)	A collective committee made up of representation from clinical commissioning groups (CCGs) in SYB.
L	
Lead / prime provider	A trust within a Hosted Network from which services are commissioned, which then sub-contracts service delivery to other trusts within the network. The lead / prime provider holds other providers to account for outcomes and for adoption of clinical protocols and pathways.
M	
Midwifery	The profession which leads on normal pregnancy and birth and provides expert care to mother and baby during pregnancy, childbirth and the postnatal period within a family centred environment.
Midwifery Led Units	Units run by midwives that can either be run alongside a main hospital maternity unit (AMLU) or completely standalone from hospital (SMLU). MLUs are ideal for handling births with no complications. Women facing complications may be advised to give birth at a consultant-led maternity unit.
N	
Neonatal Unit	A unit of a hospital that provides care and treatment of new-born babies who are too sick to be cared for by their mothers.
Networked services	The coordinated provision of care within a particular specialty across a number of providers or sites in a region. Different elements of care may be provided at different

	sites, requiring patient transfer to the appropriate care location.
Nurse Practitioner	An Advanced Practice Registered Nurse who has completed graduate-level education (either a Master of Nursing or Doctor of Nursing Practice degree). Nurse Practitioners treat both physical and mental conditions independently including prescription of select medications.
O	
Obstetrics	The medical speciality dealing with the care of pregnant women and their babies during pregnancy, childbirth and the postnatal period.
P	
Pairing	Two trusts working closely together to deliver an agreed set of joint functions. This may include coordination of staff and resources across the two sites, supported by appropriate contractual arrangements.
Physician Associate (PA)	Physician associates are medically trained, generalist healthcare professionals, who work alongside doctors and provide medical care as an integral part of the multidisciplinary team. Physician Associates work with a dedicated medical supervisor, but are able to work autonomously with appropriate support.
Place	The term used in the SYB STP plan for the main areas and their healthcare organisations that make up the SYB footprint. These are Barnsley, Bassetlaw, Doncaster, Rotherham and Sheffield. They encompass health and social care providers, in acute and community settings, as well as commissioners, local authorities and other key stakeholders in an area based around key population centres.
Place Plans	Statements that set out the vision, ambitions and proposed direction of travel for the design and delivery of health and care services in a Place. These plans are generally produced by commissioners of health and care services, usually in cooperation with service providers.
Primary care	Primary care services provide a first point of contact in the healthcare system for many patients, acting as the 'front door' of the NHS. Primary care includes general practice, community pharmacy, dental, and optometry (eye health) services. Patients may be treated in this setting or referred for onward treatment in a different setting (such as secondary or tertiary care).
R	
Reconfiguration	The rearrangement of the location and type of clinical service provided across a given area. It may include transferring the provision of different service components between acute providers, as well as transfer of some care to alternate settings such as the community.
Referral	The process whereby a patient is transferred from one professional to another, usually for specialist advice and/or treatment.
Rotations	The formalised process of organising for staff to work across multiple sites or services in a routine way. It may be used to facilitate provision of services in multiple locations or to support staff development and training.

Royal Colleges	The Royal Colleges are professional organisations for doctors, nurses and allied health professionals. In general, they have a vision of improving, maintaining and promoting standards of care within the specialist area which they cover. They work jointly to develop policy on some issues and work closely with other organisations and associations that have similar objectives. They promote education and research in their respective fields.
S	
Secondary care	Specialist healthcare usually provided in hospital after a referral from a GP or other health professional.
Seldom heard groups	'Seldom heard' is a term used to describe groups who may experience barriers to accessing services or are under-represented in healthcare decision making. Traditionally, some of the groups identified in engagement activities include rural communities, black and minority ethnic (BME) groups, gypsies and travellers, lesbian, gay, bisexual and transgender, asylum seekers and refugees and young carers. However, teenagers, employees, people with mental health issues and many others may also be considered as seldom heard, since they may not find it easy to engage with traditional methods of public engagement.
Sentinel Stroke National Audit Programme (SSNAP)	The Sentinel Stroke National Audit Programme (SSNAP) aims to improve the quality of stroke care by measuring both the structure and processes of stroke care against evidence based standards. These standards are informed by the National Clinical Guideline for Stroke, and national and local benchmarks.
Short Stay Paediatric Assessment Unit (SSPAU)	A facility within which children with acute illnesses, injuries or other urgent referrals (from GPs, community nursing teams, walk-in centres, NHS Direct and emergency departments) can be assessed, investigated, observed for a short period of time and treated without recourse to in-patient areas. May be co-located with ED.
Single service model	A network where care is delivered directly by the lead trusts and responsibility for patient care and clinical governance rests with that lead trust. Staff and resources are paid for and managed directly by the lead trust and activity is commissioned directly from the lead trust.
South Yorkshire and Bassetlaw (SYB)	SYB refers to the more specific region within SYB(MYND) that covers acute trusts which will be members of the SYB shadow Integrated Care System, as well as the footprint of SYB Sustainability and Transformation Plan.
South Yorkshire and Bassetlaw and North Derbyshire (SYB(ND))	SYB(ND) refers to the area within scope of this review (see SYB(MYND)), excluding Mid Yorkshire. It may be used to refer to recommendations on reconfiguration of services, in which Mid Yorkshire Hospitals NHS Trust is not included.
South Yorkshire and Bassetlaw Integrated Care System (SYB ICS)	SYB is one of the first and largest Integrated Care Systems. An ICS brings partner organisations closer together, taking further responsibility for finances in return for greater flexibility in delivering NHS services. ICSs are in shadow form and due to go into operation at the beginning of 2018/19 financial year. The shadow period refers to the period before the full operation of the ICS, during which the system will develop and gradually implement the governance, structural and financial arrangements required to 'go live' as an integrated care system.
South Yorkshire and	SYB(MYND) refers to the area serviced by acute trusts within the scope of this review.

Bassetlaw, Mid Yorkshire and North Derbyshire (SYB(MYND))	There are seven acute trusts in SYB(MYND): Barnsley Hospital NHS Foundation Trust, Doncaster and Bassetlaw Hospitals NHS Foundation Trust, Rotherham NHS Foundation Trust, Sheffield Children's NHS Foundation Trust, Sheffield Teaching Hospitals NHS Foundation Trust, Chesterfield Royal Hospital NHS Foundation Trust, and Mid Yorkshire Hospitals NHS Trust.
Standalone Midwifery Led Units (SMLU)	Maternity units that are led and staffed by midwives without consultant presence, in a setting that is unattached to a hospital. They generally provide prenatal, midwifery and postnatal care to lower risk mothers. They may be in community settings and are sometimes called Community Birth Hubs or Centres.
Sustainability and Transformation Plan (STP)	Five-year plans covering all aspects of NHS spending within a given geographical footprint. STPs have a broad scope in planning healthcare, including: improving quality and developing new models of care; improving health and wellbeing; and improving efficiency of services. STPs are developed by Sustainability and Transformation Partnerships, made up of NHS organisations and local councils. The SYB STP has now become an Integrated Care System (see ICS).
T	
Tertiary care	Highly specialised treatment such as neurosurgery, transplants and secure forensic mental health services.
U	
Unwarranted clinical variation	Variation that cannot be explained by the condition or the preference of the patient; it is variation that can only be explained by differences in health system performance
Urgent Treatment Centre (UTC)	Urgent care centres designed as an alternative to ED departments for patients with less severe, non-emergency conditions. Often co-located with EDs with patients triaged and streamed at the front door, and equipped to diagnose and deal with many of the most common patient conditions. May also be standalone at sites without an ED.
W	
Whole-time equivalent (WTE)	Whole-time equivalent is a unit that indicates the workload of an employed person (or student) in a way that makes workloads or class loads comparable across various contexts. For medical staff, it generally refers to 10 programmable activities per week of resource.

South Yorkshire and Bassetlaw, Mid Yorkshire and North Derbyshire: Hospital Services Programme

Strategic Outline Case Annex A:

Response to stakeholder feedback on the recommendations of the Hospital Services Review

CONTENTS

1 INTRODUCTION

The South Yorkshire and Bassetlaw, Mid Yorkshire and North Derbyshire (SYBMYND) Hospital Services Review was published on May 10th 2018. Stakeholders were asked to respond to the recommendations of the Review by 12th July 2018.

The Boards of the acute trusts, and the Governing Bodies of the Clinical Commissioning Groups, discussed the document in their public meetings. The Joint Health Overview and Scrutiny Committee also discussed the document. Some other organisations also discussed the document and have submitted responses which are identified below.

In addition, although this was not a formal consultation, members of the public were invited to submit their views on the full report, and the submissions which were received are included in this document.

This document includes all the responses received, from CCGs, Trusts, Local Authorities, and other stakeholders. It responds in detail to the individual points raised. A summary of the key themes, and the response to them, is included within the Strategic Outline Case, of which this is an annex.

1.1 PROCESS OF IDENTIFYING RESPONSES TO THE HOSPITAL SERVICES REVIEW FINAL REPORT

The final report of the independent Hospital Services Review, with its recommendations, was published on 9th May 2018.

Following the publication of the Report, the partners involved in the HSR have been considering their response to the Review and its recommendations. A standard briefing paper and presentation were prepared which were made available to the Boards and Governing Bodies of the organisations represented on the CPB. Members of the CPB were invited to discuss the report, in public sessions of their Boards or Governing Bodies, and to submit their response to the recommendations in writing by 12th July 2018.

The dates of the Board and Governing Body discussions in public are attached at **Annex D**. The minutes of these public discussions will be made available by the individual organisations through the usual processes.

The organisations' written responses to the Review, with a detailed response to each, are laid out in this separate report.

Other stakeholders including patients and the public were invited to respond with their views on the full report by 12th July[1]. The public feedback received, as well as our response, is also detailed in this report.

The agreed way forward in the Strategic Outline Case is informed by feedback from all of the organisations and members of the public.

[1] Individuals and organisations who had expressed an interest in the Review, and who had responded to GDPR requests saying that they wished their details to continue to be included, were emailed directly to alert them of the timeline for comments (by 12th July). Communication leads in CCGs also contacted Local Authorities and other key stakeholders to alert them to the deadline. An extension was given to one public stakeholder group who requested more time to respond.

1.2 ENGAGEMENT WITH PATIENTS AND THE PUBLIC

The Integrated Care System is continuing to engage with members of the public around the work on hospital services. The first cross-system public session on the HSR was held in August 2017 and a programme of engagement has been ongoing ever since, and has shaped each stage of the work:

- The results of the engagement up to the publication of the HSR final report, including a focus on seldom heard groups, were published alongside the Review and helped to shape the recommendations in the review.
- The specific written responses to the HSR final report have been included in this document and have, along with the wide range of public views collected during 2017-18, helped to shape the drafting of the SOC.
- An engagement report covering all of the engagement that has taken place since the publication of the final report in May 2018 will be published to correspond with the final approval of the Strategic Outline Case. This will ensure each of the workstreams taking the work forward from October does so with full understanding of patient and public views on the work thus far.

2 RESPONSES FROM CLINICAL COMMISSIONING GROUPS

2.1 BARNSLEY CCG

2.1.1 Response from Barnsley CCG

The following response was received:

Thank you for attending our Governing Body on 14 June to present the independent Hospital Services review report. The CCG welcomes the report and recognises the hard work that has gone into the review from all partners across the region. We remain committed to improving the health and wellbeing of the population of Barnsley and across the wider region, and as such are supportive of the aims of the review.

One issue we raised at Governing Body was the principle that underpins the ICS MOU, the JCCC MOU and the HSR, the "no worse off principle" which is that none of our population across SYB should be made worse off and that we should not inadvertently increase health inequalities through our joint working and collective decision making processes. This is very important in Barnsley as we border another ICS and could see increased patient flows out of the ICS geography from any reconfiguration proposals.

Therefore before we progress to site specific modelling there is some assurance that our Governing Body would request regarding the due diligence that will be undertaken in relation to the capacity and preparedness of providers who sit outside the ICS to receive our patients, work to SYB clinical network protocols and reconfiguration models, as well as any future network management and payment structures. Otherwise there is a danger that we model on the basis of assumptions about provider partners, their capacity and their ability to engage that are just not realistic or not agreed.

To commission consistent care and quality standards against agreed clinical protocols for all SYB patients, ensuring equality of access without unwarranted clinical variation we must ensure that all providers who sit outside SYB together with their lead commissioner are signed up to this aspiration. We will also need to assure ourselves that the lead commissioner is comfortable that the provider has the capacity to take on extra patients to these defined parameters, without any detrimental effect on their local populations.

I would welcome your views on how this due diligence can be carried with Mid Yorkshires Hospitals NHS Foundation Trust and the agreement of NHS Wakefield CCG secured in order to provide the assurance to Barnsley CCG and our partner commissioners that the principles we are working to and the options we evaluate will be consistent for all our SYB population.

2.1.2 Response to points raised by Barnsley CCG

The ICS has noted the response from Bassetlaw CCG, and the valid concerns raised about making sure that the SYB population are not worse off following any reconfiguration. The response to the key points is as follows:

Patients being worse off as a result of being sent out of area - It is the intent of the entirety of the joint working collaborative in SYB, to deliver the best care possible to patients in our region, working together to improve performance against the challenges we face.

As the response from Barnsley CCG identifies, under some options, a patient's 'next nearest' hospital for some services might become a hospital outside SYB(ND). The system cannot exclude particular options on this basis, but the SOC recognises the challenge this represents for commissioners in ensuring that they commission services to the same standard for patients inside and outside SYB(ND).

The SOC has addressed this point through the following proposed action points:

- The hospital services programme will model all the appropriate options, including those where some patients' next nearest trust might be outside SYB(ND). However, in parallel with undertaking the modelling, the team will undertake due diligence around understanding any quality, safety and capacity issues at the potential receiving sites. This will include dialogue with the receiving site and their commissioners, to understand the issues from their perspective, as well as consideration of publicly available data on quality, capacity etc. The team will engage with SYB commissioners in designing this process of due diligence.

- In evaluating the options, one of the existing evaluation criteria is quality, and the team will consider any implications of quality for patients receiving care from trusts outside SYB(ND). The assessment against the criterion around access will also consider the potential equality implications of some patients receiving care at sites which are not signed up to the principles of the SYB Hosted Network.

Modelling will also consider the implications of changes happening in STPs outside South Yorkshire and Bassetlaw. The ICS is already in contact with the leads on reconfiguration in neighbouring STPs, and contacts with these groups will continue.

2.2 BASSETLAW CCG

2.2.1 Response from Bassetlaw CCG

The following response was received:

Bassetlaw CCG's Governing Body discussed the Hospital Service Review's report in its public session on 12 June 2018. This letter briefly summarises the outcome of the Governing Body's discussion.

Our Governing Body wishes to ensure that the services it commissions provide high quality care, are sustainable and are provided as locally as practically possible. Bassetlaw is the most rural area across South Yorkshire and Bassetlaw, covering the largest geography but having the lowest population. For example, for most of the population of Bassetlaw the distance to the next nearest hospital (Doncaster Royal Infirmary) is over three times greater than the distance between Rotherham and Sheffield. In addition, public transport is limited and car ownership is relatively low. The model of acute care in a number of specialties in Bassetlaw has been designed to support the majority of care being provided locally but more specialist inpatient care being provided elsewhere. For example, hyper acute stroke has been provided at DRI for approximately 7 years and acute paediatric admissions at night are transferred to DRI but the majority of patients are diagnosed and treated in Bassetlaw without the need to transfer them. We are therefore pleased to see that the Hospital Services Review has concluded that this type of arrangement can be a successful approach that could potentially be adopted elsewhere in some of the specialties that were covered by the review.

The Governing Body therefore welcomed the findings regarding maintaining district general hospitals and their A&E departments. We support the review of out-of-hours acute gastroenterology in the other DGHs. We are keen to support the proposed Hosted Networks and feel paediatrics in particular is a network that it would be very beneficial to establish as soon as possible. We also welcome the proposals for system collaboration rather than competition and the development of a Health and Care Institute and an Innovation Hub.

In summary our Governing Body welcomed the report, agreed to the recommendations and supported the proposal for this work to now be taken forward.

2.2.2 Response to points raised by Bassetlaw CCG

The ICS has noted the response from Bassetlaw CCG, including the points made around the specific geography and population of Bassetlaw. The majority of the response is supportive of the HSR recommendations with the following points being raised that will be relevant to the next steps:

Access - *"for most of the population of Bassetlaw the distance to the next nearest hospital (Doncaster Royal Infirmary) is over three times greater than the distance between Rotherham and Sheffield. In addition, public transport is limited and car ownership is relatively low."*

Access is one of the main themes that will be addressed in the site-specific modelling going forward. The modelling of options will include both the additional physical distance that patients and families would have to travel in the event of any reconfiguration, and the impact of this on travel times by ambulance, public transport and private transport.

The modelling will also look at the impact on communities of different socioeconomic status, by undertaking a postcode analysis. This should enable identification of to what degree communities where car ownership is likely to be low will be affected.

2.3 DONCASTER CCG

2.3.1 Response from Doncaster CCG

The following response was received:

I am writing to provide feedback from the NHS Doncaster Clinical Commissioning Group (DCCG) Governing Body (GB) in relation to the Independent Hospital Services Review that was published 9 May 2018.

Firstly, I would like to thank you for attending the DCCG GB on Thursday 21 June 2018 to present the key points of the review. GB members welcomed your presentation and wanted to feed back that it was helpful, provided clarity on a complex programme of work and promoted a positive discussion when considering the recommendations in the SYB ICS Briefing Paper.

In response to the recommendations, I can confirm that:

1. *The DCCG GB noted the content of the paper including the process and next steps of the HSR. It was also noted that a process to identify funding for the next stage of the HSR is currently underway and that this is not yet agreed.*
2. *The following comments on the content of the HSR were also presented:*
    a. *Any proposal in future would have to be affordable and would have to be within existing resources.*
    b. *There is a need to review and potentially agree a different funding model.*
    c. *Clinical Networks are supported and we would want to encourage a SY&B model across the wider system to avoid a centralist approach.*
    d. *The group reflected that clinical variation and innovation are important factors but workforce is the key driver and we should be open and transparent about this.*

In addition, the Governing Body asked for clarification on the reconfiguration recommendations for A&E. Could you please confirm that the report is recommending a 24 hour A&E service in each of the current sites across SY&B?

3. *The DCCG confirmed acceptance of the Review recommendations and support further work to be undertaken.*

I hope this provides you with the information needed to support next steps. If you require anything further please do not hesitate to get in touch and I look forward to receiving your response on A&E in due course.

2.3.2 Response to points raised by Doncaster CCG

The ICS notes Doncaster CCG's acceptance of the Review recommendations. In response to the specific comments raised by the CCG:

Funding - A capital bid has been submitted to NHS England requesting capital funding to support a range of programmes across the ICS to improve care in SYB; the acute sustainability programme is one of these workstreams.

In relation to revenue funding, one of the evaluation criteria is that the running costs of future models of care should not cost more than current configurations. The costs of all options will be assessed in the modelling of the site-specific options. With regard to the need to review and potentially agree a different payment approach in the system, the hospital services programme team has noted this feedback. This will require discussion with commissioners going forward.

Hosted Networks - Support for Hosted Networks is welcomed, and moving forward the system will engage Trusts to develop a framework for the establishment of these for each of the services. The aim is for Host roles to be distributed equitably across the trusts in the region, provided that trusts are able to meet the criteria that will be developed around the requirements of a Host. The hospital services programme team will support providers and commissioners to develop a robust approach to assigning Hosts in an equitable fashion, whilst ensuring that potential Host providers are able to fully deliver against their roles and responsibilities.

Workforce - workforce is the key driver behind the need for service change. In recognition of the point raised by Doncaster CCG here, the SOC says that design of workforce roles will be the first step in the work programme for the Clinical Working Groups. This will feed into the reconfiguration modelling and into the Hosted Networks.

A&E – The SOC says that the system intends to retain all six emergency departments plus the paediatric emergency department at Sheffield Children's Hospital. The SOC does not propose to close emergency departments overnight. The SOC states that emergency departments will keep their doors open 24/7, with consultant coverage appropriate to the size of the unit, guided by Royal College of Emergency Medicine guidelines. The Clinical Working Groups will consider what staff presence is appropriate in A&Es at different times of the day and explore how we can use staff in different ways. Alternative staff roles, such as advanced nurse or medical practitioners, or support from GPs, could help to address workforce challenges in urgent and emergency care services.

2.4 NORTH DERBYSHIRE CCG

2.4.1 Response from North Derbyshire CCG

The following response was received, as an extract from the minutes of the North Derbyshire CCG Governing Body meeting.

Notes on the HSR from North Derbyshire CCG's Governing Body.

Feedback on the Hospital Services Review is required by today. Feedback from Hardwick CCG has also been provided. Governing Body have been aware of the Hospital Services Review (HSR) for some time. The remit of the HSR is to identify ways in which the acute providers, working together, can improve the sustainability of acute services.

The areas being reconfigured are: Emergency Departments, Paediatrics, Maternity, Stroke and Gastroenterology. The timing of the reconfiguration is critical as staff migrate to bigger units. The plan will be formally published 8th May. The joint Committee will formally receive the plan on the 23rd May. Further conversations will need to take place at Governing Body in relation to our views of the implications.

Transport Services between hospitals are important and how do we get it right. The Derbyshire STP footprint also needs to be taken into account and how we connect.

Dr Milton confirmed that these issues have been raised on a regular basis and are being heard and understood more clearly. A separate governance group has been set up of which Dr Milton is a member, to ensure that the HSR is cognisant of the Derbyshire challenge. Hardwick CCG is an Associate Member of the joint committee rather than a member.

Dr Clayton took the action to write to the joint committee formally about Hardwick CCG, and the united commitment from a Derbyshire perspective.

Dr Spooner asked how much influence Chesterfield does have within the joint committee. Dr Clayton responded that we have significant influence and the terms of reference is very strong and together with Hardwick CCG is strengthened further. Conversations took place regarding the STP and addressing boundary issues. The joint committee is the forum for addressing these issues for all borders beyond South Yorkshire and Bassetlaw.

NHSE regional reconfiguration will be led by the North of England and will be part of the assurance process but NHSE North Midlands will feed into this from a regulatory perspective. The Governing Body were delighted this has been recognised and very helpful.

Dr Clayton asked if there was any further feedback from the Governing Body in addition to Hardwick CCGs feedback.

Dr Austin added that she would like the consideration of as the HSR progresses how will it affect Chesterfield Royal Hospital and our patients and that a Derbyshire approach is required.

Governing Body DISCUSSED the Hospital Service Review Draft Report and identified concerns for the CCG.

CLARIFIED the CCG's position within the South Yorkshire Joint Committee of CCGs as a member and Hardwick CCG as an Associate Member

2.4.2 Response to points raised by North Derbyshire CCG

The ICS notes North Derbyshire CCG's comments around the importance of patient transport, and how any service change might impact on Chesterfield Royal Hospital and having a solution for Derbyshire and its patients.

Transport - The response notes that it is important we consider and ensure that we get right the transport services for patients following any service change.

To address any concerns, the ICS will establish a strategic transport group to bring together representatives from stakeholder groups in order to better understand the needs around transport and access. This will provide a forum to enable through discussion of travel implications across SYB and will identify best ways to mitigate them.

Minimising the effects of travel on patient safety is paramount, so evidence from academic papers and learning from previous reconfigurations is being gathered to better understand this topic. This evidence base

will be discussed and reviewed by the strategic transport group and will inform the site specific modelling process to ensure any risks are mitigated and minimised.

A Solution for Derbyshire - The SYB stakeholders recognise the role that Derbyshire commissioners and Chesterfield play in networks more widely across the Derbyshire STP. The SOC commits to continued engagement with Derbyshire commissioners in discussions around the implications of the potential service change for the Derbyshire STP. Any potential impacts and mitigations will be explored.

It is an important principle to note, that in undertaking site-specific modelling on options, all sites will need to be treated equally and will need to be aware of the possibility that changes to their services could result from the work. Moving forward we will involve the Derbyshire CCGs and Chesterfield Royal Hospital in the development of proposals, through the various governance groups that oversee the work of the programme.

2.5 ROTHERHAM CCG

2.5.1 Response received from Rotherham CCG

The following response was received:

Thank you coming to the Rotherham CCG Governing Body to present the HSR. Your presentation was helpful and allowed GB members to better understand the recommendations of the review.

The GB welcomed the report and was very supportive of many of the recommendations. More specific comments were;

1. *The GB particularly supported maintaining A&Es in each place.*
2. *The GB supported the principle of clinical networks between providers but raised concerns about provider buy–in.*
3. *The GB supported the recommendation for each acute provider to host one of the networks and would not wish to see all networks hosted by the specialist providers.*
4. *The GB raised concerns about 16 hour Paediatric units and how maternity, neonatal and A&E services would operate safely with reduced Paediatrics and were not assured that this approach would deliver safe and sustainable services.*
5. *The GB supported the implementation of Better Births and more choice of settings for births for parents.*
6. *The GB supported a central excellence hub but raised questions about how this would be funded and how it relates to the AHSN.*

I hope this feedback is helpful.

Please don't hesitate to get in touch with us if you need any further information or if anything is unclear.

2.5.2 Response to points raised by Rotherham CCG

The ICS notes Rotherham CCG's support of the HSR recommendations. The following response provides clarification with regard to the particular concerns raised in their feedback:

Hosted Networks – Support for Hosted Networks is welcomed, and moving forward the system will engage Trusts to develop a framework for the establishment of these for each of the services. The aim is for Host roles to be distributed equitably across the trusts in the region, provided that trusts are able to meet the criteria that providers and commissioners will develop around the requirements of a Host.

The hospital services programme team will support providers and commissioners to develop a robust approach to assigning Hosts in an equitable fashion, whilst ensuring that potential Host providers are able to fully deliver against their roles and responsibilities.

The establishment of Hosted Networks will be driven by the Trusts, and supported by wide clinical engagement through the Clinical Working Groups, to ensure they fulfil requirements and gain provider and staff buy-in.

Paediatric Assessment Units - The concern raised by Rotherham CCG is noted. It is important to reiterate that any proposals for reconfiguration will be developed in close collaboration with clinicians to ensure they meet safety and quality requirements. Clinical evidence supports the safety of SSPAUs as an alternative to full-time inpatient units, particularly when there is not enough activity or resource to sustain a full paediatric inpatient unit, assuming appropriate transfer protocols are in place for those patients requiring overnight care. The Royal College of Paediatrics and Child Health support such a care model, stating that for many patients they are a more appropriate care setting than an inpatient unit, and these models are being increasingly used to deliver high quality paediatric care[2].

Moving forward, the SOC says that the system will model the impact of changing one or two inpatient paediatric units (from the existing units in South Yorkshire and Bassetlaw and North Derbyshire) into SSPAUs. If an SSPAU is proposed, the Clinical Working Groups and ultimately the Hosted Network will be engaged to ensure that it is supported by robust referral and patient transfer protocols to ensure children are able to access the care they need out-of-hours. The ICS will also consider the close interdependencies between paediatric, maternity and neonatal care in this modelling to ensure that the provision of paediatric and paediatric-related services remain safe.

Maternity services - The ICS is aware that implementing an SSPAU model would impact on the type of maternity services that the same site could offer. Traditionally, changes to inpatient paediatric presence would result in changes to maternity services, meaning high-risk births (which require obstetrician presence) and neonatology services would not be provided on that site. Owing to the concerns raised by Rotherham CCG and other organisations in the system, the SOC says that the Clinical Working Groups will be asked to look at alternative models that might offer different ways to meet the requirements of this interdependency.

Neonatology - Concerns about the interdependencies between neonatology, paediatrics and maternity services are noted. In the light of this, the membership of the paediatric Clinical Working Group has been refreshed to include neonatologists, and SOC says that the implications for neonatology will be included within work on reconfiguration.

Central Health and Care Institute & Innovation Hub - As an ICS, SYB will need to consider how these Hubs will fit into an existing landscape of clinical networks, academia, Health Education England and the Academic Health Sciences Network. Moving forward, the system will engage both NHS and non-NHS partners to develop the detail of the model, considering carefully any overlap with existing networks, making sure that the right capabilities and organisations are represented in the Institute and Hub, and also considering any funding implications.

[2] Royal College of Paediatrics and Child Health, Standards for Short-Stay Paediatric Assessment Units, March 2017. Available at: https://www.rcpch.ac.uk/sites/default/files/SSPAU_College_Standards_21.03.2017_final.pdf

2.6 SHEFFIELD CCG

2.6.1 Response received from Sheffield CCG

The following response was received, as an extract from the minutes of the Sheffield CCG public meeting to discuss the HSR final report:

The NHS Sheffield CCG Governing Body met in public on Thursday 5 July 2018 to discuss and consider the content and recommendations of the Hospital Services Review paper that had been published on 9 May 2018. The HSR's Programme Director attended the meeting for this discussion. She reminded Governing Body that the objective for them was to consider the HSR and the recommendations which were made within it, and to agree what their position was, as a Governing Body, in the process. She reported that feedback from all Governing Bodies on the report was required by 12 July and would be passed to a central team to form the development of a strategic outline case (SOC), and that a further final draft would be presented to Governing Bodies for approval by the end of July 2018.

Governing Body noted that, as part of the system response to the HSR, the SOC would be presented to the Joint Committee of Clinical Commissioning Groups (JCCCGs) on 25 July 2018, and were reminded that as this committee was not constituted it meant that it had no delegation to agree, approve, or reject the recommendations, so the final decision would be taken by the CCGs.

Governing Body were reminded that the review had been launched in June 2017, with the objective of the review to look at how acute services could be put on a more objective footing, identifying vulnerable services that required a different model of delivery, and through an agreed methodology had identified five services as the focus of the review: paediatrics, maternity, urgent and emergency care, gastroenterology and endoscopy, and stroke, all services that were particularly challenged in areas such as workforce, clinical variation across the Trusts, and uptake of innovation, especially around IT systems

Governing Body members confirmed that they had considered the report and its recommendations following its publication in May. They agreed that the reconfiguration recommendations seemed sensible, given the environment in which the CCG was working. However, they questioned whether staff and members of the public had been asked to address specific issues during engagement or if it had been more of an open feedback, but noted that the reconfiguration options would be subject to further discussion and wider engagement with staff and members of the public at a later stage. They also suggested that, given the statutory responsibilities of the CCG to engage and consult with members of the public, it would be important to have an early discussion at the CCG's Strategic Patient Experience, Engagement and Equality Committee' (SPEEEC), to discuss and consider what resources would be required for the engagement and where they would come from, and in what form the consultation would take place. They noted that engagement had been a developing process as ideas had developed, and that consultation had been, and would still be, with patients, members of the public, staff, clinicians, and senior leadership teams around the main challenges of the five services. They noted that, going forward in terms of engagement, statutory consultation on a document that was well defined would take place from June to September 2019, along with ongoing engagement with Patient Participation Groups (PPGs), and the CCG's SPEEEC.

Governing Body were pleased to note that some of the more difficult to reach and seldom heard groups had been included in the engagement process, which they acknowledged could sometimes be difficult, and suggested that for future consultation this could be co-ordinated through the South Yorkshire Community Foundation.

Governing Body were reminded that engagement with clinicians had been through the Clinical Working Groups (CWGS), one for each specialty, that had met to discuss and consider what the problems were and

what solutions might work, which they had turned into reconfiguration options for discussion at a large joint working group earlier in the year. The feedback from that workshop had been discussed with the above engagement groups and incorporated into the report prior to publication.

Governing Body asked if a transport to services group could be established, particularly to discuss what the impact level would be on travel and transport times following reconfiguration of services and what the main issues would be on wider communities.

Governing Body asked whether equality impact and health inequalities assessments would help to make the system better. They were advised that equality screening had been undertaken during public engagement, and that over the past few months a mapping exercise looking at age, disability, etc, had been undertaken against the five services. They were also advised that at this point the HSR team was looking at what sort of modelling would be needed, but at this stage it would not be site specific and would include looking at postcode and socio-deprivation need to access to services. They were advised that, going forward it was planned to use this for targeting engagement, and would also be something that would have to be submitted to NHS England as part of the assurance process prior to going out to public consultation in from June to September 2019.

Following our discussion and consideration of the report and recommendations at our meeting held in public on 5 July 2018, on behalf of the NHS Sheffield CCG, the Governing Body confirmed acceptance of the review recommendations, as set out in section 11 of the report presented to them the meeting.

2.6.2 Response to points raised by Sheffield CCG

The ICS thanks Sheffield CCG for its response. Their acceptance of the review recommendations is noted and the following concerns are addressed:

Engagement – Patient and public engagement, as well as engagement with the healthcare professionals in SYB, was a key part of the HSR. In relation to the specific point raised in this note, the HSR team has confirmed that members of the public were invited, at the third SYBMYND-wide event, to comment on the specific proposals that had been developed so far, and on the outcomes of the modelling.

Moving forward, the ICS will build on the engagement undertaken to date and ensure that the patient public voice feeds in to the development and evaluation of options, which will be co-developed with the expert healthcare staff in our system.

The approach to engagement and communications will be outlined in the ICS's engagement strategy. In summary, the acute sustainability programme will continue to engage regularly through the ICS Citizens' Panel, with CCG Engagement Groups (including Patient and Partnership Groups), patient and citizen community groups, community forums and groups (with support from organisations such as the South Yorkshire Community Foundation and South Yorkshire Housing Association), and other relevant forums (such as local Maternity Voices Partnerships). The Hospital Services team has also given a commitment to bring the engagement approach to the Sheffield CCG SPEEEC.

The ICS will work with the Citizens' Panel, Joint Health Overview Scrutiny Committee and communications and engagement colleagues to determine the best engagement approach throughout this next phase. As respondents have pointed out, as proposed modelling work progresses, the nature of engagement will become more specifically related to changes to individual sites and services, whereas it has tended thus far to relate to broader discussion of concepts.

Engagement will be frequent and regular to ensure clarity and transparency around proposals as they develop. The communications team will also build upon the learning from previous consultations undertaken by the ICS and other systems, to ensure relevant experience informs the work going forward.

Travel and Transport – Maintaining equitable and timely access services is an important tenet of the acute sustainability programme. The hospital services programme team will work with the ambulance services to model the potential impact of increased travel times both for ambulance and for private and public transport. The analysis will break this down by demographic to give a detailed view of implications for different groups of patients, and the team will work with transport experts when developing any proposals.

The ICS will engage with local partners to set up a strategic travel group. This group will comprise representation from local acute trusts, commissioning bodies, ambulance services (both Yorkshire and East Midlands Ambulance services), local authorities, patients and the public, and other relevant local travel and transport stakeholders (such as local public transport providers). The programme will engage this group regularly as options are developed and assessed.

Clinical Working Groups will review the national and international evidence base, to fully understand the safety implications of increased travel times for patients. In such a way the hospital services programme will ensure that options taken forward seek to minimise and mitigate any increase in travel.

Equalities – Ensuring equitable access to high quality care is a key priority for the programme. Moving forward, the hospital services programme team will ensure that a robust equalities impact assessment is undertaken to assess and inform any future proposals. This will be supported by quantitative modelling and qualitative engagement that seeks to identify any potential impact on patients, broken down into demographic groups, to understand and assess the impact on different groups in society. In addition to this, the programme will continue to engage seldom heard groups, and other relevant groups of patients and the public, to hear and understand their views and concerns to ensure that voices heard are reflective of the entire patient cohort.

2.7 WAKEFIELD CCG

2.7.1 Response received from Wakefield CCG

The following response was received:

Just to confirm that agenda item 11 'South Yorkshire Hospital Service Review – Stage 2' was an agenda item with a covering paper, with a link to the report embedded in the paper (given the size of the report). The recommendation to discuss and support the recommendations within the report was approved by the Governing Body.

2.7.2 Response to points raised by Wakefield CCG

The ICS notes Wakefield CCG's support for the HSR recommendations.

3 RESPONSES FROM ACUTE TRUSTS

3.1 BARNSLEY HOSPITALS NHS FOUNDATION TRUST

3.1.1 Response received from Barnsley Hospitals NHS FT

The following response was received:

Thank you for your letter dated 13 June 2018 in which you set out the next steps to implementing the changes described in the Hospital Services Review (HSR) for South Yorkshire, Bassetlaw, Mid Yorkshire and North Derbyshire (SYBMYND). The Trust welcomes the report and recognises the hard work that has gone into the review from your team and all partners across the region. Barnsley Hospitals NHS Foundation Trust (BHNFT) remains committed to improving the healthcare and lives of patients with the local and wider region, and as such is broadly supportive of the aims of the review. There are a number of points raised in your letter and the following response takes each of these in order.

Since the letter was sent, Professor Chris Welsh has attended Trust Board and has given the Trust further clarity with regard to some of the aspects of the review and the detail within your letter. It is understood that the main emphasis of the response is to allow the development of a Business Case in the form of a Strategic Outline Case (SOC). It is further understood that this relates the potential reconfiguration options and the need to plan the capital implications of any potential reconfiguration. This letter summarises the Trust's response on this and the broader outcome of the review, with respect the development of hosted networks and other transformation proposals.

Transformation proposals

We generally support your recommendations around transformation of the five identified services. We agree the current arrangements around collaborative work which have been developed over the past few years under the 'Working Together Programme' are now at a stage where a new approach is needed. There was strong support for the 'Hosted Network' model with each SYB Trust hosting one of the five networks with a common framework that covers standard guidelines, standard job descriptions, potentially equipment procurement etc. The other two network models are more problematic from the Trust's perspective. Whilst we recognise that some other SYB providers may be interested in a Lead Provider network model for paediatric services, this does not currently interest BHNFT and our clinical staff are not supportive. However, as long as the lead provider aspect was on a mutually voluntary basis, the Trust would be happy to work with other providers as part of a paediatric 'Hosted Network'. BHNFT did not see the rationale for an UEC provider network other than as a 'standard' Hosted Network. We would have significant concerns about the feasibility of a centrally controlled UEC network moving staff from one Trust to another but we would welcome further exploration of more effective UEC partnership.

The Trust strongly welcomed the suggestions of a SYB Innovation Hub and Workforce Centre. The three tiers of hosted networks clearly need further discussion and refinement dependent upon the areas for which each is likely to be designated. BHNFT would welcome detailed discussions on this as part of the plans going forward.

Potential Reconfiguration Options:

The table below describes the potential reconfiguration options and the Trusts response to these options in the fives services identified in the review.

Proposal	***Trust Response***
Urgent and Emergency Care *Maintain six Consultant Led Emergency Departments.*	*The Trust continues to perform well against national targets overall and in particular the four hour standard (greater than 95% - June 2018). We are pleased that there is no suggestion to reduce the number of Emergency Departments and/or reconfigure within the report.* *At this stage the Trust is assuming no change to its service - the Trust will continue to deliver Urgent and Emergency Care via a 24/7 Consultant Led Emergency Department.* *The Trust's view is that improvement efforts to deliver better UEC services have to be place-based, focussed on whole system issues, driven by reducing breaches through optimised care pathways rather than counting additional activity and are best led through the local 'A&E Delivery Boards'. A future Hosted Network in UEC would need to be carefully designed to be value adding to local arrangements and would likely obviate the need for the regional UEC ICS work stream.*
Maternity *Replace one or two Obstetric Units with Midwifery Led Units (MLU).*	*The Trust has a sustainable Consultant led Maternity service and performs well against clinical indicators in this area. The reduction of one or two Obstetric Units in the region would have significant consequences for BHNFT. In addition there are a number of issues to consider, which would make BHNFT unsuitable for a 'stand alone midwife led unit (MLU)', these are:* *Geography - a significant proportion of the local population live in the North of Barnsley. The impact of changing the designation of Barnsley to an MLU would have consequences on the flow of patients both within the region and outside of it. If there was no Consultant led service in Barnsley, it is likely that many patients in this part of the area would have travel to Pinderfields for Maternity services. It is known that Mid Yorkshire would have significant capacity issues should patients from Barnsley opt to travel to Pinderfields, given their recent reconfiguration. In addition, plans at Calderdale and Huddersfield are to centralise Consultant led services on the Calderdale site; this would leave the population in the North West of Barnsley with less choice overall and would necessitate investment in other STP areas to bolster their maternity capacity.* *Risk – based on a recent audit the majority of pregnant women in Barnsley (circa 66%) are classed as 'high risk' and would therefore be unsuitable for delivery in an MLU. The Barnsley population therefore have a higher proportion of high risk women compared to national averages (circa 40% high risk).* *Midwifery Led Units – local experience of stand alone MLUs would question the sustainability of such a service. The nearest MLUs at Pontefract and Dewsbury are known to be significantly underutilised. This questions the long term viability of such a unit both clinically and financially. This along with the risk profile described above, would reduce the potential for the use of this service.* *At this stage the Trust is assuming no change to its service – the Trust anticipates that it will continue to deliver Consultant Led Obstetric and Maternity Services*

Paediatrics *Replace one or two Consultant Led units with Assessment Units.*	*The Trust continues to develop its Paediatric services, has recently received significant investments for paediatric A&E services and is upgrading the neonatal unit following a long-standing fund raising project. The Trust performs well against clinical indicators in this area and delivers a sustainable service. We have recently increased our Consultant establishment to provide 12 hour onsite Consultant presence, seven days per week. We are currently fully established at Consultant level.* *Key to any changes in this area is the co-dependency with Maternity services; the two services are intrinsically linked and in the Trusts opinion cannot be separated out and would be extremely difficult to disaggregate. Co-location of both Maternity and Paediatrics is required to deliver a safe and sustainable service. The Trust assumes that any reduction in the numbers of units in SYB would mean that a site losing a unit would likely lose both maternity and paediatric services – clarification on this point would be helpful.* *At this stage the Trust is assuming no reconfiguration change to the service – the Trust delivers a successful Paediatric service to the local population and anticipates that this will continue.*
Stroke *Sheffield, Doncaster and Pinderfields HASU units supporting other DGHs acute stroke units.*	*Following the Public Consultation on Hyper Acute Stroke Units (HASU) the Trust had to urgently cease provision of some aspects of HASU care as our medical consultant workforce did not wish to work within a non-HASU site. However, the Trust has continued to develop its Acute Stroke Unit and to work with the SWYPNFT delivered stroke rehabilitation service. It is important to note that we have recently been successful appointing a consultant to the ASU, albeit from another part of the stroke service in Barnsley. We recognise that following the recent agreement to reconfigure HASU services there will be challenges to deliver this model.* *We are already well on with considering how the existing ASU and rehabilitation stroke services in Barnsley could be improved in partnership with BCCG and SWYPNFT.* *At this stage the Trust is assuming no further externally mandated change to the remaining service following the recent reconfiguration. The Trust would welcome further collaborative work around the reconfigured HASU units and further discussions about the future of the service within and outside of the region.*
Gastroenterology and Endoscopy *Consolidation of evening and weekend cover on three or four sites so all have access to 24/7 GI Bleed cover, if necessary on another site.*	*The Trust recognises the difficulties the region faces in delivering compliant cover across the region for acute GI bleed treatment. However, locally we deliver a high quality and well organised and compliant service to the population of Barnsley.* *We feel that the Trust would be extremely well placed to take a leading role in this area as part of a hosted network. We are currently assisting another local provider with clinical support around Gastroenterology and would be prepared to enter into discussions around increasing support for GI Bleed on a larger footprint.*

General points

I think it is also important, as the HSR moves into a site-specific modelling phase, to make some more general points about healthcare in Barnsley. Whilst deprivation and social inequality affect multiple parts of the SYB region, Barnsley is most severely affected. The comparative data shared by Greg Fell at a recent ICS meeting demonstrates that across a wide range of public health measures, Barnsley is an adverse outlier. Whilst these sorts of issues are best tackled through a coordinated place-based partnership of health and social care, it is essential that reconfiguration assessments factor in the need to maintain locally delivered healthcare (ideally

left-shifted) and to consider that any move to centralisation is likely to have a particularly detrimental impact on the ability of our more deprived citizens to access services.

The Board's view is that any centralisation of services through reconfiguration must be based on a clear case that the reduction in local access is more than balanced by the safety and quality benefits that result. Whilst few would argue that some clinical services, such as primary angioplasty or neurosurgery, rightly can only be delivered in centralised hubs, it should not be argued by analogy that this is right across a wide range of other services – the case for each should be made based on the evidence and a carefully reasoned analysis. In fact, the Board would like to see the HSR focus on developing a more hub and spoke approach to some of the long-standing centralised specialist services; for many of these, once the initial phase of treatment has concluded, there should be strong consideration of delivering a more decentralised long-term follow up plan.

The Board would like the HSR to urgently clarify which hospital sites/Trusts are within the modelling scope – specifically, the status of Chesterfield hospital as we believe Mid Yorkshire Hospitals have already been excluded based on their prior local reconfiguration. Modelling 1 or 2 fewer paediatric or maternity units has a significantly different consequence dependant on whether Chesterfield is in or out of those numbers.

We hope this makes absolutely clear our current position with regard to the recommendations of the Hospital Services Review. We have and will continue to be well represented on all of the major groups involved in this work and see collaborative/partnership work across South Yorkshire as a potential major improvement for the care of all of our patients. We do hope our detailed response in each of the five areas above is helpful in development of the decision making process going forward.

We will provide active membership to the Clinical Working Groups as before and we will continue to provide support from a senior executive perspective (including any modelling work). In addition, we feel it is essential to be involved in the two groups described in your letter – Travel and Transport Reference Group and Data Stakeholder Group.

In Summary the above represents the distilled opinion from BHNFT based upon a) discussions at Executive and Trust Board, b) engagement with our Clinical Groups including Consultants, Nursing and AHPs from the five areas described and c) the wider group of stakeholders in the hospital including the Medical Staff Committee.

3.1.2 Response to points raised by Barnsley Hospitals NHS FT

The ICS has noted the response from Barnsley Hospitals NHS Foundation Trust. The majority of the response is supportive of the HSR recommendations.

The ICS responds to the specific concerns raised as follows:

Hosted Networks - *"Whilst we recognise that some other SYB providers may be interested in a Lead Provider network model for paediatric services, this does not currently interest BHNFT and our clinical staff are not supportive. BHNFT did not see the rationale for an UEC provider network other than as a 'standard' Hosted Network."*

As laid out in the HSR, the approach to Hosted Networks will consist of three tiers of Hosted Networks, with increasing levels of collaboration: a basic Hosted Network, a Co-ordinated Delivery Network, and a Single Service Model.

The Strategic Outline Case makes it clear that the 'basic' Hosted Network will be the starting point, and the first step in the work programme will be to develop the template around this. The decision around establishing any specialties at a level higher than this will be for providers to discuss and agree going

forward. The SOC is clear that participating in a 'single service' model would be entirely optional; it is likely that some trusts will be interested in a closer relationship to support delivery while others will not.

The ICS notes Barnsley's offer to lead a Gastroenterology network given their current role in networked gastroenterology services. Moving forward, the programme will engage Trusts and Commissioners in developing a robust approach to equitably assigning Host organisations for each of the Hosted Networks. This will include developing criteria around what requirements a Host must be able to meet. This will ensure that that whilst lead roles are shared across the system, all Hosts have the resources and ability to perform the role.

Local Risk Factors and Access to Services - The ICS notes Barnsley Hospital FT's comments about the Barnsley's higher than average patient risk profile, and concerns raised about equality of access for all population groups.

Risk factors and local population demography will be incorporated into modelling in the next steps.

Access will be addressed in the site-specific modelling going forward. The modelling of options will include both the additional physical distance that patients and families would have to travel in the event of any reconfiguration, and the impact of this on travel times by ambulance, public transport and private transport.

The modelling will also look at the impact on communities of different socioeconomic status, by undertaking a postcode analysis. This should enable us to capture to what degree communities where car ownership is likely to be low will be affected.

Paediatrics and Maternity Interdependencies - Comments made about the interdependencies between paediatrics, maternity and neonatal services are noted. The ICS is aware of these interdependencies and the indirect impact that reconfiguration of a paediatric inpatient unit may have on any co-located maternity and neonatal services. In recognition of this, the SOC says that neonatologists will be added to the paediatrics Clinical Working Group, and neonatology will be included in work on reconfiguration going forward. The ICS will consider the close interdependencies between paediatric, maternity and neonatal care in the modelling, and will work with the Clinical Senate to ensure that paediatric and paediatric-related services remain safe.

Site-Specific Options - In their response Barnsley notes that: "*At this stage the Trust is assuming no reconfiguration change to its service"*

The HSR's recommendations were site agnostic, based on the collective availability of workforce and capacity across the SYBND region relative to forecast activity levels and care quality requirements.

As a priority, the acute sustainability programme will work with CCGs, Trusts and Clinical Working Groups to develop site-specific reconfiguration options to be taken forward for more detailed modelling and analysis.

As the work is taken forward, all Trusts will be considered in the context of the site-specific modelling; and the hospital services programme has an open mind in relation to how they are included. At an early stage, the system may wish to designate some fixed points, based on permissible criteria and in line with guidance and precedence. There will be an agreed approach to determining any fixed points, with full engagement from system leaders, patients and the public.

Refreshed hurdle and evaluation criteria will be used to assess all options to ensure that any proposals that are taken further meet robust quality and safety requirements, optimising care for the local population. We will engage with system leaders, patients and the public in refreshing and agreeing weightings for the evaluation criteria.

3.2 DONCASTER AND BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST

3.2.1 Response received from Doncaster and Bassetlaw Teaching Hospitals

The following response was received:

Thank you for attending Doncaster and Bassetlaw's Board of Directors on 26 June 2018 to present us with an update on the Hospital Services Review. Our Board commends the amount of time and effort that has gone into producing the work and fully supports the direction of travel.

The Board considered the review's recommendations in detail during a special workshop we held on 19 June. During the session, the Board had an opportunity to consider plans for each of the five services and to ask questions of our Medical Director. A number of points were raised which we would like to feed in as part of your consultation.

1. *The Hospital Services Review needs to describe the future for South Yorkshire and Bassetlaw (SYB) and each of the areas that make it up. We need a compelling vision for how the future of hospital services will be delivered and the improvements it will bring in order to improve people's lives.*
2. *All proposed change should meet the following key principles: equity of access to services for all SYB residents; improvement of quality of healthcare; filling of skills gaps with employed rather than agency personnel; and reduction of the overall deficit facing acute trusts in SYB.*
3. *Decisions on change need to be made and delivered quickly to reduce anxiety for staff and patients. At the same time, they should be underpinned by robust equality impact assessments that assess the impacts on different groups of people.*
4. *As well as integrating services, it is important that the Review leads to further integration of staffing resource. One of the biggest issues we have as a Trust is moving staff between our two sites in Doncaster and Bassetlaw. It is vitally important that, in recruiting new people, we sell the vision of multi-site working.*
5. *Staff will only buy into multi-site working if they see their system leaders doing the same. We feel, therefore, that every time a very senior post becomes vacant Trusts should explore opportunities for a shared post in order to provide a guiding influence.*
6. *When public money is spent in reconfiguring services, it is crucial that governance arrangements include non-executive representation. Non-executives provide constructive challenge, give confidence and credibility that the process is fair, open and transparent and promote the vision to governors who are the link to our local communities.*
7. *All change needs to have a robust evaluation framework, within agreed timelines, to assure everyone that perceived benefits are being delivered. A performance framework for monitoring and measuring impact is also needed.*
8. *Finally, it goes without saying that the political ramifications of the Review will need to be managed carefully, especially with significant local elections next May. The Review commits to a District General Hospital in each area and that is a positive message we need to promote to our local representatives, alongside the need for greater specialisation.*

I would be grateful if you would take the above comments into consideration as part of your consultation

3.2.2 Response to points raised by Doncaster and Bassetlaw Teaching Hospitals

The ICS has noted the response from Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust. Specific concerns were raised over equality impacts, workforce integration difficulties and the importance of strong governance, to which the ICS responds as follows:

Equality - *"Decisions…should be underpinned by robust equality impact assessments that assess the impacts on different groups of people."*

Ensuring equitable access to high quality care is a priority for the programme. Moving forward, the hospital services team will ensure the completion of a robust equalities impact assessment to inform any future proposals. This will be supported by quantitative modelling that seeks to identify any potential impact on patients, broken down into demographic groups, to understand and assess the impact on different groups in society.

The programme will also continue to engage with seldom heard groups, patients and the public to hear and understand their views and concerns to ensure that the voice of the patient is reflective of the entire patient cohort.

Integration of Workforce - *"As well as integrating services, it is important that the Review leads to further integration of staffing resource...Staff will only buy into multi-site working if they see their system leaders doing the same"*

The SOC says that the system will establish Hosted Networks across each of the five specialties in the HSR as a vehicle to tackling workforce issues through more integrated working. As laid out in the HSR, the approach to Hosted Networks will consist of three tiers of Hosted Networks, with increasing levels of collaboration: a basic Hosted Network, a Co-ordinated Delivery Network, and a Single Service Model. The co-ordinated Delivery Network will have a role in integrating workforce across sites, within a speciality, identifying shortfalls in capacity and staff, and rotating resources to meet demand.

Broader engagement will also be conducted to ensure the buy-in of staff across the various organisations, with both senior management and front line staff. As the response from Doncaster and Bassetlaw suggests, leadership from senior clinicians will be vital to ensure that the new ways of working are taken forward within Trusts. The Clinical Working Groups will include senior representation, both consultants and nurses, from all trusts.

Further to this the development of Hosted Networks will be alongside that of the Health and Care Institute and Innovation Hub, which will provide another forum for the integration of workforce functions.

Governance - *"It is crucial that governance arrangements include non-executive representation. Non-executives provide constructive challenge, give confidence and credibility that the process is fair, open and transparent"*

The ICS is currently undertaking a review of governance arrangements, which will be ongoing during September. As the ICS develops, its governance will ensure rigorous scrutiny and ensure that Boards and Governing Bodies are discharging their statutory functions

With regard to Non-Executive representation, major programme decisions will continue to be scrutinised through individual Boards and Governing Bodies, and so will receive NED scrutiny through this route.

Further detail on the approach to governance arrangements moving forward is available in the full Strategic Outline Case, and will emerge from the ICS governance review.

Key principles and vision - *"All proposed change should meet the following key principles: equity of access to services for all SYB residents; improvement of quality of healthcare; filling of skills gaps with employed rather than agency personnel; and reduction of the overall deficit facing acute trusts in SYB."*

Equity of access, improving quality of care, and addressing workforce and finance issues were all key principles of the original Hospital Services Review.

Going forward, these will continue to be key principles of the work of the acute services programme. When the implications of changes to patient flows is evaluated, the assessment will consider not just access issues, but the implications of quality for patients for patients receiving care from Trusts not signed up to the principles of the SYB Hosted Network. This work will include identifying capacity implications at the receiving sites, and due diligence on the quality and safety performance of the sites.

The existing evaluation criteria will be refreshed going forward, with engagement with patients, the public, clinicians and system leaders. This will provide a further opportunity to ensure that the priorities that the Trust identifies here are fully addressed in the evaluation criteria.

3.3 CHESTERFIELD ROYAL HOSPITAL NHS FOUNDATION TRUST

3.3.1 Response received from Chesterfield Royal Hospital

The following response was received:

Thank you for the opportunity to make final comments on the HSR proposals. The trust has already made a number of comments during the process demonstrating our support for the review but also recognising the unique position of Chesterfield on the border with SYB and sitting formally in the Derbyshire STP footprint. We offer the following comments on the report.

- *We welcome the acknowledgement that Chesterfield is serviced by a different ambulance provider in the East Midlands.*
- *We note the point about equitable distribution of the network leads but would wish to have some assurance that the nominated host trust has the necessary capacity and capability to lead the network in the best interests of patients. For example, we understand our current relationship with STH as a tertiary provider but are unclear as to how it will work should a trust with less externally acknowledged expertise/specialist capacity be designated to lead the network. We recognise that CRH would not initially be considered to become a designated lead for a specific network acknowledging the position of CRH outside the SYB ICS footprint.*
- *With regard to the proposal for Lead Organisations to assume delegated responsibility for redeployment of staff between units at times of operational pressure, we seek acknowledgement while Trusts remains accountable for their individual performance to external regulators (in a different region) and for their governance and the delivery of safe care that clear and agreed minimum staffing standards would need to be in place to provide necessary assurance in relation to this and signed off by all trusts.*
- *Our maternity service has a mandate to deliver against the objectives of the Derbyshire LMS action plan and these pre-commitments will need to be taken account of in any future reconfiguration decisions. We do not support the proposal to establish stand – alone midwife-led care units.*
- *We agree that the acute pathways of our integrated Paediatric service will be part of the SY network as our patient pathways are integral to this system although account will need to be taken of Derbyshire STP acute care priorities where there is variation. Future decisions in relation to reconfiguration will need to take account of both the interdependency with the maternity service, the neonatal service and the importance of maintaining CRH status as a paediatric general paediatric and community training unit within the Health Education East Midlands network as well the views of Derbyshire commissioners. We will be looking to continue to ensure sustainability*
- *Locally in Chesterfield with the establishment of a PAU and with a potential opportunity to step up to level 2 respiratory support in our HDU if a solution can be found for this to be commissioned and resourced. We hope this will represent an opportunity for further development of the service in a structured way and not to reduce the services we offer.*

- *We have for many years provided an out of hours GI bleeding service. Our clinicians' view is that should this be dis-established it would increase the clinical risk for the management of patients with GI bleeding as the proposed model is to transfer these high risk patients. If patients required anaesthetic support during transfer, this would also impact adversely on anaesthetic cover.*
- *We suggest it would be more appropriate to pool cover at weekend for stable GI bleeds to enable all the trusts to offer a seven day a week service for stable patients. Such lower risk patients could be transferred safely elsewhere with minimal supervision.*
- *With regard to stroke we welcome the network protocols that are being developed for thrombolysis, thrombectomy, management of mimics and repatriation and the opportunity to participate in the further development of the service so that all new stroke patients can reviewed within 14 hours of admission.*
- *Chesterfield welcomes the opportunity to continue to participate in the SYB ICS while recognising that we remain outside many of the formal mechanisms of the ICS, for example, system control total, place development and capital bids etc. As we move towards consideration of the site specific recommendations it will be necessary to ensure that any proposals take clear account of the Derbyshire Commissioners view as more specific proposals are developed.*
- *With regard to partnership for elective work, the trust will continue to look to work both within the Derbyshire STP footprint and in collaboration with South Yorkshire ICS.*

3.3.2 Response to points raised by Chesterfield Royal Hospital

The ICS notes that Chesterfield Royal Hospital NHS Foundation Trust supports the review and responds to the specific comments made as follows:

Site Specific Options - *"Chesterfield welcomes the opportunity to continue to participate in the SYB ICS while recognising that we remain outside many of the formal mechanisms of the ICS, for example, system control total, place development and capital bids etc."*

The HSR's recommendations were site agnostic, based on the collective availability of workforce and capacity across the SYBND region relative to forecast activity levels and care quality requirements.

As a priority, the hospital services programme will work with CCGs, Trusts and Clinical Working Groups to develop site-specific reconfiguration options to be taken forward for more detailed modelling and analysis. The implications for Chesterfield, of any scenarios which involve it, will be worked through as the work progresses.

While Chesterfield has indicated in its response that it wishes to be within scope for the Review, it is also a member of the Derbyshire STP and proposals would need to be agreed with the other networks or which it is a member. The SOC commits that the SYB organisations will work with Derbyshire commissioners to identify and mitigate any potential implications for the Derbyshire STP.

Maternity - *"We do not support the proposal to establish stand–alone midwife-led care units… Future decisions in relation to reconfiguration will need to take account of [interdependencies between maternity, neonatology and paediatrics]"*

The HSR focused on being able to expand the choice of services available to women, and being able to deliver high quality care at each of these care settings, given the current constraints on consultant and midwife numbers in the system.

In the interest of maintaining patient choice, the SOC says that SMLUs are not ruled out as an option for care delivery. However, moving forward the maternity and paediatric Clinical Working Groups will be asked to look at other models (national and international) to explore other alternative ways in which the

interdependencies between obstetrics and paediatrics may be met. The Clinical Senate will be engaged to assure any models which are proposed, to ensure that they are safe for patients.

The ICS will seek to engage significantly with mothers and women of child bearing age to understand their thoughts and concerns on how and where they would like to give birth.

The SOC identifies the following way forward on maternity services:

- We will model the impact of a reduction in the number of obstetrics units by one or two units, from the existing units in South Yorkshire and Bassetlaw and North Derbyshire.

- We will engage with the public on their preferences for midwifery-led care and we will continue to work with clinicians to understand if SMLUs can be delivered safely and efficiently.

- For those Places which potentially would not have an obstetric unit, we will model the implications of offering choice through standalone midwifery-led units, supported by robust referral and patient transfer protocols if needed. However we will also explore alternative clinical models. Traditionally, if changes to the maternity services are being proposed on a site, this would be mirrored by changes in paediatric services. We will explore alternative models that might allow the interdependency between maternity and paediatrics to be satisfied in other ways, and will assure the safety of any such models with the Clinical Senate.

- We will include neonatology in the modelling moving forward and involve neonatologists fully in the acute sustainability programme through the Care of the Acutely Ill Child Clinical Working Group.

- We will continue to model 'transformation options' e.g. using mid-grade staff and ANPs / AMPs in different ways, and changing job roles, to address workforce challenges.

Gastroenterology and Endoscopy - *"We have for many years provided an out of hours GI bleeding service. Our clinicians' view is that should this be dis-established it would increase the clinical risk for the management of patients with GI bleeding as the proposed model is to transfer these high risk patients."*

Maintaining the quality, safety and sustainability of services are all key criteria taken into consideration throughout the development of any options and their evaluation. In depth site-specific modelling of options will be done to assess and evaluate future options before any are taken to public consultation.

The alternative option of transferring consultants to the patient out of hours was discussed by the Gastroenterology Clinical Working Group during the first stage of the work, and was rejected on the grounds that it was less safe. Concerns were raised by clinicians that a consultant might travel to one site, and then be unable to provide support to a patient at another site.

Any options for service change will be co-developed with local specialists through our Clinical Working Groups, and will be assured by the Clinical Senate, to ensure the clinical safety of any proposed models of care.

Hosted networks - *"We would wish to have some assurance that the nominated host trust has the necessary capacity and capability to lead the network in the best interests of patients… We seek acknowledgement while Trusts remain accountable for their individual performance"*

Part of the process of designing a Hosted Network will be for Trusts and Commissioners to develop criteria around the requirements that a Host must be able to fulfil. This will ensure that that whilst the aim is for lead roles to be shared across the system, all Hosts have the resources and ability to perform the role of Host.

Under the basic Hosted Network model, all Trusts would remain accountable for their own individual performance. Potentially, two trusts might decide - under mutual agreement and in line with maintaining statutory responsibilities - to participate in a single service network, in which case one trust might support delivery at another site. Nationally, there are different models for this arrangement, and if any trusts wished to follow such a model the organisations would work with clinicians and lawyers to ensure that accountability requirements were appropriately met. Participation in a single service network would be entirely voluntary.

3.4 Mid Yorkshire Hospitals NHS Trust

3.4.1 Response received from Mid Yorkshire Hospitals

The following response was received:

The paper went to our Trust Board today. There were no significant issues raised with the paper or any comments to provide back to the review team.

3.4.2 Response to points raised by Mid Yorkshire Hospitals

The ICS notes Mid Yorkshire Hospitals Trust's agreement to the HSR.

3.5 The Rotherham Hospital NHS Foundation Trust

3.5.1 Response received from The Rotherham Hospital

The following response was received:

May we take this opportunity to thank you for coming to The Rotherham NHS Foundation Trust (TRFT) on Tuesday 26th June to discuss the Hospital Services Review. Your presentation was very informative and allowed us to understand the recommendations more broadly.

We have also noted the request to receive comments back from Trust Board's to inform the development of the Strategic Outline Case by 12th July, and therefore we are responding as outlined below.

The first section of our feedback addresses many of the recommendations made against the five specific services, and captured under the "service reconfiguration" concept within the report.

As a Trust Board:

- *We welcome and support the recommendation to keep all hospitals open and have a District General Hospital (DGH) in every place*
- *We welcome and support the recommendation to retain all existing Emergency Departments (ED) within South Yorkshire & Bassetlaw (SYB)*
- *We would expect this to be supported with emergency access on a 24/7 basis for both adults and children and to be supported by a 24/7 emergency medical and surgical take*
- *We note the recommendation to consider a reduction in the number of paediatric inpatient units and we are concerned about the impact such a move would have on the provision of safe and sustainable services within a DGH*
- *We are very concerned about the concept of Short-Stay Paediatric Assessment Units (SSPAU's) and how this allows for the safe and sustainable provision of maternity, neonatal and ED services within the DGH*

- *We also believe that the provision of inpatient paediatric wards needs to be explicitly taken in the context of both the local population and provision of services and the wider impact across SYB partners*
- *We welcome the recognition and acknowledgement that the high level of risk in the population of SYB makes a higher level of consultant-led obstetric services appropriate and that this needs to be factored in to future models*
- *We support the recognition given in the report to the interdependencies between obstetric led maternity services, paediatric services and neonatology and believe this is a critical aspect in any future modelling and recommendations*
- *We support the recommendation that the configuration of maternity services should support and enable sustainable paediatric services*
- *We support the recommendation to adopt a pairing approach between sites with HASU's (Hyper Acute Stroke Units) and those with ASU-only (Acute Stroke Unit) services.*
- *We agree with the benefits to be had in co-location of ASU's and Inpatient rehabilitation. However, we feel that more clarity is required on future model configurations in order to comment further*
- *We support the recommendation to consolidate overnight GI bleed services onto 3 or 4 sites, provided they are supported by robust patient transfer protocols and appropriately available, qualified and experienced medical staff*
- *We support the recommendation that all sites that currently provide daytime GI bleeds and (full diagnostic and therapeutic) elective endoscopy services continue to do so*
- *We would also welcome a recommendation for partners to work together across SYB to maximise all day-time capacity across the various sites as well as just additional weekend capacity*

We also welcome the "service transformation" approaches outlined within the HSR, and have further comments against some of the recommendations and proposal as follows:

- *We welcome the recognition and importance of integration at Place, and whilst acknowledging it was outside the scope of the review, we strongly support the concept that Place-based integration needs to be a key consideration for any work taken forward*
- *We also support the concept of treating as many patients as possible in the most appropriate care setting and that this may mean patients who currently attend acute hospitals are better treated in the community and that this move is in line with existing Place Plans*
- *We support the recommendation for service specific Hosted Networks and for each DGH / Organisation to host one of the networks. We also strongly support the recommendation that there is a fair and equitable distribution of hosts across SYB organisations*
- *We support the recommendation to develop a Health and Care Institute, particularly to help address some of the workforce challenges all organisations are experiencing and anticipate to continue, and to also address issues such as clinical variation, which are often inherent within the workforce*
- *We also support the development of an Innovation hub in principle to take forward system-wide innovation and how this will interface and work with existing institutions such as universities and colleges, to maximise the opportunity and avoid duplication*

One area of particular concern that we do need further assurance on, is around the associated timescales and next steps. The recent experience around the consultation on hyper-acute stroke services and the destabilising effect that this process had on the local clinical teams and the subsequent impact on services within Rotherham, from what was a reasonably strong service overall, is something that needs to be considered and learnt from. Any further de-stabilisation of services, particularly those under review within the report, needs to be avoided and where appropriate, system-wide mitigation plans put in place to help

avoid this from happening. We would welcome a discussion as a Board on how this could be addressed moving forward.

A final area of particular note is around the principle that "service transformation is the first stage, and the opportunities identified would be taken into consideration as to their impact before service reconfiguration is adopted. On this basis, we would like to understand more around the timescales for working this impact through and the rationale for addressing reconfiguration in advance of transformation schemes being developed and impact assessed. This is of particular importance given the concerns we have as a Trust Board around the potential destabilisation effect of any reconfiguration.

Overall, we support the review process and its aims to provide sustainable services across SYB whilst also providing a commitment to retain the majority of services within the local DGH.

3.5.2 Response to points raised by The Rotherham Hospital

The ICS notes The Rotherham Foundation Trust 's support of the HSR recommendations.

In response to the specific points raised by the Trust on paediatric assessment units, transformation themes and timescales:

Urgent and Emergency Care - The ICS welcomes Rotherham's support for the maintenance of all existing Emergency Departments within the scope of the Review, and in response to comments around opening hours can confirm that these EDs will remain open 24/7. To support better care at ED we will be exploring how we might better use our staff, such as through expanding alternative roles, within Royal College staffing guidelines

Paediatric Assessment Units - *"We are very concerned about the concept of Short-Stay Paediatric Assessment Units (SSPAU's) and how this allows for the safe and sustainable provision of maternity, neonatal and ED services within the DGH"*

This concern is noted, and it is important to reiterate that any proposals for reconfiguration will be developed in close collaboration with clinicians to ensure they meet safety and quality requirements.

Clinical evidence supports the safety of SSPAUs as an alternative to full-time inpatient units, particularly when there is not enough activity or resource to sustain a full paediatric inpatient unit, assuming appropriate transfer protocols are in place for those patients requiring overnight care. The Royal College of Paediatrics and Child Health support such a care model, stating that for many patients they are a more appropriate care setting than an inpatient unit, and are being increasingly used to deliver high quality paediatric care[3].

Moving forward, the SOC says that the system will model the impact of changing one or two inpatient paediatric units (from the existing units in South Yorkshire and Bassetlaw and North Derbyshire) into SSPAUs. If an SSPAU model is proposed, the Clinical Working Group will be involved to ensure that it is supported by robust referral and patient transfer protocols to ensure children are able to access the care they need out-of-hours. Any proposed changes will also be referred to the Clinical Senate to ensure that they are safe for patients.

The ICS will also consider the close interdependencies between paediatric, maternity and neonatal care in this modelling to ensure that the provision of paediatric and paediatric-related services remain safe. Neonatologists will be added to the Clinical Working Group on paediatrics, and neonatology will be included in the development of reconfiguration options going forward.

[3] Royal College of Paediatrics and Child Health, Standards for Short-Stay Paediatric Assessment Units, March 2017. Available at: https://www.rcpch.ac.uk/sites/default/files/SSPAU_College_Standards_21.03.2017_final.pdf

Modelling will also look at the impact that service change has on the sustainability of sites following reconfiguration, and maintaining quality and sustainability will be a key evaluation criteria in assessment options. The expectation is that modelling will be done using detailed data which will allow the model to capture nuances in local population demographics.

Transformation - Feedback from Rotherham emphasised the importance of the transformation workstrand, before any reconfiguration takes place. In response to this, the Strategic Outline Case has restructured the workstreams and work programme as laid out in the Hospital Services Review, to give a clearer emphasis to transformation elements before options are modelled in relation to reconfiguration. The SOC says that Clinical Working Groups will be asked to focus on transformation of the workforce and developing the shift out of hospital in the first months of their work programme, and this work will inform reconfiguration modelling so that reconfiguration is assessed on the basis of a transformed workforce rather than the status quo.

Hosted Networks - "*We support the recommendation for service specific Hosted Networks and for each DGH / Organisation to host one of the networks. We also strongly support the recommendation that there is a fair and equitable distribution of hosts across SYB organisations*"

The ICS notes Rotherham's support for the establishment of Hosted Networks, a Health and Care Institute and an Innovation Hub, to address the three key issues of workforce, unwarranted clinical variation and innovation.

Moving forward, the first step will be to work with Trusts and Commissioners to develop a framework that outlines the proposed form of the Hosted Networks and the lines of accountability between the Hosted Network, member trusts and the ICS. This will also lay out the responsibilities of both Hosts, and network members.

Trusts and Commissioners will work together to develop a robust approach to equitably assigning Host organisations for each of the Hosted Networks. This will include developing criteria around the responsibilities that a Host must be able to meet in order to act as a Host. This will ensure that that whilst lead roles are shared across the system as far as possible, all Hosts have the resources and ability to perform the role of Host.

Timescales - The ICS notes the recent destabilising effect experienced by the Trust following the hyper acute stroke service change proposals.

Some workstrands, such as those around the Hosted Networks, can proceed more quickly and we will aim to take these forward as quickly as possible.

Others such as reconfiguration will be longer and more complex. The Strategic Outline Case recognises that decisions on change need to be made and delivered with enough pace to not create undue uncertainty for staff while allowing sufficient time allowed to consider the implications for staff, patients, and the public, and for all organisations to discharge their statutory responsibilities. The timeline laid out in the full Strategic Outline Case aims to balance this.

3.6 SHEFFIELD CHILDREN'S HOSPITAL NHS FOUNDATION TRUST

3.6.1 Response received from Sheffield Children's Hospital

The following response was received:

Thank you for sharing with us a copy of the Stage 2 Report for the Hospital Services Review and the accompanying presentation that went to the Steering Group last week. A number of the team have reviewed this, as well as attended the most recent Clinical Working Groups.

As an organisation we are very supportive of the approach proposed and are keen to work with you and lead the paediatric elements of the programme going forward. At this stage there are obviously many possible variants to the models detailed that will require further work, but having discussed these with clinical colleagues, we wanted to raise the following two points that will require additional discussion and agreement:

1. *At this stage we are unclear whether our paediatric emergency department would best sit under the remit of the Co-coordinated Delivery Network for UEC or the single service model for Paediatrics. The exact nature of the models proposed will determine this and we can see both advantages and disadvantages of either option.*
2. *Similarly, whilst maternity is proposed to be part of a hosted network and paediatrics part of a single service model, we feel that further conversations need to occur as to how neonatal services will interact with both parts of this overall system. This is not clearly defined in the documentation at this stage.*

Neither of these two points are insurmountable but we would just like them to be noted at this point.

We look forward to working with you and the wider team in the future.

Addendum – further response from Sheffield Children's Hospital

1. *Capital funding drawn down from the ICS should be prioritised to support the outcome of HSR.*
2. *Sheffield Children's Hospital, as the specialist provider in the region, is happy to take a leading role in developing the networked approach.*

3.6.2 Response to points raised by Sheffield Children's Hospital

The ICS has noted the response from Sheffield Children's Hospitals NHS Foundation Trust, including the points made around the need to find the best fit for neonatology within the maternity and paediatric service models. The response is supportive of the HSR recommendations, with the following points being raised that will be relevant to the next steps:

Paediatric Hosted Network - *"…we are unclear whether our paediatric emergency department would best sit under the remit of the Co-coordinated Delivery Network for UEC or the single service model for Paediatrics."*

Moving forward, Trusts and Commissioners will be working together to develop the model for Hosted Networks. Establishing a framework for their development, and identifying Hosts and member trusts/sites for each of the networks will be a priority.

It will be for providers to agree, during this process, which Hosted Network SCH's paediatric A&E will be a part of. The hospital services programme team will support this process to ensure close engagement and thorough discussion to develop the most appropriate approach.

The ICS notes SCH's offer to take a leading role in developing the networked approach to paediatrics. Over the coming months the programme will engage Trusts and Commissioners in developing a robust approach to equitably assigning Host organisations for each of the Hosted Networks. This will include developing criteria around what requirements a Host must be able to meet. This will ensure that that whilst lead roles are shared across the system, all Hosts have the resources and ability to perform the role of Host.

Neonatology: *"Whilst maternity is proposed to be part of a hosted network and paediatrics part of a single service model, we feel that further conversations need to occur as to how neonatal services will interact with both parts of this overall system."*

Consideration has been given to the interaction of neonatology with the two differing service models suggested for maternity and paediatrics. Neonatologists have been added to the membership of the Care of the Acutely Ill Child Clinical Working Group and neonatology will be included in work on reconfiguration going forward.

Funding - The ICS notes SCH's comments on the capital funding within the ICS. As outlined in the Strategic Outline Case, a capital bid for funding to support the various ICS workstreams has been submitted to NHS England. A breakdown of the existing workstreams and funding requested for each is included in the SOC. Acute services improvement comprises a significant amount of the funding requested.

3.7 SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST

3.7.1 Response received from Sheffield Teaching Hospitals

The following response was received:

I am writing to you in your capacity as the lead of the shadow integrated Care System (sICS) for South Yorkshire and Bassetlaw on behalf of the Board of Directors of Sheffield Teaching Hospitals NHS Foundation Trust (STH).

Following the presentation by Chris Welsh to the private Board of Directors meeting on 26 June 2018, I am writing to confirm that Sheffield Teaching Hospitals NHS Foundation Trust accept, in principle, the proposals outlined in the Hospital Services Review.

3.7.2 Response to points raised by Sheffield Teaching Hospitals

The ICS notes Sheffield Teaching Hospitals NHS Foundation Trust's support for the recommendations put forward in the HSR.

4 RESPONSES FROM COMMUNITY AND MENTAL HEALTH TRUSTS

4.1 SHEFFIELD HEALTH AND SOCIAL CARE NHS FOUNDATION TRUST

4.1.1 Response received from Sheffield Health and Social Care

The following response was received:

Further to the email below and following discussions at the Board of Sheffield Health and Social Care Trust on Wednesday 11 July 2018, SHSC FT Trust, note the content of the paper including the significant engagement undertaken and confirm acceptance of the Review recommendations.

4.1.2 Response to points raised by Sheffield Health and Social Care

The ICS notes Sheffield Health and Social Care Trust's support for the recommendations in the HSR.

4.2 SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST

4.2.1 Response received from South West Yorkshire Partnership NHS Foundation Trust

The following response was received:

The Board has discussed the HSR in public and there has been general support for it. The Trust does provide the rehabilitation stroke service in Barnsley and we have been working with the Acute Trust on a stronger integrated approach on the care pathway. We would expect this joint work to support the direction of travel of the HSR.

4.2.2 Response to points raised by South West Yorkshire Partnership NHS Foundation Trust

The ICS notes South West Yorkshire Partnership NHS Foundation Trust's support for the HSR recommendations

We note the Trust's provision of stroke rehabilitation services in Barnsley and their work with the Acute Trust and expect this joint working to be aligned with the direction of travel of the HSR.

5 RESPONSES RECEIVED FROM OTHER PROVIDER ORGANISATIONS

5.1 EAST MIDLANDS AMBULANCE SERVICE NHS TRUST

5.1.1 Response received from East Midlands Ambulance

The following response was received:

Further to your briefing paper June 2018, I am writing with our response to the Hospital Services Review as requested. We welcome the opportunity to be involved in this important piece of work.

You will be aware that our involvement with the SYB sICS partnership is in the management and transportation of patients and service users via urgent and emergency ambulance services in North Derbyshire and Bassetlaw, using South Yorkshire, Bassetlaw and Chesterfield hospitals. In addition, we currently hold the contract for the majority of non-emergency patient transport for Derbyshire, linking primarily to Chesterfield and Sheffield Hospitals. We have therefore considered the impact of outcomes of the review with respect to both of these services, and across both our Nottinghamshire and Derbyshire divisions.

Following discussion, our views can be summarised as follows:

- *We regard the findings of the review, in general, as a positive step for patient care.*
- *The maintenance of six consultant led emergency departments across the footprint, plus paediatric services at Sheffield is welcomed and we expect to see a minimal impact on travel and turnaround times or patient safety as a result.*
- *We believe that the consolidation and networking of other services as described within the review will benefit patient care, and similarly overall, will not have a significant impact on our ability to transport patients safely.*
- *We are aware that whilst plans have progressed to consultation/engagement in some areas (stroke), further pathways continue to be developed. We will remain appropriately engaged with this work, in particular major trauma, stroke and PCCI, in order to understand the implications for our services more completely, and drive a comprehensive response to any proposed changes in service delivery.*
- *The review suggests the establishment of a strategic transport group and we welcome membership of that as discussed with you.*

Please do not hesitate to contact me if you have any queries and I will be happy to discuss these at our mutual convenience.

5.1.2 Response to points raised by East Midlands Ambulance

The ICS has noted the response from East Midlands Ambulance Trust. Overall, the response supports the recommendations of the HSR with specific comments raised about any potential transport and travel implications:

Transport - *"The review suggests the establishment of a strategic transport group and we welcome membership of that as discussed with you."*

The SOC says that the ICS will form a strategic transport group to bring together representatives from all stakeholder groups in order to better understand the issues around transport and access. This will provide a forum to enable through discussion of travel implications across SYB and will identify best ways to mitigate them.

The ICS welcomes EMAS' membership, and will communicate the next steps of the formation of this group as it progresses.

The ICS is committed to minimising the effects of travel on patient safety, and a review of academic papers and learning from previous reconfigurations is being undertaken to better understand this topic. The strategic transport group and the Clinical Working Groups will be asked to review this work, and this evidence base will inform the site specific modelling process to ensure any risks are mitigated and minimised.

5.2 YORKSHIRE AMBULANCE SERVICE NHS TRUST

5.2.1 Response received from Yorkshire Ambulance Service

The following response was received:

Our Board had a briefing on the work of the ICS and Hospital Services Review in May 2018.

The Board welcomed the clear approach and the potential implications for the ambulance service as plans progress.

We are generally supportive of the approach being taken and have no further comments at this time.

5.2.2 Response to points raised by Yorkshire Ambulance Service

The ICS notes Yorkshire Ambulance Service's support for the HSR recommendations.

Moving forward, the implications of service change on travel times, for both ambulance and non-ambulance travel, will be a key criterion in the evaluation of options. As such, we plan to continue our significant engagement with Yorkshire Ambulance Service, through the Clinical Working Groups and the soon to be formed strategic transport group.

6 RESPONSES RECEIVED FROM LOCAL AUTHORITIES

6.1 JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

6.1.1 Action points from the JHOSC

On 12th June 2018, the HSR team and the ICS presented the HSR recommendations to the South Yorkshire, Derbyshire, Nottinghamshire and Wakefield Joint Health Overview and Scrutiny Committee.

The formal minutes of that meeting will be published by the JHOSC in due course. However, the key action points which the ICS identified during the meeting were as follows:

- ***Public engagement**: the JHOSC asked that an easy read version of the HSR be made available, and that in future easy read versions be included alongside the publication of major documents.*

  An easy read version of the HSR report has been produced by SpeakUp, a social enterprise which specialises in advocacy for and communication with people with learning disabilities. This has been submitted to the JHOSC and will be published shortly. Going forward, we will produce easy read versions of major documents in parallel with the full versions.

- *The JHOSC also asked that the team ensure that the deadline of 12th July 2018 for responses to the HSR document be publicised to stakeholders.*

  The communications team emailed stakeholders, including those groups and individual members of the public who have asked to be kept informed about the Hospital Services Review and who had confirmed their details under the General Data Protection Regulation, to make them aware of the 12th July deadline.

6.2 ROTHERHAM BOROUGH COUNCIL

6.2.1 Response received from Rotherham Borough Council

The following response was received:

We note this independent review of hospital services within SYB footprint and welcome the commitment that the majority of services should remain in local hospitals. Our priority is to ensure that Rotherham residents retain access to high quality services within easy access and acknowledge the report's commitment to maintaining most locally provided services. We acknowledge and are supportive of the concept of the hub model and whilst we would welcome further details, if indeed this proposal does seem to offer a cost effective way of retaining local services. However it is important that the "hubs" are distributed across the geographic area and not entirely based in Sheffield, we would be concerned if this signalled a shift to simply place more services within the city of Sheffield. We appreciate the issue regarding shortages of key staff and as a general principal agree with the hub model but would want to see Rotherham play a key role in at least one of the hubs

We do support the concept of excellence in health care so see the setting up of a Health and Care Institute (pleasing bearing in mind the move towards further integration we welcome that care is mentioned as well as health) and an innovation hub, developing closer links with universities, colleges and schools. It is also a

positive step that future workforce planning is included especially bearing in mind current medical staff shortages.

The concept of shared working and collaboration in terms of strengthening the workforce, reducing unwarranted variation and introducing innovation to tackle complex challenges is supported however we will await further detail on how this may operate and the local impacts before making any specific comments.

We are pleased that all existing A and E Departments in the area are proposed to stay open and there is a commitment to keep all the hospitals open as District General hospitals with the range of services one would expect. We would oppose any move towards "cottage hospitals".

In terms of Children's wards we support that the children's wards in local hospitals are proposed to stay open and fully support where appropriate care being provided in the community which is exactly the stance many of the services such as Adult Social Services at the Council where this is in the interests of patients. However we have concerns that further reviews may well lead to fewer units and a concentration into a smaller number of hospitals. Linked to this is that whilst we welcome having Sheffield Children's hospital a centre of good practice in the ICS area, traffic to it including parking is extremely difficult whether you are attending as a visitor or patient and we would expect to see proposals brought forward which would address such practical considerations.

Whilst we can support in principle the concept of specialist units, we do have concerns that overnight and weekend gastroenterology services will only be provided in three or four hospitals. Clearly it remains important that appropriately qualified and experienced medical staff are readily available "out of hours", further detail is needed on this aspect to understand the clinical benefits and any impacts on residents.

We support the concept of more choice being given to mothers in terms of delivery options as long as these are real options within each borough and that adequate information is given to the expectant mother in order to make the right choice. We note that the current model does not meet the requirements as laid out in Better Births to give a wide range of choices to women and are very supportive of improving the local offer.

We are aware that the report stresses the need for consultation but have concerns regarding the type and level of consultation in the development of this report and would stress the need for further engagement and consultation with residents and stakeholders as proposals are developed.

One of the biggest concerns in Rotherham in relation to recent experience of consultation related to the acute stroke units and the issues of distance to Sheffield. This aspect featured in all the preliminary reports and is featured in the review, but we feel very strongly that the timescale and consultation on this was poor. Likewise in terms of consultation with the Council and the communities it represents, up to this point on the Hospital Services Review, we do not feel that overall there has been adequate communication and consultation with communities and local Councils and would strongly urge the regional ICS to take this point on board. We are aware of local public meetings in New York Stadium and elsewhere but we strongly believe that Council's and Councillors as democratically elected representatives of their communities should be consulted separately.

6.2.2 Response to points raised by Rotherham Borough Council

The ICS notes the response from Rotherham Borough Council, including the points made around the need for much clearer communication and consultation, the need to assure appropriate levels of access to sites, and the need to provide equitable access to hubs to all patients in SYB through the even distribution of sites. The response is supportive of the HSR recommendations, and the ICS would like to provide the following response to the particular concerns raised:

Engagement - *"…we feel very strongly that the timescale and consultation on [stroke] was poor… we do not feel that overall there has been adequate communication and consultation with communities and local Councils and would strongly urge the regional ICS to take this point on board."*

The ICS is in the process of developing an engagement strategy for the work on hospital services going forwards. This will draw on learning from the consultation on Hyper Acute Stroke Units. The engagement strategy will be published in due course.

With regard to engagement with Councils, ICS acknowledge these comments and will endeavour to improve the communication and engagement with local councils during the next stages of the work on hospital services. The Hospital Services Review has engaged both with the Collaborative Partnership group and with the Joint Health Overview and Scrutiny Committee, and the hospital services programme will continue to do so. More generally, the Integrated Care System will engage with Local Authorities, including Leaders, around the development of shared working across the system. Leads in individual CCGs will continue to maintain close links to Local Authority colleagues in their areas.

The ICS will engage with Directors of Public Health, and with Health and Wellbeing Boards as the modelling is developed, to ensure that population health implications are understood.

Hosted Networks - *"It is important that the "hubs" are distributed across the geographic area and not entirely based in Sheffield"*

The intention for the Hosted Networks is that the role of Host will be distributed equitably across the Trusts, provided that a Trust is able to meet the criteria necessary to act as a Host. It should be noted that the Hosted Networks approach is not a 'hub' model as it does not involve moving services between sites.

Some of the reconfiguration models that the SOC proposes to explore would involve a 'hub and spoke' model, with for example a concentration of paediatric inpatient activity on a smaller number of sites. The trusts which act as 'hubs' will be identified through the site-specific modelling.

Access - *"whilst we welcome having Sheffield Children's hospital a centre of good practice in the ICS area, traffic to it including parking is extremely difficult whether you are attending as a visitor or patient and we would expect to see proposals brought forward which would address such practical considerations".*

The SOC states that the ICS will set up a strategic transport group which will bring together different stakeholder groups to provide a forum for thorough discussion on how to best mitigate concerns around access issues, such as travel and parking.

This group will comprise representation from local acute trusts, commissioning bodies, ambulance services (both Yorkshire and East Midlands Ambulance services), local authorities, patients and the public, and other relevant local travel and transport stakeholders (such as local public transport providers) who can share their expertise on how to best address any potential impact for patients following reconfiguration.

Gastroenterology - *"Whilst we can support in principle the concept of specialist units, we do have concerns that overnight and weekend gastroenterology services will only be provided in 3 or 4 hospitals…, further detail is needed on this aspect to understand the clinical benefits and any impacts on residents".*

Maintaining the quality, safety and sustainability of services are all key criteria taken into consideration throughout the development of any options and their evaluation, and in depth site-specific modelling of options will be done to assess and evaluate future options before any are taken to public consultation.

Any options for service change will be co-developed with local clinicians through our Clinical Working Groups, to ensure the clinical safety of any proposed models of care, and will be reviewed by the Clinical Senate.

The ICS notes the Council's concerns about the safety implications of moving to full out of hours services on three or four sites rather than on all sites; however, the system does not currently provide out of hours services on all sites. At present, some sites provide some cover on some nights and not others; or not at all. The aim of this approach is to provide a consistent and standardised level of cover for SYB(ND) patients.

7 RESPONSES RECEIVED FROM PATIENTS AND THE PUBLIC

7.1 MEMBER OF THE PUBLIC - 1

The following response was received from a member of the public, writing in an individual capacity.

7.1.1 Response received from a member of the public

This is a response to four documents, listed below [4], published on 9 May 2018, together with videos on the same website and slides presented at the Joint Health Overview and Scrutiny Committee on 12 June 2018.

1 Issues of geography

There is a slippage from SYB to SYB-MYND, evident on the website, Health and Care Working Together SYB, and in the report, entitled Hospital Services Review South Yorkshire and Bassetlaw, North Derbyshire and Mid Yorkshire: Stage 2 Report, but with the logo of South Yorkshire and Bassetlaw Working Together. This raises questions such as: Whose money? Which patients? Who is in charge?

2 Governance, transparency and pace of change

Issues of governance arise in a series of increasingly impatient statements throughout the report:

> *The current arrangements between providers are unlikely to be fit for purpose when considering the scale of change that is included in this report. It is not the role of the HSR to design the future working arrangements of the provider and commissioner sectors in SYB(MYND). However, the effectiveness of these arrangements will impact how successfully the HSR recommendations are implemented. (Doc 1, page 11, italics added)*

These comments are echoed, with progressively less reserve on later pages:

> *The current arrangements between providers are unlikely to be fit for purpose when considering the scale of change that is included in this report. SYB(MYND) should review current governance arrangements and ensure these enable rapid decision making at pace to support the successful implementation of the recommendations in this report. (p 18)*

Arrangements are still "unlikely to be fit for purpose", but the review now states that they should be reviewed, to enable "rapid decision making" and, in case that was not understood, "at pace" is added.

> *The current arrangements between providers are not fit for purpose when considering the scale of change that is included in this report. SYB(MYND) should review current governance arrangements and ensure these enable rapid decision making at pace to support the successful implementation of the recommendations in this report. (p 160)*

By page 160, nearing the conclusion, any doubt about unfitness for purpose has gone. Even more disquietingly, the reviewers are urging ways around the lack of legislation provision to enable the rapid change they want to see:

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[4] Doc 1 *Hospital Services Review South Yorkshire and Bassetlaw, North Derbyshire and Mid Yorkshire: Stage 2 Report*
https://www.healthandcaretogethersyb.co.uk/application/files/2515/2579/1881/1._HSR_Stage_2_Report.pdf
Doc 2 *South Yorkshire and Bassetlaw Hospital Services Review – Annexes*
https://www.healthandcaretogethersyb.co.uk/application/files/3315/2577/3849/2._HSR_Stage_2_Report_Annexes.pdf
Doc 3 *South Yorkshire and Bassetlaw Accountable Care System The Hospital Services Review Technical Annex: Financial Analysis*
https://www.healthandcaretogethersyb.co.uk/application/files/6715/2577/3840/3._HSR_Stage_2_Report_Technical_Annex.pdf
Doc 4 *Hospital Services Review Report Question and Answer sheet – May 2018*
https://www.healthandcaretogethersyb.co.uk/application/files/6615/2639/7198/4._HSR_Stage_2_Report_Questions_and_Answers.pdf

> *Current governance arrangements do not go far enough to give the system the level of control required to effect change. Any future model will require all organisations to cede some sovereignty to the system – this will be difficult, particularly without legislative change and while the end-state clinical model is not yet fully defined. We would therefore expect that there would be a number of interim milestones along this journey. (p 160)*

This impatience to achieve control regardless of legislative change seems worryingly undemocratic and may not enable the best decisions to be made. It sits oddly with a proclaimed "long history of collaborative working" (Doc 1, page 157), despite which there appears to be a lack of trust evident here and also in the paucity of financial data made available for the HSR, which is discussed in section 7 below.

The £571m cuts target in the STP makes a mockery of the idea of local decision-making, since local managers are rushing to meet deadlines and receive transformation money from government.

3 Rationale for the review

Apparently, there are always two reasons for doing something: a good reason and the real reason. The Summary of proposals for public engagement lists these challenges for hospitals in SYB-MYND:

- *The population is ageing*
- *Demand is increasing*
- *Our workforce is increasingly overstretched*
- *People's needs are changing*
- *The types of healthcare that we can provide are changing*

However, they say, the NHS has not changed to keep up. As each of these premises can be challenged, the real reasons for the review may lie elsewhere – in the financial and policy constraints imposed centrally.

The population is ageing

Victim blaming and the idea that burdensome older people are to blame for increasing pressures on health and care services has been challenged elsewhere[5]. For example, many pensioners remain active, contribute to society and do all kinds of work, paid and unpaid. At the same time, many younger people are also suffering from deteriorating health. Given this, the focus on one age group seems misplaced and ageist. It masks the crisis in social care, which has been underfunded and undermined by successive governments, and underplays chronic ill health, both mental and physical, in other age groups and simplistically juxtaposes ageing and complex needs:

> *As people live longer, chronic diseases such as type II diabetes, or illnesses associated with ageing such as dementia, are replacing traditional morbidities. Frail and elderly people make up an increasing proportion of patients. At the same time, healthcare can now treat increasingly complex acute illnesses with ever more personalised and intensive therapies. (Doc 1, page 20)*

Demand is increasing

The so-called increase in demand has existed since the early days of the NHS and is driven by many factors, including air pollution[6], poverty, benefit 'reforms', failed housing policy and austerity cuts. The Director of Public Health for Sheffield, Greg Fell, stated in his 2017 report:

> *Demand for health and social care in England is currently increasing by about 4% per year, faster than the ageing population. Moreover, there is now consistent evidence from a macro perspective that the key drivers of cost growth are: disease incidence (prevention); lack of attention to primary care, high cost technology (manufacturer pressure & patient expectation)' and over diagnosis (clinical culture and system pressure).[7]*

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[5] http://www.nhsbill2015.org/wp-content/uploads/2015/03/Myth-of-Ageing-fact-sheet.pdf

[6] https://www.thestar.co.uk/news/hospital-blamed-over-intolerable-air-quality-in-sheffield-suburb-where-pollution-is-nearly-twice-the-legal-limit-1-9220793

[7] *Director of Public Health Report for Sheffield 2017* https://www.sheffield.gov.uk/content/dam/sheffield/docs/public-health/health-wellbeing/Director%20of%20Public%20Health%20Report%202017.pdf

In the same report, he also listed risk factors for mental wellbeing, including housing insecurity, homelessness, poverty, debt problems, low wages, insecure employment, long-term unemployment, ongoing consequences of welfare reform and austerity. However, where the HSR touches on public health, it overlooks root causes and risks to health. It also refers in a limited fashion to health inequalities:

> *There are significant inequalities in health outcomes in the population of SYB. Part of addressing these inequalities is ensuring that all patients, wherever they live, can access the highest quality specialist care. (Doc 1, page 20)*

There is just one passing reference to "existing inequalities in population health" (Doc 1, page 28), which surely merit more attention.

Our workforce is increasingly overstretched

This is a strangely impersonal way to refer to overwhelming pressures on staff, which have been thoroughly documented, most movingly by the Royal College of Nursing in two reports on Safe and Effective Staffing published in 2017[8]. These make heart-breaking reading, and nothing in the HSR reports comes anywhere near addressing the concerns of the RCN or of NHS Providers, who described the challenges facing our NHS in 2017 as Mission Impossible, risking patient safety and creating unfair and unsustainable burdens on staff[9]. We have heard similar concerns from local union reps, dismayed by the pressures on their members. Yet the review blithely proclaims that our region will be transformed into "a place where people want to come and work". (Doc 1, page 19)

People's needs are changing

The changing health needs of local people are barely addressed in this HSR, appearing only in a section of the annexes entitled Place Definitions (Doc 2, pages 88-147) where common issues across the five towns appear to be cancer and cardio-vascular deaths, alcohol, smoking, diabetes and obesity. There is nothing to indicate how needs have changed in South Yorkshire and Bassetlaw, nor how they should be addressed.

The types of healthcare that we can provide are changing

Changing types of healthcare are not spelt out, nor are the ways that our NHS has changed, noted elsewhere as related to repeated reorganisations, privatisations, outsourcing and the hollowing out of the state, losing experts and their skills to private enterprises.[10]

4 Purpose of the Review

The real purpose of the review is evident in its approach. Five services were identified as "facing significant difficulties with workforce and quality". These difficulties were to do with staff shortages, clinical variation despite national standards, and not making the most of new technologies. The services were:

- *Maternity*
- *Care of the Acutely Ill Child*
- *Urgent and Emergency Care*
- *Gastroenterology and Endoscopy*
- *Stroke*

The choice of services does not appear to be related to the health needs of the population set out in the Review Annexes (Doc 2), but to system pressures.

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[8] RCN (May 2017) *Safe and Effective Staffing: The Real Picture* https://www.rcn.org.uk/professional-development/publications/pub-006195
RCN (December 2017) *Safe and Effective Staffing: Nursing Against the Odds* https://www.rcn.org.uk/professional-development/publications/pub-006415

[9] NHS Providers (2017) *Mission Impossible? The Task for NHS Providers in 2017-18* http://nhsproviders.org/mission-impossible

[10] http://www.oxfordscholarship.com/view/10.1093/oso/9780198786108.001.0001/oso-9780198786108-chapter-8

For each service a Clinical Working Group was set up. These met five times, were sporadically attended and seem to have involved managers rather than frontline staff (see Doc 2, pages 154 onwards). These groups considered two types of solutions: hospitals working together better or reconfiguring services. They use terms such as streamlining, standardising, shared approaches, interoperable systems, standards and protocols. They concluded that there would be three different levels of networks with different degrees of shared working: hosted networks, coordinated delivery and single service model.

Although there is a glossary, it is not very helpful for people unfamiliar with this kind of management-speak. As yet, there is no clear indication of where responsibilities for hosting networks, coordinating delivery or driving single service models will be located.

5 Lack of staff involvement

Few frontline staff were involved in the Clinical Working Groups set up to discuss the challenges of workforce, clinical variation and innovation, and the possible restructuring of various services. Strangely, a comment on stakeholder engagement states: "It will be essential to the programme that financial and clinical leads continue to be engaged." (Doc 3, slide 63). Since when were such people the only stakeholders? Staff were apparently included in consultations with patients and the public through paper-based surveys made available in "areas convenient for staff" (Doc 1, page 16). How many staff encountered these conveniently scattered surveys or had time to fill them in is not stated.

There is only one reference to staff unions being involved in any way, and this was only in response to a question published on the website in Doc 4 Hospital Services Review Report Question and Answer sheet – May 2018:

> *As part of the work of Health and Care Working Together, a Staff Partnership Forum has been set up with key union representatives involved. This group meets regularly and is kept up to date with all developments. This group will continue to meet and will be involved in further work should any of the recommendations be taken forward. (response to question 25)*

Thus, there has clearly been no formal consultation with unions related to the Hospital Services Review.

We know from many conversations that staff are scared to speak out about the stress they face at work, their misery at not being able to deliver care as they would like to and their frustration with shifts that never finish on time, and that are not allocated in accordance with their needs and preferences. There is a palpable climate of fear that suggests a culture of bullying. None of this supports the claim that "The HSR has worked extensively with patients, the public and clinicians." (Doc 1, page 26)

6 Staffing shortages

Here is the HSR vision for addressing staffing issues:

> *By working together, the acute trusts will strengthen their workforce, building on existing expertise to improve quality of care for patients, enhancing the reputation of our hospitals. We will work creatively with schools and universities to attract new entrants to healthcare professions, as well as those who wish to return to clinical practice. We will become a leading innovative system, identifying and adopting new approaches to healthcare to solve some of our most complex challenges. We will make SYB(MYND) into a place where people want to come and work. (Doc 1, page 19)*

This suggests glamorous advertising campaigns, with competition across the country replacing real solutions to staffing problems.

The Review talks about how to "attract interested talent" (page 30), which has to undergo "thorough and effective induction and on-boarding" (page 26). The section on retention of staff begins with "improved professional support, supervision and guidance" and reflects a management culture of control, rather than development. It also mentions issues such as "pastoral support and other benefits to support staff health and

wellbeing, such as through the provision of healthy food and snacks in any staff canteens" (page 29), rather than tackling underlying causes of low morale. In contrast, Sarah Wollaston told the House of Lords Select Committee on the Long-Term Sustainability of the NHS:

> *It is not only about recruiting them but about the ongoing, continuing professional development that you give people that allows them to feel valued and retained within the service…*
> *Also, as people get towards the end of their careers, rather than retiring, encouraging people to be retaining their skills within the system, within management and training is a very positive thing.*
> *There is much more we could learn from other systems about morale more generally and how other systems maintain that.*[11]

Similarly, two Royal College of Nursing reports, published in 2017 and cited earlier, argued that there are too few nurses, which means terrible working conditions, which mean that the workforce is shrinking even further. Their solutions lie in funding, coherent planning and training in order to meet patient needs.

There have been many reports of students approaching graduation who are looking for work abroad, taking their expensive training and skills away from our NHS, and of staff leaving in droves, unable to stand the pressures any longer, unable to provide the quality of care they would like to, to work the shifts they have requested to fit in with family commitments, or even to make ends meet. All this suggests that recruitment is not the main issue, as staff are working in desperate conditions that are driving them to leave our NHS. While the HSR acknowledges that staff shortages mean that staff work long and sometimes unpredictable hours, lack time for training and are leaving because of the pressures, their main emphasis seems to be on sharing HR management to end competition for staff within SYB, whatever that means.

Another cause for concern is the willingness to go below safe staffing levels as defined by the Royal Colleges when considering how to reorganise services, treating safe levels as "aspirational" (Doc 1, page 113). Ignoring threats to patient safety is unacceptable. The shortage of 150 midwives in SYB-ND is mentioned on page 141, along with shortages of neonatology nurses, radiologists, sonographers, paramedics and anaesthetists. Much of the report is about coping with staff shortages by cutting services: this does not seem a sustainable, long-term solution.

7 Lack of public voice

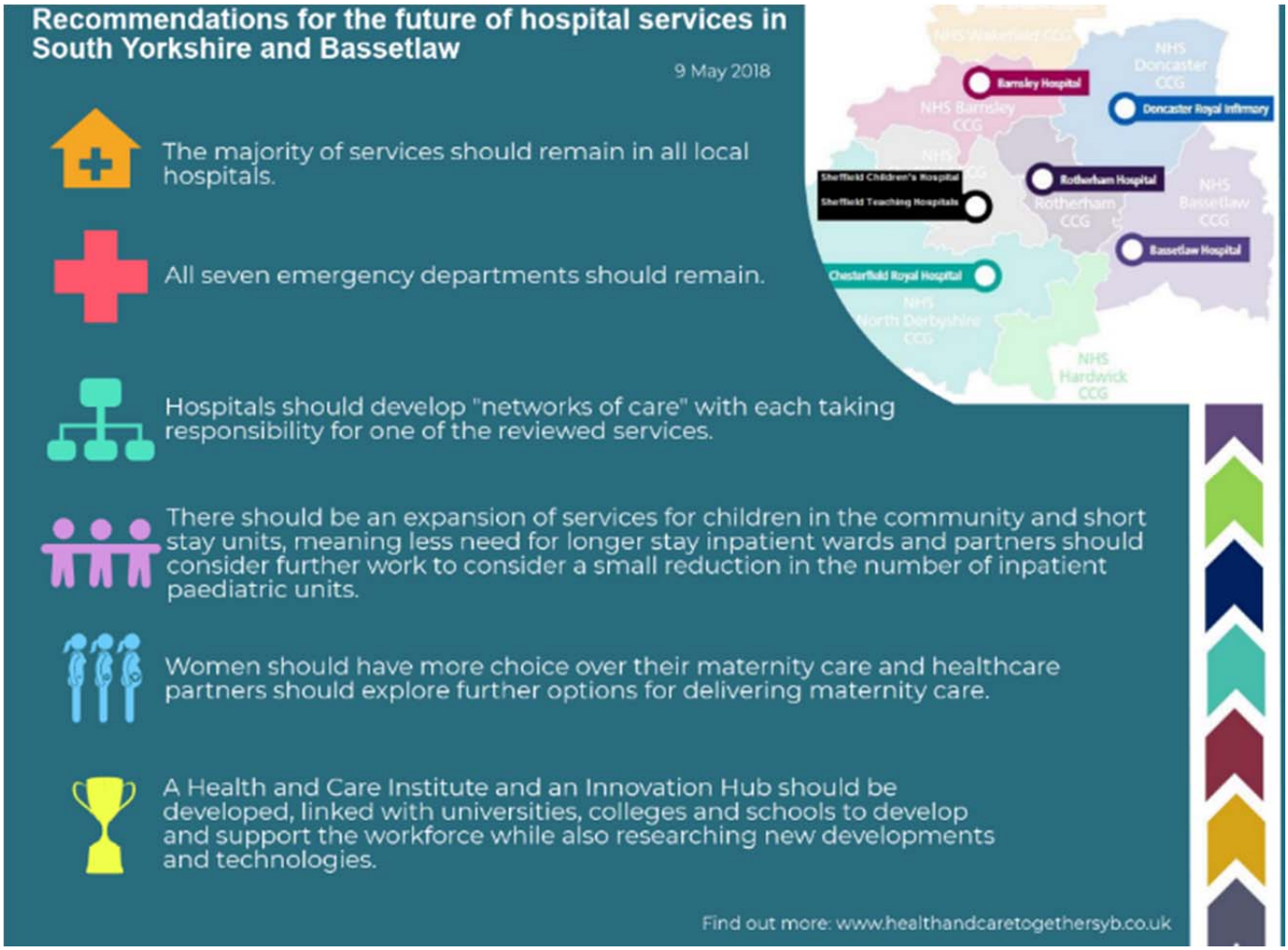
Members of the public were invited to comment only in very controlled ways at meetings held at Meadowhall in 2017. For instance, we were asked to rank criteria that were not ours, and to comment on staffing levels with no explanations about their implications.

A Citizens Panel has been set up, but the membership is unknown; it is said to provide an independent view and critical friendship[12]*, aims which seem difficult to reconcile.*

The presentation of the key points of the review simplifies the issues beyond belief, no doubt in an attempt to reassure the general public, rather than invite serious comment:

[11] http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/nhs-sustainability-committee/longterm-sustainability-of-the-nhs/oral/44553.html December 2018, Q 288

[12] Citizens Panel information https://www.healthandcaretogethersyb.co.uk/index.php/about-us/whychange/latest-news/could-you-be-part-our-citizens-panel



1 *The majority of services should remain in all local hospitals. We have already been asked whether this means that 51% of services will remain and 49% be cut, which may seem flippant, but highlights the mistrust provoked by the lack of transparency around the review. The above slide does not include the reconfiguration recommendations for stroke, which was understandable as a legal decision was pending. However, it also omits proposed cuts in obstetrics units and gastroenterology services. The technical/financial annex includes the possibility of cutting beds from 5,178 to 4,637 by 2021/22 (Doc 3 slide 25). This raises concerns about premature discharge as well as the possible rationing of admissions.*

2 *All seven emergency departments should remain. Should does not mean that they will remain. Perhaps in the end only some emergency services will remain. Already there is huge concern in Sheffield about proposals to shift facilities from the Minor Injuries Unit and the Walk-in Centre to an Urgent Treatment Centre at the overstretched and inaccessible Northern General Hospital.*

3 *Hospitals should develop "networks of care" with each taking responsibility for one of the reviewed services. Details of these responsibilities remain unclear, and much of the discussion about hosted networks, single service models or coordinated delivery to manage flows of resources and patients treats people are treated as units to be shifted around the system, omitting impacts on quality.*

4 *There should be an expansion of services for children in the community and short stay units, meaning less need for longer stay inpatient wards and partners should consider further work to consider a small*

reduction in the number of inpatient paediatric units. In fact, the proposal is to convert one or two children's wards into paediatric assessment units, but the implications are not spelt out.

5 *Women should have more choice over their maternity care and healthcare partners should explore further options for delivering maternity care. 'Choices' refers to a document called Better Births[13], which promotes women's choices, including the choice to give birth at home. The possible over-medicalisation of childbirth by (male) consultants is one issue, but 'choosing' home births might be inadvisable, since a higher proportion of women in SYB are at high risk than the national average and only 23% of births might be eligible for safe treatment in standalone midwifery led units (pages 137-138 of HSR Doc 1). Even with the positive spin, this recommendation has begun to alarm local people: after all, 'low risk' does not mean there is no risk. Moreover, the focus on 'choice' may exacerbate existing health inequalities.*

6 *A Health and Care Institute and an Innovation Hub should be developed, linked with universities, colleges and schools to develop and support the workforce while also researching new developments and technologies. Details of the proposed Institute are tucked away in chapter 9 of the main report, with functions and faculties illustrated on pages 56-7. This seems an expensive way to address the £17m cost of temporary staff in the past year, the staffing gaps required to meet Royal College guidelines (17% in paediatrics and 18% in maternity, slide 25 of Doc 3), let alone cope with the demoralisation of staff reported by the Royal College of Nursing, nurses' recourse to food banks, the PTSD reported to us, and so on. Professor Welsh casually suggests in his video that the proposed South Yorkshire Health and Care Institute would encourage young people not in education, employment or training to join the health service. He seems unaware that many young people are not in education or training because of high student fees and debt burdens, the abolition of EMAs and nursing bursaries, though bursaries are mentioned several times in the report. How would an HCI overcome these problems? Where would it find staff and on what terms and conditions would they be employed?*

Of the Innovation Hub, Prof Welsh says in his video that this is to find gizmos to meet needs, rather than to benefit the gizmos. The main report refers to Care 2050[14], a University of Sheffield proposal:

> *The Sheffield City Region has today (22 January 2016) been announced as one of seven national Test Bed innovation centres to take part in a major new drive to modernise how the NHS delivers care.*

On 28 June 2018, the Sheffield Telegraph reported Richard Caborn's plans for two further facilities at the Olympic Legacy Park (an Orthopaedic and Rehabilitation Research and Innovation Centre and Sheffield Children's Hospital's proposed Centre for Child Health Technology). How far have all these projects been thought through?

6 Lack of resources and lack of adequate data

The Technical Annex: Financial Analysis considers the capacity challenge and the workforce challenge. Aims include how to cut beds and reduce the £17million spent on temps in the past year.

> *The system needs more ambitious out-of-hospital shifts to reduce the number of beds over the next five years. There are currently c. 5,178 beds in the system at an average bed utilisation of 89%. If no other changes were made apart from activity growth, to achieve a target utilisation of 85%, 6,048 beds would be required in 2021/22. (Doc 3 slide 26)*

They claim that saving money is not the issue, despite the £571m cuts required by the STP. The reason for closing beds, when the population and complex needs are growing, is unclear. Moreover, the report states that there is limited spare capacity in all of the services reviewed except paediatrics, so that new bed capacity

[13] https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf
[14] https://www.sheffield.ac.uk/news/nr/leading-the-way-with-new-test-beds-1.543143

would generally be required. References to "more ambitious out-of-hospital plans", in order to free up capacity (slides 57, and 59-61) are also worrying.

Financial data are incomplete, having been obtained only from Barnsley, meaning that the review is based on unwarranted assumptions. This is admitted in the technical annexe (Doc 3, slide 65), which gives a list of 13 limitations:

HSR analysis

There are currently significant limitations to this initial financial analysis

Limitations and assumptions of this initial analysis

1. **Data sources.** The analysis was developed using reference cost data, STP financial forecasts and SLR information where provided (Barnsley). HES/SUS/wider SLR data could not be used as not all Trusts provided the information.
2. **Financial challenge.** The estimates of the 5-year financial challenge were taken from the model developed as part of the STP process. Information was available solely for overall income and expenditure under a do-nothing and a 'do-something' scenarios (after CIPs and out-of-hospital schemes). 21/22 was not estimated as part of the STP process and has been projected based on the latest trend.
3. **Stretch out-of-hospital impact.** The impact of the stretch out-of-hospital scenario on the provider cost base has been estimated by proportionately increasing the impact of these solutions (x2).
4. **Split of Doncaster, Bassetlaw and Montague cost base.** The Trust-level financial projections and service-level reference costs have been apportioned to the different sites using planned capacity figures.
5. **Apportionment to HSR services.** The STP provider financial projections have been apportioned to the services considered as part of the HSR by using Reference Costs dataset.
6. **Split of total cost across fixed, semi-fixed and variable.** Barnsley SLR was used to estimate the proportion of each service costs.
7. **Workforce efficiencies & service model benefits application.** The workforce efficiencies and service model benefits derived from the workforce analysis have been applied to the proportion of semi-fixed costs related to staffing of the impacted providers. This has been done after having normalised the system-wide impacts to capture the impacted sites and having taken the average of the three scenarios considered.
8. **Split of A&E Type 1, 2 and 3 costs.** The split of total costs identified through Reference Costs dataset has been adjusted to reflect activity volumes weighted by cost as the costs.
9. **Alignment of workforce and finance analysis.** It has been assumed that the STP baseline finance analysis has incorporated similar assumptions in terms of workforce growth as the ones presented in the pack.
10. **Fixed costs savings.** Fixed cost savings have been estimated only when leaving capacity/beds generated a new build at the receiving site.
11. **New build and refurbishment costs.** New build and refurbishment costs have been developed based on publically available information (examples below) on business cases and capital development programmes and stakeholder engagement.
12. **Capital expenditure.** Estimates capture the capital costs related to areas such as cubicles, theatres, equipment etc. through the number of beds and new build/refurb costs associated with that. These additional areas have not been assessed separately as part of this analysis.
13. **Reviews.** Whilst the results have been shared with Directors of Finance, the analysis has received limited QA.

Briefly, not all Trusts provided the information. Thus, some costs were estimated based on the latest trend or data from Barnsley or on publicly available information. Finally, as if all those limitations were not enough, "the analysis has received limited QA." Even without specialised knowledge, the financial assumptions and data can be seen to be questionable, if not useless.

The shakiness of data admitted here does not inspire confidence in how public money is being spent. Nor does it augur well for "collaborative working" if data cannot be collected.

Moreover, finance is not the only area in which data were incomplete. Other sections of the technical analysis state that figures were drawn only from one or two trusts, or that trusts did not always update their data. (See, for instance, slides 27, 37, 38, 39 in Doc 3).

7 Transport issues

Chapter 22 is devoted to Transport because:

> *Clinicians, patients and the public consistently told the HSR that transport is one of the most crucial factors to consider. This includes transport from patients' homes to hospitals and transport between hospitals. (Doc 1, page 161)*

The report also states:

In order to consolidate work to date and develop a consistent transport strategy for SYB(MYND), a Transport Reference Group (TRG) should be created, with representation from acute trusts, commissioners, Yorkshire Ambulance Service and East Midlands Ambulance Service, local transport authorities, as well as patients and the public. Increased collaboration with transport stakeholders is already underway, such as through the regional Chambers of Commerce. This should be expanded to develop closer relationships between SYB(MYND) health and care providers and local public transport operators. The TRG should have a remit for developing the SYB(MYND) transport strategy, as well as developing and implementing specific functions to deliver on it. In this way, it should act with comparable governance, delegated decision-making rights and scope to the service-specific clinical reference groups proposed by the HSR to address unwarranted clinical variation. (Doc 1, page 162)

Apart from the governance and decision-making issues reviewed earlier, all this might be easier said than done, given the woeful and continually changing state of public transport in the area and the detailed knowledge of timetables and bus stops required in order to assess accessibility. Elsewhere, the review seems to suggest that transport will not be an issue in most of the towns, as car ownership is around the national average. Sheffield has a high proportion of households without cars, but "public transport within the city is assumed to be effective." (of Doc 2, page 94). Sheffielders might dispute this assumption. Doncaster fares even worse. It is reported to have low car ownership but plenty of motorways, with no further explanation. In fact, in the Sheffield Urgent Care Review process, it has become evident that public transport and parking issues are very important and have been underestimated by NHS managers. The same seems to apply here.

Conclusion
To conclude, the HSR raises a number of concerns, including issues of governance and transparency, lack of public and staff involvement, and weak data. Staff and patients risk being let down and real questions about what makes good hospital services have been ignored.

7.1.2 Response to points raised by member of the public

The ICS thanks the member of the public for their response.

Responses to the specific points raised are laid out below:

1. Geography

The different geographies referenced in the report reflect the fact that different local health economies are involved in different recommendations for the Review. In light of the response from the member of the public the SOC has been drafted to make it very clear which recommendations refer to which organisations.

In summary:

- **South Yorkshire and Bassetlaw**: the organisations in the Sustainability and Transformation Partnership for South Yorkshire and Bassetlaw (SYB) are now members of the Integrated Care System (ICS). For CCGs, this is Barnsley, Bassetlaw, Doncaster, Rotherham and Sheffield. For acute hospitals, it is the Foundation Trusts of Barnsley, Doncaster and Bassetlaw, Rotherham, Sheffield Children's, and Sheffield Teaching. For mental health organisations it is the Foundation Trusts of Rotherham, Doncaster and South Humber and Sheffield Health and Social Care.

- **South Yorkshire and Bassetlaw and North Derbyshire**: these are the organisations above, plus Chesterfield Royal Hospital Foundation Trust, and North Derbyshire CCG (Hardwick CCG is engaged through North Derbyshire CCG). This area covers the Trusts which are included within scope for potential reconfiguration options.

North Derbyshire is included because a significant number of patients who live in North Derbyshire travel in to SYB for some of their care. Mid Yorkshire Hospitals NHS Foundation Trust is not included in reconfiguration options because it has already been through a reconfiguration.

- **South Yorkshire and Bassetlaw, Mid Yorkshire and North Derbyshire**. SYBMYND refers to the geography of the organisations in the Joint Commitee of Clinical Commissioning Groups (JCCCG) which has seven members. These are Barnsley, Bassetlaw, Doncaster, North Derbyshire, Rotherham, Sheffield and Wakefield. Hardwick CCG is not a member of the Joint Committee but has taken decisions in parallel with the JCCCG.

  For providers, in parallel to the JCCCG, there is the Provider Working Together partnership, which is made up of seven acute hospital Trusts. These are Barnsley Hospital NHS Foundation Trust, Chesterfield Royal NHS Foundation Trust, Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust, Mid Yorkshire Hospitals NHS Trust, The Rotherham NHS Foundation Trust, Sheffield Children's Hospital NHS Foundation Trust, Sheffield Teaching Hospitals NHS Foundation Trust.

  The organisations in this area have historically worked together because of natural patient flows between the areas.

  These seven Trusts are included within the scope of recommendations on the hosted network, ie they will be building on their collaborative history to develop shared working on clinical services.

2. Governance

Accountability for decision making - The member of the public asks about accountability for decisions made in relation to the HSR.

The legislative framework of the 2012 Act means that statutory accountability and decision making remains with NHS Foundation Trust Boards or NHS Clinical Commissioning Group Governing Bodies, except where they have formally delegated powers. Statutory responsibility for decision making on service change rests with CCG Governing Bodies.

SYBMYND commissioners have established a Joint Committee of Clinical Commissioning Groups, and providers have established a Committees in Common, to which decision making powers may legally be delegated.

At present the Trust Boards and CCG Governing Bodies have not delegated any decision making powers related to the hospital services programme to the JCCCG or CIC. Joint discussion between commissioner and provider organisations from across SYBMYND takes place in a number of forums. None of these holds statutory accountability or decision making powers, so key decisions are referred to CCG Governing Bodies and Trust Boards as required to be made by them as required by statute.

Recommendations in the HSR - As the response from the member of the public highlights, the HSR suggests that collaborative working is difficult within the current legislative framework. There is a recognition at national level that the current legislative framework is not suited to delivering the level of collaboration between organisation that is the basis of shared working going forward. The Health Select Committee into integrated care (published 11 June 2018) recognised this, saying

> The existing legal context does not necessarily enable the collaborative relationships local leaders are building, and in places adds significant complexities.[15]

The committee concluded that

> The law will need to change to fully realise the move to more integrated, collaborative, place-based care. … The purpose of legislative change should be to address problems which have been identified at a local level which act as barriers to integration in the best interest of patients. We wish to stress again that proposals should be led by the health and care community.[16]

Within the existing legal framework, a number of opportunities exist (e.g. through JCCCG and CIC) for shared working. The HSR suggests that, going forward, the partners needs to continue to explore these approaches and develop ways, within the existing statutory framework, to allow organisations to work together when needed to deliver high quality, safe services for patients.

The ICS is undertaking a review of governance and the HSR analysis will be considered during this review.

3. The rationale for the Review

The response from the member of the public questions the pressures that are identified within the Review.

The main pressures that the HSR is aiming to address (the ageing population, rising demand etc) are well evidenced in a number of national reports. See for example Gareth Iacocobucci writing in the British Medical Journal[17] and a recent report by the Health Foundation and the Institute of Fiscal Studies[18].

Changes in the nature of healthcare - The member of the public asks what is meant by references to changes in the way that care can be provided. This refers to the significant changes that have been made in medical care over recent decades. This can mean changes to the type of care, where care can be delivered, or how long it takes to recover. Many conditions which were once incurable can now be prevented altogether through vaccinations, or cured through new drugs or medical procedures. Changes in medical techniques, such as the shift to laparascopic surgery, means that many patients face much shorter recovery times and do not need to stay in hospital. Many chronic conditions such as childhood asthma can now be largely managed at home.

4. Purpose of the review

The member of the public asks about the rationale behind choosing the five services within the HSR. In order to provide clarity around this question, the SOC includes a short summary of how the five services were selected and prioritised. A more detailed account is published in the Section 1A report of the HSR, available on the website (https://www.healthandcaretogethersyb.co.uk/application/files/7515/0903/4254/Hospital_Services_1a_Report.pdf)

In selecting five core services, the review followed the key priorities outlined in its Terms of Reference. This included defining and agreeing a set of criteria for what constitutes 'Sustainable Hospital Services' for each

[15] https://publications.parliament.uk/pa/cm201719/cmselect/cmhealth/650/650.pdf p.75
[16] https://publications.parliament.uk/pa/cm201719/cmselect/cmhealth/650/650.pdf p.78
[17] https://www.bmj.com/content/356/bmj.i6691.full
[18] https://www.ifs.org.uk/uploads/R143.pdf

Place and for SYBMYND; and identifying any services that are unsustainable against these criteria, in the short, medium and long-term.

A 'sustainable' service was defined as one where:

- There are enough patients to operate a safe and efficient service;
- There is an appropriate workforce to meet staffing needs;
- There are interdependent clinical services in place, and in reach, to operate core clinical services safely and effectively; and,
- The service is likely to be deliverable within the resource envelope that is likely to be available.

The Hospital Services Review assessed acute services across SYBMYND against these criteria, in order to select some significantly challenged services.

Hosted Networks - The respondent points out that there is as yet no clear indication of where responsibilities for Hosted Networks will sit. This point has been addressed in the Strategic Outline Case, which describes the process for developing the Hosted Networks and agreeing which Trust will become the Host.

Lack of staff engagement - The respondent queries the degree of engagement with staff that has taken place so far. Engagement with staff is a key priority for the ICS. There has been a significant level of engagement to date, and, in line with the concerns raised by the respondent, the ICS team will continue and intensify this engagement going forward.

Engagement so far – the HSR team and the ICS communications team engaged with the following groups of staff during the development of the HSR:

- **Lead clinicians and nurses from the five specialties**: The HSR established five Clinical Working Groups, which engaged clinicians and nurses from across the specialties. Each Trust was asked to nominate clinicians and other staff, such as nurses and midwives, as members of the Clinical Working Groups. Five workshops were held for each CWG.
- **Wider engagement with staff in the five core specialties**: CWG members were asked to act as the leads to engage with their wider team of colleagues across their home Trusts. After each meeting, the HSR team provided CWG members with a short summary of the points that had been made (these summaries are available on the website). CWG members were asked to discuss these points with colleagues, and to bring back feedback from the wider staff groups to a session at the beginning of the following meeting.
- **Wider engagement with frontline staff**: In addition to this, the HSR team engaged with frontline staff from across the Trusts, more widely than the five core specialties.
    - Trusts were provided with regular updates on the HSR, which they were asked to share with staff across the organisation. Staff briefings, as well as ICS organised nurse forums, were held in many sites, and staff communications with links to the online survey shared through all partners' regular communications mechanisms.

- The ICS communications team attended a number of events at healthcare sites across the footprints, including some open sessions with nurses. Some of the hospitals invited members of the team to set up a stall in their reception areas, and the team also attended some GP surgeries. This gave an opportunity to talk directly with both patients and staff at the sites, and to distribute surveys to get their views on the issues. Copies of the survey were left at the sites for any staff who were interested and had not been able to attend.

- A number of staff were also interviewed in the telephone surveys.

- **Trades unions**: SYB ICS meets with regional union representatives in the Staff Partnership Forum every two months. Members of the Forum have been kept up to date with the Review throughout the process and have discussed the findings of the Hospital Services Review. Comments from the group have informed the development of the next stage: for example, junior doctors will be invited to become members of the Clinical Working Groups at the request of union representatives.

Engagement going forward - The ICS is developing an engagement strategy for the next stage of work, with advice from the Citizens' Panel. In developing the strategy the communications team will engage with the issues picked up in the response from the member of the public, including engagement with staff, clinicians and trades unions.

5. Staff shortages

The response from the member of the public notes pressures on staff and notes recent reports from the Royal College of Nursing and NHS Providers. The member of the public asks how the ICS can be sure that the proposals in the HSR report, particularly around Hosted Networks, will solve the workforce challenges that providers are facing.

HSR recommendations - The pressures on workforce that the respondent identifies were one of the main issues raised by nurses and clinicians in the Clinical Working Groups. The challenges that they raised, and the groups' suggestions as to possible solutions, are recorded in the summaries of the CWGs that are published on the website. The proposals outlined in the HSR report recommendations are what staff told the HSR team would help tackle the challenges of recruitment and retention, improve the quality of care, and reduce the burden on NHS staff. Thus, the proposals in the Strategic Outline Case around shared working on recruitment and retention, standardised job roles and support for workforce planning have been designed to address the concerns of staff within the system.

Royal College guidelines - The member of the public asks about the system's ability to meet the Royal College guidelines on staffing, and what was considered an acceptable level of staffing.

The review chose to use the relevant Royal College guidelines as standards for the levels of workforce services should be aiming for. All options were modelled against the Royal College guidelines and will continue to be so in the next stage of the review.

Royal College guidelines are not statutory, and are designed to allow a level of resilience within the workforce. In addition, the Royal College guidelines have historically been focused on consultant presence. The development of new job roles such as Physicians' Associates, Advanced Nurse Practitioners and Nurse Endoscopists can change the requirements for numbers of consultants, if a role can be carried out by a different, appropriately trained member of staff. For this reason, going forward, the assessment of workforce will look not just at compliance with Royal College guidelines but at the possibilities for workforce transformation. The Clinical Working Groups will be asked to identify appropriate approaches to workforce

roles, and will work with the Clinical Senate to ensure that any proposed models meet requirements for patient safety.

Reconfiguration - The response suggests that the report is about addressing staff shortages by cutting services. The HSR recommended reconfiguration only when clinical engagement and modelling suggested either that services cannot be maintained through transformation alone (for example through the Hosted Networks, Workforce Institute or Innovation Hub); or that they are closely linked to another unsustainable service. The HSR recognises that while reconfiguration can have positive outcomes, it also carries risks, and so recommends reconfiguration only as a last resort. This approach has been carried forward into the Strategic Outline Case.

8. Lack of public voice

The member of the public raises concerns about a lack of public voice in the development of the HSR. The ICS has focused on engagement with the public as a key priority and will continue to do so during the next stage of the work, including engaging with the Citizens' Panel, a group of members of the public who advise SYB on public engagement.

Public engagement to date -

- **Face to face engagement**: Three large public events were held which were open to any member of the public, in addition to individual meetings in specific Places. Further events were held in the foyers of some of the acute hospitals, and members of the team also visited other healthcare spaces such as GP surgeries to raise awareness. Patient Participation Groups in some of the Places also ran sessions on the HSR.

- **Public survey**: In addition, the HSR published a public survey, which received 1,849 responses. 1,000 of these were from people, chosen to mirror the demographic makeup of the health economy, who took part in a telephone survey.

- **Targeted engagement with seldom heard groups**: The engagement work also includes in-depth sessions with 96 representatives of seldom heard groups (including for example BME groups, young carers, the Deaf community, older people, asylum seekers, and the LGBT community).

The results of this public engagement were used to inform the drafting of the HSR. The engagement is summarised in a report at: https://www.healthandcaretogethersyb.co.uk/application/files/4815/2231/8192/15._HSR_Stage_1b_Engagement_Report.pdf

The detailed responses, including the responses to the surveys, the write-ups of the public sessions, and the analysis of the engagement with seldom heard groups, are all available on the website. https://www.healthandcaretogethersyb.co.uk/index.php/what-we-do/working-together-future-proof-services/looking-at-hospital-services

Citizens' Panel - The respondent is unclear about the membership of the Citizens' Panel. The Citizens' Panel has been developed and set up to provide an independent view and critical friendship on matters relating to our Integrated Care System and is not a replacement for wider public engagement and consultation. For its purpose, aims, and background see: https://www.healthandcaretogethersyb.co.uk/index.php/get-involved/meet-citizens-panel. Membership of the Panel will be published in due course.

Summary slide - The slide that the member of the public analyses in the response was developed at the request of, and with input from, the Citizens' Panel, as a way to simply convey the main points of the Hospital Services Review recommendations in a single slide.

In addition to this, the ICS is producing an Easy Read version of the HSR. This has been submitted to the Joint Health Overview and Scrutiny Committee (at their request) for comments and will be published shortly.

The messages included in these documents were intentionally simplified. Should any member of the public require more detail on the specifics of any proposal the detailed reports can be downloaded from the review's website (https://www.healthandcaretogethersyb.co.uk/what-we-do/working-together-future-proof-services/looking-at-hospital-services). Hard copies of the reports have also been made available when requested.

Regarding some of the specific comments raised on the proposals:

- **The majority of services should remain in all local hospitals.** This was a principle of the HSR and also underpins the Strategic Outline Case. District General Hospitals provide services along a spectrum from low acuity and complexity through to higher acuity and complexity. The SOC is based on the principle that the majority of services should remain on the sites of local DGHs or be moved closer to home if possible. Some higher complexity services (for example inpatient paediatrics) may benefit from consolidation within a network, due to concentrations of workforce and expertise.

- **The reduction in bed numbers.** It is the aim of SYBICS and its individual Places to prevent people from getting ill, and to provide care as close to home as possible, with people only staying in hospital if it is necessary. It is in this context that each Place is anticipating a shift to support closer to home wherever possible. This does not mean patients will be prematurely discharged from hospital, or that people who need to be in hospital will not be cared for there.

- **Changes to emergency departments.** The SOC says that the system will retain all six emergency departments plus the paediatric emergency department at Sheffield Children's Hospital. In response to the feedback from the respondent we have made this statement very clear in the SOC. The SOC states that emergency departments will keep their doors open 24/7, with consultant coverage appropriate to the size of the unit, guided by Royal College of Emergency Medicine guidelines. Clinical Working Groups will be asked to consider what staff presence is appropriate in A&Es at different times of the day and explore how we can use staff in different ways. Alternative staff roles, such as advanced nurse or medical practitioners, or support from GPs, could help to address workforce challenges in our urgent and emergency care services.

- **Home births.** Better Births laid out a strategy to increase the choices available to women, including more midwifery-led services and more home births for mothers who are at low risk of complications. Home births and Midwifery Led Units were discussed by the public at public events, with members of the public expressing different views on how the system should balance patient choice with patient risk. Some people were in favour of home births and midwifery led units, and some were concerned that they exposed women to higher levels of risk.

  The risk profile of women across SYB will continue to be considered into the work on maternity services going forward. Any changes to services would be modelled through an Equalities Impact Assessment to understand the impact increased choice may have on health inequalities.

- **The Health and Care Institute.** The respondent asks for clarity around the role of the Health and Care Institute. Many of the workforce and quality issues raised by staff and the public were to do with the significant differences in care patients receive from one site to another. The Health and Care Institute is intended to create cross-system working in order to eliminate these differences, through delivering a comprehensive workforce strategy in a consistent way across each Place, and assuring the system-wide adherence to a standardised approach to developing and implementing shared clinical protocols. The

Institute will be designed going forward. Before any investment is made, all change proposals would be subject to a robust business case which included a cost benefit analysis.

The respondent raised questions around sourcing staff, terms and conditions, student fees and the availability of bursaries. Some of these factors are nationally determined and outside the control of SYB. Others will be addressed as more detailed planning on the Institute is undertaken in the next phase of work.

- **Olympic Legacy Park**. The respondent queries how far the Orthopaedic and Rehabilitation Research and Innovation Centre and Sheffield Children's Hospital's proposed Centre for Child Health Technology has been thought through. The HSR and the SOC cannot comment on programmes outside the scope of the hospital services work.

Engagement going forward – The ICS is developing an Engagement Plan for the next stage of work, with advice from the Citizens' Panel and the Consultation Institute.

In summary, all the next phases of work will continue to have significant public and patient engagement to ensure public views are captured and inform the development of options and proposals. The hospital services programme will continue to engage regularly through the ICS Citizen's Panel, CCG Engagement Groups (including Patient and Partnership Groups), provider Trust Engagement groups and other relevant forums (such as local Maternity Voices Partnerships).

Several large engagement events will also be held throughout this next phase of the Review, which will be specific to this programme of work. As respondents have pointed out, as proposed modelling work progresses, the nature of engagement will become more specifically related to changes to individual sites and services, whereas it has tended thus far to relate to broader discussion of concepts.

Engagement will be frequent and regular to ensure clarity and transparency around proposals as they develop, and for the views of patients and the public to be incorporated into the work. We will also build upon the learning from previous involvement and consultations undertaken by the ICS and other systems, to ensure relevant experience informs our work.

9. **Lack of resources and a lack of data**

Limitations slide - The member of the public expresses concerns about some limitations to the modelling which are identified in the financial annex. The limitations slides in the financial annex are a standard feature that is presented alongside modelling, to outline the technical limitations of the modelling. Modelling, by its very nature, is theoretical, and the assumptions which make up the model, and their limitations, must be transparent and well understood.

The HSR modelling was designed as a high level assessment of the impact of some core elements of possible models, in particular the upper and lower limits of activity shifts, and capital costs. At this stage of work, the findings were intended to be indicative and non-site specific.

Quality assurance was conducted on the modelling and included:

- A quality check of the data file and its functionality.
- Reconfirmation of all baseline data used in the model through validation with each trust
- A quality check of all assumptions inputted into the model, through one-to-one conversations with each trust.
- Review of the outputs of the model by the Directors of Finance group.

Provision of data - The respondent queries in particular a statement in one of the 'limitations' slides in the Review, stating that not all trusts provided SLR data to the HSR. To clarify, this does not mean that the

Review did not include data from all trusts. Publicly available Reference Cost data was used for all trusts, in addition to the system-wide STP assumptions.

The comment in question relates to SLR – Service Line Reporting – data. This is more granular cost data that was not essential to the high level analysis conducted in the HSR. In the next phase, which will be more granular and site specific, detailed data will be collected from all trusts.

Some updated activity data for three trusts was made available to the modelling team shortly before publication of the HSR. This was used to update the workforce modelling in the HSR final report but there was not time to update the capacity and finance modelling with the most up to date numbers. The modelling was therefore updated subsequent to publication, and is published as Annex E of the SOC. The marginal changes to the activity data had very marginal impact (in most cases costs increased by around £0-£0.3m with a maximum cost increase of £1.3m) and therefore did not change the conclusions of the work.

Modelling going forward - For the next stage of modelling, the respondent's emphasis on the importance of rigorous modelling is being taken into account. A specification for the model, and a template for data collection, are being co-developed by representatives from across the system including clinicians and HR, estates, finance and operational directors. All trusts will complete the data request in a uniform way to deliver a consistent set of data, at a granular level of detail.

10. Transport

The respondent notes the challenges with modelling changes to transport due to the complexities with public transport and changes to timetables and bus stops. As the respondent requests, the ICS will ensure that the Transport Advisory Group which is being set up will include representatives from the main travel and transport organisations across the area, so that transport issues can be discussed at a strategic level. The ICS will also set up a public group specifically to focus on transport and access issues.

7.2 MEMBER OF THE PUBLIC – 2

The following response was also received from a member of the public, writing in an individual capacity. The comments relate mainly to governance and accountability arrangements in the HSR.

7.2.1 Response received from a member of the public

GOVERNANCE

1. *At Barnsley CCG Board meeting (14/6/18) Professor Welch (Independent Review Team Lead) accepted, when asked by a public question, that the financial section in the Technical Annex was estimated and based on the information given by only one hospital, no data being received from the other hospitals. He said further work was needed over the next nine months which would require data from all the hospitals to allow a full financial analysis.*
   Both Professor Welch and Lesley Smith (System Reform Lead and Barnsley CCG Chief Officer) stated that none of the HSR recommendations are driven by the financial analysis.
   It is disturbing to hear that:
   a) *The recommendations cannot be said to 'not make the financial situation worse' which was the agreed position of the review as a full financial analysis has not been possible.*
   b) *The answer to Q.9 in the Question and Answer Sheet part of the report is therefore not true.*
   c) *That only one hospital provided the data required in the ten months since the Review began and before the Report was published, despite the claim that these hospitals had worked together in a collaborative partnership for about five years.*

d) *This non-co-operation does not demonstrate a strong collaborative or bode well for future partnership working.*
e) *That a decision will be made to approve a review's recommendations that cannot be guaranteed as cost neutral, as required.*
f) *This is not sound business practice and is not ethical given the business is a public service funded from the public purse.*

2. *The Report states that each public body partner will retain their responsibility for meeting their own statutory duties should the Hospital Service Review Report recommendations be implemented. However the Report assumes that individual statutory duties can be delegated to the Integrated Care System, when statutory duties cannot legally be delegated. Also to do so would not be compatible with the statement that each public body partner retains responsibility for their statutory duties.*
   Some examples include:
   a) *The duties of CCGs for commissioning functions, including service specifications, and protocols, cannot just be assumed by the Hosted Networks that are managed by a Trust as implied in Section B Transformation.*
   b) *The duty of each Trust to develop, support and recruit its own workforce cannot just be assumed by the hosted networks that are managed by another Trust.*
   c) *There is an assumption that responsibilities that are laid down in statute can just be transferred across organisational boundaries without affecting staff employment status, and individual organisational statutory responsibilities.*

ACCOUNTABILITY

1. *The Report assumes the statutory duties of the CCGs and the Trusts are the same for Public Involvement, which is not the case. It assumes that the changes proposed by the transformation recommendations can be implemented quickly and no public involvement would be required. This is because the Report authors appear to be unaware that CCGs have a Public Involvement Duty requiring the public to be involved in commissioning arrangements, as described in Section 26 14Z2 of the Health and Social Care Act 2012:*

*"**14Z2 Public involvement and consultation by clinical commissioning groups***

(1) This section applies in relation to any health services which are, or are to be, provided pursuant to arrangements made by a clinical commissioning group in the exercise of its functions ("commissioning arrangements").

(2) The clinical commissioning group must make arrangements to secure that individuals to whom the services are being or may be provided are involved (whether by being consulted or provided with information or in other ways)—
(a) in the planning of the commissioning arrangements by the group,
(b) in the development and consideration of proposals by the group for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals or the range of health services available to them,
and
(c) in decisions of the group affecting the operation of the commissioning arrangements

where the implementation of the decisions would (if made) have such an impact.

(3) The clinical commissioning group must include in its constitution—
(a) a description of the arrangements made by it under subsection (2), and
(b) a statement of the principles which it will follow in implementing those arrangements.

(4) The Board may publish guidance for clinical commissioning groups on the discharge of their functions under this section.

(5) A clinical commissioning group must have regard to any guidance published by the Board under subsection (4).

(6) The reference in subsection (2)(b) to the delivery of services is a reference "

In all the plans for transforming services 14Z2 CCG Public Involvement Duty applies. This is clarified by the Statutory Guidance for Patient and Public Participation in Commissioning published in April 2017 by NHS England (the Board).

Whereas the Public Involvement Duty of Trusts remains the same as in Section 242 the 2006 Health and Social Care Act and requires them to involve patients and potential patients in service planning and delivery, and proposals to change these – but not in commissioning arrangements.

2. *The Hosted Networks are described, in Section B as being monitored and accountable to the ICS which has no statutory status and is not a public body with no public accountability for the public funds it uses. The Hosted Networks should be accountable to the public and to the commissioners (CCGs) who carry the statutory duty, responsibility and risk for all that the ICS does.*

7.2.2 Response to points raised by member of the public

1. Governance

Cost neutrality - The respondent raises comments about whether the HSR proposals are cost neutral, and why the numbers are estimates at this stage.

The modelling done for the HSR was designed as a series of indicative scenarios, providing a maximum and minimum range of activity shifts, capacity availability, and financial costs. Detailed costings will only be possible once the work moves to the point of developing site-specific analysis and will be taken forward in the next stage of the analysis. However the modelling done so far gives an indication of the likely costs associated with capital investment, while the workforce modelling gives an indication of the degree of quality improvement that would be possible by getting closer to meeting Royal College standards.

It was a criterion for the HSR that proposals should not cost more, in terms of day-to-day running costs, than current service provision. There would be some transitional costs. For this reason, the HSR modelling looked at which options would be closest to achieving the Royal College quality standards within the current available staff and the funded establishment, as well as future available staff, with the aim of avoiding locum costs.

The financial implication of proposals will continue to be a key evaluation criterion when assessing options to make sure that the system is not to be made worse off.

Financial data - The respondent queries a statement in one of the 'limitations' slides in the Review, stating that not all trusts provided SLR data to the HSR. To clarify, this does not mean that the Review did not include data from all trusts. Publicly available Reference Cost data was used for all trusts, in addition to the system-wide STP assumptions. The comment in question relates to Service Line Reporting (SLR) data. This is more granular cost data that was not essential to the high level analysis conducted in the HSR. In the next phase, which will be more granular and site specific, detailed data will be collected from all trusts.

Joint working – The respondent asks about the level of joint working between the Trusts around the Hospital Services Review. All of the work of the HSR, and the development of the SOC, has been done through shared working across the partner organisations, and all Trusts and commissioners have participated actively in the development of the work. This is supported by formal governance arrangements (such as the Collaborative Partnership Board, the Joint Committee of Clinical Commissioning Groups, and the Committees in Common) as well as by regular shared working.

2. Statutory duties

The respondent comments about the legal status of an Integrated Care System and the delegation of statutory duties.

Legal accountability - The legislative framework of the 2012 Act means that statutory accountability and decision making remains with NHS Foundation Trust Boards or NHS Clinical Commissioning Group Governing Bodies, except where they have formally delegated powers. Statutory responsibility for decision making on service change rests with CCG Governing Bodies.

SYBMYND commissioners have established a Joint Committee of Clinical Commissioning Group, and SYBMYND providers have established a Committees in Common, to which decision making powers may legally be delegated.

At present the Trust Boards and CCG Governing Bodies have not delegated any decision making powers related to the hospital services programme to the JCCCG or CIC. Joint discussion between commissioner and provider organisations from across SYBMYND takes place in a number of forums. None of these holds statutory accountability or decision making powers, so key decisions are referred to CCG Governing Bodies and Trust Boards as relevant to be made by them as required by statute.

Accountability and statutory functions in Hosted Networks - The respondent is concerned that Hosted Networks will assume commissioning functions and workforce planning functions that could undermine the statutory responsibilities of Trust Boards and CCG Governing Bodies.

The Hosted Networks are a proposed approach to allow shared working between providers; they build on established practice and existing legal frameworks. For example, service specifications and protocols will be co-designed between commissioners and providers, as has been the case for many years. Similarly, it is common practice for staff employed by one Trust to work in another Trust under formal agreements.

The concerns raised by the respondent will be addressed throughout the development of the Hosted Networks. As the Hosted Networks are developed, statutory responsibilities of organisations will be respected and legal advice will be obtained to ensure that all proposals are in line with the current legal framework.

Commissioners will be involved in the Hosted Network governance and will maintain responsibility for contracting care from providers, holding them to account through the CCG contract.

The respondent asks about how Hosted Networks relate to the role of the ICS. The ICS has an emerging remit to support performance across the system moving forward. It is this role that could support Hosted Networks. This does not replace the legal accountabilities and statutory duties of Trust Boards and CCG Governing Bodies.

Public Accountability – As the respondent points out, Trusts and CCGs have different statutory duties around public involvement in change programmes and in public engagement and consultation. CCG Governing Bodies have the statutory power to agree service change, and have statutory responsibilities to ensure that public engagement and consultation takes place. The work of the hospital services programme will continue to reflect the different statutory roles of CCG Governing Bodies and Trust Boards, with Governing Bodies being asked to formally make decisions under their statutory powers. However, public involvement activities will continue to be coordinated across organisations with messages remaining consistent.

Public engagement – The respondent is concerned that the transformation workstream might be taken forward without public engagement. To provide reassurance on this, the Strategic Outline Case lays out how public engagement will underpin all the workstrands in the hospital services programme.

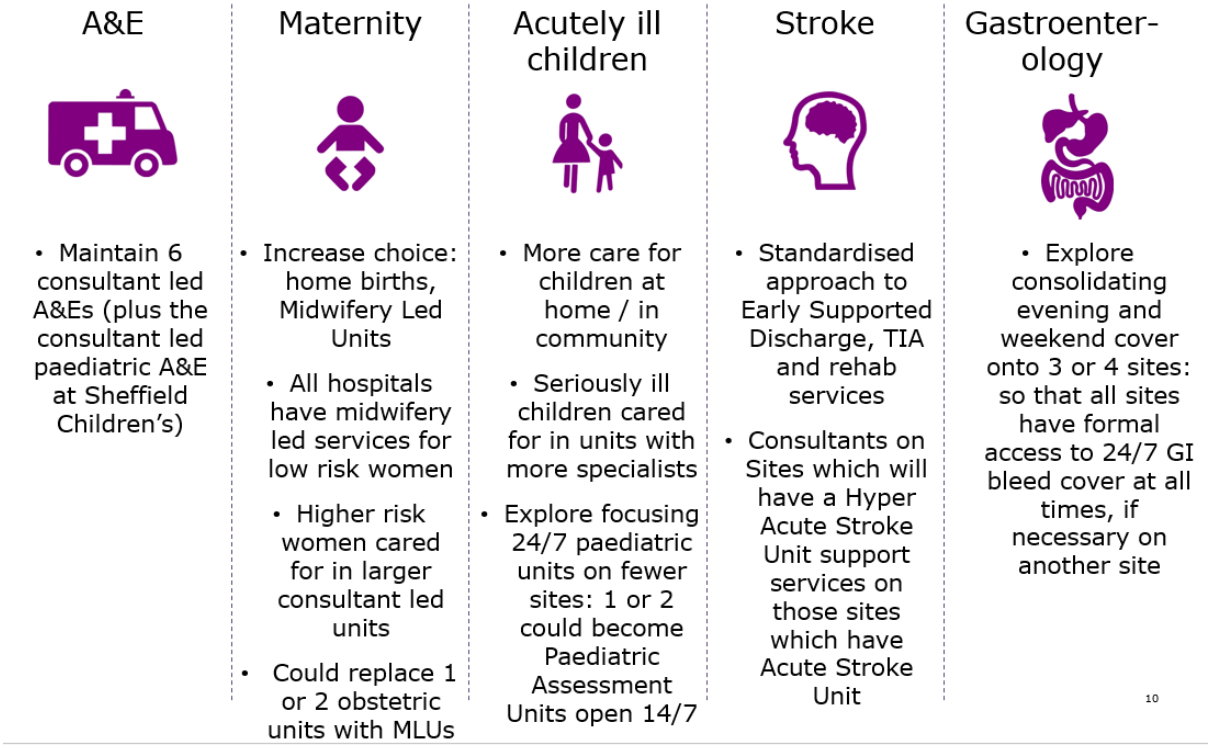
7.3 FEEDBACK FROM A SURVEY CONDUCTED BY MEMBERS OF SAVE OUR NHS

Some members of Save Our NHS undertook a short survey to ask the views of some people about the recommendations of the Review. It is included here as it was submitted as a response to the Review. However it does not represent a response to the full Report of the HSR which is the purpose of the current document. It will therefore be considered alongside other public engagement responses which are being gathered by the ICS team and will inform the workstreams going forward from October.

7.3.1 Response received from Save Our NHS

We talked to people on street stalls and showed them these proposals:

The Review's recommendations were as follows



We also sent an online questionnaire which included the above proposals and these ideas as well:

We asked a series of questions, as below, and report the comments we received, spelling mistakes and all.

What do you think is good about hospitals?

1 *When admitted at 9 years old, it was good they let my mum stay overnight.*
2 *Whenever I've needed the NHS, they've been there.*
3 *Access for acute patients to therapeutic services, i.e. activities that are engaging, creative and promote physical activity. Well done, Occupational Therapy!!*
4 *Commitment of staff.*
5 *Blood testing service at the Hallamshire is speedy and efficient.*
6 *Great care and repair for my grandson (cleft lip and palate).*
7 *Been in hospital at Hallamshire and everything was good, from surgeon to cleaning staff!*
8 *Friendly, helpful nurses – how do they do it when they're so overworked?*
9 *It's good to see some welcoming entrances and child-friendly waiting areas.*
10 *Congrats NH's70's. Its good service and maintenance.*
11 *They are good because they are local to communities*
12 *Quality of some of the services. Range of specialist services. Their apparent willingness to work together.*
13 *Sheffield hospitals are linked to the medical school, which is good.*
14 *SY - outpatients / theatre /*
15 *Sheffield hospitals are linked to the medical school, which is good.*

16 *The care*
17 *A good spread of hospitals*
18 *Their capability of excellence is often compromised by the capacity of funds and the corrosive nature of targets and paperwork foisted in clinical staff*
19 *Acute medical Care and A&E*
20 *The dedicated staff working against the odds to look after us*
21 *they try their best*
22 *Free ate the point of need*
23 *Re eye clinic: fast appointments; good service and follow-up*
24 *SY&B hospitals seem to have been fairly resilient so far in the face of continuous de-funding by Conservative-led governments.*
25 *the expertise and specialism they all have*
26 *Excellent surgery.*
27 *Good for preventative care, e.g. mammograms*
28 *Patients helping each other bath meals, due to shortages of nursing staff*
29 *Its free at point of service*
30 *They provide equipment for impaired people*

What could be better?

1 *More funding.*
2 *Give admin staff time to look up and smile when I go into reception.*
3 *Nurses and professionals try hard but it is hard – no pay rises, not valued. It's all about computers rather than care.*
4 *Look after our staff!*
5 *Take care to employ the cleaning staff in-house to improve everyone's chances.*
6 *Shorter waits for transport home after treatment.*
7 *Wrong to send somebody home poorly.*
8 *Must respect DNR wishes.*
9 *Ask frontline staff this question!*
10 *Make main entrances to hospital more welcoming and waiting areas child friendly.*
11 *Better signage would help at Northern General.*
12 *Police treat the Northern General as a violence hot spot! No more pressure please.*
13 *Take away the paper work and let nurses do the job they love and are good at doing.*
14 *Divide the tasks differently: senior staff doing breakfast and meds in one round takes longer and wastes their valuable time.*
15 *Improve the hospital environment on acute wards: give patients access to more gardens and green spaces. Hospital wards are claustrophobic and oppressive.*
16 *In-source cleaners and reduce hospital infections.*
17 *Eliminating private participation*
18 *More actual sharing (of specialist staff) and networking of key services. Involvement of patients and public in decision-making. Better quality buildings (e.g. DRI). Reform of out-patients services - e.g. better use of local facilities, linked to the hospitals. Intelligent use of GIRFT - with patient involvement.*
19 *Reversal of the privatisation of services*
20 *several answers - seeing in-patients more as people not just bodies*
21 *Reversal of the privatisation of services*
22 *A solution to the parking problem, particularly own-transport to A&E (on GP advice).*

23 *Better funding, more staffing and better support for staff, better liaison with social care, less overcrowding so that winter pressures can be coped with, stop closing beds and services*
24 *Obviously a massive increase in capacity/funding; to reintroduce training bursaries better pay and shift arrangements for clinical staff; awareness and ability to take advantage of the changes and improvements to treatments brought about by new technology and governments prepared to invest in these and train personnel to make best use of them to have ancillary staff who are employed in House and in permanent positions to increase the numbers of regular workers who are attached to wards, rather than workers who work to an outside private company with other priorities than patients comfort and service.*
25 *Stopping the reorganisations. Waste of money and resources.*
26 *"22.1.3 Public transport: I am very glad that you have highlighted this issue. The ongoing concentration of services at the Northern General Hospital has led to increasingly high illegal levels of nitrogen dioxide in the streets around the hospital. We have been monitoring this pollutant at three local sites on a monthly basis. This constitutes a health emergency for those of us living near the hospital, and is a particular threat to the health of local children. It is also a health risk to those within the hospital and those travelling there. The irony of this situation of the hospital causing ill health is not wasted on us. A number of local residents have formed the Burngreave Clean Air Campaign and have expressed our concerns on local TV, radio and the press. There seems to be an unwillingness by various authorities to improve transport to within the hospital campus. The current bus stops involve long and sometimes steep and dark walks, often along unsafe pedestrian routes, to the clinical areas of the hospital. This poor public transport results in many staff, out patients and hospital visitors being forced to take cars or taxis, further increasing local pollution and congestion. The hospital is already at breaking point with the number of cars coming to the site. There is a rolling out of low emission buses by local bus companies which would make this an opportune time to allow regular services from the city centre/Hillsborough and Firth Park through the hospital grounds to the central buildings. In the longer term, we share the hospital's view that the extension of the Supertram to the hospital would solve some of these problems and would help reduce local levels of pollution. The hospital authorities claim that there is a courtesy bus within the hospital but this is infrequent and does not connect with local bus stops. The inter hospital (RHH/NGH) link does not connect with other transport hubs or centres of population. The Burngreave Clean Air Campaign would be pleased to cooperate with you in working on these issues to the benefit of those using and working at the hospital and local residents alike. [name and email address supplied]*
27 *More beds wards & staff*
28 *targeted increased resources to restore service levels*
29 *more investment of staff and properties and the removal of private firms*
30 *Staff are over stretched. The "good service" provided is because they work over and beyond their contracts - which puts pressure on them and their health*
31 *Stop wasting money on buying in services that could be provided by the NHS*
32 *Re-open the A&E at the Royal Hallamshire AND open a MIU at the Northern General. A city of 600,000 population plus outlying communities needs more than just one northerly located facility.*
33 *Stop giving over beds to private facilities within NHS hospitals."*
34 *more staff*
35 *different specialisms need to be better at talking to each other, rather than just saying "nothing to do with us – see your GP" when it was more than 1 problem caused by the anaesthetic*
36 *Meeting an elderly female patient who was on the same ward as my mother who had been there for 12 months, as there wasn't anyone to care for her at home and there wasn't any social care facilities for her*
37 *1 nurse able to administer a particular treatment for over 7 wards. Grossly under supported.*

38 *No cuts*
39 *Commitment to staff recruitment and retention*
40 *Do outpatients need to be at the hospital?*
41 *Easier access to hospitals and cheaper parking*
42 *Nurses doing their best under extreme underfunding and lack of support*

What do you think about A&E Services?

1 *Keep Minor Injuries at RHH. Closing it = madness.*
2 *Sae our Minor Injuries Unit at the Hallamshire where we can get to it.*
3 *A must. Minor injuries clinic. Keep it open!*
4 *Any changes should be evidenced based.*
5 *Our Children's A+E is a lifesaver – please let us keep it!*
6 *They should not be cut*
7 *Needs a proper 'front-end', sifting out and dealing with in some other way, of people who should not be in A&E in the first place. Also, 24/7 service for genuine emergencies. Proper arrangement between YAS and EMAS - Bassetlaw gets a poor service from EMAS.*
8 *Waiting times at A&E are too long*
9 *Waiting times at A&E are too long*
10 *Excellent, apart from the transport problem.*
11 *Agree with proper minor injuries support in appropriate locations - especially in Sheffield*
12 *Once again it's a question of capacity. There is no slack in the provision, which means that in the case of an emergency that affects significant numbers the services would be under extreme pressure. This is not satisfactory for patients or workers. There are also known times when numbers increase dramatically and it should be possible to manage these more effectively. Walk in clinics and minor injury units play a crucial part ~ but they are (or have) disappearing. the problem often is that because some people have difficulty accessing health centres or GPs so everything becomes an Emergency*
13 *No experience*
14 *NGH A&E needs better public transport access.*
15 *Should have more staff, equipment & beds*
16 *DO NOT CHANGE*
17 *Essential that these are strengthened to improve the service given as more and more people have need of them*
18 *Yes to all services remaining*
19 *A&E services are just about adequate, but would be better if there were 2 UTC locations in Sheffield (i.e. A&E plus MIU plus Out-Of-Hours GP at BOTH Northern General and Royal Hallamshire.*
20 *should all remain where they are to treat the patients that use them*
21 *Sheffield cannot afford to lose Walk In Centre – services at NGH not adequate to cope.*
22 *Minor Injuries Unit Excellent service when I broke my wrist (2017). MUCH better than queuing in A+E at NGH. It should stay open to enable A+E to deal with serious illness and injuries.*

What do you think about maternity services and proposals?

1 *Ethnic minority women and cultural issues. Listen to what women are saying. Respect birth plans.*
2 *More midwives.*
3 *Get Tory thieving hands off!!*
4 *'Home choice' is not a choice. Deliver a baby in a safe environment. i.e. hospital is better and the reason why we have a low death rate. In case of sudden emergency, home is a bad idea.*
5 *No the resources are not there this is just a way to let in private providers*

6 *Seems sensible - but have we got enough midwives?*
7 *Not sure as maternity is not relevant to me personally*
8 *Good idea, though the facilities at HH are lovely*
9 *Not sure as maternity is not relevant to me personally*
10 *I don't know.*
11 *Although women may be classed as low risk things can change during labour. It's bad enough with current arrangements where senior and expert help may be delayed. It will be much worse if midwife levels remains low, if midwives are subjected to tick box procedures and if units are closed. MLUs should only be instituted when there are adequate levels of trained and experienced midwives and medical advice and assistance are quickly available if necessary.*
12 *I have been very disappointed that some of the specialist services that supported young and possibly single mothers, have closed. These were crucial in their ability to support individuals and also to refer or signpost them on to other services where young parents can find longer term personal support*
13 *Excellent*
14 *Our mat services are fine as they are. Leave them alone.*
15 *"Choice" = code for privatisation*
16 *The MLUs should be in addition to existing services which also need to be improved*
17 *No current knowledge*
18 *Encouraging less use of hospitals / maternity units and more home births is NOT "increasing choice for women". It is a deeply irresponsible path to take, and surely just a cover for reducing maternity beds across the region, when capacity is already overstretched (Barnsley closed its doors only last week, and has frequently reported women giving birth in inappropriate circumstances).*
19 *Not much knowledge on these services so would go with those in the know. It may be that all are useful in the right place and at the right time*

What do you think about Services for Acutely Ill Children?

1 *'More care for children at home/in community'. Translation. This means more parents looking after sick children.*
2 *'Explore focusing 24/7 paediatric units on few sites.' This means further away from families.*
3 *Children's ward @ Bassetlaw! Now moving ill children to Doncaster as no overnight facilities! JUST WRONG!*
4 *No disagree with proposal*
5 *Sounds unconvincing. Has a proper review actually happened?*
6 *It sounds like a cop out and less care overall*
7 *agreed*
8 *It sounds like a cop out and less care overall*
9 *In the community' can mean almost anything.*
10 *Nobody wants their children to be in hospital but I feel this proposal is driven by staffing issues and cost issues, not by need. There is a real risk of overcrowding specialist facilities if IP units close.*
11 *Sheffield Children's Hospital has a fine reputation locally ~ people tend to trust them. Whilst the case for more community services is a good, we mustn't assume it's a cheap one. So once again how these are funded and whether they are then classed as 'social care' responsibilities is critical to their success. We cannot see the problems associated with the elderly replicated within children's health needs*
12 *Sheffield Children's Hospital wonderful*
13 *They should be treated in their own local hospital whenever possible*
14 *Why proposals - should not need to be asked, just done!*

15 *I support increases of services in the community, short stay units and long stay units. We need to excel in all areas*
16 *Let's see the expansion demonstrate its effectiveness before removing in-patient beds*
17 *I don't think we can lose any hospital provision and retain patient safety.*
18 *Short stay units is a good idea as are community but would not like to see a reduction in the number of inpatient beds. This would not alleviate the issues as more children are being treated as inpatient because of their complex needs*

What do you think about Stroke Services?

1 *There should be a drive to staff these services in every day*
2 *Much of this depends on good and fast diagnosis; and provision of good rehab services locally. Have they looked at the whole pathway? And do we have enough vascular nurses to help with the rehab locally?*
3 *I am worried that the acute stroke unit in Rotherham looks like closing. Stroke victims need to be seen as soon as possible, not transported miles to Sheffield or Doncaster. Irreversible brain damage is more likely with delays.*
4 *n/a*
5 *I am worried that the acute stroke unit in Rotherham looks like closing. Stroke victims need to be seen as soon as possible, not transported miles to Sheffield or Doncaster. Irreversible brain damage is more likely with delays.*
6 *What exactly is the 'standardised approach'. Discharge should be timely and patient-appropriate, not 'early' (too early?).*
7 *Centralising Hyperacute stroke unit services makes sense but acute stroke units must not be blighted. Consultant presence and support is important at these sites as well. If acute stroke units fail, then the hyperacute service will get blocked up and people will spend longer further away from home with all the difficulties that causes.*
8 *I'm always suspicious of anything labelled 'standardised', it has to be responsive to local conditions. Having said that there have been significant advance in understanding and responses to Strokes, and certainly these need to be 'standard' in every area. If paramedics can receive the appropriate training so treatment can be given with as little delay as possible , this has to be a good thing*
9 *excellent*
10 *Hyper Acute should not be centralised, they should remain local. I disagree with early discharge. It is a cost cutting exercise & I don't know what you mean by 'support services on... Acute Stroke Unit'. Do you mean there will be no doctors? If so, I disagree.*
11 *personal experience was of a lacklustre service under pressure*
12 *Sounds sensible*
13 *No current knowledge*
14 *Stroke patients and their families should be absolutely ready for discharge, never pushed or hurried into it. DO NOT CLOSE the HASUs at Barnsley or Rotherham: lives and post-stroke quality of life will be risked.*
15 *all units should give the best, specialist treatment possible to enable quicker recovery times*

What do you think about Gastroenterology Services?

1 *Which sites? Is this a review or half a review?*
2 *Not sure. It may be ok*
3 *n/a*
4 *Not sure. It may be ok*

5 *How will the public know which hospital to go to? Will this result in relying on the 999 service to know? Will patients always be discharged by ambulance? What arrangements have been made for inter-hospital transport (for visitors)? Has the proposed inter-hospital bus service been implemented?*
6 *Seems fair enough if gastroenterologists are happy with it and can staff it.*
7 *I am unsure of the reasons for or practicality of this*
8 *no experience*
9 *Keep them local.*
10 *n / a*
11 *We should extend the availability of emergency services to all A&E departments*
12 *No current knowledge*
13 *All hospitals with A&E departments should be treating emergency GI cases. Reducing provision in any location risks patient safety. It is a faulty mentality to be referring to "out of hours" in relation to any kind of emergency; provision should be consistently available at all 7 hospitals.*
14 *not sure how this differs from current but think at least 1 in each area*

What do you think about creating a Health and Care Institute?

1 *What is this?*
2 *Yes, but this will take 10 years to impact on workforce shortages. There needs to be actions on workforce that impact quicker than that.*
3 *It could be a good idea but I don't know enough about it*
4 *Good*
5 *It could be a good idea but I don't know enough about it*
6 *What is it? Is it public and within the NHS? What would it do? Who would fund it?*
7 *Money should only be spent on this if it offers a genuine step forward and is welcome by those already providing workforce training*
8 *Sounds like a good plan. However my recent experience in setting up an institute in a professional workforce is that although everyone says great, employers say excellent idea, the only people who will pay for it will workers themselves. It could be the neoliberal answer to Unions, and it is hard to see an institute being able or willing to mount the challenge to government that has been seen over the last few years*
9 *NO MORE REORGANISING!*
10 *The workforce have been kicked around for years, underpaid and pushed to the limits. You must reduce staff stress which causes massive amounts of sickness and loss of valuable and experienced staff. It also leads people to retire at the earliest opportunity. For example, dear person reading this, when would you like to retire? Point proved! Never mind bursaries, student nurses should be paid like they used to be. I worked on a ward where the majority of the nursing staff were mature entrants. How can these people get in now? In my NHS years 1972- 2000, I didn't know of one person being sacked but 2000- 2013, I saw dozens being sacked. A little more human understanding would reduce a climate of management intimidation. Please don't bleat about staffing issues unless you are prepared to treat your workers properly.*
11 *I have no idea what this is but no doubt it will involve private companies so I am against it*
12 *Stop sabotaging the NHS at a structural level designed for privatisation*
13 *Keen that it supplements existing services*
14 *Yes*
15 *Only if it does not divert money from NHS services or Social Care provision. Underfunding is now so severe, and money is wasted in costly private contracts - we simply can't afford to lose another penny. There are already very strong links with the universities in Sheffield; can this be extended to encompass the SY&B region more effectively?*

16 *Quite a good idea.*

What do you think about creating an Innovation Hub?

1 *Should not duplicate stuff elsewhere bad not from clinical resourced*
2 *good idea, but every hospital should also practice innovation as part of their job too.*
3 *Again, it sounds like a good idea*
4 *Good*
5 *Another one? What is wrong with the existing one? What influence/pressure would it have on persuading consultants, GPs and CCGs to accept any new innovations?*
6 *I'd rather see money spent on getting our existing services right than on developments which may only have small effects despite costing quite a lot to develop. Not convinced by the claimed outcomes of the Perfect Pathway testbed*
7 *Sounds like a plan~ obviously publically funded and nit left to 'the market' that will sell new technologies and innovation to highest bidder*
8 *NOT NEEDED*
9 *What the Dickens is that?*
10 *not with power and resources - not the current sham*
11 *It should supplement existing services*
12 *Yes please*
13 *is this not already in place via HEE?*

Do you have any more comments?

1 *The review has involved only 20% of hospital services - we need to be saying more about the other 80% too. And there needs to be much more staff and public engagement. The over-riding impression of the review is it is primarily about cutting costs. May be necessary, but we need to be more open and honest about the impact on the quality of services.*
2 *No more privatisation and reverse it. No Accountable Care Organisation (Integrated Care Systems) as these are just back door privatisation.*
3 *No more privatisation and reverse it. No Accountable Care Organisation (Integrated Care Systems) as these are just back door privatisation.*
4 *I'm worried by the review. It hasn't come out with some of the recommendations I feared (e.g. new closures) but it is not really clear how problems will be solved. I don't understand the specialist networks proposed for hospitals and how they will work or how each network established will affect work in hospitals providing the service but not leading.*
5 *ICS is the devil's child of that monster FYFV*
6 *Please put the hospital back in the local community, for staff recruitment and respect for local residents. Look after your own people too!*
7 *the nhs is being hollowed out so as to create space for privatisation*
8 *Need to target corporations to fund the health of their workforce*
9 *In Sheffield we have a lot to be very proud of in our hospital services. Let's protect it all and keep it working free, for all, with no downgrading of provision. Work as effectively as possible with community and volunteer groups to improve out-of-hospital care - I would prioritise this, and ensure that it is well integrated in a Health and Care Institute should that go ahead.*

7.3.2 Response to the survey conducted by Save Our NHS

The review thanks the respondent for collecting further patient feedback regarding the proposed changes to services.

The Integrated Care System has been undertaking a survey of patient and the public views around the HSR recommendations. When the feedback is independently analysed for this work, we will include responses from your survey, which will ensure all the key themes from conversations with the public are taken into consideration.

South Yorkshire and Bassetlaw, Mid Yorkshire and North Derbyshire: Hospital Services Programme

Strategic Outline Case Annex B:

Case for Change

This annex provides an outline of the Case for Change using performance metrics from the most recently available data, an update of the original analysis performed by the Hospital Services Review. A more detailed review of the Case for Change can be found in the Hospital Services Review Stage 1B report:

https://www.healthandcaretogethersyb.co.uk/application/files/9615/1809/8702/Hospital_Services_Review_1b_report.pdf

CONTENTS

1 CHALLENGES WITH WHOLE-SYSTEM PERFORMANCE

1.1 PERFORMANCE AGAINST NATIONAL STANDARDS

Since the HSR's initial assessment of performance, there continues to be variation in performance in some trusts.

1.1.1 A&E Performance

The national standard requires 95 per cent of patients who attend Type 1 A&E to be discharged, admitted or transferred within four hours of arrival.

In line with national trends, the hospitals in SYBMYND have struggled to meet this target for some time, with many not having achieved this target since Q2 2015/16. The graph below shows declining performance against this target across the trusts since 2015/16[1].

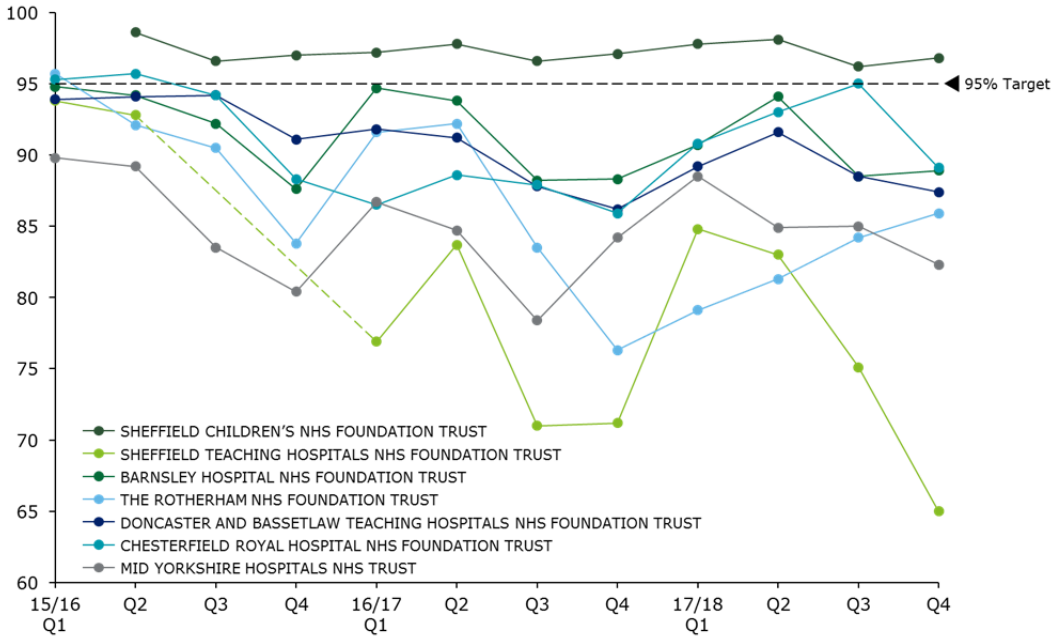


Figure 1: Per cent of Type 1 A&E attendances admitted, discharged or transferred within four hours of arrival, by trust

1.1.2 18 Week Consultant-Led Referral to Treatment Target

The NHS Constitution states that patients should wait no longer than 18 weeks from GP referral to treatment for consultant-led services. The national standard is for at least 92 per cent of patients to be seen within this time frame. As with A&E performance, hospitals across the country have been struggling to meet this.

Performance against this metric varies across the SYBMYND trusts, from 85.1 per cent in Q4 2017/18 at Mid-Yorkshire Hospitals NHS Trust to 94.8 per cent at Sheffield Teaching Hospitals NHS FT. The below chart shows this[2].

[1] NHS Statistics, A&E attendances and emergency admissions, 2015/16 – 2017/18
[2] NHS Statistics, Consultant-led referral to treatment (RTT) waiting times, 2015/16 – 2017/18

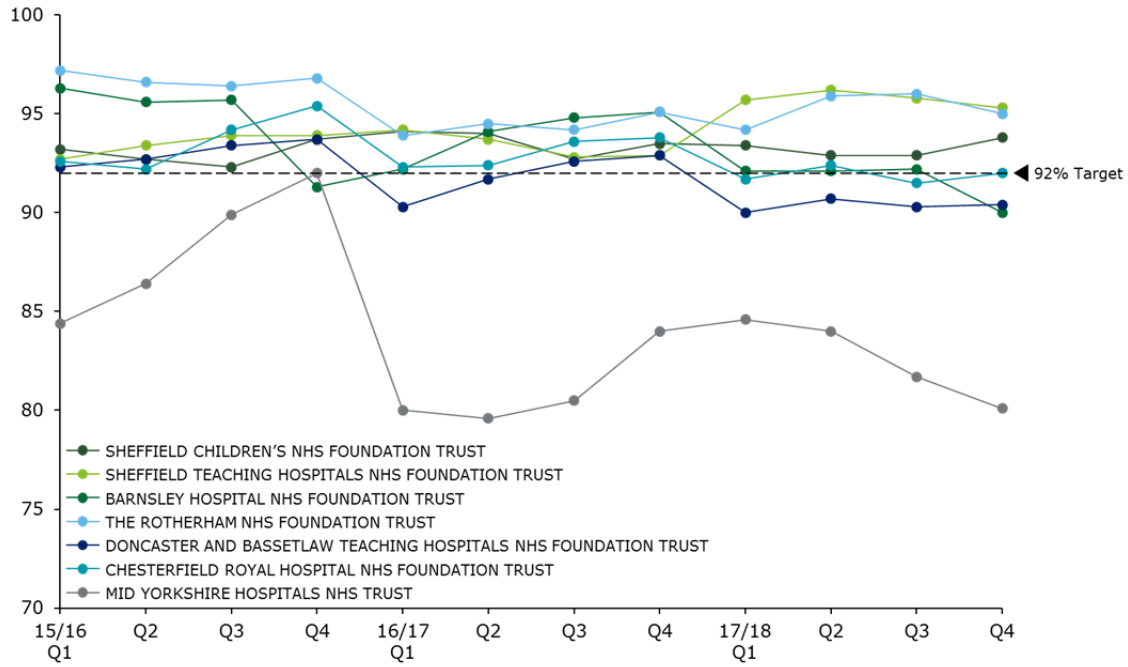


Figure 2: Per cent of referral to consultant-led treatment waiting times for incomplete pathways within 18 weeks, by trust

1.1.3 Cancer 62-Day Wait Target

NHS guidelines stipulate a target of at least 85 per cent of patients waiting no longer than two months (62 days) from GP urgent referral to first definitive treatment for cancer.

Performance in SYBMYND against this target again is varied, ranging from 78.8 per cent at Sheffield Teaching Hospitals NHS FT to 90.5 per cent at Barnsley Hospital NHS FT[3].

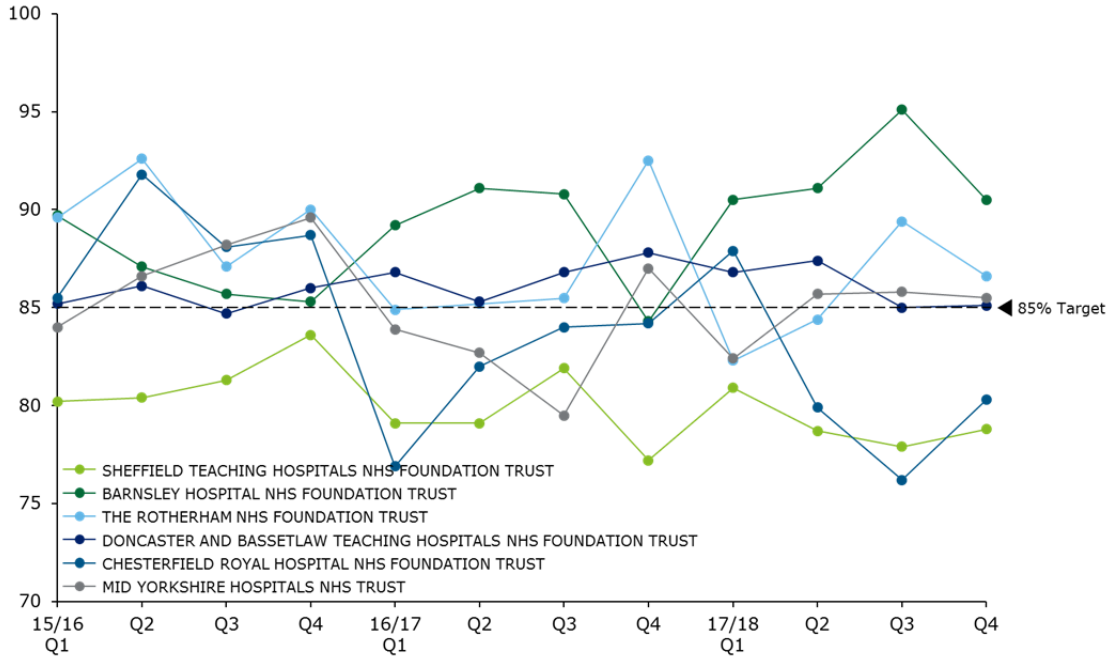


Figure 3: Per cent of patients who start cancer treatment within 62 days following urgent GP referral, by trust

[3] NHS Statistics, Cancer waiting times, 2015/16 – 2017/18

1.2 CQC FEEDBACK

Several clinical services across the SYBMYND trusts are now less resilient to pressures. Shortages in key workforce are undermining the ability to provide consistently high quality care in every hospital.

The Care Quality Commission observed this in their latest inspections, and their findings for each service area and trust are summarised below[4]. The Care Quality Commission reports looks at each core service area within a hospital and provides a summary of its current position against 5 criteria, judging whether a service is safe, effective, caring, responsive and well-led. The scores from these 5 criteria produce a score per service, and the scores per service feed into an overall hospital score.

Three of the seven trusts in the SYBMYND footprint are rated overall as Requires Improvement. This is an improvement upon the previous position with Barnsley Hospital NHS FT having been reclassified as Good in March 2018. Within these trusts, seven out of 13 individual hospital sites are also classified as Required Improvement. With regards to the HSR core services, several sites are flagged as Requires Improvement in their urgent and emergency care, as well as maternity and gynaecology.

[4] Care Quality Commission

Figure 4: CQC rating by site, service area and trust

2 ANALYSING THE 5 CORE SERVICES

The Hospital Services Review focused on five core specialties, following a prioritisation exercise with the system. These services are:

- Urgent and Emergency Care
- Acute Paediatrics (Care of the Acutely Ill Child)
- Maternity
- Stroke
- Gastroenterology and Endoscopy

Five Clinical Working Groups, one for each of the core services, were convened and invited to take part in a series of workshops to identify the challenges in their service and ideate potential solutions:

- Workshop 1 asked attendees to identify the main challenges facing their respective services;
- Workshop 2 asked attendees to identify possible solutions to the challenges;
- Workshop 3 asked attendees to reflect on whether the solutions suggested so far would meet the scale of the challenge; and if not, to consider more radical options;
- Workshop 4 brought together all the 5 CWGs in a shared session. The HSR team fed back the options which they had developed using the input from workshops 1-3. They shared an early draft of the recommendations for the HSR, with attendees being asked to comment on the proposed recommendations for their service;
- Workshop 5 was a short session shortly before the publication of the independent report, to give the CWGs early sight of the likely recommendations in the final Report.

Summary notes of workshops 1-4 were produced, capturing the key points, and were shared with staff in trusts. Members of the CWGs were asked to lead discussions on the key points that had emerged from the workshops, and to relay these views back to the CWGs at the beginning of the next meeting.

Many of the key themes emerging from discussions were common across all of the CWGs. Themes which were mentioned in most or all of the groups included workforce, innovation and clinical variation. These three themes were selected as being three of the most frequently mentioned themes, and ones which the HSR was likely to be able to address.

Other issues were raised during the sessions and these are outlined in the notes of the meetings published online (available via the links in section **Error! Reference source not found.**.) Some of these, such as the increasing complexity and acuity of patients, were identified as very important across multiple specialties but were excluded from the HSR because they were outside the direct ability of the HSR to address them.

2.1 WORKFORCE CHALLENGES

Workforce was the issue most frequently mentioned across all five of the Clinical Working Groups.

Specific issues that were mentioned included:

- **Difficulties with recruiting staff**: A number of different causes were cited, including national shortages; a failure to capitalise on those strengths that SYB does have in attracting applicants (such as the brand value of Sheffield Children's Hospital); for nurses, the end of

the nursing bursary; for junior doctors, the requirement for junior doctors to apply to the wider Yorkshire and the Humber region which was thought to put applicants off. There were also specific issues that were believed to make particular services unattractive, such as the physically hard nature of stroke nursing, or the high pressure and long hours in A&E units.

- **Difficulties with retaining staff**: Causes identified included workloads, particularly in units which were heavily understaffed; working conditions (e.g. lack of car parking); limited access to flexible working or planned rotas. Clinicians flagged that attrition rates amongst junior doctors can be particularly high, as high as 40 per cent for specialist trainees in obstetrics.

- **Retirement:** Upcoming retirement of large numbers of staff was flagged as a future challenge in particular areas of the workforce. Over 30 per cent of midwives are over 50, implying that over the coming decade a large number will retire, leaving significant gaps in the workforce should recruitment not be increased.

- **Training and development:** There was perceived to be significant variation in the breadth and scope of training received at different sites in SYB, leading to a variation in the relative attractiveness of each site as a workplace. Smaller DGHs are perceived to offer a less varied case mix of patients, limiting the exposure to complex cases; they also tend to offer fewer opportunities to participate in research.

- **Competition for workforce between sites:** Variation in staff contracting arrangements between sites was reported, for example around pay and benefits, affecting the relative attractiveness of trusts as a workplace. This, compounded by an overall shortage of specialists in the system, was perceived to have led to competition for the same workforce between trusts, leading to escalating costs and grade inflation to attract talent. Such issues were reported both for substantive and locum positions. Competition between public and private sector organisations was also reported as an issue.

These difficulties were reported as affecting the majority of the grades, in most of the specialties, although the CWGs did identify a few professional groups, such as obstetricians, which were under less pressure.

Following the CWGs, the HSR team undertook more detailed modelling of current and projected staff availability, and found that in general the empirical evidence supported the self-reported staffing issues.

The two tables below summarise the workforce challenge insights garnered from the engagement with CWGs and workforce data analysis. Note, due to data limitations, not all staffing groups and services were modelled.

Table 1: CWG observations on current and projected staff availability by service and staff type

	Nurses	Mid Grades / Junior Doctors	Consultants	Allied Health Professionals
UEC	Nursing staff shortage recognised, particularly following changes to nurse bursaries	Significant gaps in CT4 doctors and above, in particular specialist registrars given high number required	Shortage in senior decision makers	Shortage in consultant psychiatrists flagged
Paediatrics	Considerable gaps in nursing workforce, due to discontinuation of nursing bursary and limited development opportunities	Middle and junior-grade doctors in particularly short supply, thought partly to be due to perceptions of the specialty	Consultant posts mostly filled but locum spend high. Many qualified consultants work as locums.	Variation in use of alternative workforce, such as Advanced Neonatal Nurse Practitioners, reported
Maternity	Midwifery and nursing gaps variable across trusts	All trusts have middle-grade gaps, with the problem recognised nationally, leading to high locum spend	Consultant posts mostly filled but upcoming retirements and lack of succession planning seen as an issue	Shortages in neonatology nurses and sonographers flagged
Stroke	High nurse turnover and vacancy rate reported, given demanding nature of stroke care	Lack of consultants had knock on effect on mid-grades	Shortage in specialist consultants. Trusts not able to fill all their posts even with locums	No problem recruiting therapists but budget too low to pay for sufficient numbers
Gastroenterology and endoscopy	Nursing shortage, along with consultants, considered to be significantly challenging	Not enough trainees in post to meet service demand	Consultant gaps flagged as particular issue, especially for out of hours and weekend rotas, considered to be at "breaking point"	Issues with supply of radiologists, with a 50% shortage nationally

Table 2: Insights from quantitative modelling on current and projected workforce availability relative to forecast requirements by service and staff type.

	Nurses	Mid Grades / Junior Doctors	Consultants
UEC	N/A	124 middle grade WTEs currently; 119 WTEs forecast in 2021/2022 64 WTEs required to meet guidelines in 2021/22	60 consultant WTEs now; 70 forecast in 2021/2022 Gap of 5 FTEs for 2021/22
Paediatrics	N/A	3% decrease in available middle grade WTE complement in 2021/22	47 consultant WTEs currently; 53 forecast in 2021/2022 10 WTEs required to meet guidelines
Maternity	552 nurses at present across SYB(ND) 150 Band 5 and 6 midwives required to meet Royal College guidelines	4% decrease in available middle grade WTE complement in 2021/22	69 WTEs currently; 72 WTEs forecast in 21/22 Sufficient to staff current 60 hour units, but shortfall if increase to 98 hour cover

2.2 CLINICAL VARIATION

The Clinical Working Groups also raised concerns around clinical variation. This manifested itself in a number of different ways:

- **Variation in transfer protocols:** CWGs raised concerns around the variation in transfer protocols, with no consistent, unified approach taken by trusts. There was a concern about lack of communication between trusts, which often led to lengthy waits for patients being transferred, with staff having to negotiate with receiving trusts on behalf of their patients. Clinicians expressed a desire for clear "rules of engagement" to align behaviours regarding patient transfers.

- **Variation in clinical protocols:** The adoption of different standards and clinical protocols at different trusts, and different approaches to implementing national guidance, has led to different patients receiving different care at different hospitals for the same condition. Each CWG flagged multiple conditions and pathways for which treatment protocols varied between trusts and Places. Variation in approaches taken also impedes the flexible working of staff across sites, given often significant differences in ways of working.

- **Variation in commissioning specifications:** Clinicians raised concerns around certain conditions for which the commissioning specifications varied significantly. For example post-acute rehabilitation services packages ranged from 3 to 12 months across SYBMYND. Available of pre- and post-natal support for mothers was also reported as being subject to variation across the region. This reinforced perceptions of a "postcode lottery" for certain services across the different Places in SYB.

- **Variation in equipment:** CWG attendees flagged the variation in medical devices and equipment found at different sites. For example, variation in endoscopy equipment between trusts limits clinicians' ability to work across multiple sites with ease, as additional training is required for them to operate the different equipment found on each site.

2.3 INNOVATION

A further theme was around innovation. Key points raised were:

- **Incompatible information technology:** CWGs raised concerns around the variation in electronic health record technologies. SystemOne, Rio, Lorenzo and Meditech are just some of the examples of software used across the region. In places there were different systems being used in different specialties in the same trust. Even where trusts were nominally on the same system, there was variation in the functionality and deployment of the same software packages. This amounts to barriers to the ease in patient record transfer and continuity of care, sometimes within the same hospital. Systems were also said to be different across secondary and primary care, again making shared working more difficult.

- **Outdated IT systems:** As well as systems not being interoperable between sites, clinicians flagged that many systems were outdated, slow to use and were not fit-for-purpose, requiring updating or replacing.

- **Slow adoption of new technologies across the region**: CWG attendees flagged that best practice and innovation was not always shared across the SYB trusts. Opportunities for improvement were identified where innovations in one trust could usefully have been rolled out across others in the system, sharing learning and advancements; but this was rarely the case.

South Yorkshire and Bassetlaw, Mid Yorkshire and North Derbyshire: Hospital Services Programme

Strategic Outline Case Annex C:

Organisations Represented at the SYB ICS Collaborative Partnership Board

This annex lays out the organisations represented at the Collaborative Partnership Board which commissioned and oversaw the Health Services Review (HSR).

ORGANISATIONS REPRESENTED AT THE SYB ICS COLLABORATIVE PARTNERSHIP BOARD:

- NHS Barnsley Clinical Commissioning Group
- Barnsley Hospital NHS Foundation Trust
- Barnsley Metropolitan Borough Council
- NHS Bassetlaw Clinical Commissioning Group
- Bassetlaw District Council
- Chesterfield Royal Hospital NHS Foundation Trust
- Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust
- NHS Doncaster Clinical Commissioning Group
- Doncaster Metropolitan Borough Council
- East Midlands Ambulance Service NHS Trust
- NHS England
- Nottinghamshire Healthcare NHS Foundation Trust
- Nottinghamshire County Council
- The Rotherham NHS Foundation Trust
- NHS Rotherham Clinical Commissioning Group
- Rotherham, Doncaster and South Humber NHS Foundation Trust
- Rotherham Metropolitan Borough Council
- Sheffield Children's NHS Foundation Trust
- Sheffield City Council
- NHS Sheffield Clinical Commissioning Group
- Sheffield Health and Social Care NHS Foundation Trust
- Sheffield Teaching Hospitals NHS Foundation Trust
- Yorkshire Ambulance Service NHS Trust

OTHER STATUTORY ORGANISATIONS WITH WHOM THE REVIEW WORKS:

- Bolsover District Council
- Chesterfield Borough Council
- Derbyshire Community Health Services NHS Foundation Trust
- Derbyshire Healthcare NHS Foundation Trust
- Doncaster Children's Services Trust
- NHS Hardwick Clinical Commissioning Group
- The Mid Yorkshire Hospitals NHS Trust
- NHS North Derbyshire Clinical Commissioning Group
- North East Derbyshire District Council
- South West Yorkshire Partnership NHS Foundation Trust
- NHS Wakefield Clinical Commissioning Group
- Wakefield Metropolitan Borough Council

South Yorkshire and Bassetlaw, Mid Yorkshire and North Derbyshire: Hospital Services Programme

Strategic Outline Case Annex D:

Dates of CCG Governing Body and Trust Board Discussions on HSR, Post-Publication

This annex lays out the dates of the meetings at which the Hospital Services Review recommendations were formally received and discussed by CCG Governing Bodies and Trust Boards.

DATES OF HOSPITAL TRUST BOARD AND CLINICAL COMMISSIONING GROUP GOVERNING BODY DISCUSSIONS ON HSR, POST-PUBLICATION

All dates 2018

ICS Collaborative Partnership Board	8 June
Bassetlaw CCG GB	12 June
Barnsley CCG GB	14 June
The Mid Yorkshire Hospitals Board	14 June
Doncaster CCG GB	21 June
Sheffield Children's NHSFT Board	26 June
Sheffield Teaching Hospitals NHSFT Board	26 June
The Rotherham NHSFT Board	26 June
Doncaster & Bassetlaw Teaching Hospitals NHSFT Board	26 June
Wakefield CCG GB	26 June
JCCCG (in public)	26 June
Chesterfield Royal Hospital NHSFT Board	27 June
Barnsley Hospital NHSFT Board	28 June
North Derbyshire CCG GB	28 June
ICS Hospital Committees in Common	2 July
Rotherham CCG GB	4 July
Sheffield CCG GB	5 July
ICS Executive Steering Group	17 July
JCCCG	25 July
CPB FINAL AGREEMENT	TBC

Note: "ICS" = Integrated Care System; "GB" = Governing Body; "CCG" = Clinical Commissioning Group; "JCCCG" = Joint Committee of Clinical Commissioning Groups; "NHSFT" = NHS Foundation Trust

Annex E

South Yorkshire and Bassetlaw Integrated Care System

Hospital Services Programme

Strategic Outline Case

Annex F: Addendum to HSR Financial Modelling

Changes to the financial analysis in the HSR

Changes to figures in the financial analysis: technical annex

In the last few days before publication of the Hospital Services Review, some Trusts provided the Review team with updated activity data. This supplemented the Reference Cost data which the Review team had used during the analysis as it was the most consistent source of publicly available data.

Owing to time constraints, the new activity data was used to inform the workforce analysis, but could not be used to update the financial and capacity analysis.

For purposes of consistency the financial and capacity analysis was updated following publication to incorporate the new data. The revised activity data, and the changes to the numbers that this contributed to, are summarised in the following 2 slides.

The changes were marginal and did not alter the recommendations of the Review.

Slides 6 onwards lay out an updated version of the Technical Annex including the revised activity data for all areas.

Activity summary

Clarification of changes

The table below shows the

- **Activity values, based on reference costs, that were used throughout the HSR analysis** and which inform the finance and capacity modelling published in the HSR Final Report (blue columns)
- **Revised activity values** (green columns) that were supplied by three trusts shortly before publication. These were used to inform the workforce analysis in the Final Report, but owing to time constraints were not used to re-model the finance and capacity modelling at that stage.
- The changes can be seen to be marginal in most cases, with the greatest change relating to paediatrics activity at Rotherham hospital.

	Activity figures used in finance/capacity modelling published 9th May	Updated activity figures	Activity figures used in finance/capacity modelling published 9th May	Updated activity figures
	Maternity activity		Care of Acutely Ill Child activity	
BH	**2,949**	**3,012**	**3,134**	**3,217**
DON	3,391	3,391	4,277	4,277
BAS	1,507	1,507	1,493	1,493
MON				
SCH			10,043	10,043
STH	**6,745**	**6,924**		
RH	**2,562**	**2,678**	**2,089**	**3,833**
CRH	2,845	2,845	4,838	4,838
Total	**19,999**	**20,357**	**25,874**	**27,701**

Financial impact

Following publication of the HSR Final Report, the HSR team has, for purposes of consistency, re-run the financial analysis (and the capacity analysis that sits behind it) based on the new activity figures.

The updates have had limited impact. The majority of costs changed by no more than £300,000 from previous estimates, with the greatest impact being an increase of c.£1m in the upper range of certain scenarios. As a result, the changed financial data did not affect on the recommendations put forward by the HSR.

Absolute change from figures published on the 9th of May		UEC	Care of the acutely ill child	Maternity	Gastroenterology and endoscopy
Option 1 (1 site fewer)	Current out-of-hospital plans	£0.1m to £0.1m	£0.1m to £0.1m	£0.1m to £0.7m	£0.0m to £0.0m
	More ambitious out-of-hospital plans	£0.0m to £0.9m	£0.0m to £0.0m	£0.0m to £1.3m	£0.0m to £0.0m
Option 2 (2 sites fewer)	Current out-of-hospital plans	£0.0m to £0.2m	£0.1m to £0.7m	£0.1m to £0.6m	£0.0m to £0.0m
	More ambitious out-of-hospital plans	£0.0m to £0.8m	£0.0m to £1.1m	£0.0m to £1.4m	£0.0m to £0.0m
Option 3 (3 sites fewer)	Current out-of-hospital plans	£0.1m to £0.1m	£0.7m to £0.4m	£0.3m to £0.6m	£0.0m to £0m
	More ambitious out-of-hospital plans	£0.0m to £0.2m	£0.3m to £1.1m	£0.1m to £1.3m	£0.0m to £0.0m

Updated version of the

Technical annex: financial analysis

for the Hospital Services Review

Contents

Executive Summary

Executive Summary (1/5)

Introduction

South Yorkshire, Bassetlaw, and North Derbyshire (SYB(ND)) is facing significant sustainability problems which are laid out in the Hospital Service Review's (HSR) Stage 1A, Stage 1B and Stage 2 reports.

A number of transformational solutions have been proposed by the HSR to tackle workforce challenges, reduce unwarranted clinical variation and solve the problems of tomorrow through innovation. The HSR has not modelled the financial impact of these transformational solutions, in order to avoid the risk of double counting with provider cost improvement programmes (CIPs) and commissioner QIPP schemes.

Despite these solutions, with growing workforce shortages and constrained resources, all five advisory Clinical Working Groups took the view that it is not possible to continue to provide all the services that are currently provided, on all the sites that currently provide them. In some areas, the scale of the challenge is so great that the HSR team do not consider that they can be met by transformation alone (e.g. solely through new workforce models)

A number of reconfiguration scenarios have been modelled that consolidate senior consultant presence and middle grade doctors onto fewer sites in order to increase quality and consistency of care through meeting the Royal College guidelines. Each option has been assessed against the HSR's five evaluation criteria, and this report focusses on the workforce and affordability aspects of this evaluation.

The analysis was undertaken at a high-level, with workforce, activity, capacity and financial modelling targeted at providing greater clarity around the cost and benefits related to the different configuration scenarios. Six scenarios have been modelled, to test the impact of the removing the smallest and largest 1, 2 and 3 sites.

Executive Summary (2/5)

Reconfiguration scenarios

The reconfiguration scenarios we have looked at include the following:

Stroke options were not modelled, in the context of an ongoing challenge to the hyper-acute stroke unit (HASU) business case.

	Option 0 – status quo	Option 1	Option 2	Option 3
Urgent and emergency care	6 Emergency Departments + 7 MIUs (or equivalent)	5 Emergency Departments + 7 UTC	4 Emergency Departments + 7 UTC	3 Emergency Departments + 7 UTC
Care of the acutely ill child	6 IP Units + 3 24/7 SSPAUs + 3 part time SSPAUs	5 IP Units + 5 24/7 SSPAUs + 1 part-time SSPAU	4 IP Units + 4 24/7 SSPAUs + 2 part-time SSPAUs	3 IP Units + 3 24/7 SSPAUs + 3 part-time SSPAUs
Maternity	6 CLUs + 2 AMLUs + Home births service	5 CLUs + 5 AMLUs + 1 SMLU + Home births service	4 CLUs + 4 AMLUs + 2 SMLUs + Home births service	3 CLUs + 3 AMLUs + 3 SMLUs + Home births service
Gastroenterology and endoscopy	5 independent Out-of-Hours (OOH) rota	4 full OOH rotas & formal network arrangements	3 full OOH rotas & formal network arrangements	2 full OOH rotas & formal network arrangements

Interdependent

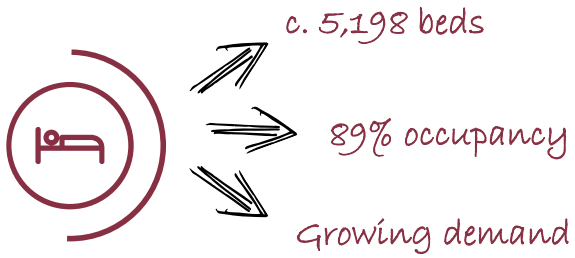
Scenarios definition

- In order to assess the range of potential impacts resulting from the configuration scenarios, site specific scenarios were required (i.e. defined activity shifts from one site to another).
- Given that the analysis is meant to be non-site specific, these site specific scenarios were developed by the HSR using high-level rules based on service size (defined by level of activity).
- While the scenarios used data from actual sites (the smallest and largest units in the system for each service) in order to generate a realistic range of potential impacts, data from these sites are used for illustrative purposes and do not imply that any specific sites are being considered for reconfiguration.

Executive Summary (3/5)

The capacity challenge

There are currently c.5,198 beds in the system with an average bed occupancy rate of 89%. The STP's current assumptions around the impact of out-of-hospital schemes means that additional capacity would be required in five years time to meet growing levels of demand. To avoid this, while achieving an average bed occupancy of 85% and freeing up some space to allow for potential services changes, the HSR has considered the potential impact of more ambitious out-of-hospital schemes.



The workforce challenge

c. £17M

Temporary staffing costs

- For three of the services considered by the HSR – urgent and emergency care, care of the acutely ill child, and maternity – high-level workforce analysis was undertaken to inform the overall cost-benefit assessment.
- Based on the information returned from the trusts, the system has spent c.£17m on temporary staff (including bank and agency) in the previous year, and many trusts are not meeting the suggested staffing levels outlined by Royal College guidelines.
- Expected growth in workforce based on numbers supplied by Health Education England (HEE) will help trusts to reduce reliance on temporary staff and support trusts in bridging the gap with Royal College Guidelines where these are not currently met. However in some cases this is not sufficient to bridge the gap.

Urgent and Emergency Care

A very small investment in ED consultants would be required to meet the Royal College guidelines under the status quo option, although we recognise these are aspirational in nature.

A gap in Middle Grade doctors persists, and would need to be rectified by alternative workforce models.

Care of the acutely ill child

An investment in paediatric consultants would be required to meet the Royal College guidelines under the status quo option.

Converting up to two inpatient sites into Short Stay Paediatric Assessment Units (SSPAUs) would enable SYB(ND) to better meet the consultant requirements. Commissioners may wish to consider changing 24/7 SSPAUs to part-time SSPAUs to further reduce the consultant requirement.

Maternity

Further work is required to understand the direct clinical care PAs in addition to those covering the delivery suite across each DGH. Three scenarios have been considered in this analysis for units between 2500-4000 deliveries per year, depending on the specific specialties covered by the unit. which show that consultant numbers are projected to be sufficient to staff 6 units with lower levels of consultant presence.

Should commissioners wish to move units up to a minimum of 98 hours of consultant presence to reflect the high levels of complex births in SYB(ND)'s population, this could be achieved by converting two obstetric units into Standalone Midwifery Led Units.

An investment in midwives is required in order to meet Royal College guidelines around the ratio of midwives to births.

There are important interdependencies between maternity and paediatrics, and neonatology. Therefore solutions for maternity and paediatrics will need to be considered jointly.

Executive Summary (4/5)

Financial Impacts

- Due to the limited spare capacity estimated to be available in the system in 2021/22, most configuration scenarios would require additional investment to be undertaken. This investment is in the form of capital for additional new build beds or refurbished beds.
- This could be partially offset by assuming a greater impact of out-of-hospital schemes, which would free up capacity at existing sites and reduce the requirement for additional beds.
- When reconfiguration occurs from a small 'donor' site to a 'receiving' site with spare capacity, the overall capacity change and associated capital investment is low.

Urgent and emergency care

Capital costs of replacing an ED with a GP-led UTC can become very large. This is because a significant amount of non elective activity can no longer be treated on the site and has to be moved elsewhere. Removing consultant led services at the ED significantly reduces the services that a site can provide. However, better use of primary care onsite (through the UTCs) and the expected impact of out of hospital schemes can help to prevent unnecessary A&E attendances and admissions.

Small **workforce savings** are possible with the replacement of two small EDs (due to fewer ED doctors being required), however, Commissioners may wish to consider if these are sufficiently large to warrant significant disruption for staff and the public. UTCs on all sites will also reduce the ED workforce requirement, notwithstanding that more GPs would be required.

Care of the acutely ill child

Capital costs depend on the size of the 'donor' site and the spare capacity of the 'receiving' site. For example, if one site is running below 85% bed utilisation, capital costs are lower in scenarios involving transferring activity to this site.

Some capital investment is required across all options and this should be seen in the context of meeting the Royal College guidelines around safer staffing levels. Capital would also need to be found to expand neonatology on the receiving site.

Workforce savings may not be possible given there is a consultant gap currently, however consultant locum usage may be mitigated as the IP units across the system are consolidated. However, Health Education England anticipates a reduction in the number of other medical grades.

Maternity

Capital costs can be significant. At present there is little spare capacity across SYB(ND) in maternity, which creates the requirement to build additional capacity upon reconfiguration.

Greater levels of out-of-hospital shift could create additional capacity, however, this spare capacity would need to be refurbished. In addition, capital would need to be found to expand neonatology on the receiving site, which is expensive.

Capital investment should be seen in the context of achieving greater levels of consultant presence for the high risk births across SYB(ND).

Workforce savings may not be possible given an apparent gap in midwives.

Next Steps

- The analysis was not prepared at business case level at this stage; and does not constitute level of detail that would be required for consultation. As such further refinements and analysis will be needed to inform the final decision on a proposed option for each of the services under consideration.

Executive Summary (5/5)

Recommendations

The below recommendations have been developed through the careful consideration across all the HSR's evaluation criteria (workforce, affordability, access, quality and interdependencies). Based on all these factors, the HSR recommends:

01

Urgent and Emergency Care (Emergency Departments):

- The HSR recommends maintaining all 6 consultant-led EDs with the proposition that these would be the front door to different ranges of services on different sites.
- The sustainability of other medical grades should be supported through new and alternative workforce roles
- Commissioners should note this model needs to be supported by a strong and effective model for Urgent Treatment Centres and out-of-hospital care.

02

Care of the acutely ill child:

- The HSR recommends further site-specific modelling to understand the implications of closing 1 or 2 inpatient paediatric units across SYB(ND), to meet the Royal College guidelines for consultant staffing.
- Commissioners may wish to consider if the shortfall in consultant numbers could be mitigated to some degree by converting full-time SSPAUs into part-time SSPAUs on sites that have an inpatient unit.

03

Maternity:

- The HSR considers that the current range of provision does not meet the aims of patient choice laid out in *Better Births*, nor does it account for the high degree of complex births for the population of SYB(ND).
- The HSR recommends this is not an area where gaps in consultant numbers is driving reconfiguration, however, the HSR heard from clinicians that the pressure in some units of delivering high and medium risk births with only 60 hours of consultant presence was putting significant pressure on staff.
- Commissioners may wish to consider moving to a minimum of 98 hours of consultant presence, which would only become sustainable if 2 obstetric units were to convert to a midwifery-led unit across SYB(ND).
- Further work is required to understand the impact of additional clinical care PAs not relating to the delivery suite across each DGH in SYB(ND). For example, PAs allocated to gynaecology and other non-delivery suite related obstetrics activity.
- There are important interdependencies between maternity, paediatrics, and neonatology. Therefore solutions for maternity and paediatrics will need to be considered jointly. In addition, capacity would need to be found to expand neonatology on the receiving site.

04

Gastroenterology and Endoscopy

- The HSR recommends consolidating services for urgent gastrointestinal bleeds out-of-hours onto a smaller number of sites, with elective endoscopy services maximised on each site where possible.

05

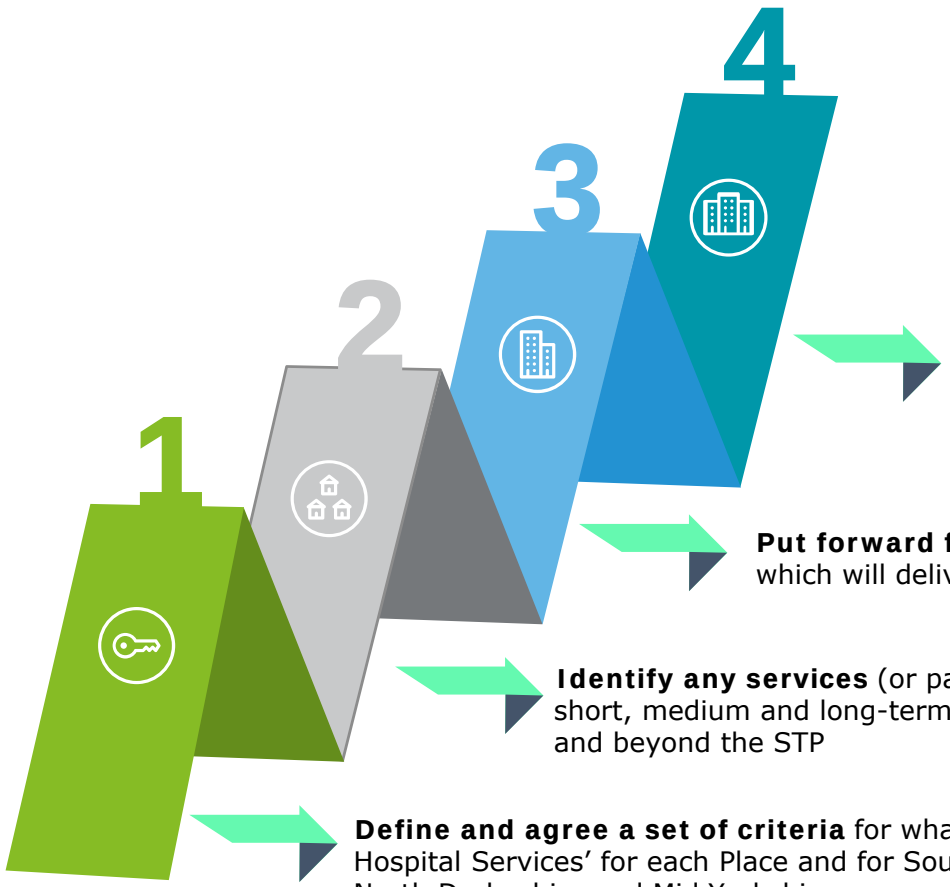
Stroke:

- No reconfiguration options have been proposed; it is believed that services can be made sustainable through shared working.

Introduction

Aims and objectives of the Hospital Services Review

The Hospital Services Review (HSR) has the following aims and objectives.



Define and agree a set of criteria for what constitutes 'Sustainable Hospital Services' for each Place and for South Yorkshire and Bassetlaw, North Derbyshire and Mid Yorkshire

Identify any services (or parts of services) **that are unsustainable**, short, medium and long-term including tertiary services delivered within and beyond the STP

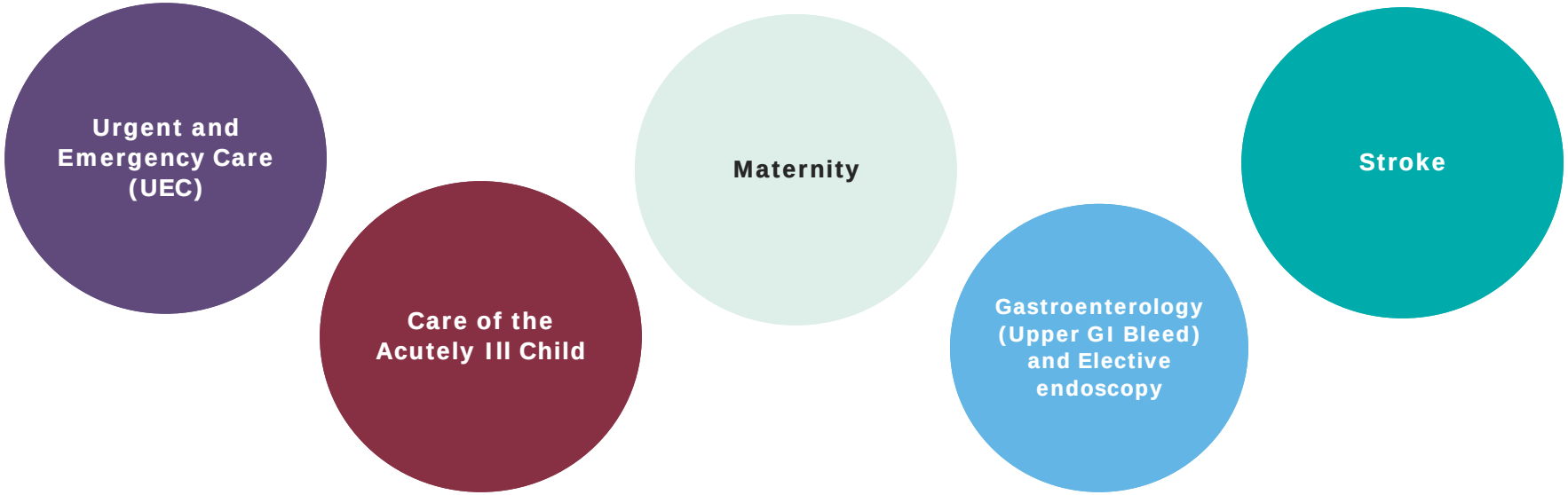
Put forward future service delivery model or models which will deliver sustainable hospital services

Consider what the future role of a District General Hospital is in the context of the aspirations outlined in the South Yorkshire and Bassetlaw Sustainability and Transformation Plan (STP) and emergent models of sustainable service provision

.

Rationale for the final choice of services

The services chosen focus largely on the emergency, 24/7 services. The HSR team anticipate that the review will also consider how elective services might be located across the system in order to support any proposals in these services



The services identified by the HSR are those which:

- **Are facing significant difficulties with workforce and / or quality of care.**
- **Have a significant number of interdependencies:** setting these services on a more sustainable footing will significantly help to improve the service as a whole.
- **Have a significant impact on the service as a whole.**

HSR analysis

The analysis to support this review will be developed through 3 stages

1

High-level non site specific scenario analysis

We have undertaken high-level workforce and capacity modelling targeted at understanding the feasibility of 'extreme' scenarios to provide a range. The analysis is non site specific.

Early- to mid-February

We are here!

2

Non site specific scenario analysis

We have undertaken high-level financial, workforce activity and capacity modelling targeted at providing greater clarity around the cost and benefits related to the different scenarios. The analysis is presented in a non site specific way.

Mid-February to mid-April

3

Site specific option analysis

Financial, workforce, activity, travel time and capacity modelling should be refined and undertaken to provide greater clarity around the cost and benefits of each site specific option.

After publication of the Report

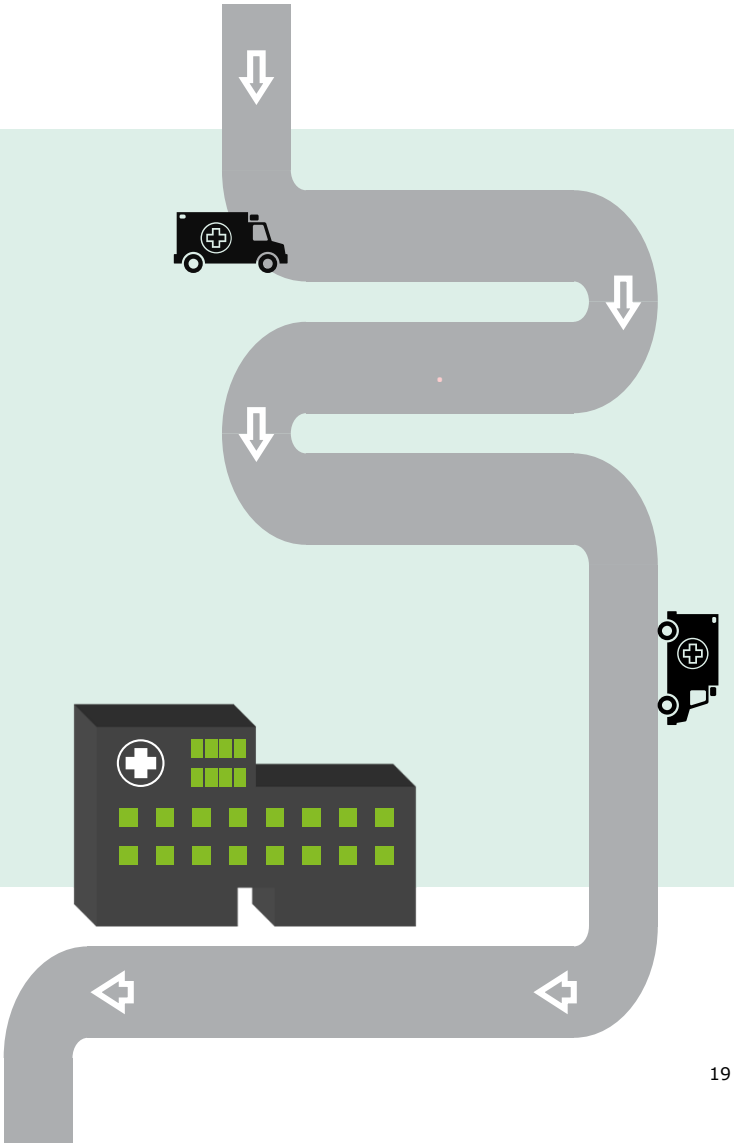
Our approach to the analysis

HSR analysis overview (1/4)

The purpose of the analysis is to inform a view of which reconfiguration options are most likely to address the scale of existing challenges

The Hospital Services Review analysis was undertaken at a high-level, with financial, workforce, activity and capacity modelling targeted at providing greater clarity around the cost and benefits related to the different configuration scenarios.

The analysis is used to inform a view of which reconfiguration scenarios are most likely to mitigate the scale of the existing challenges. It seeks to enable the system to **rule out** scenarios at this stage rather than providing recommendations on a preferred way forward.



HSR analysis overview (2/4)

Collecting and validating data

The following process was followed in terms of collecting and validating data:

Data request

A data request on workforce, activity, service components and other key performance indicators was sent to all the trusts in September 2017 and data was received throughout Q4 of 2017.

Sense-checking

A process of discussing and sense-checking the data as it was received was followed.

Quantitative analysis

The HSR used this data to quantitatively assess the service challenges and summarised findings in service-specific data packs which were circulated to all trusts for sign-off in December 2017. Where incomplete data was received from trusts, the HSR drew on publicly available 2016/17 Reference Costs data to supplement it. Reference Costs data was used for the capacity analysis.

Validation of workforce data

The trusts were asked to reconfirm workforce figures in February 2017 to ensure they were still valid and up to date. More detail was requested on the workforce split within the specialties (e.g. detailed assumptions around workforce split / time spent for e.g. obstetrics and gynaecology; and paediatrics and neonatology care).

Validation of other specific data sets

Further requests were made to trusts to validate specific areas of data:

- Service definitions in February 2018 (email sent on 20 February);
- Staff in post FTEs (email sent on 20 February);
- Locum expenditure and FTEs in April 2018; and
- Staff in post and establishment FTEs, as well as activity in April/May 2018.

HSR analysis overview (3/4)

Validating the assumptions behind the modelling

The modelling is intended to be high level and non site specific. As such it is based on a number of assumptions, which are described in detail in this document.

These assumptions were discussed in the following forums:

- Discussions were held with clinical leads and clinicians in the system in March and April 2018 (following an email sent on 20 March) to discuss and refine assumptions used in the workforce analysis.
- Key financial assumptions, for example the costs of capital, were discussed with Directors of Finance on 19 March and 11 April.
- Assumptions around workforce, e.g. the use of Royal College Guidelines, were discussed with the HSR Steering Group and the AOs / CEOs throughout January and February 2018.
- Detailed data and assumptions pack sent to the steering group on 31st April and discussed individually with Medical Directors.

HSR analysis overview (4/4)

Key assumptions used in the HSR analysis

Activity shifts

The HSR has identified a range of services which are currently facing sustainability challenges. The Clinical Working Groups set out a range of reconfiguration scenarios that would potentially improve service sustainability by moving services between sites.

The aim of the analysis was to identify the maximum and minimum potential impact of any reconfiguration scenario for South Yorkshire and Bassetlaw. In order to do this realistically, the analysis used a set of rules to identify the largest and smallest sites in each service, and modelled the potential maximum and minimum impacts using scenarios and data from these sites.

The use of this real data does not indicate that a site is being considered for reconfiguration. The modelling is illustrative and the data has been presented in a non site-specific way to show the maximum and minimum potential impacts. This is intended to allow the system and the public the opportunity to comment on the proposed approach before modelling is carried out for all the potential combinations of potential sites.

Site-specific modelling will need to be taken forward in the next stage of the work to understand the detailed implications of the different scenarios for all the possible combinations of SYB(ND) sites.

Workforce

The purpose of the workforce analysis is to inform the cost-benefit analysis and provide an indication of the scale of the current workforce challenge, spend on locums, and potential gap in medical workforce in 5 years' time based on HEE projections.

The analysis is based on Royal College standards for consultant numbers, acknowledging their aspirational nature, but using them to give an indication of how close a particular option takes the system to guidelines.

Capital

The modelling of capital costs is intended to give a range of smallest to largest impacts of any changes within the system. The analysis is based on activity shifts, on the basis of which bed requirements are estimated across sites. As mentioned above, the results are presented in a non site specific way.

Capital requirements for interdependent services have been considered at a high-level. Capital expenditure for some of these might be higher than the general rule of thumb used.

Scope and limitations

HSR analysis

The scenarios were developed by the HSR based on high level rules to provide a wide range of potential reconfiguration impacts

As described in the previous slide, data from the largest and smallest sites in the system, and those with the largest and smallest travel times, were used to create an illustrative range of the maximum and minimum potential impacts. The analysis is presented in a non site specific way and cannot be used to draw any conclusions about sites.

This is in order to give the public and stakeholders the opportunity to comment on the proposed approach before it is applied to potential sites. These discussions will occur in the period following April 2018.

For the purposes of this analysis, specific scenarios were developed by the HSR using a range of high-level rules based on size (defined as activity) and travel distance across different sites. This is described in more detail in the example below.

Example

This illustrative example is a high-level description of service relocation rules:

- *The targeted sites are progressively identified based on size (i.e. smallest and largest). This is because size is one of the key drivers of reconfiguration impacts (such as capacity and economies of scale). As such, this enables the analysis to reflect the widest possible range of impacts on most metrics.*
- *Each service moves individually, based on service size.*
- *For example, in the 1 site fewer scenario, the activity covered by the service is relocated to the nearest hospital within the system currently providing the same service, identified by the shortest drive time from the hospital site rather than patients' homes.*

HSR analysis

The capacity and workforce analysis has been developed to identify how far the scenario meets the evaluation criterion of costing no more than the current system

Workforce

Is the scenario likely to deliver workforce standards without increasing workforce costs?

Capacity

Is additional capacity required to accommodate services? How much spare capacity is generated?

Activity

What is the scale of consolidation across the different scenarios?

Finance

Is the scenario cost-neutral?

HSR analysis

There are limitations to this initial analysis that would need to be addressed in the next stage of modelling

Summary limitations

Data sources. To ensure consistency between trusts, the capacity and hence the financial analysis were developed using Reference Costs data rather than more detailed HES/SUS data. In the next stage of modelling we would ask trusts to complete all original data returns. For the workforce analysis, data on FTEs provided by trusts was used.

Information gaps. The analysis was developed using the information provided by the system. Gaps have been noted and addressed through assumptions which are clearly reported in the Appendices.

Scenario development. The scenarios were developed using simplistic rules to give an indication of the range of potential impact. As such, these will need to be revisited at an operational level of detail with real life costs when the reconfiguration scenarios and options are developed in the next stage of modelling.

Travel time and catchment areas. The analysis currently assumes that as a service is reconfigured, all activity moves to the site closest to the original service provider. This does not take into account that activity may go to different sites based on different patient travel times and patient choice.

Quality Assurance and level of detail. Due to the high number of scenarios considered the analysis has currently been conducted at a relatively high-level. This has included engagement with clinical leads, Medical Directors and the Directors of Finance, and this will need to be revisited with more detailed engagement as the HSR conducts the next stage of site specific modelling.

Interdependencies and flow backs. The analysis provides an initial account of the potential clinical interdependencies and additional changes that could be implemented to free up capacity. This would need to be revisited in further detail in the next stage of modelling.

A more detailed description of the limitations related to the finance, workforce and capacity analysis, and the assumptions behind them, is provided in the Appendices.

Notwithstanding the limitations above, the data is necessarily high level and represents in principle scenarios at this stage. However, it provides an indication of the potential workforce and capital implications to enable us to assess the relative impacts of the different options and advance to the next stage of identifying and modelling high level options.

Findings

HSR analysis

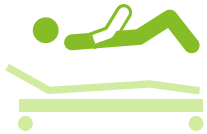
Summary of HSR analysis

This rest of this section is structured as follows:

1. Baseline
    - o Capacity challenge
    - o Workforce challenge
2. Reconfiguration impacts
    - o Scenario definition
    - o Workforce impacts
    - o Financial impacts

1. Baseline

Summary



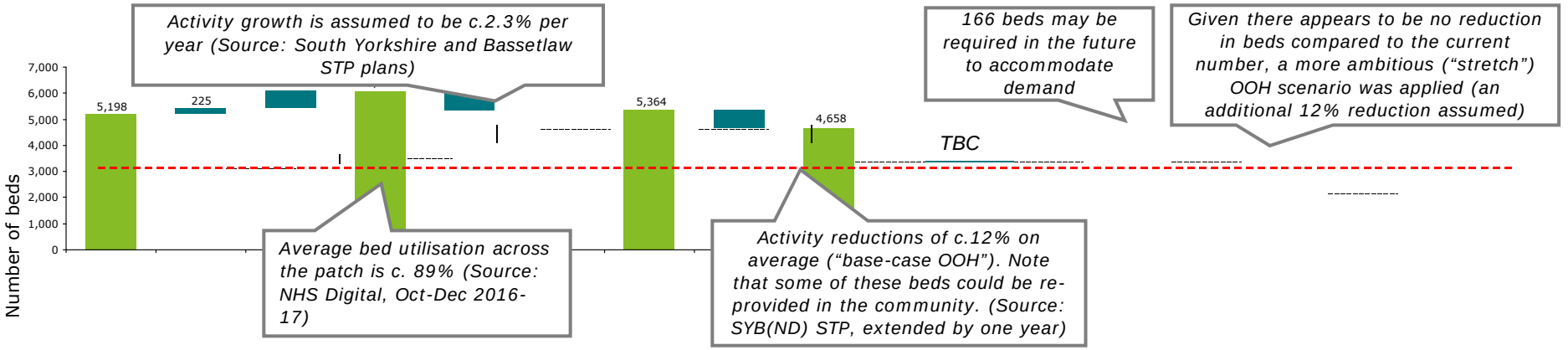
The capacity challenge

The workforce challenge

1.HSR analysis – capacity challenge

The system needs more ambitious out-of-hospital shifts to reduce the number of beds over the next five years

There are currently c. 5198 beds in the system at an average bed utilisation of 89%. If no other changes were made apart from activity growth, to achieve a target utilisation of 85%, 6,070 beds would be required in 2021/22.



Source: HSR Analysis

Current STP(ND) estimates (extended by one year) for out-of-hospital schemes (c. 12% reduction) would reduce the number of beds to c. 5,364 beds in 5 years time. At the next stage of the analysis, the HSR will further consider the deliverability of the 12%, given evidence from other systems across the NHS.

The HSR has considered the impact of a more ambitious OOH impact (working assumption of 24% activity reduction). This would result in the system requiring c. 4,658 beds.

Note that the system would need to consider the potential impact on transformation funding required to deliver these more ambitious schemes.

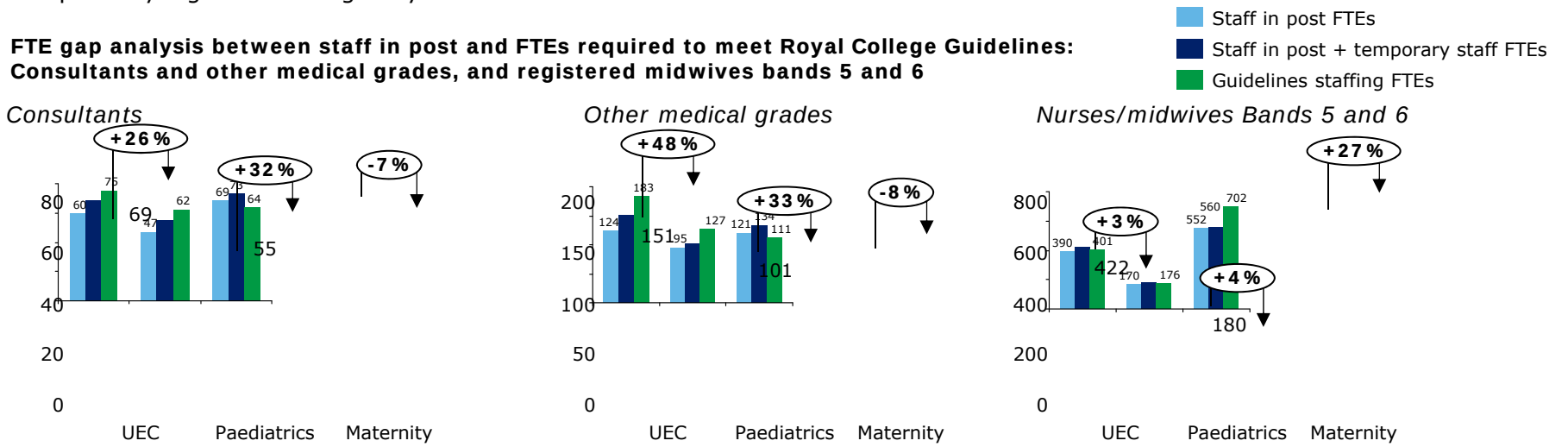
1. HSR analysis – workforce challenge

The services considered as part of the review are also facing workforce challenges

For three of the services considered by the HSR – maternity, paediatrics (care of the acutely ill child) and UEC – workforce analysis has been undertaken. Current staff in post FTEs have been compared against Royal College Guidelines FTEs. Royal College Guidelines have been used as they represent good practice and as an indication of how close different options take the system to the guideline level, although in some cases clinicians have noted these are aspirational in nature.

Based on the information returned from the trusts, the system has spent c. £17m on temporary staff (including bank and agency) in the past year. The equivalent number of FTEs was estimated to be c. 145, although in some cases this may be distorted by exceptionally high rates charged by some locums for some shifts.

FTE gap analysis between staff in post and FTEs required to meet Royal College Guidelines: Consultants and other medical grades, and registered midwives bands 5 and 6



Source: Reference Costs for activity data, with updated figures from some of the trusts received in April/May 2018. For FTE values, trust returns from September 2017, with updates received in April/May 2018.

Notes: 2016/17 workforce data was collected from Trusts in September 2017. Some but not all Trusts subsequently updated their data with 2017/18 numbers. For locum FTEs 2017/18 data was used.

The FTE values above include consultants and other medical grades, and registered midwives bands 5 and 6. Other categories of staff not included. Maternity numbers are consistent with Scenario A, as described on the following slides.

Workforce analysis was conducted for Maternity, Paediatrics and UEC as reconfiguration on these services is more likely to yield direct workforce efficiencies. Reconfiguration for Stroke was not included in the context of the ongoing challenge to the HASU business case. Reconfiguration analysis for GI Bleeds services was not undertaken given the extremely low volumes of activity; and the fact that the major driver behind reconfiguration is to remove inequalities in access across SYB(ND) by ensuring that all patients can access emergency services overnight.

For further details on workings and assumptions refer to Appendix: Workforce data pack and assumptions.

2. Reconfiguration impacts

A. Scenario definition

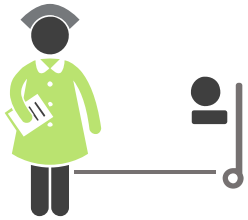
B. Workforce

C. Financial impacts

2. Reconfiguration impacts

A. Scenario definition

Summary



Scenarios definition

2.HSR analysis – reconfiguration scenarios

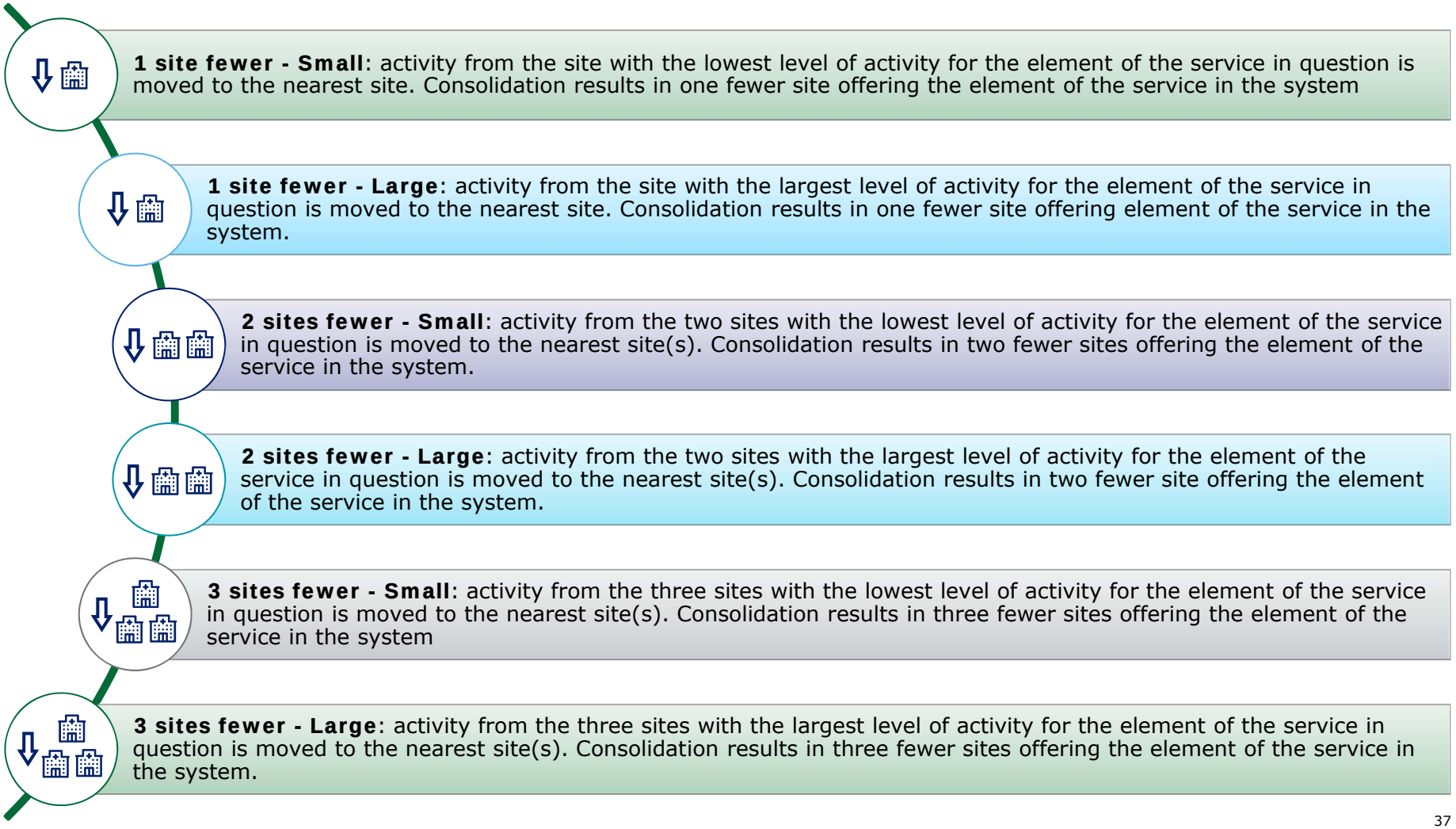
Reconfiguration impacts have been estimated for a range of scenarios

The reconfiguration scenarios we have looked at include the following:
Stroke options were not modelled, in the context of the ongoing challenge to the HASU business case.

		Option 0 – status quo	Option 1	Option 2	Option 3
	Urgent and emergency care	6 Emergency Departments + 7 MIUs (or equivalent)	5 Emergency Departments + 7 UTC	4 Emergency Departments + 7 UTC	3 Emergency Departments + 7 UTC
Interdependent	**Care of the acutely ill child**	6 IP Units + 3 24/7 SSPAUs + 3 part time SSPAUs	5 IP Units + 5 24/7 SSPAUs + 1 part-time SSPAU	4 IP Units + 4 24/7 SSPAUs + 2 part-time SSPAUs	3 IP Units + 3 24/7 SSPAUs + 3 part-time SSPAUs
Interdependent	**Maternity**	6 CLUs + 2 AMLUs + Home births service	5 CLUs + 5 AMLUs + 1 SMLU + Home births service	4 CLUs + 4 AMLUs + 2 SMLUs + Home births service	3 CLUs + 3 AMLUs + 3 SMLUs + Home births service
	Gastroenterology and endoscopy	5 independent Out-of-Hours (OOH) rota	4 full OOH rotas & formal network arrangements	3 full OOH rotas & formal network arrangements	2 full OOH rotas & formal network arrangements

2.HSR analysis – reconfiguration scenarios

We have provided a range of reconfiguration impacts with the range being driven off the smallest and largest sites

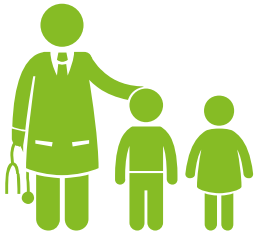


2. Reconfiguration impacts

B. Workforce

Workforce Summary

UEC:



Care of the acutely ill child:

Maternity

1. HSR analysis – notes on HEE projections

Future growth in consultants could improve service sustainability if the expected decrease in other medical grades is mitigated effectively

HEE projections

There are a number of factors to consider when utilising HEE projections:*

- **Comparison to establishment**. Where growth rates suggest consultant numbers are above current establishment rates, the system would need to decide whether to hire the additional staff or maintain establishment rates. According to Health Education England (HEE), consultant numbers could grow by 2021/22 (compared to current numbers) for all three services considered. This growth in consultant numbers could help reduce reliance on temporary staff and support trusts in bridging the gap with Royal College Guidelines where these are not currently met.
- **Reduction in other medical grades**. However, other medical grades FTEs are projected to decrease. This will increase either the gap to the Royal College Guidelines or reliance on locums for these roles. This could potentially be mitigated by training / employing more ANPs or ENPs to fill the middle grade rota, or by substituting consultants or nurses to fill these roles where available.
- **Configuration impact on nursing**. The HSR has focussed closely on how nurse and midwife numbers can be supported. However, nurse numbers are linked to the absolute number of patients much more closely than consultants or other medical grades. Number of nurses needed would only be marginally impacted by the configuration scenarios and, as such, were not considered in this stage of quantitative analysis. Royal College guidelines around midwifery ratios have been analysed and are included in this report.
- **Growth in nursing.** The impact on nursing staff has not been estimated by HEE at this stage. If there are insufficient nurses in the future, this would make role substitution more of a challenge (e.g. there may be less ANPs/ENPs to assist with the middle grade rota).
- **Retirement rates.** HEE numbers do not include retirement rates. Therefore the estimated projections may be on the high side and should be treated with caution.

Workforce growth estimates provided by HEE will factor in historic trends on retirement profiles; however, we have not included trust-specific projections on retirement as these are difficult to predict given changes to the retirement age, and data was not available at trust and service level.

As the analysis becomes site-specific, and service models are further defined, workforce modelling will need to be updated regularly to respond and take into account flows into and out of the workforce.

**Notes from HEE:*
These numbers have been formulated using the Forecast function in Excel and do not account for trainee supply currently in the system or the current demographics of current staff (i.e. age and expected retirements). Due to the limited numbers of staff in each area, estimates could be made more robust by having a greater sample.

2. HSR analysis – workforce growth

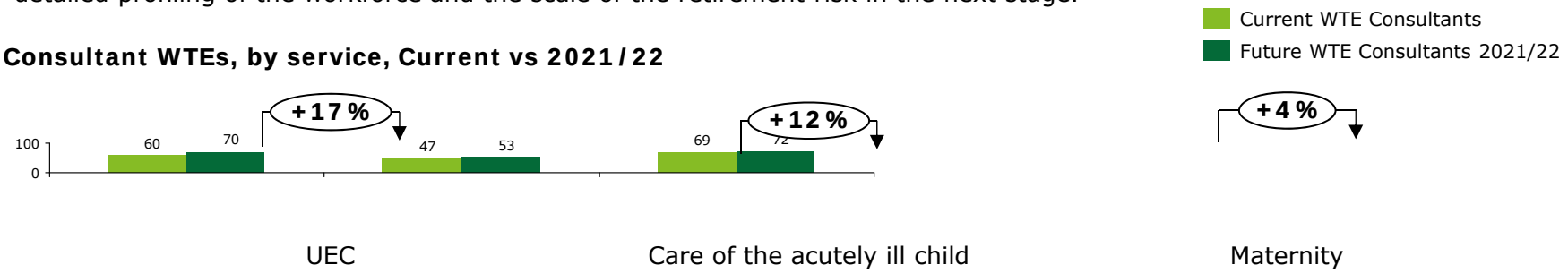
HEE is anticipating a growth across all services, with strong growth in UEC, and lower growth in maternity and paediatrics

According to Health Education England (HEE), consultant numbers could grow by 2021/22 for all three services considered. This growth in consultant numbers could help reduce issues around the reliance on temporary staff and help trusts meet the Royal College Guidelines for consultants.

- For urgent and emergency care, this represents a 17% increase from the current base of 60 to 70 consultants in 2021/22.
- For care of the acutely ill child, this represents a 12% increase from the current base of 47 to 53 consultants in 2021/22.
- For maternity, this represents only a 4% increase from the current base of 69 to 72 consultants in 2021/22.

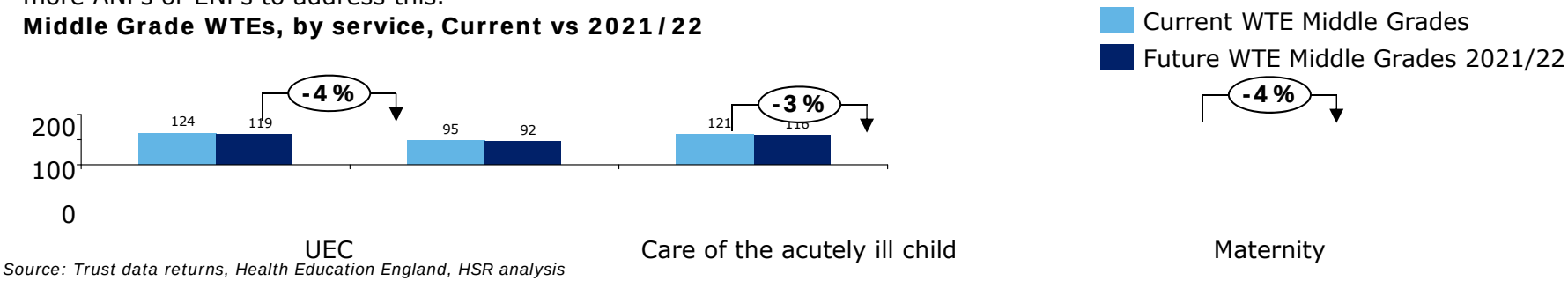
However, some of the projected growth might be outweighed by retirement rates. The system will need to engage in more detailed profiling of the workforce and the scale of the retirement risk in the next stage.

Consultant WTEs, by service, Current vs 2021/22



The same analysis for other medical grades suggests that the position will worsen across all services. Role substitution (e.g. consultants, nurses) could potentially mitigate this reduction in trainee grades. Another alternative could be to train or employ more ANPs or ENPs to address this.

Middle Grade WTEs, by service, Current vs 2021/22



Source: Trust data returns, Health Education England, HSR analysis
Notes: For FTE values, trust returns from September 2017 were used, with updates received in April/May 2018. SCH FTEs not included in UEC analysis, as SCH is not part of UEC reconfiguration due to its specialised nature (paediatrics A&E). Trust / Staff Grade doctors, middle grade doctors and junior doctors are included in this middle grade category.

3.HSR analysis – UEC

Consultant numbers

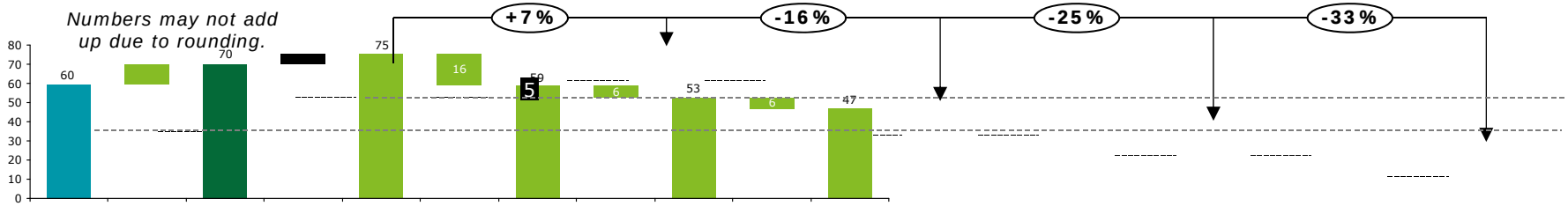
Key findings:

There are 58 consultant WTEs now and this is anticipated to rise to 76 in 2021/2022. Based on this growth, there is a small gap of 5 consultant FTEs in order for all six emergency departments to meet the Royal College guidelines for emergency medicine under the status quo option. Given the guidelines are anticipated to be aspirational in nature, the HSR deems this gap sufficiently small to retain all 6 EDs. This analysis is based on two main assumptions:

1. That trusts in SYB(ND) are able to **retain** their consultant workforce through making SYB(ND) a more attractive place to work. Should retention continue to be a problem and consultant numbers subsequently decrease, further consolidation may have to be considered.

2. That the **Urgent Treatment Centres** reduce activity that flows into each Emergency Department, reducing the requirement for a greater number of Consultants in the Emergency Department. An assumption of 6 GPs per UTC has been made by the HSR at this stage. Whilst this has been included in the cost-benefit analysis, it is not shown on these slides. The future service model, which will be defined at the next stage of the analysis, will need to balance the workforce across GPs and ED consultants, given the difficulties in recruiting GPs, and taking into account growth in both workforces and the use of ENPs in the UTCs.

Consultant WTEs, UEC, Current vs 2021/22 vs Option 1, 2, 3



Source: Trust data returns, Health Education England, HSR analysis
Notes: Reference Costs for activity data, with updated figures from some of the trusts received in April/May 2018. For FTE values, trust returns from September 2017 were used, with updates received in April/May 2018. SCH FTEs not included in UEC analysis, as SCH is not part of UEC reconfiguration due to its specialised nature (paediatrics A&E). 6 scenarios have been modelled, for simplicity the average impact for the 1 site fewer, 2 sites fewer and 3 sites fewer is presented

3.HSR analysis – UEC

Other medical grades numbers

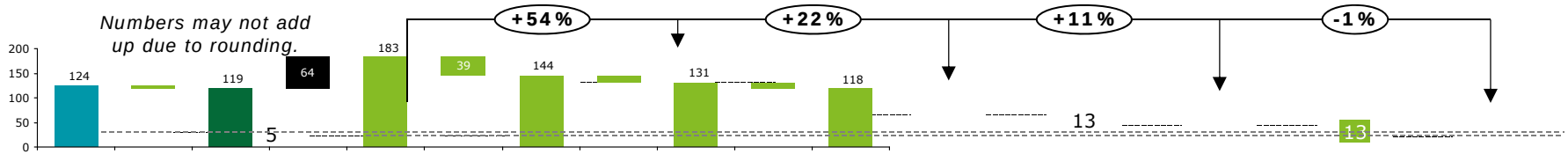
Key findings:

There are 124 other medical grades WTEs now and if current trends continue this is anticipated to decrease to 119 in 2021/2022. These trends could be reversed by the workforce recommendations outlined in the HSR Report around workforce recruitment and retention. In order to meet the Royal College Guidelines in 2021/22 an additional 59 Middle Grade WTEs would be required. This gap in Middle Grade doctors is consistent with the clinical opinion in the UEC Clinical Working Group which cited the key issue around middle grade sustainability in particular. There two options to reduce this significant gap in other medical grades:

- Role substitution (for example, consultants or nurses) could partially mitigate this reduction in other medical grades. Another alternative could be to train or employ more Physician Associates, Advanced Nurse Practitioners or Emergency Nurse Practitioners to address this (for example the training of c. 20 ENPs could address a third of this gap, but this would risk creating a shortage in nurses in the absence of creating a truly incremental workforce). The CWGs recognised this alternative workforce could be used to provide support although time would be needed for the appropriate training.
- If the above workforce solution does not go far enough, then SYB(ND) might need to consider the reconfiguration to two fewer Emergency Departments in the longer term to allow for the sustainable staffing of Middle Grade doctors. However this would be a significant step given the level of public concern that is likely, and the significant capital costs that would be involved, so the HSR does not recommend it.

The challenges around other medical grades represent a long term sustainability challenge that must be addressed through making SYB(ND) an attractive place to work. Since nursing numbers are based on activity ratios; the consolidation of emergency departments does not affect the numbers of nurses, and has not been modelled.

Other medical grades WTEs, UEC, Current vs 2021/22 vs Option 1, 2, 3



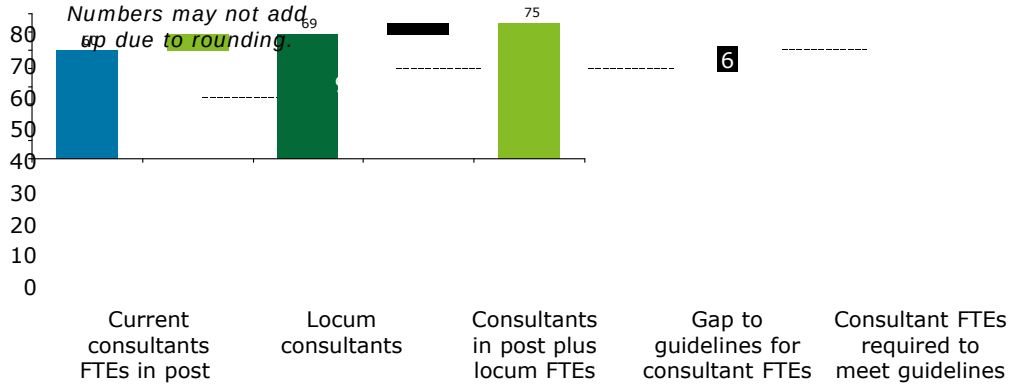
Other medical grades in post FTEs | Growth in other medical grades to 2021/22 | Other medical grades complement 2021/22 | Gap to guidelines for other medical grades | Other medical grades required to meet guidelines | 1 site fewer | Other medical grades required after reconfiguration (1) | 2 sites fewer | Other medical grades required after reconfiguration (2) | 3 sites fewer | Other medical grades required after reconfiguration (3)

Source: Trust data returns, Health Education England, HSR analysis
Notes: Reference Costs for activity data, with updated figures from some of the trusts received in April/May 2018. For FTE values, trust returns from September 2017 were used, with updates received in April/May 2018. SCH FTEs not included in UEC analysis, as SCH is not part of UEC reconfiguration due to its specialised nature (paediatrics A&E). Trust / Staff Grade doctors, middle grade doctors and junior doctors are included in this other medical grades category.
6 scenarios have been modelled, for simplicity the average impact for the 1 site fewer, 2 sites fewer and 3 sites fewer is presented

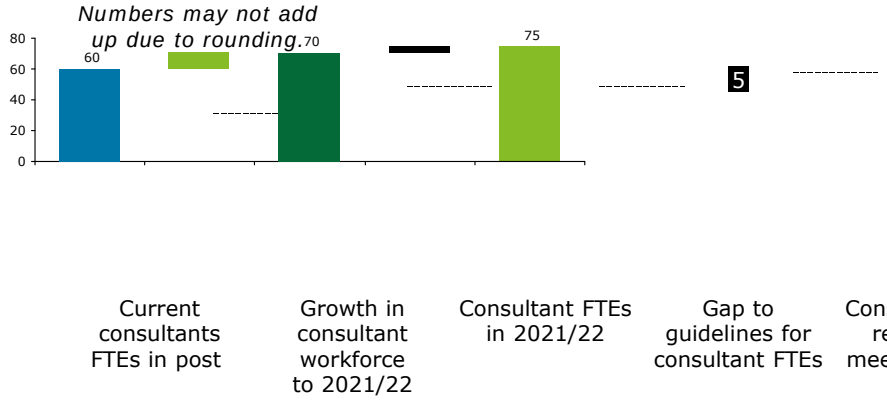
3.HSR analysis – workforce challenge

UEC locum expenditure could be mitigated in the future if the consultant workforce grows in line with HEE projections

Current consultant FTEs



Projected consultant FTEs



- Currently the system spends c. £1.7m on consultant locums, equivalent to c. 9 FTEs.
- The agency premium rate appears to be c. 20%. This has been calculated based on HSR data returns submitted in April 2018.
- In the future, if HEE projections materialise, the system will have 10 more consultants in post, however there would still be a gap to guidelines of c. 5 FTEs, which may need to be filled with locums if the system intends to meet the guidelines in full.

Source: Based on HSR data returns, with assumptions where data was inconsistently filled in or not provided.
Notes: Reference Costs for activity data, with updated figures from some of the trusts received in April/May 2018. For FTE values, trust returns from September 2017 were used, with updates received in April/May 2018. Locum expenditure is based on 2017/18 data provided by the Trusts in April 2018.

3.HSR analysis – Care of the acutely ill child

Consultant numbers

Key findings:

There are 47 consultant WTEs attributed to acute paediatrics now and this is anticipated to rise to 53 in 2021/2022. There is currently a 10 WTE shortfall against the number of consultants that would be required to meet Royal College guidelines under the status quo option. While the guidelines are aspirational, the HSR considers that they represent a sustainable workforce, and the system should aim to get closer to them.

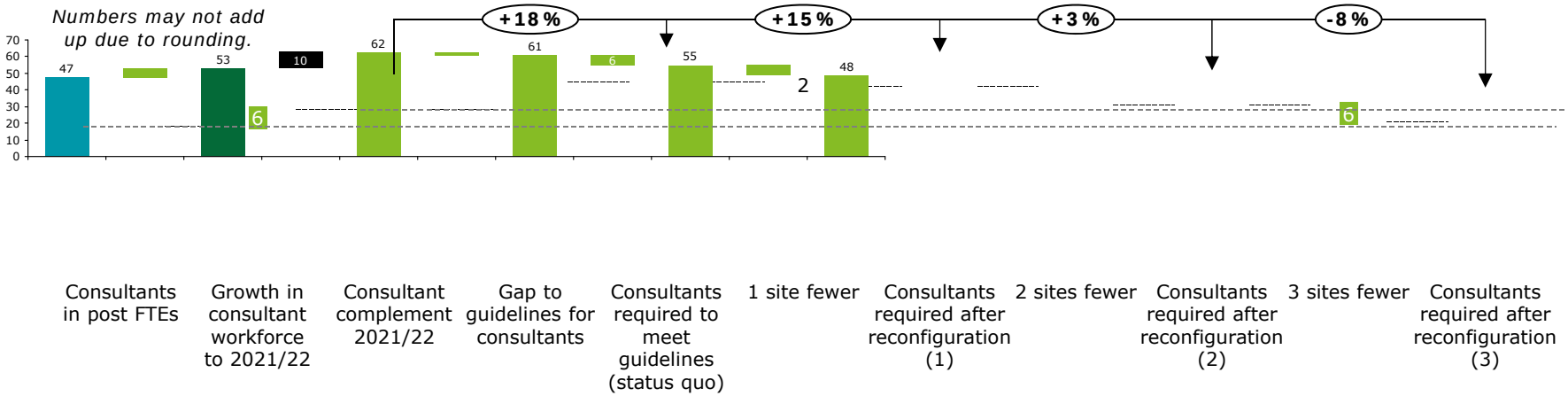
One way to reduce the number of consultants needed is to consolidate inpatient paediatric units (although as the size of units increase upon consolidation, so does the requirement for additional consultant presence on both larger inpatient units and co-located 24/7 SSPAUs.)

Changing two or three inpatient units into SSPAUs would allow SYB(ND) to get closer to or meet the Royal College guidelines, and reduce the reliance on locum staff which is explored overleaf. A further option would be to convert the 3 current 24/7 SSPAUs to part-time SSPAUs. This would reduce the overall consultant requirement across SYB(ND) by 4 consultant FTEs under the Status Quo option.

Given the guidelines are aspirational in nature and the significant disruption that could be caused by converting 3 inpatient units into SSPAUs, the HSR recommends commissioners further explore the converting 1 or 2 inpatient units into SSPAUs in the site-specific stage of modelling.

Other medical grades numbers have not been modelled in the same way, as no comparable Royal College guidelines could be found. Since nursing numbers are based on activity ratios; the consolidation of inpatient units does not affect the numbers of nurses, and has not been modelled.

Consultant WTEs, Care of the Acutely Ill Child, Current vs Option 1, 2, 3



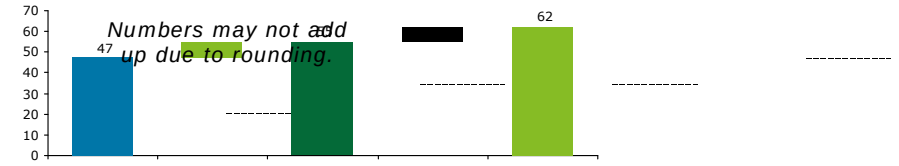
Consultants in post FTEs	Growth in consultant workforce to 2021/22	Consultant complement 2021/22	Gap to guidelines for consultants	Consultants required to meet guidelines (status quo)	1 site fewer	Consultants required after reconfiguration (1)	2 sites fewer	Consultants required after reconfiguration (2)	3 sites fewer	Consultants required after reconfiguration (3)

Source: Trust data returns, Health Education England, HSR analysis
Notes: Reference Costs for activity data, with updated figures from some of the trusts received in April/May 2018. For FTE values, trust returns from September 2017 were used, with updates received in April/May 2018. Staff WTEs exclude estimated time commitment for neonatology services, and are for acute paediatrics only. Only hospital sites with Level 1 Neonatology units have workforce that covers both the paediatrics and neonatology rotas.
6 scenarios have been modelled, for simplicity the average impact for the 1 site fewer, 2 sites fewer and 3 sites fewer is presented.

3.HSR analysis – workforce challenge

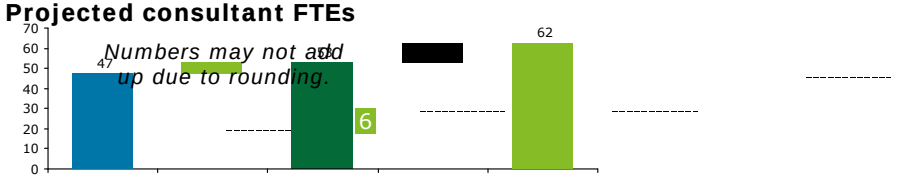
Paediatrics locum expenditure could be partially mitigated in the future if the consultant workforce grows in line with HEE projections, however there may still be a need for locum consultants

Current consultant FTEs



Current consultants FTEs in post | Locum consultants | Consultants in post plus locum FTEs | Gap to guidelines for consultant FTEs | Consultant FTEs required to meet guidelines

Projected consultant FTEs



Current consultants FTEs in post | Growth in consultant workforce to 2021/22 | Consultant FTEs in 2021/22 | Gap to guidelines for consultant FTEs | Consultant FTEs required to meet guidelines

- Currently the system spends c. £1.7m on consultant locums, equivalent to c. 8 FTEs.
- The agency premium rate appears to be c. 29%. This has been calculated based on HSR data returns submitted in April 2018.
- In the future, if HEE projections materialise, the system will have 6 more consultants in post. However the growth in workforce does not appear sufficiently high to entirely mitigate the need for locums, if the system retains 6 inpatient sites.

Source: Based on HSR data returns, with assumptions where data was inconsistently filled in or not provided.
Notes: Reference Costs for activity data, with updated figures from some of the trusts received in April/May 2018. For FTE values, trust returns from September 2017 were used, with updates received in April/May 2018. Locum expenditure is based on 2017/18 data provided by the Trusts in April 2018.

3.HSR analysis – Maternity

Consultant numbers (1/3)

Key findings

There are 69 consultant obstetrician and gynaecologist WTEs in SYB(ND) and this is anticipated to rise to 72 in 2021/2022. The HSR team has used RCOG 2009 Guidelines, *The future workforce in obstetrics and gynaecology*, to estimate the number of consultant WTEs that are required according to the size of unit (the guidelines are attached in the appendix). The HSR recognises these are aspirational in nature, so have been used as a target to understand the potential shortfall in consultants and how to potentially address this.

The RCOG guidelines allow of a wide range of consultant presence, depending on the specific specialties covered by the unit. The HSR team have modelled three scenarios for units between 2500-4000 deliveries per year:
Scenario A: a total of 8 consultants are required across obstetrics and gynaecology combined; and
Scenario B: 10 consultants are required.
These two scenarios reflect the advice in the guidelines that each hospital should have a range of direct clinical care PAs in addition to those covering the delivery suite (that is, for maternal and foetal medicine, antenatal clinic, gynaecology theatre or outpatient clinics). Further analysis would need to be undertaken in the next stage of the HSR to understand the relative requirements across the trusts in SYB(ND).
Scenario C: involves all units that are currently operating at 60 hours of consultant presence increase to 98 hours of consultant presence to account for the high levels of medium or high complex births across the SYB(ND) population.

In order to meet Royal College guidelines an additional 0.3 WTEs would be required under the status quo option for Scenario B and a decrease in 7.7 WTEs for Scenario A. Under both scenarios, consultant numbers does not appear to be driving the need for reconfiguration although further work is required to test the appropriate number of direct clinical care PAs that are required in addition to the delivery suite (that is, for maternal and foetal medicine, antenatal clinic, gynaecology theatre or outpatient clinics).

Whilst the consultant workforce for maternity may not be a driving a requirement for change, the interdependency with paediatrics mean that if there is a change in the number of IP paediatric units there will ned to be a change in the number of obstetric units and neonatal units. There is also a quality driver, as members of the Clinical Working Groups have said that workload pressures led to significant amounts of unplanned overtime. Moving to a 98 hour unit would potentially reduce the pressures on staff.

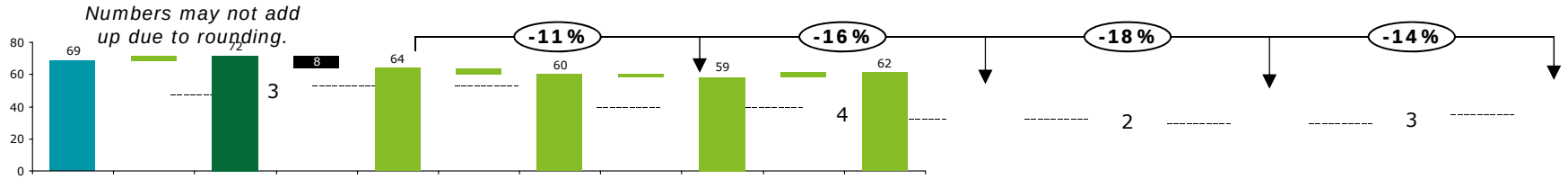
All three scenarios are presented on the following two pages.

Source: Trust data returns, Health Education England, HSR analysis
Notes: 2016/17 workforce data was collected from Trusts in September 2017. Some but not all Trusts subsequently updated their data with 2017/18 numbers
WTEs are for both obstetrics and gynaecology to mirror how the RCOG 2009 guidelines have been stated.

3.HSR analysis – Maternity

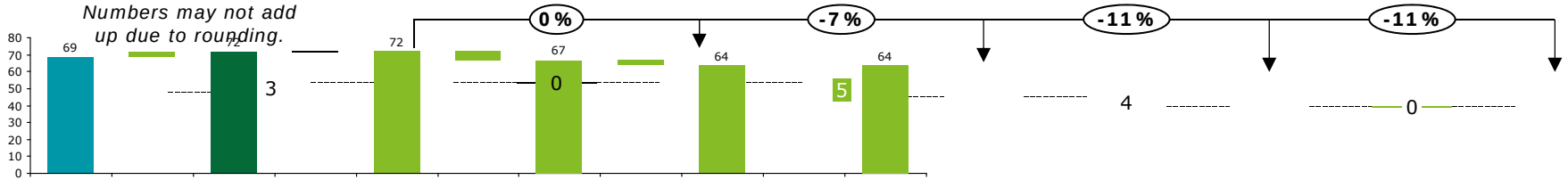
Consultant numbers (2/3)

Consultant WTEs, Obstetricians and Gynaecologists, Current vs 2021/22 vs Option 1, 2, 3 – Scenario A



Consultants in post FTEs | Growth in consultant workforce to 2021/22 | Growth in consultant workforce to 2021/22 | Gap to guidelines for consultants | Consultants required to meet guidelines (status quo) | 1 site fewer | Consultants required after reconfiguration (1) | 2 sites fewer | Consultants required after reconfiguration (2) | 3 sites fewer | Consultants required after reconfiguration (3)

Consultant WTEs, Obstetricians and Gynaecologists, Current vs 2021/22 vs Option 1, 2, 3 – Scenario B



Consultants in post FTEs | Growth in consultant workforce to 2021/22 | Growth in consultant workforce to 2021/22 | Gap to guidelines for consultants | Consultants required to meet guidelines (status quo) | 1 site fewer | Consultants required after reconfiguration (1) | 2 sites fewer | Consultants required after reconfiguration (2) | 3 sites fewer | Consultants required after reconfiguration (3)

Source: Trust data returns, Health Education England, HSR analysis
Notes: Reference Costs for activity data, with updated figures from some of the trusts received in April/May 2018. For FTE values, trust returns from September 2017 were used, with updates received in April/May 2018. WTEs are for both obstetrics and gynaecology to mirror how the RCOG 2009 guidelines have been stated. Interdependencies with paediatrics and neonatology have not been considered at this stage. 6 scenarios have been modelled, for simplicity the average impact for the 1 site fewer, 2 sites fewer and 3 sites fewer is presented

3.HSR analysis – Maternity

Consultant numbers (3/3)

Key findings:

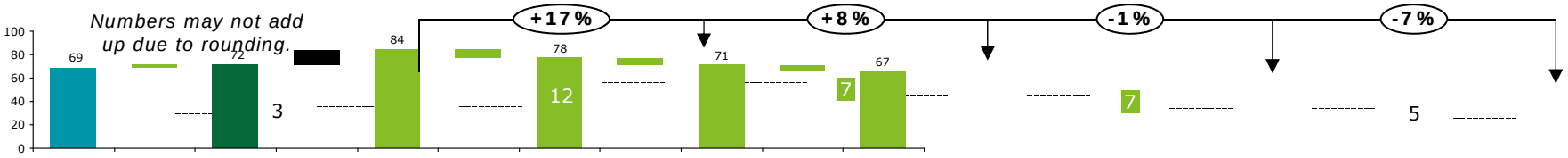
Currently there are 69 consultant obstetrician and gynaecologist WTEs in SYB(ND) and this is anticipated to rise to 72 in 2012/22. The average proportion of low risk births across SYB(ND) is 29% of total deliveries, which represents a relatively complex population compared to the national average, with 71% of all deliveries being medium or high risk.

This translates into a high intensity role for obstetricians, and during the Clinical Working Groups, we were told that the current consultants encounter high levels of overtime.

In the context of a higher risk population, we have therefore modelled a Scenario C which increases the levels of consultant presence on sites that are currently offering 60 hours of consultant presence to 98 hours of consultant presence. Under this scenario, there is a 12 consultant FTE gap between the predicted consultant complement in 2021/22 and the number of consultants required to meet 98 hours of consultant presence.

The consolidation of two obstetric units offsets this additional requirement and allows SYB(ND) to meet Royal College guidelines of greater consultant presence, which is in keeping with the relatively high risk population across SYB(ND).

Consultant WTEs, Obstetricians and Gynaecologists, Current vs 2021/22 vs Option 1, 2, 3 – Scenario C



Consultants in post FTEs	Growth in consultant workforce to 2021/22	Growth in consultant workforce to 2021/2	Gap to guidelines for consultants	Consultants required to meet guidelines (status quo)	1 site fewer	Consultants required after reconfiguration (1)	2 sites fewer	Consultants required after reconfiguration (2)	3 sites fewer	Consultants required after reconfiguration (3)

Source: Trust data returns, Health Education England, HSR analysis
Notes: Reference Costs for activity data, with updated figures from some of the trusts received in April/May 2018. For FTE values, trust returns from September 2017 were used, with updates received in April/May 2018. WTEs are for both obstetrics and gynaecology to mirror how the RCOG 2009 guidelines have been stated. 6 scenarios have been modelled, for simplicity the average impact for the 1 site fewer, 2 sites fewer and 3 sites fewer is presented.

3.HSR analysis – Maternity

Midwife numbers

Key findings:

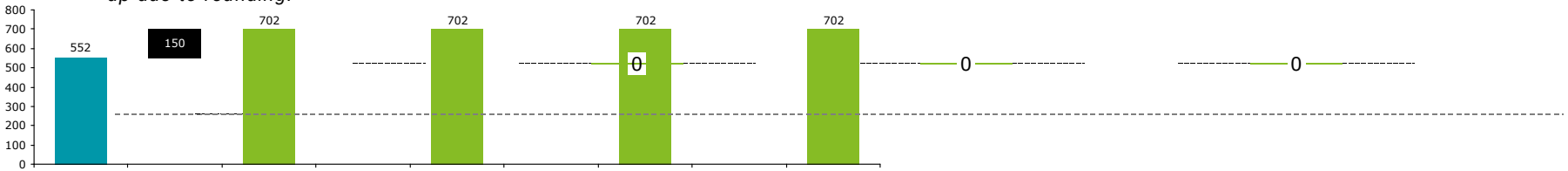
There are 552 midwives (Bands 5 and 6) across SYB(ND). No growth projections have been supplied by Health Education and as such all modelling has occurred off the current baseline. Clinicians in the Maternity Clinical Working Group cited the removal of the bursary as having a significant negative impact on the number of midwives being trained.

Standards for midwifery range from 1:28 to 1:30. For the purposes of this analysis, an average of 1 midwife to 29 births, which was ratified through engagement with clinicians, was used. Based on this, SYB(ND) would require an additional 150 band 5 and 6 midwives to ensure appropriate care during labour. Any growth in the number of midwives over the next five years would reduce the size of the gap.

Since midwife numbers are based on activity ratios, and each option maintains midwifery-led care in each place, the consolidation of obstetric-led care does not affect the numbers of midwives. The Clinical Working Group noted that many midwives are now approaching retirement age, and there was a risk that they might decide to retire early rather than move to a new model of working. However the timeline for reconfiguration would be likely to be long enough that there would be limited impact.

Midwives Bands 5 and 6 WTEs, Maternity, Current vs Option 1, 2, 3

Numbers may not add up due to rounding.



Source: Trust data returns, Health Education England, HSR analysis

Notes: Reference Costs for activity data, with updated figures from some of the trusts received in April/May 2018. For FTE values, trust returns from September 2017 were used, with updates received in April/May 2018. 6 scenarios have been modelled, for simplicity the average impact for the 1 site fewer, 2 sites fewer and 3 sites fewer is presented

4. HSR analysis – further notes

In addition, future transformation focused on new workforce models and technologies could further mitigate existing workforce challenges

Transformation benefits

The HSR is exploring a wide range of additional transformation benefits, for example as a result of new workforce models or increased use of technology such as Robotic Process Automation ('RPA'). These could be represented by the "frontier shift" in efficiency which has been estimated as part of the National Tariff development. This term captures increases in efficiency over time, as new technologies and processes enable lower service delivery costs.

The frontier shift can lead to up to 1% savings on costs p.a. However, given the level of risk in the existing Cost Improvement Plans (CIPs) developed by each Trust, these benefits have not been incorporated into the analysis.

2017/18 and 2018/19 National Tariff Payment System. NHS England and NHS Improvement.
https://nhsicorporatesite.blob.core.windows.net/green/uploads/documents/2017-18_and_2018-19_National_Tariff_Payment_System.pdf

Growth in activity

The analysis is based on 2016/17 activity levels, as taken from Reference Costs 2016/17. Growth in activity for paediatrics and UEC was assumed to be mitigated by the impact of OOH schemes. For maternity growth in activity is estimated to be c. 1.6% over 5 years, 2022 compared to 2017 (ONS, 2014-based Subnational population projections, Table 5).

See *Appendix: Workforce data pack and assumptions* for further details.

2. Reconfiguration impacts

C. Financial impacts

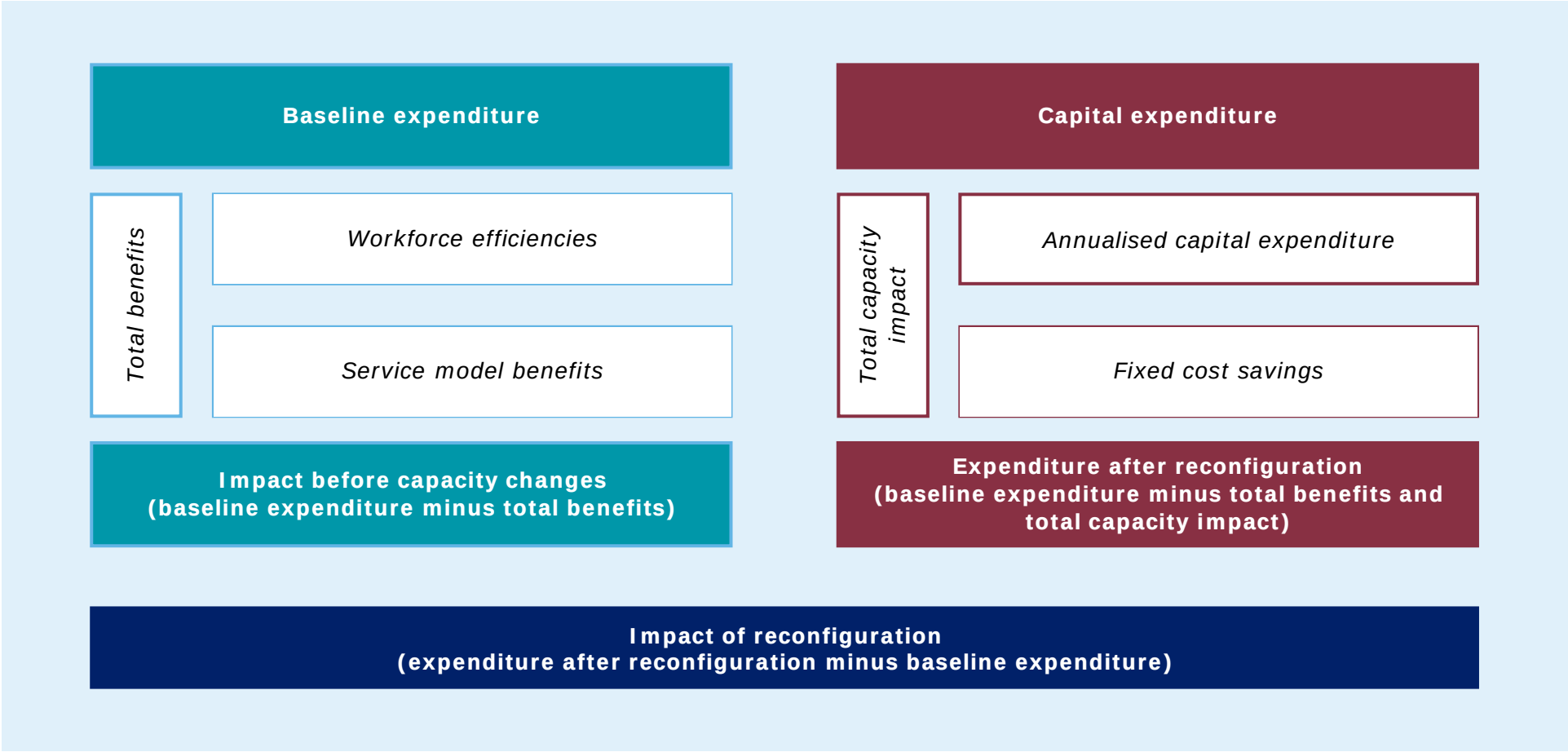
Financial impact summary

Range of finance impacts (with annualised capital costs)		UEC	Care of the acutely ill child	Maternity	Gastroenterology and endoscopy
Option 1 (1 site fewer)	Current out-of-hospital plans	**-£0.3m** to **£62.9m**	**£0.3m** to **£3.3m**	**£1.2m** to **£12.2m**	GI: **£0.1m** to **£0.2m** EL: **£0.4m** to **£1.8m**
	More ambitious out-of-hospital plans	**-£1.2m** to **£48.1m**	**£0.1m** to **£2.6m**	**£0.6m** to **£10.9m**	GI: **£0.0m** to **£0.0m** EL: **£0.0m** to **£0.8m**
Option 2 (2 sites fewer)	Current out-of-hospital plans	**£8.1m** to **£84.3m**	**£0.3m** to **£4.6m**	**£2.4m** to **£15.9m**	GI: **£0.2m** to **£0.4m** EL: **£0.5m** to **£2.6m**
	More ambitious out-of-hospital plans	**£2.3m** to **£65.7m**	**£0.1m** to **£4.2m**	**£1.7m** to **£14.6m**	GI: **£0.0** to **£0.1m** EL: **£0.0m** to **£1.2m**
Option 3 (3 sites fewer)	Current out-of-hospital plans	**£22.7m** to **£103.9m**	**£0.8m** to **£5.0m**	**£4.3m** to **£18.8m**	GI: **£0.2m** to **£0.5m** EL: **£1.2m** to **£3.2m**
	More ambitious out-of-hospital plans	**£15.2m** to **£76.9m**	**£0.3m** to **£4.6m**	**£3.0m** to **£17.4m**	GI: **£0.0m** to **£0.2m** EL: **£0.3m** to **£1.5m**

Financial saving | **Cost impact <= £1m** | **Cost impact > £1m**

3. Financial impacts

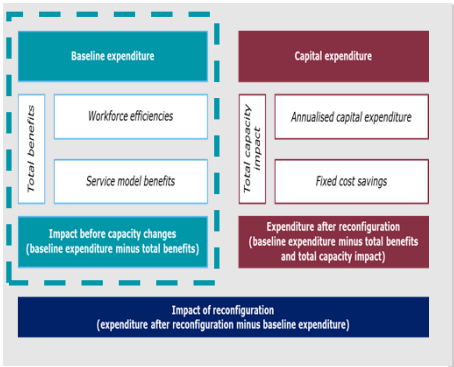
The following analysis looks at the below finance areas.



Descriptions are expanded overleaf

HSR analysis

The table below presents a description of the different areas considered in the financial cost-benefit analysis

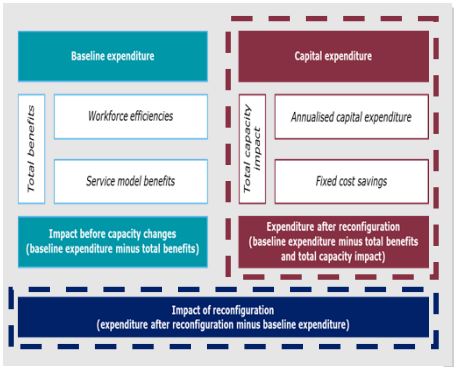


Finance area	Description	
Baseline expenditure	Total provider costs in 2021/22 before any configuration changes. This was taken from the STP plans and includes the impacts of Cost Improvement Programmes (CIPs), out-of-hospital schemes and other service changes.	
Workforce efficiencies	These are benefits resulting from reductions in locum usage and from economies of scale as you consolidate.	These benefits combined are realised when configuration changes take the required workforce below the estimated workforce available in 2021/22 as presented in the workforce analysis. These are generated only for UEC whilst care of the acutely ill child and maternity require investment to meet standards.
Service model benefits	These are benefits from new delivery models such as UTCs which take out activity out of A&Es and have lower costs (as not staffed by ED medics, but by GPs and nurses). These service benefits can also be qualitative.	
Total benefits	The combination of workforce efficiencies and service model benefits.	
Impact before capacity changes	Baseline expenditure minus total benefits.	

Note that the level of activity and costs that would potentially move out of the system has not been modelled at this stage, since the scale of this and the sites affected would be dependent on site-specific modelling. This will be assessed in the next stage of the analysis'.

HSR analysis

The table below presents a description of the different areas considered in the financial cost-benefit analysis



Finance area	Description
Capital expenditure	Costs required to accommodate the reconfigured service on another site. These are developed based on the additional number of beds required. If the receiving site has no spare space, the incoming bed would be a new build and cost £750k. If the receiving site has spare space but not in the same department, the spare bed would need to be refurbished for £375k (50% of new build cost). If the receiving site has spare space in the same department, the incoming bed could be accommodated for no cost.
Annualised capital expenditure	Revenue cost of the capital expenditure required to accommodate the reconfigured service on another site. These are equally phased over a 10-year period.
Fixed cost savings	Savings generated by spare capacity when activity is shifted out of a site. This has been estimated on the basis of a percentage reduction in beds associated with the activity that is shifted out. The % reduction is quantified only for the spare capacity that generated the requirement for a new build bed at the receiving site. Note that fixed costs are typically around 20% of total costs.
Total capacity impact	The combination of annualised capital expenditure and fixed cost savings.
Expenditure after reconfiguration	Baseline expenditure minus total benefits and capacity impact.
Impact of reconfiguration	**Expenditure after reconfiguration minus baseline expenditure.**
Transition costs	Estimated as 6 months of double-running for the reconfigured service.

3.HSR analysis – Financial analysis

The financial analysis focuses on the cost impacts of the different scenarios

The following slides show the impacts of the different scenarios considered (1,2 or 3 sites fewer*) under three lenses:

Base-case out-of-hospital shifts

- Activity reductions of c.12% on average, based on the SYB(ND) STP assumptions.

Stretch out-of-hospital shifts

- HSR sensitivity: doubling the impact of the base-case out-of-hospital assumptions c. 24%.

3.HSR analysis – Bed impacts

Given limited spare capacity in the system, most scenarios would result in additional capacity being required…

Amount of additional inpatient capacity, after using up any spare capacity

UEC		
1 site fewer	2 sites fewer	3 sites fewer
11-1,074 beds	**164 – 1,428 beds**	**410-1,746 beds**

These beds represent activity related to Type 1 and Type 2 admissions. Due to limited spare capacity in the system, most of the activity shifted would generate a requirement for additional capacity at the receiving site.

Care of the Acutely Ill Child		
1 site fewer	2 sites fewer	3 sites fewer
3-76 beds	**3-98 beds**	**9-99 beds**

These beds represent activity related to long-stay paediatrics beds. Due to limited spare capacity in the system, most of the activity shifted would generate a requirement for additional capacity at the receiving site.

Maternity		
1 site fewer	2 sites fewer	3 sites fewer
16-199 beds	**43-260 beds**	**56-307 beds**

These beds represent activity related to consultant led births and neonatology. Due to limited spare capacity in the system, most of the activity shifted would generate a requirement for additional capacity at the receiving site.

GI bleed		
1 site fewer	2 sites fewer	3 sites fewer
0-3 beds	**1-4 beds**	**2-6 beds**
Elective endoscopy		
1 site fewer	2 sites fewer	3 sites fewer
3-25 beds	**7-38 beds**	**12-48 beds**

These beds represent activity related to out-of-hours GI bleed and Endoscopy/Colonoscopy/Sigmoidoscopy. Due to limited spare capacity in the system, most of the activity shifted would generate a requirement for additional capacity at the receiving site, although volumes are extremely small.

Source: HSR Analysis

Comments

- After accounting for growth, changes in bed utilisation and the impact of out-of-hospital schemes the system requires additional inpatient capacity.
- This limits the ability to accommodate additional services at any particular site without having to incur capital expenditure.

Note: *the activity figures use data from 16/17 Reference Costs.*

3.HSR analysis – Bed impacts

….this could be partially offset by a greater impact of OOH schemes…

Amount of additional inpatient capacity, after using up any spare capacity

UEC		
1 site fewer	2 sites fewer	3 sites fewer
0-835 beds	**54 – 1,135 beds**	**263-1,330 beds**

Care of the Acutely Ill Child		
1 site fewer	2 sites fewer	3 sites fewer
0 beds	**0-23 beds**	**0-23 beds**

Maternity		
1 site fewer	2 sites fewer	3 sites fewer
0-124 beds	**0-185 beds**	**0-232 beds**

GI bleed		
1 site fewer	2 sites fewer	3 sites fewer
0 beds	**0 beds**	**0 beds**

Elective endoscopy		
1 site fewer	2 sites fewer	3 sites fewer
0 beds	**0 beds**	**0 beds**

Source: HSR Analysis

Comments

- Greater impacts of out-of-hospital schemes (c.24% vs c.12%)* could contribute to generating spare capacity – reducing capital expenditure required
- Capacity modelling for UEC considers the beds which would be impacted if an ED would be changed into an UTC. Therefore the bed numbers reflect the activity associated with admissions via the ED (non-elective activity).
- **The South Yorkshire and Bassetlaw STP assumes that activity reductions of c.12% on average could be achieved by 2021/22 as a result of investing in out-of-hospital (OOH) schemes. However, because the current STP assumption on the impact of OOH schemes does not free up any capacity across the system, the HSR has considered the potential impact of more ambitious OOH schemes (working assumption of 24% activity reduction).*

Note: *the activity figures use data from 16/17 Reference Costs.*

3.HSR analysis – Financial impacts

With limited spare capacity in the system, most scenarios would require additional investment to be undertaken…

Summary impacts (with annualised cost of capital)

UEC		
1 site fewer	2 sites fewer	3 sites fewer
-£0.3m to £62.9m	£8.1m to £84.3m	£22.7m to £103.9m

The workforce analysis identified the potential to achieve an average c.20% workforce efficiencies and service model benefits on Type 1 and Type 2 activity. This offsets a proportion of the capital requirement to build new capacity. In addition, more ambitious out-of-hospital impacts could further reduce capital expenditure required.

Care of the Acutely Ill Child		
1 site fewer	2 sites fewer	3 sites fewer
£0.3m to £3.3m	£0.3m to £4.6m	£0.8m to £5.0m

There is limited scope for workforce efficiencies and service model benefits for this service due to the high levels of consultant requirements in inpatient units and SSPAUs. Capital requirements are slightly mitigated by the spare capacity available at one of the providers. In addition, more ambitious out-of-hospital impacts could further reduce capital expenditure.

Maternity		
1 site fewer	2 sites fewer	3 sites fewer
£1.2m to £12.2m	£2.4m to £15.9m	£4.3m to £18.8m

There is limited scope for workforce efficiencies and service model benefits for this service due to the investment in midwives required and the growing levels of consultant presence as units sizes grow. The finance impact is largely driven by the requirement to build new capacity and, if out-of-hospital services delivered more ambitious targets, refurbish existing beds.

GI bleed		
1 site fewer	2 sites fewer	3 sites fewer
£0.1m to £0.2m	£0.2m to £0.4m	£0.2m to £0.5m

Elective endoscopy		
1 site fewer	2 sites fewer	3 sites fewer
£0.4m to £1.8m	£0.5m to £2.6m	£1.2m to £3.2m

There is limited scope for workforce efficiencies and service model benefits for this service given the low levels of activity that moves. The finance impact is largely driven by the requirement to build new capacity and, if out-of-hospital services delivered more ambitious targets, refurbish existing beds.

Comments

- After accounting for growth, changes in bed utilisation and the impact of out-of-hospital schemes the system requires additional inpatient capacity
- This limits the ability to accommodate additional services at any particular site without having to incur capital expenditure
- Note these assessments do not account for transition costs (assumption of 6 months of double-running across sites) – these are reported in the Appendix
- Note that these tables include the annualised cost of capital.

Source: HSR Analysis

Legend Financial saving | Cost impact <= £1m | Cost impact > £1m

3.HSR analysis – Financial impacts

....this could be partially offset by a greater impact of OOH schemes...

Summary impacts (with annualised cost of capital)

UEC		
1 site fewer	2 sites fewer	3 sites fewer
-£1.2m to **£48.1m**	**£2.3m** to **£65.7m**	**£15.2m** to **£76.9m**

Care of the Acutely Ill Child		
1 site fewer	2 sites fewer	3 sites fewer
£0.1m to **£2.6m**	**£0.1m** to **£4.2m**	**£0.3m** to **£4.6m**

Maternity		
1 site fewer	2 sites fewer	3 sites fewer
£0.6m to **£10.9m**	**£1.7m** to **£14.6m**	**£3.0m** to **£17.4m**

GI bleed		
1 site fewer	2 sites fewer	3 sites fewer
£0.0m to **£0.0m**	**£0.0** to **£0.1m**	**£0.0** to **£0.2m**

Elective endoscopy		
1 site fewer	2 sites fewer	3 sites fewer
£0.0m to **£0.8m**	**£0.0m** to **£1.2m**	**£0.3m** to **£1.5m**

Comments

- Greater impacts of out-of-hospital schemes (c.24% vs c.12%)* could contribute to generating spare capacity – reducing capital expenditure required
- Note these assessments do not account for transition costs (assumption of 6 months of double-running across sites) – these are reported in the Appendix
- Note that these tables include the annualised cost of capital.
- ** See note on previous slide*

Source: HSR Analysis

Legend **Financial saving** | **Cost impact <= £1m** | **Cost impact > £1m**

3. HSR analysis

UEC – base case

This analysis considers the impact (which is derived from workforce efficiencies and service model benefits) and compares that against expenditure (which is largely made up of capital expenditure and any applicable transition costs).

£m	1 site - small	1 site - large	2 site - small	2 site - large	3 site - small	3 site - large	Comment
Baseline expenditure	£2,304.2	£2,304.2	£2,304.2	£2,304.2	£2,304.2	£2,304.2	*The workforce analysis identified the potential to achieve an average c.20% workforce efficiencies and service model benefits on Type 1 and Type 2 activity. This offsets a proportion of the capital requirement to build new capacity. In addition, more ambitious out-of-hospital impacts could further reduce capital expenditure required.*
Leakage	*To be modelled in next stage*						
Workforce efficiencies & service model benefits	-£1.3	-£1.3	-£2.0	-£2.2	-£2.7	-£2.9	
Total benefits	-£1.3	-£1.3	-£2.0	-£2.2	-£2.7	-£2.9	
Impact before capacity changes	£2,303.0	£2,302.9	£2,302.3	£2,302.0	£2,301.5	£2,301.3	
Capital expenditure	£9.8	£807.0	£124.5	£1,071.8	£309.0	£1,311.0	*Due to limited spare capacity in the system, most of the activity shifted would need a new build bed. More ambitious out-of-hospital plans would free up capacity in non-elective wards, lowering overall capital requirements.*
Annualised capital expenditure	£1.0	£80.7	£12.5	£107.2	£30.9	£131.1	
Fixed cost savings	£0.0	-£16.5	-£2.4	-£20.7	-£5.5	-£24.3	
Total capacity impact	£1.0	£64.2	£10.1	£86.5	£25.4	£106.8	
Expenditure after reconfiguration	£2,303.9	£2,367.1	£2,312.4	£2,388.5	£2,326.9	£2,408.1	
Impact of reconfiguration	**-£0.3**	**£62.9**	**£8.1**	**£84.3**	**£22.7**	**£103.9**	
Transition costs	£15.9	£207.5	£40.4	£261.1	£80.2	£306.1	

Capex requirement

3. HSR analysis

Care of the Acutely Ill Child – base case

This analysis considers the impact (which is derived from workforce efficiencies and service model benefits) and compares that against expenditure (which is largely made up of capital expenditure and any applicable transition costs).

£m	1 site - small	1 site - large	2 site - small	2 site - large	3 site - small	3 site - large	Comment
Baseline expenditure	£2,304.2	£2,304.2	£2,304.2	£2,304.2	£2,304.2	£2,304.2	*There is limited scope for workforce efficiencies and service model benefits for this service due to the high levels of consultant requirements in inpatient units and SSPAUs. Capital requirements are slightly mitigated by the spare capacity available at one of the providers. In addition, more ambitious out-of-hospital impacts could further reduce capital expenditure required.*
Leakage	*To be modelled in next stage*						
Workforce efficiencies & service model benefits	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	
Total benefits	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	
Impact before capacity changes	£2,304.2	£2,304.2	£2,304.2	£2,304.2	£2,304.2	£2,304.2	
Capex requirement							
Capital expenditure	£3.0	£58.5	£3.0	£74.3	£7.5	£80.3	*One provider is currently operating at bed utilisation levels below 85%. This enables it to accommodate a degree of paediatrics capacity at no capital expenditure. More ambitious out-of-hospital plans would free up capacity, lowering capital requirements.*
Annualised capital expenditure	£0.3	£5.9	£0.3	£7.4	£0.8	£8.0	
Fixed cost savings	£0.0	-£2.6	£0.0	-£2.9	£0.0	-£3.0	
Total capacity impact	£0.3	£3.3	£0.3	£4.6	£0.8	£5.0	
Expenditure after reconfiguration	£2,304.5	£2,307.5	£2,304.5	£2,308.8	£2,305.0	£2,309.2	
Impact of reconfiguration	**£0.3**	**£3.3**	**£0.3**	**£4.6**	**£0.8**	**£5.0**	
Transition costs	£0.5	£33.1	£1.4	£35.4	£3.6	£36.7	

3. HSR analysis

Maternity – base case

This analysis considers the impact (which is derived from workforce efficiencies and service model benefits) and compares that against expenditure (which is largely made up of capital expenditure and any applicable transition costs).

	£m	1 site - small	1 site - large	2 site - small	2 site - large	3 site - small	3 site - large	Comment
	Baseline expenditure	£2,304.2	£2,304.2	£2,304.2	£2,304.2	£2,304.2	£2,304.2	*There is limited scope for workforce efficiencies and service model benefits for this service due to the investment in midwives required and the growing levels of consultant presence as units sizes grow. The finance impact is largely driven by the requirement to build new capacity and, if out-of-hospital services delivered more ambitious targets, refurbish existing beds.*
	Leakage	*To be modelled in next stage*						
	Workforce efficiencies & service model benefits	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	
	Total benefits	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	
	Impact before capacity changes	£2,304.2	£2,304.2	£2,304.2	£2,304.2	£2,304.2	£2,304.2	
Capex requirement	*Capital expenditure*	£13.5	£150.8	£33.8	£195.8	£52.5	£231.0	*Due to limited spare capacity in the system, most of the activity shifted would need a new build bed. More ambitious out-of-hospital plans would free up capacity but not on maternity wards, lowering capital requirements at refurbishment levels.*
	Annualised capital expenditure	£1.4	£15.1	£3.4	£19.6	£5.3	£23.1	
	Fixed cost savings	-£0.2	-£2.9	-£1.0	-£3.6	-£0.9	-£4.3	
	Total capacity impact	£1.2	£12.2	£2.4	£15.9	£4.3	£18.8	
	Expenditure after reconfiguration	£2,305.4	£2,316.4	£2,306.7	£2,320.2	£2,308.6	£2,323.1	
	Impact of reconfiguration	**£1.2**	**£12.2**	**£2.4**	**£15.9**	**£4.3**	**£18.8**	
	Transition costs	£1.8	£29.0	£6.8	£40.2	£14.1	£46.6	

3. HSR analysis

GI bleed – base case

This analysis considers the impact (which is derived from workforce efficiencies and service model benefits) and compares that against expenditure (which is largely made up of capital expenditure and any applicable transition costs).

£m	1 site - small	1 site - large	2 site - small	2 site - large	3 site - small	3 site - large	Comment
Baseline expenditure	£2,304.2	£2,304.2	£2,304.2	£2,304.2	£2,304.2	£2,304.2	*There is limited scope for workforce efficiencies and service model benefits for this service. The finance impact is largely driven by the requirement to build new capacity and, if out-of-hospital services delivered more ambitious targets, refurbish existing beds.*
Leakage	*To be modelled in next stage*						
Workforce efficiencies & service model benefits	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	
Total benefits	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	
Impact before capacity changes	£2,304.2	£2,304.2	£2,304.2	£2,304.2	£2,304.2	£2,304.2	
Capital expenditure	£0.8	£2.3	£1.5	£3.8	£1.5	£4.5	*Due to limited spare capacity in the system, most of the activity shifted would need a new build bed. More ambitious out-of-hospital plans would free up capacity, lowering overall capital requirements.*
Annualised capital expenditure	£0.1	£0.2	£0.2	£0.4	£0.2	£0.5	
Fixed cost savings	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	
Total capacity impact	£0.1	£0.2	£0.2	£0.4	£0.2	£0.5	
Expenditure after reconfiguration	£2,304.3	£2,304.5	£2,304.4	£2,304.6	£2,304.4	£2,304.7	
Impact of reconfiguration	**£0.1**	**£0.2**	**£0.2**	**£0.4**	**£0.2**	**£0.5**	
Transition costs	£0.1	£0.8	£0.3	£1.2	£0.5	£1.5	

Capex requirement

3. HSR analysis

Elective Endoscopy – base case

This analysis considers the impact (which is derived from workforce efficiencies and service model benefits) and compares that against expenditure (which is largely made up of capital expenditure and any applicable transition costs).

£m	1 site - small	1 site - large	2 site - small	2 site - large	3 site - small	3 site - large	Comment
Baseline expenditure	£2,304.2	£2,304.2	£2,304.2	£2,304.2	£2,304.2	£2,304.2	*There is limited scope for workforce efficiencies and service model benefits for this service. The finance impact is largely driven by the requirement to build new capacity and, if out-of-hospital services delivered more ambitious targets, refurbish existing beds.*
Leakage	*To be modelled in next stage*						
Workforce efficiencies & service model benefits	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	
Total benefits	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	
Impact before capacity changes	£2,304.2	£2,304.2	£2,304.2	£2,304.2	£2,304.2	£2,304.2	
Capital expenditure	£3.8	£20.3	£6.8	£30.0	£11.6	£36.8	*Due to limited spare capacity in the system, most of the activity shifted would need a new build bed. More ambitious out-of-hospital plans would free up capacity, lowering overall capital requirements.*
Annualised capital expenditure	£0.4	£2.0	£0.7	£3.0	£1.2	£3.7	
Fixed cost savings	£0.0	-£0.2	-£0.2	-£0.4	£0.0	-£0.5	
Total capacity impact	£0.4	£1.8	£0.5	£2.6	£1.2	£3.2	
Expenditure after reconfiguration	£2,304.6	£2,306.1	£2,304.8	£2,306.9	£2,305.4	£2,307.4	
Impact of reconfiguration	**£0.4**	**£1.8**	**£0.5**	**£2.6**	**£1.2**	**£3.2**	
Transition costs	£2.4	£10.0	£3.1	£12.6	£6.2	£15.4	

Capex requirement

Next steps required to develop site-specific analysis

HSR analysis

The following next steps need to be undertaken in order to finalise the analysis and reach pre-consultation stage

Baseline finance and activity. A financial gap baselining exercise would need be undertaken, to revise and confirm the assumptions used in the first stage of the analysis and align these across the system. This would result in a revised Year 0 and Year 5 position, to use as a basis for analysing the impact of the solutions.

Baseline workforce. Understanding the critical workforce gaps and challenges will be a key part of the programme. A set of recommended staffing levels for each service under consideration should be agreed by the system, and revised consolidation benefits estimated on this basis. Such analysis would need to be undertaken at PCBC stage where the scenarios become site-specific.

Defining solutions. At this stage it will be important to agree on the level of CIPs, out-of-hospital models of care, as well as the service reconfiguration options in more detail, specific to each site. For the latter it will be important to understand the proposed model for each service, the options for each service, as well as overall options across all services.

Solutions modelling. At this stage it will be important to understand the financial, activity and clinical impacts of the overall model of care at the health economy level, taking into account opex and capex, and assumptions about phasing of impacts and transition costs. Organisational level impacts could also be developed if organisations agree on pricing models.

Stakeholder engagement. It will be essential to the programme that financial and clinical leads continue to be engaged throughout, to sense-check the methodology and any outputs of the analysis, as well as provide guidance in their areas of expertise.

Key interdependencies. The system will need to agree a list of options and a set of evaluation criteria. It may be best to focus the modelling and analysis on a short list of options (and the do nothing scenario) rather than the long list. The analysis at the next stage needs to look at complete and coherent sets of potential solutions, taking into account the interdependencies across each site, rather than seeking to model impacts of services individually.

Appendix: Additional finance assumptions

HSR analysis

There are currently significant limitations to this initial financial analysis

Limitations and assumptions of this initial analysis

1. **Data sources.** The analysis was developed using reference cost data, STP financial forecasts and SLR information where provided (Barnsley). HES/SUS/wider SLR data could not be used as not all Trusts provided the information.
2. **Financial challenge.** The estimates of the 5-year financial challenge were taken from the model developed as part of the STP process. Information was available solely for overall income and expenditure under a do-nothing and a 'do-something' scenarios (after CIPs and out-of-hospital schemes). 21/22 was not estimated as part of the STP process and has been projected based on the latest trend.
3. **Stretch out-of-hospital impact.** The impact of the stretch out-of-hospital scenario on the provider cost base has been estimated by proportionately increasing the impact of these solutions (x2).
4. **Split of Doncaster, Bassetlaw and Montague cost base.** The Trust-level financial projections and service-level reference costs have been apportioned to the different sites using planned capacity figures.
5. **Apportionment to HSR services.** The STP provider financial projections have been apportioned to the services considered as part of the HSR by using Reference Costs dataset.
6. **Split of total cost across fixed, semi-fixed and variable.** Barnsley SLR was used to estimate the proportion of each service costs.
7. **Workforce efficiencies & service model benefits application.** The workforce efficiencies and service model benefits derived from the workforce analysis have been applied to the proportion of semi-fixed costs related to staffing of the impacted providers. This has been done after having normalised the system-wide impacts to capture the impacted sites and having taken the average of the three scenarios considered.
8. **Split of A&E Type 1, 2 and 3 costs.** The split of total costs identified through Reference Costs dataset has been adjusted to reflect activity volumes weighted by cost as the costs.
9. **Alignment of workforce and finance analysis.** It has been assumed that the STP baseline finance analysis has incorporated similar assumptions in terms of workforce growth as the ones presented in the pack.
10. **Fixed costs savings.** Fixed cost savings have been estimated only when leaving capacity/beds generated a new build at the receiving site.
11. **New build and refurbishment costs.** New build and refurbishment costs have been developed based on publically available information (examples below) on business cases and capital development programmes and stakeholder engagement.
12. **Capital expenditure.** Estimates capture the capital costs related to areas such as cubicles, theatres, equipment etc. through the number of beds and new build/refurb costs associated with that. These additional areas have not been assessed separately as part of this analysis.
13. **Alignment of financial and workforce pay assumptions.** The financial analysis uses Reference Costs, STP financial projections and SLR information provided. The costs identified through these datasets have been sense-checked against workforce figures, high-level pay assumptions (publically available) and locum/substantive pay provided by Trusts in April 2018. A full reconciliation of these different estimates has not been undertaken.
14. **Reviews.** Whilst the results have been shared with Directors of Finance, the analysis has received limited QA.

https://www.healthiernorthwestlondon.nhs.uk/sites/nhsnwlondon/files/documents/PAPER%203_3%2020120610_Estates_Strategy_Programme_%20Board_Presentation_v1.0_final.pdf
https://www.stgeorges.nhs.uk/wp-content/uploads/2014/11/TBR-27.11.14-Paper-10-Adult-Critical-Care-Expansion-Plan-OBC.pdf
http://hertsvalleysccg.nhs.uk/publications/your-care-your-future
https://www.northhampshireccg.nhs.uk/wp-content/uploads/2017/12/PRESENTATION-Transforming-Care-Services-in-North-and-Mid-Hampshire-Joint-Governing-Bodies-Meeting.pdf
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/144106/Healthcare_premises_cost_guides.pdf

3. HSR analysis

UEC – out-of-hospital stretch assumption

This analysis considers the impact (which is derived from workforce efficiencies and service model benefits) and compares that against expenditure (which is largely made up of capital expenditure and any applicable transition costs).

£m	1 site - small	1 site - large	2 site - small	2 site - large	3 site - small	3 site - large
Baseline expenditure	£2,189.4	£2,189.4	£2,189.4	£2,189.4	£2,189.4	£2,189.4
Leakage			*To be modelled in next stage*			
Workforce efficiencies & service model benefits	-£1.2	-£1.3	-£1.9	-£2.1	-£2.6	-£2.8
Total benefits	-£1.2	-£1.3	-£1.9	-£2.1	-£2.6	-£2.8
Impact before capacity changes	£2,188.2	£2,188.1	£2,187.5	£2,187.2	£2,186.8	£2,186.6
Capex requirement						
Capital expenditure	£0.0	£626.3	£41.3	£851.3	£197.3	£999.0
Annualised capital expenditure	£0.0	£62.6	£4.1	£85.1	£19.7	£99.9
Fixed cost savings	£0.0	-£13.3	£0.0	-£17.3	-£2.0	-£20.2
Total capacity impact	£0.0	£49.4	£4.1	£67.9	£17.8	£79.7
Expenditure after reconfiguration	£2,188.2	£2,237.5	£2,191.6	£2,255.1	£2,204.6	£2,266.2
Impact of reconfiguration	**-£1.2**	**£48.1**	**£2.3**	**£65.7**	**£15.2**	**£76.9**
Transition costs	£15.0	£196.9	£38.3	£247.7	£76.0	£291.0

3. HSR analysis

Care of the Acutely Ill Child – out-of-hospital stretch assumption

This analysis considers the impact (which is derived from workforce efficiencies and service model benefits) and compares that against expenditure (which is largely made up of capital expenditure and any applicable transition costs).

£m	1 site - small	1 site - large	2 site - small	2 site - large	3 site - small	3 site - large
Baseline expenditure	£2,189.4	£2,189.4	£2,189.4	£2,189.4	£2,189.4	£2,189.4
Leakage			*To be modelled in next stage*			
Workforce efficiencies & service model benefits	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0
Total benefits	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0
Impact before capacity changes	£2,189.4	£2,189.4	£2,189.4	£2,189.4	£2,189.4	£2,189.4
Capital expenditure	£0.8	£25.9	£0.8	£42.0	£2.6	£46.1
Annualised capital expenditure	£0.1	£2.6	£0.1	£4.2	£0.3	£4.6
Fixed cost savings	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0
Total capacity impact	£0.1	£2.6	£0.1	£4.2	£0.3	£4.6
Expenditure after reconfiguration	£2,189.5	£2,192.0	£2,189.5	£2,193.6	£2,189.6	£2,194.0
Impact of reconfiguration	**£0.1**	**£2.6**	**£0.1**	**£4.2**	**£0.3**	**£4.6**
Transition costs	£0.5	£31.4	£1.4	£33.6	£3.4	£34.8

Capex requirement

3. HSR analysis

Maternity – out-of-hospital stretch assumption

This analysis considers the impact (which is derived from workforce efficiencies and service model benefits) and compares that against expenditure (which is largely made up of capital expenditure and any applicable transition costs).

£m	1 site - small	1 site - large	2 site - small	2 site - large	3 site - small	3 site - large
Baseline expenditure	£2,189.4	£2,189.4	£2,189.4	£2,189.4	£2,189.4	£2,189.4
Leakage			*To be modelled in next stage*			
Workforce efficiencies & service model benefits	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0
Total benefits	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0
Impact before capacity changes	£2,189.4	£2,189.4	£2,189.4	£2,189.4	£2,189.4	£2,189.4
Capital expenditure	£6.4	£121.5	£16.5	£167.3	£30.4	£202.5
Annualised capital expenditure	£0.6	£12.2	£1.7	£16.7	£3.0	£20.3
Fixed cost savings	£0.0	-£1.2	£0.0	-£2.1	£0.0	-£2.8
Total capacity impact	£0.6	£10.9	£1.7	£14.6	£3.0	£17.4
Expenditure after reconfiguration	£2,190.0	£2,200.3	£2,191.0	£2,204.0	£2,192.4	£2,206.8
Impact of reconfiguration	**£0.6**	**£10.9**	**£1.7**	**£14.6**	**£3.0**	**£17.4**
Transition costs	£1.7	£27.5	£6.4	£38.1	£13.5	£44.2

Capex requirement

3. HSR analysis

GI bleed – out-of-hospital stretch assumption

This analysis considers the impact (which is derived from workforce efficiencies and service model benefits) and compares that against expenditure (which is largely made up of capital expenditure and any applicable transition costs).

£m	1 site - small	1 site - large	2 site - small	2 site - large	3 site - small	3 site - large
Baseline expenditure	£2,189.4	£2,189.4	£2,189.4	£2,189.4	£2,189.4	£2,189.4
Leakage			*To be modelled in next stage*			
Workforce efficiencies & service model benefits	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0
Total benefits	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0
Impact before capacity changes	£2,189.4	£2,189.4	£2,189.4	£2,189.4	£2,189.4	£2,189.4
Capital expenditure	£0.0	£0.0	£0.0	£0.8	£0.0	£1.5
Annualised capital expenditure	£0.0	£0.0	£0.0	£0.1	£0.0	£0.2
Fixed cost savings	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0
Total capacity impact	£0.0	£0.0	£0.0	£0.1	£0.0	£0.2
Expenditure after reconfiguration	£2,189.4	£2,189.4	£2,189.4	£2,189.5	£2,189.4	£2,189.5
Impact of reconfiguration	**£0.0**	**£0.0**	**£0.0**	**£0.1**	**£0.0**	**£0.2**
Transition costs	*£0.1*	*£0.8*	*£0.3*	*£1.2*	*£0.5*	*£1.5*

Capex requirement

3. HSR analysis

Elective Endoscopy – out-of-hospital stretch assumption

This analysis considers the impact (which is derived from workforce efficiencies and service model benefits) and compares that against expenditure (which is largely made up of capital expenditure and any applicable transition costs).

£m	1 site - small	1 site - large	2 site - small	2 site - large	3 site - small	3 site - large
Baseline expenditure	£2,189.4	£2,189.4	£2,189.4	£2,189.4	£2,189.4	£2,189.4
Leakage			*To be modelled in next stage*			
Workforce efficiencies & service model benefits	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0
Total benefits	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0
Impact before capacity changes	£2,189.4	£2,189.4	£2,189.4	£2,189.4	£2,189.4	£2,189.4
Capital expenditure	£0.0	£7.5	£0.0	£11.6	£3.0	£14.6
Annualised capital expenditure	£0.0	£0.8	£0.0	£1.2	£0.3	£1.5
Fixed cost savings	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0
Total capacity impact	£0.0	£0.8	£0.0	£1.2	£0.3	£1.5
Expenditure after reconfiguration	£2,189.4	£2,190.1	£2,189.4	£2,190.5	£2,189.7	£2,190.8
Impact of reconfiguration	**£0.0**	**£0.8**	**£0.0**	**£1.2**	**£0.3**	**£1.5**
Transition costs	*£2.3*	*£9.5*	*£3.0*	*£11.9*	*£5.9*	*£14.6*

Capex requirement

Appendix: Additional capacity workings and assumptions

HSR analysis – capacity assumptions

There are currently limitations to this initial analysis

Limitations of this initial analysis

1. **Data sources.** The analysis was developed using Reference Costs 2016-17 data and capacity. The trusts included in the analysis are: Doncaster and Bassetlaw, Rotherham, Sheffield Children's, Sheffield Teaching, Chesterfield and Barnsley. HES/SUS data was provided for some trusts but not all, as such it could not be used consistently for all organisations. Some Trusts provided revised activity estimates in April/May 2018, as such Reference Costs admissions were updated in line with these new estimates, and bed days were uplifted on the basis of the same length of stay as derived initially from Reference Costs.
2. **Activity and capacity reconciliation.** We have not reconciled activity and capacity data due to the limited information available within Reference Costs (e.g. no OPCS codes).
3. **Services captured**. The capacity (and finance) analysis captures a wider range of activity (e.g. all of paediatrics) and some interdependencies between services (e.g. neonatology) that has been accounted for in the workforce analysis. This was done to ensure a broader range of capital expenditure estimates.
4. **Non-elective beds.** We have identified the proportion of non-elective beds related to Type 1 and 2 A&E admissions using publically available data. This proportion has been used to estimate the number of beds related to these admissions without recognising the likely differential in length of stay (LoS). Type 1 and Type 2 generated admissions are likely to have longer LoS. This assumption can be improved by using SUS/HES data at the next stage of the analysis.
5. **Service definition.** The activity related to the services in the scope of this review has been identified through a combination of rules based on HRGs and LoS. These rules have been tested with the HSR Steering Group and would need to be refined and ideally updated through the use of a more suitable rule-set (e.g. based on diagnosis and OPCS codes).
6. **Utilisation levels.** These assumptions were identified through publicly available data rather than data supplied by the Trusts and do not reflect any potential differences in utilisation rates across departments within the Trusts.
7. **Leakage.** The analysis currently does not assume any activity leakage to out-of-area providers. This would be included as modelling becomes site-specific in the next stage of the analysis.
8. **Out-of-hospital (OOH) impacts.** Assumptions on the impact of out-of-hospital schemes have been mapped at point of delivery level to the services in scope of this review.
9. **Trust level.** The analysis is currently undertaken at Trust rather than site level (except Doncaster and Bassetlaw which has been split into sites based on high-level assumptions provided by the Trust).
10. **Activity flows.** Whenever a provider sends out its activity, 100% of it is assumed to flow to the nearest site which currently provides this service. This assumption does not account for a difference in the travel time from patient's homes and as such the receiving provider is the closest destination only for a fraction of shifted activity. As such, modelled beds are likely to overestimate the impact on the receiving provider and underestimate capacity requirement for other sites in the system.
11. **Travel times.** In some instances there may be more than one equally-distant provider from the site shifting its activity away. In such cases, 100% of shifted activity was assumed to flow to the largest of the equally-distant providers for the reasons of consistency with overall rule on activity moving to the single nearest provider. This may result in overestimation of capacity requirement for the receiving site and underestimate the impact on other providers.
12. **Activity leakage out of system.** This initial analysis treats the system in isolation and does not account for the fact that for some patients the next closest provider might be outside the system in consideration. Assuming 0% leakage from the system is likely to result in overestimation of capacity requirement for the receiving sites.
13. **Scenario ranking.** The non-site specific nature of this analysis and the travel time rules to the nearest site from the smallest / largest provider(s) may result in a situation where the capacity requirement is non-linear across scenarios. For example, it may be possible for a "3 less sites" scenario to result in a smaller overall capacity requirement for the system relative to the "2 less sites". This is because the activity flows to the nearest provider currently offering the service even if there is another eligible site in the system with more spare capacity.

HSR analysis – capacity assumptions

A number of additional assumptions have been used in order to undertake the analysis – these will need to be refined at a later stage of the analysis

Further assumptions

1. The **service definitions** were revised and circulated to HSR stakeholders. These expand on the initial definitions and some clinical dependencies were also assumed to be in scope (e.g. maternity and neonatology were assumed to be clinically dependent).
2. Activity captured under the following **departments in Reference Costs 2016-17** has been included: EL, NEL, EL_XS, NEL_XS, DC, NES, CC, REHABL1, REHABL2, REHABL3.
3. Activity recorded within EL_XS, NEL_XS, CC, REHABL1, REHABL2, REHABL3 was interpretad as bed days.
4. Activity shifted out of one site has been assumed to move to the next nearest site (as opposed to it being distributed equally to all other sites). The nearest site was estimated based on Google Maps driving travel times, at around 2-3pm on a Monday. This does not take into account travel times at peak times during the day, which may influence the designation of the closest site.
5. Only the sites that currently provide a service are assumed to be able to receive activity for that particular service. For example, SCH is assumed to be able to receive paediatric activity only, but no stroke, maternity, gastro or A&E activity. However, no assumptions/restrictions were applied to activity being sent out of any particular sites. For example SCH can send out paediatric inpatient activity to other sites and no assumption is made about the percentage of activity that is specialised. These assumptions would need to be refined at a later stage, once the reconfiguration scenarios are made site specific.
6. In terms of activity shifts, the following assumptions were used:
    a) Elective endoscopy was treated separately to non-elective endoscopy, a subset of the latter being captured under urgent GI bleeds (which are further assumed to the non-elective). This subset is the out of hours (OOH) activity, assumed to be 28% of total activity. This figure is an average of OOH A&E attendances across the 6 trusts, with OOH taken to mean activity between 8pm and 8am. A&E attendances are used as a proxy for urgent GI bleeds admissions, as patients are likely to present themselves to A&E before being admitted to hospital. The underlying assumption is that admissions from A&E are distributed evenly at all hours of the day, any day of the week.
    b) For maternity, activity deemed to be low-risk (and thus attributed to an MLU according to the service definition) is not shifted between sites. The CLU activity (medium or high risk) will move to wherever the closest CLU is; the MLU activity remains to be addressed in each site - either in MLU alongside CLU or if there is no CLU, the assumption is that there will be a stand-alone MLU.
    c) Other NEL indirectly in scope is 73% of total Other NEL bed days. This is based on the average share of emergency admissions from Type 1 and Type 2 A&E at an average Trust in England.
7. Assumptions provided by Doncaster & Bassetlaw NHS FT on bed capacity by site and service were used to split Reference Cost data, which is only available at trust level. Activity at Sheffield Teaching Hospitals NHS FT was not split by site.
8. MLU activity was revised to 22.5% of total activity, based on conversations with clinicians in March-May 2018. Literature suggests a two-thirds in general are a lower risk, and so there may be other changes to clinical models that increases the share of MLU births that could be factored into analysis at later stage.
9. **Alignment of scenarios between capacity and workforce modelling**. In some cases, due to service definition and/or Reference Costs data anomalies, the scenarios picked up in the capacity analysis are not fully aligned to the workforce modelling scenarios.

HSR analysis

Baseline capacity is activity-based and derived from Reference Costs 2016-17 data

Services in scope

Service Group	Service
GI bleed	GI bleed, Colonoscopy, Sigmoidoscopy
Paediatrics	Paeds SS, Paeds LS, Paediatric CC,
Stroke	HASU / ASU, Stroke Rehab, TIA
Maternity	CLU, MLU, Neonatology, Neonatology CC,
Elective Endoscopy	EL Endoscopy
Other NEL	73% of other NEL activity including Adult CC

Operational assumptions

Metric	BAR	ROT	DON	CHE	STH	SCH	BAS	MON
Utilisation rate	87.1%	88.3%	83%	91.9%	92.6%	73.5%	83%	83%
Target utilisation	85%	85%	85%	85%	85%	85%	85%	85%
Throughput	1.40	1.40	1.40	1.40	1.40	1.40	1.40	1.40

HSR analysis

Activity shift assumptions inform reconfiguration scenarios

These assumptions were tested with the Steering Group and have been used to categorise activity

Service	**HRG codes defining the service**
Endoscopy	All HRG codes within Subchapters FE and GB, excluding Colonoscopy and Sigmoidoscopy
Neonatology - CLU dependency	All HRG codes within Subchapter PB
Other	All Other HRG codes within NEL, EL, NEL_XS, EL_XS, NES, DC, CC, REHABL1, REHABL2, REHABL3 which do not fall into definitions of any other service in this table
PaedSS	All HRG codes within Subchapter PC-PX within NES or DC departments or with average LOS<2
PaedLS	All HRG codes within Subchapter PC-PX with average length of stay of at least 2
Neonatology CC - CLU dependency	All HRG codes within Subchapter XA
Paediatric CC	All HRG codes within Subchapter XB
CLU dependency	All HRG codes within NZ17-26 (A,B) and NZ27Z, NZ71Z, NZ72Z, MA18D, MA20Z, MB08A, MB08B
Colonoscopy/Sigmoidoscopy	All HRG codes referring to "Colonoscopy" or "Sigmoidoscopy"
GI bleed	All HRG codes referring to "Gastrointestinal Bleed"
MLU / CLU	NZ16Z, NZ21Z, NZ25Z
HASU /ASU if required	All AA22, AA23 and AA35 HRG codes
Adult CC	All HRG codes within Subchapter XC
High/Medium risk (CLU)	All NZ31 – NZ51 HRG codes
Low risk (MLU)	All NZ30 HRG codes
TIA	All AA29 HRG codes
Stroke rehab	All VC04 HRG codes

Appendix: Workforce data pack and assumptions

HSR analysis – UEC (1 / 3)

A number of key assumptions were required for this analysis

Key assumptions

1. The HSR assumes that each of the Urgent Treatment Centres (UTCs) are staffed by 6 GPs each, in addition to nurses, recognising this will depend on the service model and further recognising difficulties in recruiting GPs. This is a working assumption based on discussions with the trusts. The range provided by the trusts was 4 to 8, depending on the model of care, in particular support from ENPs, further depending on whether a service is co-located or on a different site, and further depending on activity (e.g. for co-located UTCs the requirement could be higher). The future service model will further need to balance out GPs against ED consultants, taking into account growth in workforce and the use of ENPs in the UTCs. The GP staffing assumptions will be refined at the next stage of the analysis, when the service model for the UTCs is further defined by the NHS England and SYB(ND).
2. SCH is not in scope of the A&E (adults) reconfiguration and remains a fixed point. As such SCH's UEC workforce and activity were not considered in the analysis.
3. Feedback from the trusts cite total budgeted FTE numbers might look small compared to guidelines because of difficulties in recruitment. The service has been tailored to match the staffing structure.
4. At this stage in the analysis, is no consideration of ambulance journeys. This will need to be factored in at the next stage of the analysis.
5. A&E attendances (incl. UTC type attendances) were taken from Reference Costs 2016/17 and updated activity numbers were provided by Barnsley Hospital NHSFT and Chesterfield Royal Hospital NHSFT. The proportion of patients that could be seen in an UTC varies significantly, depending on the service model or local factors. The range of values provided by the trusts was generally within 20 to 25%, therefore an average of 22.5% was taken. This assumption will be refined at the next stage of the analysis when the UTC service model is further defined by the NHS England and SYB(ND).
6. Attendances deemed to be minor/low-risk (and thus could be treated in UTCs) are not shifted between sites. The A&E activity (major/high risk) will move to wherever the next closest A&E is; the UTC activity remains to be addressed in each site.
7. FTE rules were taken from the Royal College of Emergency Medicine (RCEM), 2015 (https://www.rcem.ac.uk/docs/Workforce/RCEM%20Rules%20of%20Thumb%20for%20Medical%20and%20Practitioner%20Staffing%20in%20EDs.pdf). Relationships for consultant workforce and other medical grades were inferred based on the examples given in the document.
8. Nursing requirements were not estimated at this stage of the analysis because growth assumptions were not provided by Health Education England (HEE), and because nurse numbers are linked to activity (and not a fixed FTE requirement) – no efficiencies can be gained upon reconfiguration. This would need to be refined in the future, as scenarios become site-specific. Note RH did not provide FTEs for nursing; the nursing FTEs were estimated using the average consultant to nurse ratio in the system (7 nurses for one consultant).

HSR analysis – UEC (2/3)

Staffing and activity assumptions

Assumptions

Table: Current establishment FTEs

Site	Total A&E attendances (incl. UTC type) in 16/17	A&E type activity in the scenarios[1]	UTC type activity in the scenarios[1]	Consultants Establishment FTEs	Other medical grades[2] Establishment FTEs	Nursing[3] Establishment FTEs
BH	83,545	64,747	18,798	11.8	18.7	53.2
DON	106,812	82,779	24,033	12.0	19.0	76.5
BAS	59,616	46,202	13,414	6.0	8.0	39.3
MON						
SCH						
STH	147,147	114,039	33,108	18.0	36.4	91.9
RH	76,970	59,652	17,318	10.0	20.0	88.4[4]
CRH	80,431	62,334	18,097	10.0	23.0	51.3

Source: Reference Costs for activity data, with updated figures from some of the trusts. For FTE values, trust returns from September 2017, with updates received in April/May 2018. No A&E at MON and SCH out of scope for A&E reconfiguration.

Notes: [1]Assuming 22.5% of current activity could be seen in UTCs, as per the previous slide. This reflects the scenarios rather than the status quo. [2]Other medical grades include trainee grades and staff grades. [3]Nursing FTEs presented for bands 5 and 6 (registered nurses). [4]RH did not provide numbers for budgeted nursing FTEs – the staff in post number was assumed to hold instead.

Table: Staffing "rules of thumb"

	60k ED - FTEs	100-120k ED - FTEs	*100% increase in activity[2] results in x% FTE increase*
Consultants	10	14 (12 to 16)	*40%*
Tier 3/4	12	15 (14 to 16)	*25%*
Tier 2 doctors/ANPs	12	20 (16-24)	*67%*
Tier 2 and tier 3/4 combined[1]	24	35	*46%*
ENPs	5 (4 to 6)	10 (8 to 12)	*100%*

Source: RCEM, 2015. "Rules of Thumb" for Medical and Practitioner Staffing in Emergency Departments. (https://www.rcem.ac.uk/docs/Workforce/RCEM%20Rules%20of%20Thumb%20for%20Medical%20and%20Practitioner%20Staffing%20in%20EDs.pdf).

Notes: [1]Combined and used as a proxy for "other medical grades". [2]Based on the two data points given (60k and 120k attendances), the activity to FTE relationships were estimated as per the last column in this table).

HSR analysis – UEC (3/3)

A number of additional assumptions have been used in order to undertake the analysis

Assumptions

Table: Current establishment consultant FTEs compared RCEM, 2015 *"Rules of Thumb" for Medical and Practitioner Staffing in Emergency Departments*

Site	Total A&E attendances (incl. UTC type) in 16/17	Consultants staff-in-post FTEs	Consultants establishment FTEs	Consultants recommended FTEs
BH	83,545	13.0	11.8	11.6
DON	106,812	9.0	12.0	13.1
BAS	59,616	4.0	6.0	10.0
MON				
SCH				
STH	147,147	16.0	18.0	18.0
RH	76,970	10.0	10.0	11.1
CRH	80,431	7.7	10.0	11.4
Total	**554,521**	**59.7**	**67.8**	**75.2**

Source: Reference Costs for activity data, with updated figures from some of the trusts. For FTE values, trust returns from September 2017, with updates received in April/May 2018.

Table: Current other medical grades and nursing FTEs

Site	Other medical grades staff-in post FTEs	Other medical grades establishment FTEs	Nursing staff-in post FTEs[2]	Nursing establishment FTEs[3]
BH	19.0	18.7	53.2	53.2
DON	16.0	19.0	72.9	76.5
BAS	8.9	8.0	37.3	39.3
MON				
SCH				
STH	33.7	36.4	91.2	91.9
RH	20.0	20.0	88.4	88.4[1]
CRH	26.0	23.0	47.3	51.3
Total	**123.6**	**125.0**	**390.2**	**400.5**

Source: Trust returns from September 2017, with updates received in April/May 2018.

Notes: [1]Not provided – assumed same as staff-in-post. [2]Other medical grades include trainee grades and staff grades. [3]This includes only bands 5 and 6 nurses (registered nurses).

HSR analysis – Paediatrics (1/4)

Activity and staffing assumptions

Key assumptions

1. Inpatient admissions (long and short stay) were taken from Reference Costs 2016/17 and updated activity numbers were provided by Barnsley Hospital NHSFT and The Rotherham NHS FT.
2. For SCH, an assumption of 60-40% was applied to split activity between general paediatric (60%) and specialist paediatric services (40%), the latter being out of scope. This is based on discussions with SCH clinicians.
3. Assumptions on activity split between Doncaster Royal Infirmary and Bassetlaw DGH were based on assumptions provided by Doncaster and Bassetlaw Teaching Hospitals NHS FT.
4. The assumption in the reconfiguration scenarios is that only IP activity is shifted across sites – each site keeps its SSPAU activity.
5. A consultant delivered SSPAU model, given the more senior input in clinical decisions, may result in lower inpatient admissions than what is currently reflected in the data.
6. Given the medical workforce may also cover neonatology rotas, and the data returns provided by the Trusts were unclear as to whether neonatology cover was included, the following assumptions were applied: if a site has a Level 1 Neonatology unit (Bassetlaw DGH), the medical workforce complement was assumed to provide a 70-30% split between paediatric services and neonatology cover. Chesterfield Royal provided updated FTE data separating acute paediatrics from community paediatrics and neonatology, and this updated data was used in the analysis. For all other trusts, with Level 2 or 3 Neonatology units, 100% of the workforce complement was assumed to be for paediatric cover. This is based on discussions with the clinical lead.
7. Consultant FTE example requirements as per the guidance produced by the RCPCH, 2011 *"Facing the Future: A Review of Paediatric Services.* https://www.rcpch.ac.uk/sites/default/files/page/FTF%20Full.pdf (Table 7).
8. In the absence of specific guidelines, the same proportion of consultant FTE impacts were assumed to apply to all other medical grades (staff grades, middle grade and junior doctors). Note however that the impact on FTE requirements could be even higher than for consultants because of guidelines requiring a patient to be seen within 4 hours. Other medical grades are the ones who typically see patients first, therefore the 4hour standard would affect them primarily, whereas consultants need to meet a 12h standard. Therefore once a threshold of activity is reached, there will be a requirement for another middle grade rota. This should be considered in more detail at the next stage of the analysis.
9. Where a site provided both IP and SSPAU, the recommended staffing complement was estimated based on the requirements of the different units separately accounting for synergies of c. 20% across an IP unit and a co-located SSPAU. This level of synergies will be investigated further at the next stage of the analysis.

HSR analysis – Paediatrics (2/4)

Activity and staffing assumptions

Key assumptions

1. The requirements for nursing staff complements is in line with activity and/or beds.
    1. In an SSPAU the children's nurse staffing for example should be a minimum of two children's nurses for every six to eight beds, with regular audit of patient acuity using appropriate tools to ensure that levels are appropriate for the number, dependency and case mix of infants, children and young people normally cared for by the service (RCPCH, 2017 *"Standards for Short-Stay Paediatric Assessment Units".* https://www.rcpch.ac.uk/system/files/protected/news/SSPAU%20College%20Standards%2021.03.2017%20final.pdf
    2. There should be a minimum of two registered children's nurses at all times in all inpatient and day care areas. In general children's wards and departments, bedside, deliverable hands-on care for children < 2 years of age 1:3 registered nurse:child, day and night; for children > 2 years of age 1:4 registered nurse:child, day and night (RCN, 2013 *"Defining staffing levels for children and young people's"* – currently under review). https://www.rcn.org.uk/professional-development/publications/pub-002172
2. There could be consolidation savings not accounted for in the analysis at this stage, depending on type of patients (their acuity/dependency level) and on whether the rotas are fully staffed currently. For example for nursing staff consolidation could lead to a higher number of nurses being required, depending on the number of high dependency patients at the receiving sites.
3. Whilst the analysis has not assumed any change in nursing requirements at this stage, note that this assumptions would only hold true under the following assumptions:
    - All trusts apply the same standards, incl. bed occupancy rate; and
    - Nurses are willing to move with the inpatient units where these are moved.

    This will be considered further in the next stage of the analysis.

HSR analysis – Paediatrics (3/4)

Activity and staffing assumptions

Assumptions

Table: Current establishment FTEs, paediatrics including neonatology at Barnsley and Chesterfield, and community paediatrics at Chesterfield

Site	Total activity in 16/17	Long-stay (IP) activity[1]	Short-stay (SSPAU) activity[1]	Consultants Establishment FTEs[4]	Other medical grades Establishment FTEs[4]	Nursing Establishment FTEs[5]
BH	3,217	507	2,710	8.0	19.3	26.8
DON	4,277	1,107[2]	3,170[3]	13.5	23.7	36.8
BAS	1,493	260[2]	1,233[3]	4.7	8.3	12.9
MON						
SCH	10,043	2,059	7,985	7.2	13.0	46.4
STH						
RH	3,833	1,675	2,158	7.7	18.0	27.3
CRH	4838	883	3,955	11.5	21.0	26.3

Source: Reference Costs for activity data, with updated figures from some of the trusts. For FTE values, trust returns from September 2017, with updates received in April/May 2018. No paediatric activity at STH and MON.

Notes: [1]Estimated from Reference Costs 2016/17. Short stay activity was defined as activity recorded under NES and NEL with LoS <2. Long-stay activity was defined as activity recorded under NEL with LoS >2. [2]FTEs apportioned on the basis of beds capacity at Bassetlaw and Doncaster Royal Infirmary. [3]FTEs apportioned on the basis of beds capacity at Bassetlaw and Doncaster Royal Infirmary. [4]Other medical grades include trainee grades and staff grades. [5]Nursing FTEs assumed to be bands 5 and 6 (registered nurses).

Table: Staffing requirements

	8 till late SSPAU with cons cover	24 / 7 Cons led SSPAU	Small / v. small	Medium	Large
Admissions per year	n/a	n/a	0-2500	2501-5000	>5000
WTE Consultants required	4.4	6.2	7.7	9.3	10.9

Source: RCPCH, 2011 "Facing the Future: A Review of Paediatric Services. https://www.rcpch.ac.uk/sites/default/files/page/FTF%20Full.pdf (Table 7).

Notes: From the same document, Table 3, the trainee paediatric workforce requirements are listed as 10 general tier 1 and 10 general tier 2 trainees per cell. It was assumed that this applied to medium size unit, with consultant FTE requirements of 9.3. As such the consultant to trainee medical grades ratio was estimated to be c. 1 to 2.2. This ratio was used for "other medical grades". Note that in practice for other medical grades the relationship requires local consideration, for example the middle grade rota could be partly staffed by nurse practitioners, as such the implications require further analysis.

HSR analysis – Paediatrics (4/4)

Staffing assumptions

Assumptions

Table: Current Consultant FTEs compared to RCPCH, 2011 "Facing the Future: A Review of Paediatric Services

Site	Total activity 16/17	Consultants Staff-in-post FTEs (not adjusted for Neonatology)	Consultants Establishment FTEs (not adjusted for Neonatology)	Consultants Staff-in-post FTEs (adjusted to exclude Neonatology)[1]	Consultants Recommended FTEs (excluding Neonatology)
BH	3,217	8.0	8.0	8.0	9.7
DON	4,277	9.0	13.5	9.0	11.1
BAS	1,493	5.0	4.7	3.5	9.7
MON					
SCH	10,043	12.0	7.2	12.0	11.1
STH					
RH	3,833	5.7	7.7	5.7	9.7
CRH	4,838	12.0	11.5	9.0	11.1
Total	**27,701**	**51.7**	**52.6**	**47.2**	**62.4**

Source: Reference Costs for activity data, with updated figures from some of the trusts. For FTE values, trust returns from September 2017, with updates received in April/May 2018.

Notes: [1]There are 12 consultant FTEs working in paediatrics in Chesterfield, however this includes neonatology rota cover and community paediatrics. To make it comparable to other trusts, only 9 FTEs were attributed to acute paediatrics. This number was provided by the trust. For Bassetlaw, it was assumed that 70% of the medical workforce covers acute paediatrics, therefore 3.5 of the 4.7 FTE staff complement was attributed to acute paediatrics. The 47 FTEs are thus comparable to the 62 FTE guideline figure.

Table: Current other medical grades and nursing FTEs

Site	Other medical grades[1] staff-in post FTEs (not adjusted for Neonatology)	Other medical grades[1] establishment FTEs (not adjusted for Neonatology)	Other medical grades[1,2]Staff-in-post FTEs (adjusted to exclude Neonatology)	Nursing staff-in post FTEs[3]	Nursing establishment FTEs[3]
BH	19.0	19.3	19.0	24.9	26.8
DON	20.8	23.7	20.8	34.8	36.8
BAS	7.2	8.3	5.1	12.2	12.9
MON					
SCH	17.3	13.0	17.3	46.4	46.4
STH					
RH	15.5	18.0	15.5	26.7	27.3
CRH	21.0	21.0	17.7	25.2	26.3
Total	**100.8**	**103.3**	**95.4**	**170.2**	**176.5**

Source: Trust returns from September 2017, with updates received in April/May 2018.

Notes: [1]Other medical grades include trainee grades and staff grades. [2]As above, neonatology and community paediatrics were taken out for the medical workforce. No such adjustments required for nursing however. [3]This includes only bands 5 and 6 nurses (registered nurses).

HSR analysis – Maternity (1/4)

Key assumptions

Key assumptions

1. The number of deliveries were taken from Reference Costs 2016/17 and updated activity numbers were provided by Barnsley Hospital NHSFT, Sheffield Teaching Hospitals NHS FT, and The Rotherham NHS FT.
2. The primary drivers for the consolidation of delivery units would be quality and safety of care, and the need to deliver greater levels of consultant presence for high risk births.
3. The analysis has only considered deliveries (excluding the ante-natal and post-natal activity).
4. MLUs are staffed by midwives only. No medical presence.
5. The analysis focused on FTE requirements for obstetrics and gynaecology, recognising that the medical workforce typically covers both specialities. Neonatology, an important clinical dependency, has been excluded. Further exclusions include anaesthetics and theatres.
6. For maternity, activity deemed to be low-risk (and thus attributed to an MLU according to the service definition) is not shifted between sites but is retained in a midwifery-led unit. The CLU activity (medium or high risk) will move to wherever the closest CLU is; the MLU activity remains to be addressed in each site - either in MLU alongside CLU or if there is no CLU, the assumption is that of a stand-alone MLU.
7. From Reference Costs 2016/17, the average proportion of low-risk births is 29% of total deliveries. Discussions with a clinician in the system have resulted in a value of 22.5% (average of 20-25%) being used instead, as 29% was deemed to be on the high side. This is assumed to be the proportion of activity that stays on all sites.
8. Consultant cover guidelines were taken from the RCOG (https://www.rcog.org.uk/globalassets/documents/guidelines/rcogfutureworkforcefull.pdf).
9. Midwifery guidelines were also taken from the RCOG (https://www.rcog.org.uk/globalassets/documents/guidelines/wprsaferchildbirthreport2007.pdf) and other sources such as (https://www.rcm.org.uk/sites/default/files/Birthrate%20Plus%20Report_1.pdf). The assumed minimum midwife-to-woman ratio is 1:29 for safe level of service to ensure the capacity to achieve one-to-one care in labour (average of 1:28 and 1:30, which has been quoted in the literature). This assumption would need revisiting at the next stage of the analysis to take into account the level of low risk births in the system.
10. In the absence of specific guidelines, the same proportion of consultant FTE impacts were assumed to apply to all other medical grades (staff grades, middle grade and junior doctors).
11. If as a result of reconfiguration activity at the receiving site(s) becomes greater than 7000, two units are assumed instead. This may result in diseconomies of scale. The next stage of the analysis would need to consider the practical implications in more detail.

HSR analysis – Maternity (2/4)

A number of additional assumptions have been used in order to undertake the analysis

Assumptions

Table: Current establishment FTEs

Site	Total deliveries 16/17	Consultants Establishment FTEs	Other medical grades Establishment FTEs[2]	Midwifery establishment FTEs[3]
BH	3,012	8.0	19.0	71.3
DON	3,391	9.7	21.5	136.7
BAS	1,507	4.3	9.5	60.7
MON				
SCH				
STH	6,924	29.0	30.6	213.1
RH	2,678	11.0	15.0	90.6
CRH	2,845	9.0	18.0	91.0

Source: Reference Costs for activity data, with updated figures from some of the trusts. For FTE values, trust returns from September 2017, with updates received in April/May 2018. No deliveries at MON or SCH.

Notes: [1]WTEs apportioned on the basis of activity at Bassetlaw and Doncaster Royal Infirmary. [2]Junior grades, middle grades and junior doctors are included in this category. [3]This includes only bands 5 and 6 midwives (registered).

HSR analysis – Maternity (3/4)

A number of additional assumptions have been used in order to undertake the analysis

Assumptions

Table: Staffing guidelines

Type of CLU	Consultant-led Unit A	Consultant-led Unit B	Consultant-led Unit C1	Consultant-led Unit C2	Consultant-led Unit C3
Deliveries per year (1)	<2,500	2,500 – 4,000	4,000 – 5,000	5,000 – 6,000	>6,0000
# of hours of consultant presence recommended	Based on local need but at least 40 hrs	60 hours	98 hours	168 hours	168 hours
		≈ 9/7 consultant presence	14/7 consultant presence	24/7 consultant presence	two separate rotas required
# of WTEs directly related to delivery suite presence*	2	3	6	12	**
# of WTEs which are related to non-delivery suite direct clinical care (NB – these figures account for and include prospective cover)	1 WTE (HSR assumption)	5 – 7 WTE (assume 30-40 additional PAs)	7 WTE (assume 40 additional PAs)	5-13 WTE (assume 30-80 additional PAs)	**
# of total consultant WTEs required for each type of CLU	3	8 - 10	13	17-25	**

*Source: RCOG, 2009. The future workforce in obstetrics and gynaecology. *Table 2.17, breaks included. **Note that the workforce guidelines are not explicit for CLUs with more than 6000 births, as units of this size are rare and in reality the number of births in any one unit would be capped by geography (i.e. population size within the catchment area of the hospital site on which the unit is located). In the analysis, if as a result of reconfiguration activity at the receiving site(s) becomes greater than 7000, two units are assumed instead. ** The RCOG guidelines are open to interpretation regarding units greater than 6,000 deliveries, and this is primarily due to the range in the number of direct clinical care PAs that are in addition to delivery suite activities. As such we are unable to credible assume a 'guideline' figure for STH, and whilst not consistent with the other trusts we have assumed this to be the establishment rate. We recognise that at this stage modelling is not site specific and that modelling has occurred in aggregate across the system. As modelling becomes site specific, we will engage further with clinicians to understand the appropriate guideline for STH including the amount of clinical care PAs that relate to activities other than the delivery suite.*

https://www.rcog.org.uk/globalassets/documents/guidelines/rcogfutureworkforcefull.pdf

HSR analysis – Maternity (4/4)

A number of additional assumptions have been used in order to undertake the analysis

Assumptions

Table: Current establishment consultant FTEs compared to RCOG, 2009 *"The future workforce in obstetrics and gynaecology"*

Site	Total deliveries 16/17	Consultants Obstetrics & Gynaecology staff-in-post FTEs	Consultants Obstetrics & Gynaecology establishment FTEs	Consultants Obstetrics & Gynaecology recommended FTEs[1]
BH	3,012	9.0	8.0	8-10
DON	3,391	8.3	9.7	8-10
BAS	1,507	3.7	4.3	3
MON				
SCH				
STH	6,924	28.9	29.0	29[2]
RH	2,678	9.7	11.0	8-10
CRH	2,845	9.0	9.0	8-10
Total	**20,357**	**68.6**	**71.0**	**64-72**

Source: Reference Costs for activity data, with updated figures from some of the trusts. For FTE values, trust returns from September 2017, with updates received in April/May 2018.

Notes: [1]This does not account for the scenario where BH, DON, RH and CRH increase consultant presence to 98h hours/week. [2]Given the advisory nature of the guidelines, which further specify that recommended FTEs should be determined at a local level, the establishment rate of 29 FTEs at STH was taken as the recommended staffing level for a unit of that size.

Table: Current other medical grades and midwifery FTEs

Site	Other medical grades staff-in post FTEs	Other medical grades establishment FTEs	Midwifery staff-in post FTEs[1]	Midwifery establishment FTEs[2]
BH	18.0	19.0	69.0	71.3
DON	21.5	21.5	94.8	136.7
BAS	9.5	9.5	42.2	60.7
MON				
SCH				
STH	38.0	30.6	197.7	213.1
RH	16.5	15.0	65.4	90.6
CRH	17.0	18.0	83.0	91.0
Total	**120.5**	**113.6**	**552.2**	**663.3**

Source: Trust returns from September 2017, with updates received in April/May 2018.

Notes: [1]Other medical grades include trainee grades and staff grades. [2]This includes only bands 5 and 6 midwives (registered nurses).

HSR analysis – temporary spend

A number of additional assumptions have been used in order to undertake the analysis

Assumptions

Table: Temporary staff expenditure, 2017/18

	Maternity	UEC	Paediatrics
Consultants	£708,573	£1,733,053	£1,699,536
Other medical grades	£1,853,458	£4,929,113	£958,677
Nursing/midwifery (bands 5 and 6)	£425,018	£2,349,626	£783,073
Other categories of staff not included above	£291,905	£947,180	£137,674

Table: Locum FTEs, 2017/18

	Maternity	UEC	Paediatrics
Consultants	5	9	8
Other medical grades	14	27	6
Nursing/midwifery (bands 5 and 6)	8	31	10
Other categories of staff not included above	7	19	2

Source: HSR data returns received from trusts in April 2018, supplemented with HSR returns from September 2016/17. Note not all trusts have provided all of the data, as such the values in the table above may not be an accurate refection of the level of temporary staff expenditure. For SCH, 60% of the temporary expenditure was included based on discussions with SCH clinicians. This is based on the share of general paediatric activity (c. 60%), therefore excluding specialised activity.

The number of locum FTEs was provided by most trusts in April 2018 and assumptions were made were the number of FTEs was not provided, based on average pay cost per locum FTE as implied from the data received from Trusts which supplied both sets of data.

Note that the numbers above will need to be reviewed and reconciled at the next stage of the analysis to ensure they are reflective of the service definitions.

Further notes:

- *Maternity: The temporary staff expenditure may not include the additional work undertaken by current staff.*
- *UEC: Locum expenditure may not be additional to budgeted expenditure – a proportion of it might be included in the budgeted figures.*