

# Introduction to the Hospital Services Stage 1a Report

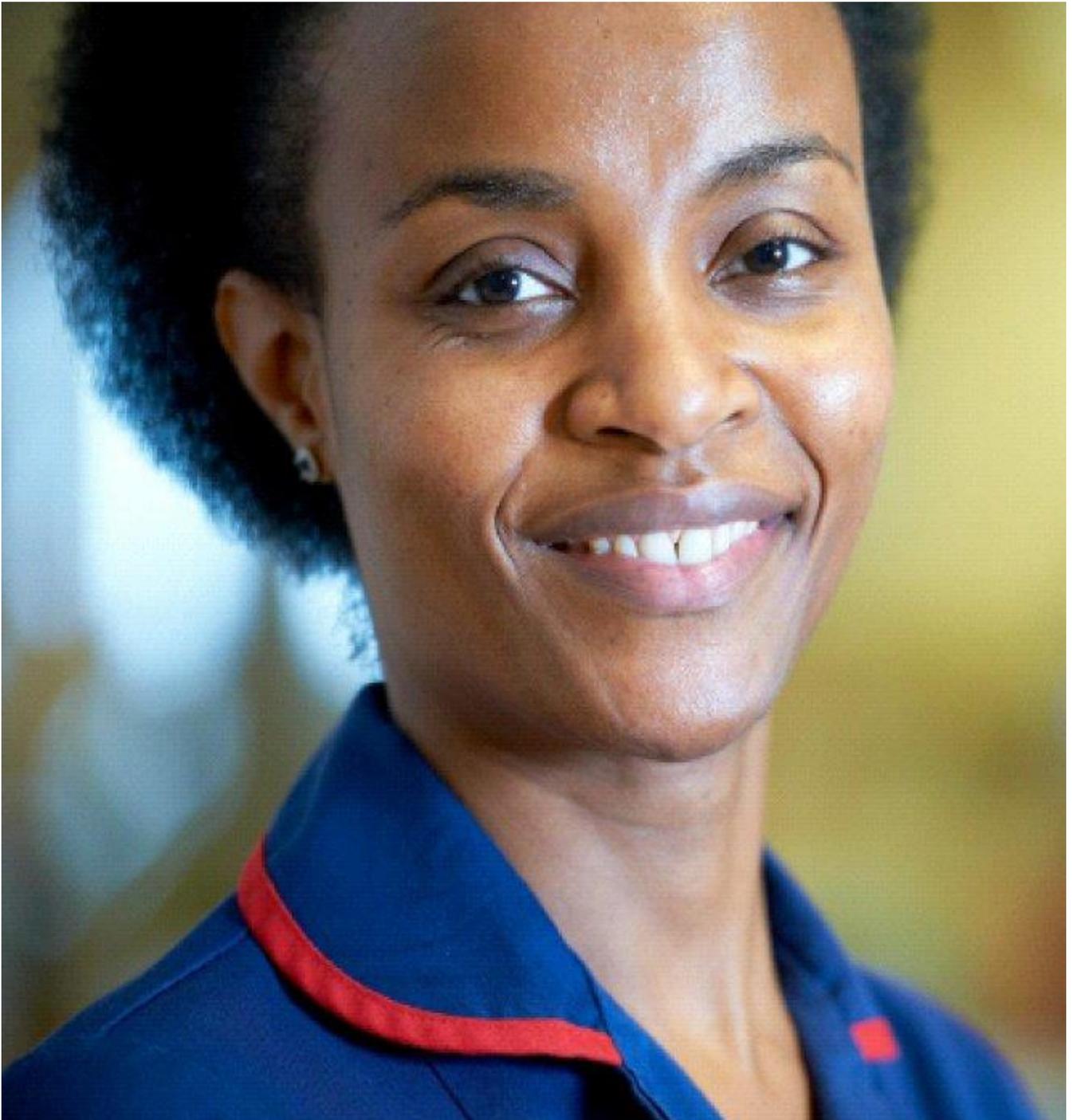
The Report outlines the process we used to identify the hospital services to be considered for further work.

The work is just one part of an overall approach to improving care and treatment for people living in South Yorkshire and Bassetlaw. At the same time, work is underway to develop more and more ways of treating and caring for people in their homes and local clinics, so that they don't need to go to hospital.

The Report covers

- The objectives of the work:
  - Define and agree criteria for 'sustainable hospital services'
  - Identify any services that are not sustainable
  - Put forward different ways of working to provide sustainable services
  - Consider how local general hospitals will provide sustainable services
- The challenges that hospitals are facing
- The shortlisting process and outcomes, including
  - Looking at and assessing the evidence
  - Input from the hospitals, patients and the public, commissioners and other key stakeholders
  - A view from three angles:
    - Independent assessment of the openly available data
    - A view from the hospitals
    - An analysis of what other services also need to be on the hospital site to support the service (service interdependencies)
- A longlist of 15 services based on the combined score (from the three angles).
- A 'long shortlist' of 8 services chosen from the top 15, based on discussions with the doctors and leaders who sit on the Review Steering Group
- Testing the impact of patient and public feedback on the longlist and consideration of conversations with stakeholders
- The final list of five services.

- A separate document outlines how the 15 were chosen and the rationale for the final five. The rationale for including and excluding services varied (and is summarised in the technical annexes). In general, the services chosen for the final five were those where the problems were greatest, and where it was felt that a whole-system solution was needed rather than a service being addressed in isolation.



## **Hospital Services Review**

### South and Mid Yorkshire, Bassetlaw and North Derbyshire: Stage 1A Report

September 2017

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# 1 Executive Summary

Since its creation in 1948 the NHS has constantly adapted and it must continue to do so as the world and our health needs change. The NHS has helped to create a revolution in the health of people in this country, with life expectancy dramatically increased, and many people now surviving illnesses which in the past would have killed them.

However, as medicine evolves, and as the population changes, the NHS across England is facing significant new challenges. The increasingly aging population not only has higher needs for health and care than the NHS has ever faced before, but also needs different kinds of care. Alongside this, changes in medical technology and dramatic shifts in the kinds of care that can now be provided outside of hospital are changing the face of health and care.

Alongside these changes, the NHS is operating in a very constrained financial environment. And there are significant workforce concerns, with national shortages of some staff. For example, the Health Foundation estimated in 2017 that the NHS could see a shortfall of 42,000 nurses by 2020<sup>1</sup>.

In this context, the NHS in the South and Mid Yorkshire, Bassetlaw and North Derbyshire region is experiencing its own challenges in all aspects of healthcare. This is against a backdrop of financial pressures (the South Yorkshire and Bassetlaw Sustainability and Transformation Plan (STP) projected a funding gap of £570m by the end of 2020-21, if services continue to be delivered in the same ways as they are now.

In response to this the Sustainability and Transformation Plans (STPs) for South Yorkshire and Bassetlaw, Derbyshire, and West Yorkshire and Harrogate laid out plans to tackle problems in primary, community, mental health and acute care. In South Yorkshire and Bassetlaw, which is the main focus of this Review, the STP is now being taken forward through plans for the Accountable Care System (ACS), which covers all areas of healthcare including mental health and primary and community care.

As one part of strengthening health services the SMYBND health organisations have agreed to set up a Hospital Services Review, which will look at how to put acute hospital services onto a sustainable footing for the future.

The Review includes five acute hospitals which are within the geographical footprint of the SYB ACS (Barnsley Hospital NHS Foundation Trust; Doncaster and Bassetlaw Hospitals NHS Foundation Trust; Rotherham NHS Foundation Trust; Sheffield Children's NHS Foundation Trust; and Sheffield Teaching Hospitals NHS Foundation Trust). It also includes two acute hospitals outside the ACS (Chesterfield Royal Hospital NHS Foundation Trust, and Mid Yorkshire Hospitals NHS Trust) being included in the Review footprint because they send significant numbers of patients into the ACS hospitals.

The region has some excellent hospital services, but the system is under great strain from mounting demand and workforce pressures. This is impacting on the quality of care that patients receive, and there are significant inequalities across the region in patients' access to healthcare and health outcomes:

- Of the 7 acute hospitals in the Review footprint, 3 are currently assessed by the Care Quality Commission as 'Good', while 4 are assessed as 'Requires Improvement';

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<sup>1</sup> The Health Foundation, *In Short Supply*, 2017. <http://www.health.org.uk/publication/short-supply-pay-policy-and-nurse-numbers>

- 6 of the 7 trusts did not meet the national standard of 95% of patients experiencing waiting times of no more than 4 hours in A&E, in Quarter 1 of 2017-18;
- 3 of the 7 did not meet the 18 week Referral to Treatment standards, in Quarter 1 of 2017-18;
- 5 of the 7 did not meet the cancer waiting times target of 85% of patients having their first treatment within 62 days of GP referral, in Quarter 4 of 2016-17.

One of the factors contributing to this is shortages of workforce in some key areas. Some hospital services on some sites currently have no permanent consultant staff in post, and rely on temporary cover including expensive locum and agency staff. This is unacceptable both for patients, who expect high quality care, and for the taxpayer, who has a right to expect that the health service will be value for money.

There are a number of opportunities for the Review recommendations to improve services.

Evidence from other health economies across the country and around the world suggests that we could significantly improve outcomes for patients if hospitals worked together more closely. The Hospital Services Review presents an important opportunity to leverage the benefits of working together across organisational boundaries. As South Yorkshire and Bassetlaw begins to establish itself as an Accountable Care System, the Review will build on the opportunity to overcome our challenges as an integrated system and deliver the high-quality healthcare that patients deserve.

Over a ten month period, the Review team, in partnership with health and care organisation leaders, clinicians, staff, patients and the public will identify a number of hospital services that are coming under increasing pressure, and develop a set of independent recommendations for how they could work better, and be sustainable for the future.

The Sustainability and Transformation Plan for South Yorkshire and Bassetlaw, and the Terms of Reference of the Review, lay out some expectations around the Review. The STP made it clear that we are committed to keeping all of our hospitals, and providing the appropriate level of emergency care at all of them. The Review will look at how services could be provided to ensure everyone in South Yorkshire and Bassetlaw has access to high quality, safe hospital services, and to reduce inequalities in access.

This report is the first in a series of documents that the Review team will publish to share its conclusions with the wider public. The report presents the shortlist of five clinical services that are recommended for further investigation:

- 1) Urgent and Emergency Care
- 2) Maternity
- 3) Care of the Acutely Ill Child
- 4) Gastroenterology and Endoscopy
- 5) Stroke

It also describes the process and methodology that the Review has applied to identify this shortlist of services and details any assumptions to ensure maximum transparency. The next stages of the Review will now explore in-depth the specific challenges that each of these services face and develop tailored alternative delivery models. To complement the Review's service-specific improvement proposals, it will consider the wider roles that each of the Hospitals can play in the future in the context of the overarching architecture of our healthcare system. Going forward, the Review will involve detailed engagement with healthcare staff from across the region; patients; and the public.

The review would not be possible without the support of countless individuals who have shared data, participated in workshops, or engaged in discussions and interviews. We look forward to continuing these conversations over the coming months and together raise the bar for the care that the people of South Yorkshire and Bassetlaw receive.

*Christopher Welsh*  
*Independent Review Director*

## 2 Introduction

This chapter provides an introduction to the Review, specifically:

- Provides an overview of the purpose of the Report;
- Outlines the objectives of the Review;
- Defines what we mean by Acute Hospital Service Sustainability;
- States the Governance overarching the Review; and,
- Provides an overview of the project timelines.

### 2.1 Purpose of the Report

South and Mid Yorkshire, Bassetlaw and North Derbyshire (SMYBND) are in the process of developing plans to put their health economies onto a more sustainable footing and to deliver better services for patients. One important part of this is to ensure that acute hospital services are providing good quality care for patients, and are sustainable for the future. To support this process an independent review of acute hospital services (the 'Review') was commissioned to set out recommendations regarding the future shape and nature of these services. The Review will be a ten month review looking at a range of acute hospital services in SMYBND, which currently are currently facing some significant challenges. SMYBND has some excellent acute hospital services, but the system is under great strain from mounting demand and workforce pressures. This is impacting on the quality of care that patients receive, and there are inequalities across the region in patients' access to healthcare and health outcomes.

Evidence from other health economies across the country and around the world suggests that we could significantly improve the sustainability of services, and outcomes for patients, if hospitals worked together more closely.

The Hospital Services Review presents an important opportunity to leverage the benefits of working together across organisational boundaries. As South Yorkshire and Bassetlaw begins to establish itself as an Accountable Care System, the Review will build on the opportunity to overcome these challenges as an integrated system and deliver the high-quality healthcare that patients deserve.

The Sustainability and Transformation Plan for South Yorkshire and Bassetlaw, and the Terms of Reference of the Review, laid out some expectations around the Review. The STP made it clear that we are committed to keeping all of our hospitals, and providing the appropriate level of emergency care at all of them. The Review will look at how services could be provided to ensure everyone in South Yorkshire and Bassetlaw has access to high quality, safe hospital services. The ultimate aim of the review is to reduce inequalities in access and outcomes.

The Review will develop recommendations as to how acute services in the footprint could be made more sustainable. The findings of the Review will be published at intervals in three reports, which will set out findings and recommendations at each key stage of the review process as set out below:

- Report 1A: Scope of services included in the Review;
- Report 1B: Service specific sustainability analysis and emerging system options;
- Report 2: Final report and recommendations.

This is the first report in the series. It sets out the objectives of the review and overall programme governance arrangements and timelines, a brief summary of the case for change, the methodology developed to select services to include in the Review and the recommended shortlist of services. Further detail is provided in a series of Appendices.

The report is intended as a technical synopsis of the work undertaken by the Review team to enable the SMYBND Oversight and Assurance Group to challenge and comment on the methodology and work undertaken. The report will also form the basis of further materials developed for ongoing public engagement and communications.

## 2.2 Objectives of the Review

The objective of the Review is to put forward proposals around how acute hospital services in SMYBND (the 'Review footprint') can be delivered on a more sustainable basis for the benefit of patients, supported by collaborative working and new models of care. Four formal objectives were set out in the initial Review terms of reference and are set out below:

1. Define and agree a set of criteria for what constitutes 'Sustainable Hospital Services' for each Place<sup>2</sup> and for SMYBND (in the context of the South Yorkshire and Bassetlaw (SYB) Accountable Care Systems (ACS));
2. Identify any services that are unsustainable against these criteria, in the short, medium and long-term, including tertiary services delivered within and beyond the Sustainability and Transformation Plan (STP);
3. Put forward a future service delivery model or models which will deliver sustainable hospital services;
4. Consider what the future role of a District General Hospital is in the context of the aspirations outlined in the South Yorkshire and Bassetlaw STP and emergent models of sustainable service provision.

The Review will build on the work that is being done across each Place to move care out of hospital. Whilst it does not have a specific objective to deliver that shift, it is built on that premise and it is intended to support the process.

The Review will also take account of the public commitment by the South Yorkshire and Bassetlaw Accountable Care System to keeping our current hospitals, and providing the appropriate level of urgent care in each of them.

## 2.3 Definition of Acute Hospital Service Sustainability

The Review has set out four components of a sustainable acute hospital service:

- 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.

Assessing these issues is complex, especially given the huge range and variety of services provided in the acute hospital sector. Therefore, a key component of this first phase of work was to create a framework to assess sustainability consistently across all services in the Review footprint. This framework was then used to shortlist a small group of acute hospital services with the most sustainability issues to consider in further detail.

The report is focused on those services which have ongoing and significant problems with sustainability, rather than trying to solve individual short term concerns with services.

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<sup>2</sup> There are seven "Places" across the SYBMYND Review Footprint; Barnsley, Bassetlaw, Derbyshire (comprising of Chesterfield, North East Derbyshire, Bolsover and Derbyshire Dales), Doncaster, Mid Yorkshire (comprising of Kirklees and Wakefield), Rotherham and Sheffield.

## 2.4 Review Governance and Membership

The Independent Review was commissioned by the South Yorkshire and Bassetlaw Accountable Care Systems (ACS) Oversight and Assurance Group (OAG) whose membership includes Trust Chairs, Health and Wellbeing Board Chairs (Local Authority Members) and Clinical Chairs of Clinical Commissioning Groups (CCGs). This group will receive each report and associated recommendations.

The work will be signed off by the Joint Committee of Clinical Commissioning Groups (JCCCG), and any other relevant CCGs, before being put to the OAG. Any proposals for future service changes will be taken forward by commissioners, who retain the responsibility for making final decisions on commissioning and leading proposals on service changes.

In total, there are over 20 organisations involved in the Review including each local CCG, NHS Trust and Local Authority whose populations may be affected by any proposed changes, as well as number of national and regional organisations including NHS England, Health Education England and the Yorkshire Ambulance Service (see Appendix 1).

The scope of the Review is to consider the sustainability of acute hospital services across seven Trusts:

- Barnsley Hospital NHS Foundation Trust (BH);
- Chesterfield Royal Hospital NHS Foundation Trust (CRH);
- Doncaster and Bassetlaw Hospitals NHS Foundation Trust (DBH);
- Mid Yorkshire Hospitals NHS Trust (MYH).
- Rotherham NHS Foundation Trust (RH);
- Sheffield Children's NHS Foundation Trust (SCH);
- Sheffield Teaching Hospitals NHS Foundation Trust (STH);

Of these, Mid Yorkshire Hospitals have recently completed a reorganisation of their services, which will not be reopened. Engagement with staff and patients in Mid Yorks will therefore be lighter touch than in other areas.

Engagement with Chesterfield is also slightly lighter touch. The Review will focus on acute services which flow into the South Yorkshire and Bassetlaw footprint, and will engage closely with the Derbyshire commissioners and the Derbyshire STP Programme around the relationship with the plans for urgent and planned care in Derbyshire laid out in *Joined Up Care Derbyshire* (the Derbyshire STP) as they relate to Chesterfield Royal Hospital. The Review will not engage with the community and out of hospital providers in Derbyshire since these are covered by the Derbyshire STP.

These hospitals draw patients from a wide range of CCGs. All the affected CCGs are members of the Review Steering Group, and going forward the Review team will ensure that those CCGs who are not also included within the South Yorkshire and Bassetlaw JCCCG are engaged as required.

The work is being managed on an ongoing basis by a Review Steering Group comprising acute provider and commissioner representatives from across the Review footprint (membership is set out in Appendix 2). It is chaired by Professor Christopher Welsh who was appointed as the Independent Review Director with support from a Programme Director and Secretariat team.

Further details of the governance arrangements are set out in the terms of reference for the Review and are available on request.

## 2.5 Project Timeline

The Review commenced on Wednesday 21 June 2017 with the first meeting of the Review Steering Group and will be conducted over a ten month period with the final report scheduled for the end of April 2018. It has been structured into two Stages:

- Stage 1 Assessment (June – December 2017). This stage includes an assessment of the sustainability of services across the whole Review footprint to agree a shortlist to be taken forward for a more detailed assessment of sustainability issues, and identifying the problems with these services.
- Stage 2. Options and New Models (January 2018 – April 2018). This stage will focus on potential solutions to the issues identified.

A detailed project plan has been developed, including key programme milestones, report dates, governance groups and communications and engagement activity with patients and the public. Appendix 3 provides an overview of the Review project plan.

# 3 Background and context

This chapter provides the background and context to the Review specifically a short outline of the challenges in the acute sector across the Review Footprint grouped into six categories: patients, clinical, operational, workforce, finance and research.

## 3.1 Challenges in the acute sector

Since its creation in 1948 the NHS has constantly adapted and it must continue to do so as the world and our health needs change. The NHS has helped to create a revolution in the health of people in this country, with life expectancy dramatically increased, and many people now surviving illnesses which in the past would have killed them.

However, as medicine evolves, and as the population changes, the NHS across England is facing significant new challenges. The increasingly aging population not only has higher needs for health and care than the NHS has ever faced before, but also needs different kinds of care. Alongside this, changes in medical technology and dramatic shifts in the kinds of care that can now be provided outside of hospital are changing the face of health and care.

Alongside these changes, the NHS is operating in a very constrained financial environment. And there are significant workforce concerns, with national shortages of some staff. For example, the Health Foundation estimated in 2017 that the NHS could see a shortfall of 42,000 nurses by 2020<sup>3</sup>.

In this context, the NHS in the South and Mid Yorkshire, Bassetlaw and North Derbyshire region is experiencing its own challenges in all aspects of healthcare. This is against a backdrop of financial pressures (the South Yorkshire and Bassetlaw Sustainability and Transformation Plan (STP) projected a funding gap of around £570m by the end of 2020-21, if services continue to be delivered in the same ways as they are now.)

In response to this the Sustainability and Transformation Plans (STPs) for South Yorkshire and Bassetlaw, Derbyshire, and West Yorkshire and Harrogate laid out plans to tackle problems in primary, community, mental health and acute care. In South Yorkshire and Bassetlaw, which is the main focus of this Review, the STP is now being taken forward through plans for the Accountable Care System (ACS), which covers all areas of healthcare including mental health and primary and community care.

As one part of strengthening health services The SMYBND health organisations have agreed to set up a Hospital Services Review, which will look at how to put acute hospital services onto a sustainable footing for the future.

SMYBND has some of the best acute hospital services in the country with national and international reputations including a specialist cancer centre, children's hospital and numerous very high quality services in many locations. It also has one of the country's busiest accident and emergency departments.

However, the health and care economy is coming under increasing strain and there are some major quality challenges:

- Of the 7 acute hospitals in the Review footprint, 3 are currently assessed by the Care Quality Commission as 'Good', while 4 are assessed as 'Requires Improvement';

<sup>3</sup> The Health Foundation, *In Short Supply*, 2017. <http://www.health.org.uk/publication/short-supply-pay-policy-and-nurse-numbers>

- 6 of the 7 trusts did not meet the national standard of 95% of patients experiencing waiting times of no more than 4 hours in A&E, in Quarter 1 of 2017-18;
- 3 of the 7 did not meet the 18 week Referral to Treatment standards, in Quarter 1 of 2017-18;
- 5 of the 7 did not meet the cancer waiting times target of 85% of patients having their first treatment within 62 days of GP referral, in Quarter 4 of 2016-17.

The pressures on the system are also showing up in measures such as trainee doctor satisfaction and a varied picture on patient satisfaction.

One of the main causes of these problems is significant workforce pressures across all hospitals. Some services have even had to close temporarily on some sites because there were not enough staff to provide them safely. Other services are managing to continue, but in some cases a significant proportion of the workforce is made up of locum or agency staff. Services which are reliant on temporary staff in this way are not only more expensive, but also risk offering poorer quality of care for patients, with a lack of continuity of care, and staff who may not be as familiar with the hospital.

These workforce shortages are national as well as local, with some specialties facing shortages across the country.

At the same time, there is rising demand on services. Hospitals are experiencing increasing numbers of people attending A&E or requiring services in other ways. In particular, the ageing population means that hospitals are seeing increasing numbers of highly complex, often very elderly patients.

Some of these issues have been addressed but others continue. The Five Year Forward View and subsequent Next Steps on the Five Year Forward View, outline the reasons why the service needs to continue to evolve and adapt to meet the needs of our population. The South Yorkshire and Bassetlaw Sustainability and Transformation Plan (STP) lays out in detail the response to how transforming the way we work would improve health and care for the people living, working and studying in the region.

The South Yorkshire and Bassetlaw STP identifies a number of problems with existing acute services, as well as missed opportunities to improve quality, experience, access and safety by identifying delivery options based on closer working together.

The Review footprint will face further challenges from demographic change, for example an ageing population and a rise in lifestyle risk factors. In addition, the system needs to contend with local factors such as the higher than average levels of deprivation and child poverty, as well as social and health inequalities.

The current and foreseeable future context can only mean that this challenging environment will continue and worsen at the same time as Trusts are having to respond to more demanding national requirements around quality of care, equity of access and efficiency. The time to act is now. This review offers a unique opportunity to fundamentally change the way care is delivered, and take the difficult steps to transform the way trusts collaborate to improve sustainability.

Through tackling these challenges together, now in the review, this will support SMYBND to become one of the most innovative, safe, caring, responsive, effective, well led and efficient health and care systems by 2020<sup>4</sup>. This will deliver the following benefits to the population of SMYBND:

- The trusts will work together to improve patient safety and care and to make systems more efficient in ways which any individual organisation would not be able to achieve by acting alone.
- By sharing collective expertise and knowledge, they will improve quality, safety and patients' experience of the care system.
- Services will reduce the variation in care quality for patients by sharing best practice to learn from each other and developing the same new ways of working.
- Patient information systems will be joined up across the organisations to improve safety and patient experience.
- The trusts also hope that by developing innovative new ways of working, they will help hospital specialities recruit and retain specialist staff.

The critical challenges acute trusts are facing can be grouped into six categories. Further analysis is provided in a separate Technical Annex.

### 3.1.1 Patients

Patients generally perceive the quality of healthcare in the Review footprint to be good with patient feedback provided via the Friends and Family Test<sup>5</sup> highlighting a broadly positive picture of patients who would recommend services. However this is variable across sites and services. Importantly, patients have different levels of access to services between different hospitals in local places, with equality of access being a major concern across the health economy. Waiting times for some services on some sites are significantly longer than the national standard, and patient and public feedback at the Review's public engagement session identified waiting times as one of the top three issues of greatest importance to patients.

### 3.1.2 Clinical

Some clinical services are struggling, particularly as a result of shortages of key workforce, which has impacted on the ability to provide sustainable safe services in every hospital. Consequently, there are different levels of quality in some hospitals both between services and between the same services in different hospitals. Overall, four of the hospitals in the footprint have been identified by the CQC as 'Requires Improvement'. The below table highlights the latest CQC ratings of services, by Trust.<sup>6</sup>

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<sup>4</sup> Source: Working Together Partnership vision and mission statement

<sup>5</sup> Source: NHS England (Friends and Family Test Data)

<sup>6</sup> Source: CQC

Table 1: CQC service rating by Trust

Trust	Barnsley Hospital NHS Foundation Trust	Diabetes Royal Hospital NHS Foundation Trust	Doncaster and Bassetlaw Hospitals NHS Foundation Trust			Mid Yorkshire Hospitals NHS Trust	Rotherham NHS Foundation Trust	Sheffield Children's Foundation Trust	Sheffield Teaching Hospitals NHS Foundation Trust				
	Requires Improvement	Good	Requires Improvement			Requires Improvement	Requires Improvement	Good	Good				
Stops	Barnsley	CRH	D&B - DR	D&B - BDGH	D&B - Mont	MY - Pinders	MY - Dewes & Dist.	MY - Ponte	Roth	Shef. Child	STH - RH	STH - NGH	STH - WPH
Categories													
Urgent and Emergency Services	Requires Improvement	N/A	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement	N/A	Good	Requires Improvement	N/A
Medical Care	Good	N/A	Good	Good	Good	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement	N/A	Good	Good	Requires Improvement
Surgery	Requires Improvement	N/A	Good	Good	Good	Requires Improvement	Requires Improvement	Good	N/A	N/A	Good	Good	N/A
Critical Care	Good	N/A	Good	Good	N/A	N/A	Good	N/A	N/A	N/A	Outstanding	Outstanding	N/A
Mat. & Gyn.	Good	N/A	Requires Improvement	Requires Improvement	N/A	Good	Good	Good	Requires Improvement	N/A	Outstanding	N/A	N/A
Services for CYP	Requires Improvement	N/A	Good	Good	N/A	Good	Good	N/A	Requires Improvement	N/A	Good	N/A	N/A
EoL care	Good	Requires Improvement	Good	Good	N/A	Requires Improvement	Requires Improvement	N/A	N/A	N/A	Good	Requires Improvement	Requires Improvement
Outpatient and diag. imaging	Good	Good	Requires Improvement	Requires Improvement	Requires Improvement	Good	Good	Good	N/A	N/A	Outstanding	Outstanding	Outstanding
Overall	Requires Improvement	Good	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement	Good	Good	Good	Requires Improvement

### 3.1.3 Operational

As a result of staff shortages some services across the Review footprint are having difficulty maintaining services and are having to close access to patients and divert them to other sites at short notice, for example, the paediatric service in Bassetlaw Hospital.

In addition, there is variation in performance between the Trusts in other operational metrics, for example 18 week waiting time performance ranges from 80.1% at Mid Yorkshire Hospitals to 95.3% at Sheffield Teaching Hospitals (Q1, 2017/18)<sup>7</sup>. A&E waiting time targets have been consistently missed for the last quarter at all trusts, apart from Sheffield Children's Hospital.

### 3.1.4 Workforce

All hospital organisations are facing significant workforce issues. Trusts are continuing to find themselves competing for the same staff for many of the same service areas with some Trusts unable to fill key staff vacancies. Some of the smaller District General Hospitals in particular, are facing workforce challenges.

Staff stability across medical staff and nursing staff is higher than the national average, indicating that relatively fewer staff left during 2015/16 compared to the national average<sup>8</sup>, however, there is significant variation across the Review footprint.

Some service areas are heavily reliant on locum cover for key service areas including A&E and smaller medical and surgical specialties. For example, across the Review footprint on average 84.5 full time equivalent (FTE) Medical Consultants posts are filled by non-substantive staff, equating to

<sup>7</sup> Source: HSJ Intelligence

<sup>8</sup> Source: HCHS dataset 2015/16

7.2% of the Medical Consultant workforce<sup>9</sup>. Specific examples include Barnsley Hospital where the Stroke – Hyper Acute Stroke Unit (HASU) is currently run by a locum workforce with support of one substantive<sup>10</sup> member of staff, and Doncaster and Bassetlaw Hospitals where c. £8m of agency staffing last year was spent in Emergency Medicine<sup>11</sup>.

The 2017 General Medical Council (GMC) annual training survey of doctors in postgraduate training (all those in foundation, core and higher speciality training programmes) highlighted a variation in the overall satisfaction levels, ranging from 69.8% at Sheffield Teaching Hospitals NHS Foundation Trust to 90.4% at Barnsley Hospital NHS Foundation Trust.<sup>12</sup>

### 3.1.5 Finance

The NHS is facing ongoing financial pressure as demand continues to increase at a time when funding is constrained at a national level. Director of Finance colleagues across South Yorkshire and Bassetlaw estimate that a 'do nothing scenario' for the NHS would result in a deficit in the region of £570 million over the next four years. The acute hospital sector is facing significant deficits and challenging budget control totals which may exacerbate existing quality and equality of access variations and challenges.

Across the Trusts, there is potential replication of services and the consequent underutilisation of equipment and expensive assets in the context of limited capital funds.

### 3.1.6 Research

Analysis of research funding received<sup>13</sup> also highlights a difference between the Trusts, ranging from Rotherham at £0.4m per annum to Sheffield Teaching Hospitals at £38m. Whilst we would expect a large teaching hospital to have higher levels of research funding, we need to be sure that patients across SMYBND receive equity of access to the latest clinical research and trials.

Examples of recent successes include Mid Yorkshire Hospitals who have recently secured a new research partnership with the University of Huddersfield to conduct research in areas such as diabetes and skin integrity. As one of 20 NIHR Biomedical Research Centres, Sheffield Teaching Hospitals NHS Foundation Trust continues to focus on translational neuroscience and lead the development of new treatments, diagnostics and prevention and care for patients suffering from debilitating disease.

## 3.2 Placed based analysis

In order to understand the need for, and sustainability of hospital services in each Place, it is important to understand the health needs of its local population. Some initial place based analysis is contained in a separate Technical Annex with the data provided by Public Health England.

This analysis will continue to be developed throughout the Review, to ensure we have a good understanding of the needs of the population so that the Review can design sustainable hospital services to benefit patients in each Place.

<sup>9</sup> Source: Information provided by the Trusts (Mid Yorkshire did not provide any information)

<sup>10</sup> Source: Trust interview

<sup>11</sup> Source: Trust interview

<sup>12</sup> Source: General Medical Council

<sup>13</sup> Source: Trust Annual Reports

# 4 Shortlisting process and outcomes

In this chapter, the approach taken to shortlisting hospital services for inclusion in the Review is set out. The aim of this shortlisting process is to identify which services the Review should include within its scope, based on a structured and evidence based assessment, as well as taking into account perspectives from each Trust, commissioners, key stakeholders and patients and the public.

The first stage of the Review, from July to early September, has focused on identifying and agreeing which services to concentrate on.

In order to make the scope of the Review manageable within a ten month timeframe, it was agreed that the Review should focus on a small number of services in detail. These services were agreed through a shortlisting process.

The shortlisting process was broken down into eight stages and agreed by all relevant stakeholders:

1. **Agreeing the methodology:** establishing the definition of service sustainability and the associated framework and criteria that were used to assess whether services are sustainable. At this point, we engaged with the public via a number of different routes, including an engagement event and online survey.
2. **Analysis of the sustainability of each hospital service** using the three lenses (defined in 4.2)
3. **Identifying the top 20 ranked unsustainable services**, compiling analysis from each lens
4. **Developing the “long shortlist”:** discussion of the results with the Review Steering Group and other stakeholders to develop a “long shortlist” of the eight most unsustainable services
5. **Testing out the robustness of data** with the trusts: added general surgery to the long shortlist
6. **Testing the impact of introducing weighting** based on patient feedback
7. **Seeking views from ‘organisation-agnostic’ senior stakeholders** from NHS England and Health Education England, and a collective response from commissioners
8. **Agreement on final proposed shortlist of five services**

Further information on each stage is provided below.

Going forward, the Review will contribute to an understanding of how hospital services form part of local Place plans and the development of Accountable Care Partnerships. In particular, the Review will consider the role of the District General Hospital and the services that need to be provided on each site taking into account the full range of elective and specialist services.

This aspect of the Review is not included within this report as it will be the focus of work later in the year. However it will build on the tiering approach that has been developed in earlier work, and will be closely linked to looking at the operational sustainability of the shortlisted services:

- Tier 1: representing services to be delivered within each local Place.
- Tier 2: representing services which could be delivered as an accountable networked service.
- Tier 3: representing tertiary or specialised services.

Any proposals around changes to services that may emerge from the Review would need to go through a full process of public involvement and engagement. The Review will put forward a range of options which the OAG and commissioners will then take a view on, and will take forward to further modelling and public engagement and consultation if appropriate.

In more detail, the shortlisting of services for the Review to focus on was taken forward as follows:

#### 4.1 Agreeing the criteria

The Review Steering Group, Trust Chief Executives, Medical Directors, Operations Directors, Strategy Directors, patients and the public all contributed to an agreed definition of what sustainability means and which were the most important criteria to take into account.

To identify the criteria the Review team listed the factors which might impact sustainability, through looking at what similar reviews had done (for example Manchester). The team also looked at the Terms of Reference of the Review to ensure that the areas highlighted as priorities in the ToR were represented in the criteria.

A session was held with Trust Chief Executives and Medical Directors to discuss the criteria and identify any gaps; the attendees confirmed that all the criteria which had been identified were important. They gave their views of which were the most important criteria and suggested how to present and structure the criteria.

Subsequently, the criteria were converted into plain English and discussed with patients and the public at a public engagement event organised with support from the South Yorkshire and Bassetlaw Healthwatches and CCG engagement teams, . The criteria were also made available in the form of a public survey, distributed via Healthwatches and CCG engagement teams. The event and the survey were used to test whether, from the public viewpoint, there was anything missing from the criteria, and which of the criteria were considered to be most important by patients and the public. The list was also discussed with commissioners in JCCCG.

The ten criteria identified as a result of the session with Trust Chief Executives and Medical Directors, the patient and public engagement, and input from the Review Steering Group, Operations Directors, Strategy Directors, and the JCCCG are:

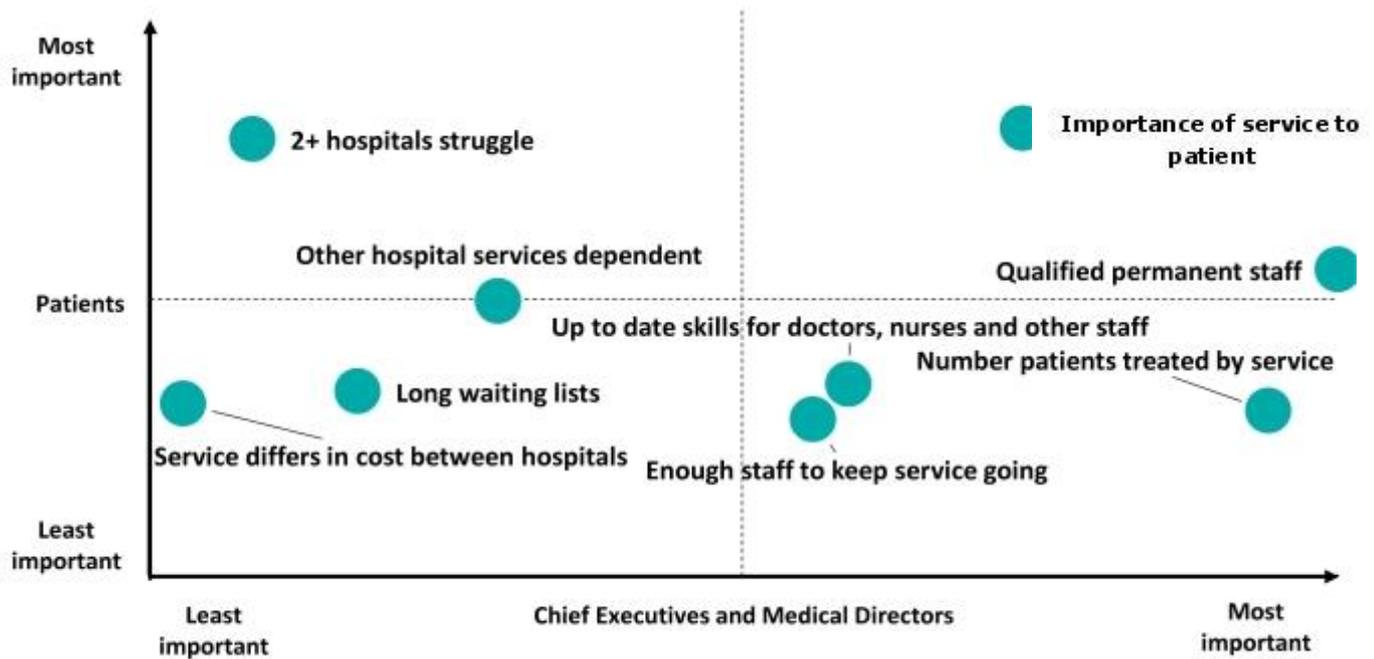
1. Whether there are sufficient numbers of appropriately qualified permanent staff to run the service safely for patients
2. Are more than two hospitals having difficulty in maintaining the service?
3. How important is this service for patients (i.e. will service problems cause major safety concerns for patients)?
4. Whether there are a large number of other hospital services which are dependent on the challenged service to be able to keep going themselves
5. Whether, if all staff were in post, there are enough staff to keep the service going so that the care is safe and quality for patients is high
6. Whether there are a large number of patients who are treated by the service and therefore are affected by the issues the service faces
7. Whether it costs more to run the service in one of the hospitals than it does in others
8. Whether patients are on waiting lists for too long
9. Whether staff who are in training have a good experience of working for that service
10. Whether doctors, nurses and other staff see enough patients to keep their skills up and provide safe care for patients

One potential criterion which was not shortlisted at this point was the impact on health inequalities. It was felt by the Review team that the options under discussion (i.e. which services to include in the scope of the review) were too broad to be able to meaningfully differentiate their impact on

inequalities, However the Review team will pay due regard to inequalities as the programme continues and as the recommendations emerge.

The figure below illustrates the how important Trust Chief Executives and Medical Directors and the public considered each criterion.

Figure 1: Scatterplot to show important criteria for Trust Chief Executives and Medical Directors and Patients



As the figure illustrates Chief Executives, Trust Medical Directors and patients and the public both regarded major safety concerns as important as well as access to qualified permanent staff. Factors considered less important included long waiting lists and differences in costs between hospitals.

At this point, the Review team did not weight the criteria based on how important the criteria were felt to be, but instead treated all criteria equally. Later in the process the team applied a weighting to the top three criteria identified by patients and the public, to test out whether this would change which services emerged as the most important.

Please see the separate Technical Annex for further details of the Sustainability Assessment Framework.

#### 4.2 Analysis of the sustainability of each hospital service, using the three lenses

In order to objectively measure sustainability across each service and criteria, the team developed three 'lenses'. These were:

- Independent analysis of standardised data on all services on all sites;
- Self-assessment by Trusts;
- The number of interdependencies between services.

This approach recognised the importance both of the Review team taking a fresh and unbiased view of the situation within all Trusts, and the benefits of drawing on existing expertise and knowledge through the self-assessment. Since it was likely that the Trusts would have different approaches to self-assessment, the independent analysis allowed for some triangulation and challenge.

In further detail, the three lenses were:

#### 4.2.1 Lens 1. Independent analysis

The independent analysis seeks to provide an objective, evidence-based perspective to the review, to challenge and triangulate the findings of the self-assessment. The criteria presented above were converted into metrics that were readily available from public data sources, and were easily comparable across services.

Of the criteria which had been shortlisted, those which could be assessed on the basis of the independent assessment were:

- There are insufficient numbers of appropriately qualified permanent staff to run the service safely for patients
- Even if all staff were in post, there are not enough staff to keep the service going so that the care is safe and quality for patients is high.
- There is a large number of patients who are treated by the service and therefore are affected by the issues the service faces.
- It costs more to run the service in one of the hospitals than it does in others.
- Patients are on waiting lists for too long.
- Staff who are in training have a poor experience of working for that service.
- Doctors, nurses and other staff do not see enough patients to keep their skills up and provide safe care for patients.

The metrics, sources and thresholds are detailed in the below table. The Review team noted some concerns with the data, with some services such as paediatrics being difficult to assess because the data was incomplete. For this reason the independent analysis was combined with and tested against the Trusts' self-assessment.

Table 2: Shortlisting criteria metrics and thresholds

Shortlisting Criteria accounted for in independent analysis	Metric	Source	Thresholds
<b>There are insufficient numbers of appropriately qualified permanent staff to run the service safely for patients</b>	Ratio of locum FTEs to total FTEs per service (substantive + non-substantive)	Trust workforce data submissions July/August 2017	<5% = Low concern 5% - 20% = Moderate concern 20%+ = High concern
<b>Even if all staff were in post, there are not enough staff to keep the service going so that the care is safe and quality for patients is high</b>	Number of Full Time Equivalent medical and nursing staff (substantive + non-substantive)	Trust workforce data submissions July/August 2017	<5 FTE = High concern 5-10 FTE = Moderate concern 10+ FTE = Low concern
<b>There is a large number of patients who are treated by the service and therefore are affected by the</b>	HES Finished Consultant Episodes	Hospital Episode Statistics activity data 2015-16	N/A

issues the service faces			
It costs more to run the service in one of the hospitals than it does in others	Reference Cost Index	National Reference Cost data 2015-16	<100 = Low concern 100-120 = Moderate concern 120+ = High concern
Patients are on waiting lists for too long	Elective Referral to Treatment waiting times	Referral to Treat 95% waiting times data March 2017 – May 2017	<18 weeks for last 3 months = Low concern <18 weeks for one or 2 of 3 months = Moderate concern <18 week in no of the last 3 months = High concern
Staff who are in training have a poor experience of working for that service	Trainee doctor satisfaction	General Council Medical training survey 2017	<20% Trainee dissatisfaction = Low concern 20-40% Trainee dissatisfaction = Moderate concern 40%+ Trainee dissatisfaction = High concern
Doctors, nurses and other staff do not see enough patients to keep their skills up and provide safe care for patients	Minimum activity levels for service	Royal College Guidelines	(NB – only available for small number of services)

#### 4.2.2 Lens 2. Trust self-assessment

Trusts were asked to undertake a self-assessment to indicate the degree of concern associated with providing each service, ranging from 'no concern' to 'moderate concern' to 'high concern' (and a 'not provided' selection).

The template also asked Trusts to provide a rationale for their rating, particularly for those services rated of high and moderate concern; articulate the impact of the respective services on patients; and whether their choice of services might change in the future (for example, in the context of changing demographics or workforce supply). The responses of the self-assessment templates were captured and converted into a numerical score, which enabled the ranking of services across all trusts from highest concern to lowest concern.

This self-assessment was supplemented by interviews with each of the seven Trusts, between the Trust senior leadership (typically the Medical Director, Strategy Director and / or Chief Operating Officer) and members of the review's Secretariat.

#### 4.2.3 Lens 3. Clinical services interdependencies

The analysis of interdependencies between clinical services was used to identify how far a particular service is important in providing other services. The aim was to ensure a particular focus on core acute hospital services, in line with the emphasis of the Review. This was done by using

the South East Coast Clinical Senate co-dependencies matrix of acute hospital services<sup>14</sup>. The original matrix helps to understand what supporting services need to be in place to enable the safe and effective operation of major acute hospital services.

The matrix defines eleven major acute hospital services (for example, A&E unselected take; Major Trauma Centre; etc) and describes what clinical services that are required (co-dependent) to support delivery of these configurations. It also defines whether services should be co-located on the same site; in reach; or accessed through other arrangements.

Following a review of the matrix by the Working Together Vanguard's Medical Director, it was proposed that further levels of detail could be added to the matrix, for example, the interdependencies required to run a consultant led maternity service or a midwifery led service, the interdependencies required for different levels of critical care cover, interdependencies associated with specific types of acute medical rota, etc. These changes were made as suggested.

The methodology focuses on each individual Trust and identifies which of the eleven major acute hospital services it delivers. Based on this delivery model, the methodology highlights only those services that are required to be provided on site and are deemed to be of concern<sup>15</sup>. For example, services where a large number of core acute services depended on them being on-site (for example critical care) were scored higher than services where no or a small number of core acute services depended on them being on-site (for example, dermatology).

This 'dependency score' was then supplemented with the level of concern for that service. The level of concern for each service was drawn from the Trust self-assessment. Where Trusts deliver services from more than one site, Trusts were invited to share site-level data; and in absence of this data, it is noted that the analysis focusses on the site with the biggest concerns.

It is also important to note that Mid Yorkshire Hospitals has recently undergone a significant reconfiguration of their A&E department, and have flexed some of the clinical co-dependencies in the matrix. Sheffield Children's Hospital also provided a separate matrix for children's services which recognised the difference between adult and paediatric requirements.

### 4.3 Identify the top ranked unsustainable services

The Review team considered the results of each of the three lenses in turn and then combined them to create a single sustainability score for each service within South Yorkshire and Bassetlaw, Mid Yorkshire and North Derbyshire. Below the results for individual lenses are presented, followed by the aggregated score.

#### The independent analysis assessment highlighted the top five ranked services as follows:

- **Histopathology** was the highest rated service (scoring 14.7). This was due to low service efficiency and a number of District General Hospitals with the service in each only comprising a small number of FTEs, making the service fragile. Trust interviews highlighted there was a small pool of potential consultant candidates, leading to challenges in hiring permanent staff and the need to consider applicants from outside the UK.
- **Ophthalmology** was the second highest rated service (scoring 13.5). Six out of seven trusts had not met the waiting time targets for the last three months, and there was low service efficiency in five out of the seven trusts. Consultant level recruitment is a challenge, and demand is increasing.
- **Cardiology** was the equal second highest scoring service (scoring 13.5,) due to low trainee satisfaction, waiting time challenges and challenges in recruiting staff.

<sup>14</sup> The Clinical Co-Dependencies of Acute Hospital Services: A Clinical Senate Review. South East Coast Clinical Senate, 2014. Available at [http://www.secsenate.nhs.uk/files/5514/2255/2355/The\\_Clinical\\_Co-dependencies\\_of\\_Acute\\_Hospital\\_Services\\_SEC\\_Clinical\\_Senate\\_Dec\\_2014.pdf?PDFPATHWAY=PDF](http://www.secsenate.nhs.uk/files/5514/2255/2355/The_Clinical_Co-dependencies_of_Acute_Hospital_Services_SEC_Clinical_Senate_Dec_2014.pdf?PDFPATHWAY=PDF)

<sup>15</sup> The trust's self-assessment is used to gauge the level of concern at this stage.

- **Dermatology**, was the fourth top service in the assessment (scoring 13.3). This was driven by long waiting times, small individual services and challenges in recruiting permanent staff. Trust interviews highlighted national workforce shortages, overwhelming demand and the need for demand management and blended staffing models in place to reduce pressure.
- **Critical Care** was the fifth highest ranked service (scoring 13.0). Trainee dissatisfaction and challenges around recruiting a permanent workforce were the main drivers behind this.

**The self-assessment completed by Trusts highlighted the top five services as follows:**

- **Dermatology** was the service which was the highest concern across the Trusts (totalling 18.0), with five of the seven trusts categorising this as “high concern” and as a system-wide challenge; with demand vastly outstripping (workforce) supply.
- **Emergency Medicine** was the second jointly highly rated service (totalling 16.0), with Trusts flagging difficulties staffing mid-grade rotas, with consultants having to act down or use locums, incurring a large agency spend and inconsistencies with the quality of care.
- **Stroke (HASU)** was a “high concern” for four Trusts (totalling 16.0). Trusts commented how workforce challenges are amplified by uncertainty about future service and whole-pathway concern.
- **Ophthalmology**, was the fourth highly ranked service. However – although three trusts scored it as “high concern”, three trusts similarly scored it as “low concern”.
- **Gastroenterology** was the fifth highly ranked service (scoring 13.0). In particular, Trusts highlighted struggles with Gastrointestinal (GI) bleed rotas and a reliance on locum staff.

**The interdependency assessment highlighted the top five services as follows:**

- Emergency Medicine
- Gastroenterology
- ENT (Ear, Nose, Throat)
- Urology
- Radiology

**The aggregated sustainability score was constructed by taking the average score of each assessment lens. The top twenty services were:**

- Emergency Medicine
- Gastroenterology
- Urology
- Stroke - HASU
- Critical Care
- Radiology
- Cardiology
- ENT
- Acute Medicine
- Paediatric Medicine
- Dermatology
- Endoscopy
- Orthopaedics
- Neonatology
- Ophthalmology
- Vascular services
- Respiratory Medicine
- Path- Histopathology
- Geriatric Medicine

- Upper GI surgery

Full results are explored within a separate Technical Annex.

#### 4.4 Developing the “long shortlist”

The top 20 services identified through the combined assessment were discussed at length by the Review Steering Group on Thursday 17 August 2017.

The Group considered some caveats in the analysis, including the completeness of data (for example, only one Trust had sent a completed workforce return for paediatrics) and in relation to the weighting of criteria. There was also a discussion about the validity of the co-dependencies matrix and how it should be applied to Trusts with multiple sites. The Group highlighted that paediatric services might need to be assessed separately due to their specialist nature and distinction to general adult services.

Following acceptance of the analysis, the remainder of the meeting was focused on considering the implications of the analysis and arriving at a position where the Steering Group could inform the review team, which services it would expect to see on the shortlist.

The Group agreed that the services that ranked highly on the list were services that they have sustainability concerns about. In some cases (for example, acute paediatrics) the service did not score highly in the independent assessment due to missing workforce data, but strong concerns were raised in interviews. The Group were content the methodology provided a robust method of prioritising services for inclusion in the Review.

Following rigorous debate at the Review Steering Group, utilising the knowledge of the member Medical Directors of the partner Trusts, it was agreed the below services would be contained within a “long shortlist” of services. These services contained ten of the services identified by the combined analysis<sup>16</sup>:

- Emergency Medicine and Medical Assessment Unit (including elements of acute medicine)<sup>17</sup>
- Acute paediatrics
- Gastroenterology and endoscopy
- Stroke
- Cardiology
- Urology
- Dermatology
- Oncology

The Steering Group decided to exclude:

- Critical Care
- Radiology
- ENT
- Orthopaedics
- Neonatology
- Ophthalmology

Other services on the list of the top 20 services were not considered to be priorities and were not discussed in detail.

<sup>16</sup> Note: It was decided to combine Gastroenterology and Endoscopy as a service at this stage

<sup>17</sup> Note: It was agreed that “Acute Medicine” should be included in this as referring to the front door A&E and MAU

The rationale for including and excluding services varied, and is summarised in the technical annexes. In general, those services which were included were those where the problems were severe, and where it was felt that a whole-system solution was needed to address the underlying problem rather than the problem being addressed in isolation.

Table 3 below highlights the scores of each of the services in the long-list, through each of the three lenses.

One service which did not appear on the list of the top 20, but which was discussed at length in the Steering Group, was maternity. Maternity scored as the 14<sup>th</sup> most problematic service in trusts' self-assessments, and emerged as a high priority in the interviews with trusts. However, it performed better on the metrics included in the independent analysis and interdependencies, so did not show up as one of the 20 most unsustainable services overall. After considerable discussion the group did not explicitly add maternity services to the longlist, since it was felt that maternity would in any case be addressed via the focus on acute paediatrics.

A record of the Steering Group discussion is held in the meeting minutes.

Table 3: Table of longlisted services and scores for each lens<sup>18</sup>

Services	Trust Self-Assessment		Independent Analysis		Co-dependency	
	Score	Ranking	Score	Ranking	Score	Ranking
Emergency Medicine	16.0	=2	13.0	6	16.0	1
Maternity (Obstetrics)	10.0	=14	8.0	31	-	-
Acute paediatrics (Paediatric Medicine)	11.0	=11	9.5	=21	11.0	=9
Gastroenterology <sup>19</sup>	13.0	5	10.2	19	15.0	2
Stroke - HASU	16.0	=2	10.3	18	11.0	=9
Cardiology	11.0	=11	13.5	3	11.0	=9
Urology	12.0	=6	12.6	7	13.0	=3
Dermatology	18.0	1	13.3	4	-	-
Oncology	10.0	=14	5.5	45	-	-

#### 4.5 Test out the robustness of data with the trusts

Trusts were subsequently asked to verify their data and confirm the analysis so far. At this point, the Review team added General Surgery to the long shortlist for further testing. This was because data is not widely collected at the level of 'General Surgery' and so it was felt that the team did not have enough data to rule it in or out. Subsequent conversations (stage 3.7) found that it was not a concern so it was ruled out again.

<sup>18</sup> Note: Excludes General Surgery

<sup>19</sup> Excludes Endoscopy

#### 4.6 Test out the impact of patient feedback

The team tested what the impact would be if extra weight were given to the three criteria that had been identified as the most important in patient and public feedback (including an online survey). This resulted in some marginal movements up and down but nothing decisive enough to identify a clear shortlist.

Table 4: Difference in service rank pre-weighting and post-weighting

Service	Rank of services pre-weighting	Rank of services post-weighting	Difference in ranking
Emergency Medicine	1	1	-
Gastroenterology	2	2	-
Urology	=3	3	-
Stroke - HASU	=3	4	-1
Critical Care	5	5	-
Radiology	6	8	-2
Cardiology	=7	7	-
ENT	=7	6	1
Acute Medicine	9	9	-
Paediatric Medicine	10	11	-1
Dermatology	11	10	1
Endoscopy	12	13	-1
Orthopaedics	13	12	1
Neonatology	=14	15	-1
Ophthalmology	=14	14	-
Vascular services	16	16	-
Respiratory Medicine	=17	17	-
Path- Histopathology	=17	19	-2
Geriatric Medicine	=19	18	1
Upper GI surgery	=19	20	-1

Table 5: Combined hospital service sustainability score (taking into account patient survey results)

Rank	Service	Independent analysis	Trust assessment	Self-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

#### 4.7 'Place agnostic' and 'organisation agnostic' conversations with senior stakeholders

There were two key elements to reducing the "long shortlist" to the final proposed shortlist. These were:

- Targeted conversations were held with organisation agnostic stakeholders, including regional representatives from NHS England, Health Education England and the Medical Director of the Working Together Vanguard. The key steers from HEE and NHSE were that the Review should focus on those areas where there system had previously been unable to reach agreement, and where addressing issues with the service would benefit the system most widely.
- Commissioners also fed in their views, in a single consolidated response that was place-agnostic. Commissioners felt strongly that maternity services should be included owing to workforce concerns, and concerns raised by the CQC at three sites. The Review team therefore added maternity services to the long shortlist.

Key messages from the discussions are in a separate Technical Annex.

#### 4.8 Agreement on final shortlist

The final shortlist of five services was reached by the Review team assessing the long shortlist of services against the qualitative findings from the conversations with the organisationally-agnostic stakeholders. Full details about the rationale for including the final five can be found in chapter 5 below. A final shortlist was developed and presented to the Review Steering Group, the JCCCG and the Collaborative Partnership Board, for agreement. It was agreed by the JCCCG on the 4th September 2017, the Partnership Board on 8th September, and at the request of the Partnership Board was also taken to the Steering Group on the 13th September where it was confirmed.

The services to be included on the shortlist going forward are:

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

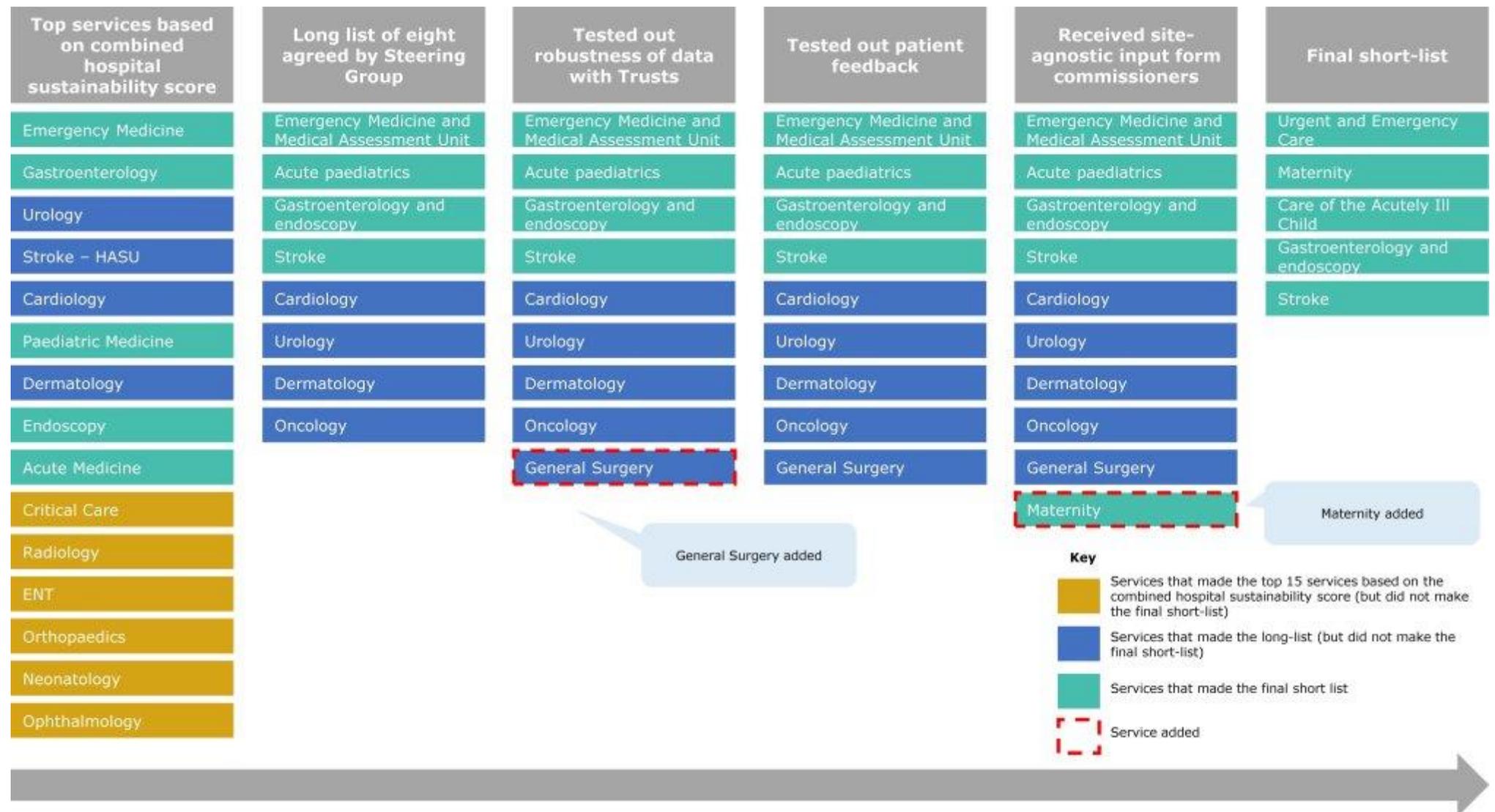
A diagrammatic representation of the shortlisting process is provided below, Figure 2.

#### 4.9 Summary process of moving from a long list, to a short-list

The diagram overleaf provides a summary of the results of the key stages to move from a long-list of services (identified through the analysis through the three lenses) to the final short-list of five services. It illustrates that a consistent group of services have been identified throughout the process with maternity added after subsequent conversations.

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Figure 2: Diagram to illustrate the process for moving from a longlist to a shortlist





# 5 Definition of shortlisted services and recommendations

This chapter provides an overview of the proposed shortlist and rationale for the selection of the final short-list of five services to progress to the next stage of the Review.

## 5.1 Services included on the shortlist and rationale

The services to be included on the shortlist going forward are:

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

Rationale for each service is provided below:

### 5.1.1 Urgency and Emergency Care

The working definition of this includes the Accident and Emergency department, and also the Medical Assessment Unit (or equivalent, i.e. the first admitted area for medical patients after A&E) of which both are staffed by clinicians focused on the assessment, diagnosis and treatment of adult patients with urgent medical needs. It excludes the Surgical Assessment Unit, emergency General Surgery, and primary and community-based models of care, but notes the strong inter-dependencies with these services.

Emergency Medicine has the highest Sustainability Score by a large margin due to sustainability concerns raised by three Trusts (Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust, Mid Yorkshire Hospitals NHS Trust and Rotherham NHS Foundation Trust). There are concerns in delivering the national targets in a number of sites. This was backed up with evidence of high agency spend, difficulties recruiting permanent staff and poor GMC trainee satisfaction scores. It is also a service on which many other services in the hospital rely.

Urgent and Emergency Care is a priority for commissioners, driven by the workforce shortages (particularly at middle grade and junior grades), quality issues, and low activity levels at some sites (particularly overnight). The CQC also raised some very significant concerns in relation to Urgent and Emergency Care, Eight separate sites in SMYBND were identified as 'requires improvement', meaning that five out of seven of the acute trusts had significant concerns with UEC.

Targeted conversations with place agnostic stakeholders highlighted that whilst the service was being explored through the ACS's Urgent and Emergency Care (UEC) workstream, it is so core and so high profile that it would benefit from additional independent review and support.

### 5.1.2 Maternity

The scope of maternity includes antenatal and perinatal services (including in relevant community settings), Early Pregnancy Assessment Clinics, obstetric, and midwifery led units. Neonatology is excluded but the strong inter-dependencies with maternity will be considered.

Maternity is a priority for commissioners. There are a number of workforce shortages across the footprint and some requirements from the national strategy have not been met.

The CQC rated maternity at three of the acute sites, across two trusts, as 'requires improvement'.

The Review team recognised that maternity services are an important part of local Place plans, and the importance of maternity for patients is significant, alongside others such as mental health or services for the frail elderly. It was also recognised that it was difficult to consider paediatrics without maternity as the interdependencies are so great. For all of these reasons maternity was considered an important service to include in the final shortlist.

### **5.1.3 Care of the Acutely Ill Child**

The scope of this service includes paediatric A&E; Paediatric Assessment Units, acute inpatient paediatric beds, and the local 'Embrace' service. Community paediatrics (including community nursing and antibiotic teams), the surgical pathways and neonatology are excluded but the strong interdependencies will be considered. A child has been defined as being up to 17 years and 364 days old.

Acute paediatrics was cited frequently in the Trust interviews and was felt to be the biggest workforce risk across the Review Footprint by some. The service is a priority for commissioners, driven by workforce shortages (particularly at consultant and middle grade), which are recognised nationally and by the local Health Education England leads as well as the by the individual Trusts, and low activity levels at some sites (particularly overnight),

The CQC has raised concerns about services for children and young people at two trusts.

There was agreement that the review would support the recent establishment of the Managed Clinical Network in acute paediatrics and that new models of community based provision should be explored. There was a clear agreement that this service was a high priority for shortlisting.

Additionally, it was recognised that it would be difficult to consider paediatrics without maternity (and vice versa), as the interdependencies (including neonatal care) are so great.

### **5.1.4 Gastroenterology and endoscopy**

The scope of this service includes urgent and emergency gastroenterology (GI bleed services and the structure of acute rotas) as well as elective endoscopy services.

The service was raised as a sustainability concern by three Trusts (Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust, Sheffield Children's NHS Foundation Trust, Rotherham NHS Foundation Trust) primarily due to difficulties with staffing the service, with some GI bleed services run entirely by locum staff. It is also a service on which many other hospital services rely, particularly because it has close links with the emergency / acute medical rota, and previous attempts to look at GI bleeds services in isolation (via the Working Together Vanguard) have floundered because they impinge upon acute rotas. The inclusion of emergency medicine as part of this review provides an opportunity to revisit this work and incorporate the clinical co-dependencies.

Endoscopy is also a priority for commissioners and trusts, driven by workforce shortages, a growing workload and consequent capacity issues. Commissioners also recognised the importance of the service in respect of the link to early access in cancer pathways and an extension of screening programmes in local out of hospital pathways.

### **5.1.5 Stroke**

The scope of this service includes Acute Stroke Units, Early Supported Discharge, inpatient rehabilitation, and Transient Ischemic Attacks (TIA) services. Hyper acute stroke services are already subject to review and are excluded from this review, however, the interdependencies will be considered.

For stroke services, there is difficulty in recruiting a consultant workforce and feedback from interviewees corroborates the challenges raised in the sustainability assessment, particularly in relation to the sustainability of acute stroke services and rehabilitation at each local hospital.

These sustainability issues are being further compounded by the recent consultation of hyper acute stroke services and the temporary uncertainty of the future of these services.

It was recognised that the existing work would be materially helped by taking a system wide view, and by resolving issues with transition and rehabilitation in each Place. At present, work has only considered HASU, and this is now impeded by concerns around other parts of the pathway. There are issues around stranded costs in some of the Acute Stroke Units, and further consideration of community service provision is required.

## **5.2 Services on the long shortlist excluded from the final shortlist and rationale**

The Review is time and resource bound, and in that context it is necessary to focus on a short list of services in the first tranche of the programme. The first group are felt to be the services which will bring the biggest general benefit in being reviewed, those with the greatest interdependencies. However there are some significant concerns with services that are not on the final shortlist, and the Accountable Care System may wish to take forward a second tranche to look at some of these other services once the first group have been considered in the current review.

### **5.2.1 Cardiology**

Cardiology was considered primarily due to concerns about service inequalities in acute cardiology treatment. Interviewees suggested that as PCIs and STEMIs have been centralised at Sheffield Teaching Hospitals, that has potentially destabilised the remaining cardiology at local hospitals. Current work is underway in relation to a second device centre and the potential for a more networked approach to delivery.

It is recognised that as no-one is currently reviewing cardiology in its entirety, there is some merit in including it as part of the review, and it would be a good service to demonstrate a hub and spoke model, but it was held to be a higher priority to “land” those areas where work is almost complete (for example, Stroke), rather than to open up another service.

### **5.2.2 Urology**

Urology was highlighted by two Trusts (Chesterfield Royal Hospital NHS Foundation Trust and Sheffield Children’s NHS Foundation Trust) mainly due to workforce shortages, whilst the high supplementary evidence score reflects current waiting time and activity pressures on this service. There were a number of concerns about sustainability as the population ages.

Interviews recognised the sustainability challenges surfaced by the assessment, driven predominantly by workforce shortages across the region, and its importance in the cancer pathway.

Work is already underway as part of the ACS to identify system-wide solutions to issues whereas the issues in urology could be tackled in relative isolation; and hence it was not felt the review should focus its efforts on this service and a number of the operational issues could be addressed separately.

### **5.2.3 Dermatology**

Dermatology was rated as a service of high concern by five of the seven Trusts and was highlighted as a common challenge with difficulties with staff recruitment and pressing waiting list / patient demand pressures. However, it achieved a low score in the clinical interdependencies assessment as few other acute hospital services rely on it.

Independent interviewees recognised the sustainability challenges surfaced as part of the assessment, particularly around significant demand increases coupled with workforce shortages and felt the solutions

to address the challenges are demand management from the commissioners and alternative workforce models. As with urology, these might be able to be undertaken in isolation of other services.

Although it was recognised that Dermatology is an important area, interviewees did not feel that the review should focus its efforts here, and they felt stakeholders had it within their gift to make changes to the service without the support of the review.

#### **5.2.4 Oncology**

Oncology did not score highly in the analysis through the three lenses, however the Review Group agreed that solid tumour Oncology warranted further discussion and should be considered, and noting that Sheffield Teaching Hospitals NHS Foundation Trust felt it had a particular role to resolve oncology issues on behalf of the system.

Independent interviewees recognised the sustainability issues presented as part of the assessment (particularly in relation to workforce shortages and the trends towards sub-specialisation), and the impact on access and patient outcomes.

Interviewees recognised the challenges with the existing hub and spoke model and the potential for the review to address operational and governance challenges of the model. The issue is a national priority and has inequalities implications. However the conclusion was that issues could be addressed separately outside of the Review.

#### **5.2.5 General surgery**

General Surgery is a key service to support A&E and concerns were raised by some clinicians. However independent interviewees did not have a strong viewpoint on General Surgery and recognised that there has been no 'noise' in the system about workforce shortages or trainee satisfaction.

With the exception of a single organisation having issues with the service, it was not felt to be a system-wide problem that should be a focus of the review. However, it was recognised a review of Emergency Medicine should consider the inter-dependencies on acute General Surgery pathways.

### **5.3 Unsustainable services which were not shortlisted**

The services identified above are those which have been identified as being unsustainable, and as being integral to the sustainability of the hospital as a whole, with many other services dependent on them.

The review will look at these 5 core services over the next 10 months. However, there are significant clinical issues affecting many of the services which were not shortlisted, and the system may well wish to take forward work in a separate context, or in a second later tranche of the Review, to look at them more closely.

### **5.4 Elective services**

For the majority of services which made the shortlist for the review the requirement for senior clinical presence 24/7, means the shortlisted services are in some ways the most integral to the delivery of hospital services.

However, the review will also need to look at how the delivery of elective care might facilitate and support sustainability of hospital services going forward. The Terms of Reference require the Review to consider the nature of the District General Hospital, including the role that the hospital plays and which services are provided where. The Review will look at a high level at wider services, such as elective services, to identify whether changes to service configuration might support the hospitals more widely in order to maximise benefits for patients.

## 5.5 Services not on the acute site

The review is looking primarily at the delivery of services on acute sites. However part of making services sustainable will be to move care out of acute hospitals and closer to patients' homes, for example in community providers or primary care, wherever possible. Going forward, the workstreams on the 5 core services will consider which services genuinely need to be provided on the site of an acute hospital, and which services could be shifted into different settings.

## 5.6 Recommendations

Concluding Stage 1A, the Independent Review recommends that:

1. The Hospital Services Review should progress the following services for further investigation:
  - Emergency Medicine and Medical Assessment Unit
  - Maternity
  - Acute paediatrics
  - Gastroenterology and endoscopy
  - Stroke
2. The Accountable Care System may wish to take forward an in-depth sustainability review of some of those services which could not be included on the shortlist, as part of a second tranche at a later date:
  - Cardiology
  - Urology
  - Dermatology
  - Oncology
  - General Surgery
3. The Hospital Service Review will consider the role of a District General Hospital and understands demand and establishes a profile of demand in each Place. This will be covered in further detail in the review's Stage 1B report.

## 5.7 Next steps

The next Stage 1B of the review will last between September and November during which time the Review will explore in-depth the specific challenges that each of the selected services face. It will also consider what alternative delivery models could make these services more sustainable. To complement the service-specific improvement proposals, the Review will consider the wider roles that District General Hospitals can play in the future in the context of the overarching architecture of our healthcare system.

This specific deliverables will be developed in close cooperation with clinicians, system leaders and patients and the public. The Review will also build on existing work across the region and draw on local, national and international best-practice.

The Review's conclusions so far have been made possible by the strong engagement from individuals and organisations across the region. As has been the case for Stage 1A of this Review, the future stages will continue to seek and rely on the input of a broad group of stakeholders. The Review therefore encourages all stakeholders to continue to engage and contribute to shaping the future of SMYBND health services.

# Appendix 1: Organisations in the Review Footprint

Some of the below organisations sit within the South Yorkshire and Bassetlaw STP, some hospitals have patient flows into the South Yorkshire and Bassetlaw area, and therefore the CCGs who commission from those hospitals need to be included.

The Review Team has a variety of structures and are currently working through how we ensure that our governance captures all the CCGs and Local Authorities who may be impacted by the recommendation of the review.

## Organisations within the ACS and / or the Review

Table 6: Organisations within the ACS and / or the Review

	Organisation	Type	Review Steering Group	Collaborative Partnership Board	Oversight and Assurance Group	Joint Committee of Clinical Commissioning Groups (JCCCG)
Within the review	Yorkshire Ambulance Service NHS Trust	<i>Ambulance Service</i>	X	X	X	
	NHS Barnsley Clinical Commissioning Group	<i>Commissioner</i>	X	X	X	X
	NHS Bassetlaw Clinical Commissioning Group	<i>Commissioner</i>	X	X	X	X
	NHS Doncaster Clinical Commissioning Group	<i>Commissioner</i>	X	X	X	X
	NHS England	<i>Commissioner</i>	X	X		X
	NHS Hardwick Clinical Commissioning Group	<i>Commissioner</i>	X			X
	NHS North Derbyshire Clinical Commissioning Group	<i>Commissioner</i>	X			X
	NHS Rotherham Clinical	<i>Commissioner</i>	X	X	X	X

	Commissioning group					
	NHS Sheffield Clinical Commissioning Group	<i>Commissioner</i>	x	x	x	x
	NHS Wakefield Clinical Commissioning Group	<i>Commissioner</i>	x			x
	Health Education England	<i>Other</i>	x			
	Barnsley Hospital NHS Foundation Trust	<i>Provider - Acute</i>	x	x	x	
	Chesterfield Royal Hospital NHS Foundation Trust	<i>Provider - Acute</i>	x	x	x	
	Doncaster and Bassetlaw Hospitals NHS foundation Trust	<i>Provider - Acute</i>	x	x	x	
	Sheffield Children's Hospital NHS Foundation Trust	<i>Provider - Acute</i>	x	x	x	
	Sheffield Teaching Hospital NHS Foundation Trust	<i>Provider - Acute</i>	x	x	x	
	The Mid Yorkshire Hospitals NHS Trust	<i>Provider - Acute</i>	x			
	The Rotherham NHS Foundation Trust	<i>Provider - Acute</i>	x	x	x	
Within the Accountable Care System but outwith the Review Steering Group	East Midlands Ambulance Service NHS Trust	<i>Ambulance Service</i>		x	x	
	Barnsley Metropolitan Borough Council	<i>Local Authority</i>		x	HWB	
	Bassetlaw District Council	<i>Local Authority</i>		x	x	
	Doncaster Metropolitan Borough Council	<i>Local Authority</i>		x	HWB	
	Nottinghamshire County Council	<i>Local Authority</i>		x	HWB	
	Rotherham Metropolitan Borough Council	<i>Local Authority</i>		x	HWB	
	Sheffield City Council	<i>Local Authority</i>		x	HWB	
	Nottinghamshire Healthcare NHS Foundation Trust	<i>Provider - Other</i>	x	x	x	
	Rotherham, Doncaster and South Humber NHS Foundation Trust	<i>Provider - Other</i>		x	x	
	Sheffield Health and Social Care NHS Foundation Trust	<i>Provider - Other</i>		x	x	
	South West Yorkshire Partnership NHS Foundation Trust	<i>Provider - Other</i>		x	x	

### Organisations outside ACS and / or Review who May be Affected

Table 7: Organisations outside ACS and / or Review who May be Affected

Organisation	Type	Link
NHS Mansfield and Ashfield CCG	<i>Commissioner</i>	Possible patient flow issues
NHS North Kirklees CCG	<i>Commissioner</i>	Possible patient flow issues
NHS North Lincolnshire CCG	<i>Commissioner</i>	Possible patient flow issues

Kirklees Council	<i>Local Authority</i>	Local hospital is review member
Wakefield Council	<i>Local Authority</i>	Local hospital is review member
Northern Lincolnshire and Goole NHS Foundation Trust	<i>Provider - Acute</i>	Possible patient flow issues
Sherwood Forest Hospitals NHS Foundation Trust	<i>Provider - Acute</i>	Possible patient flow issues

The Review team will consider these issues going forward and engage with these organisations as it becomes relevant.

# Appendix 2. Review Steering Group Representatives

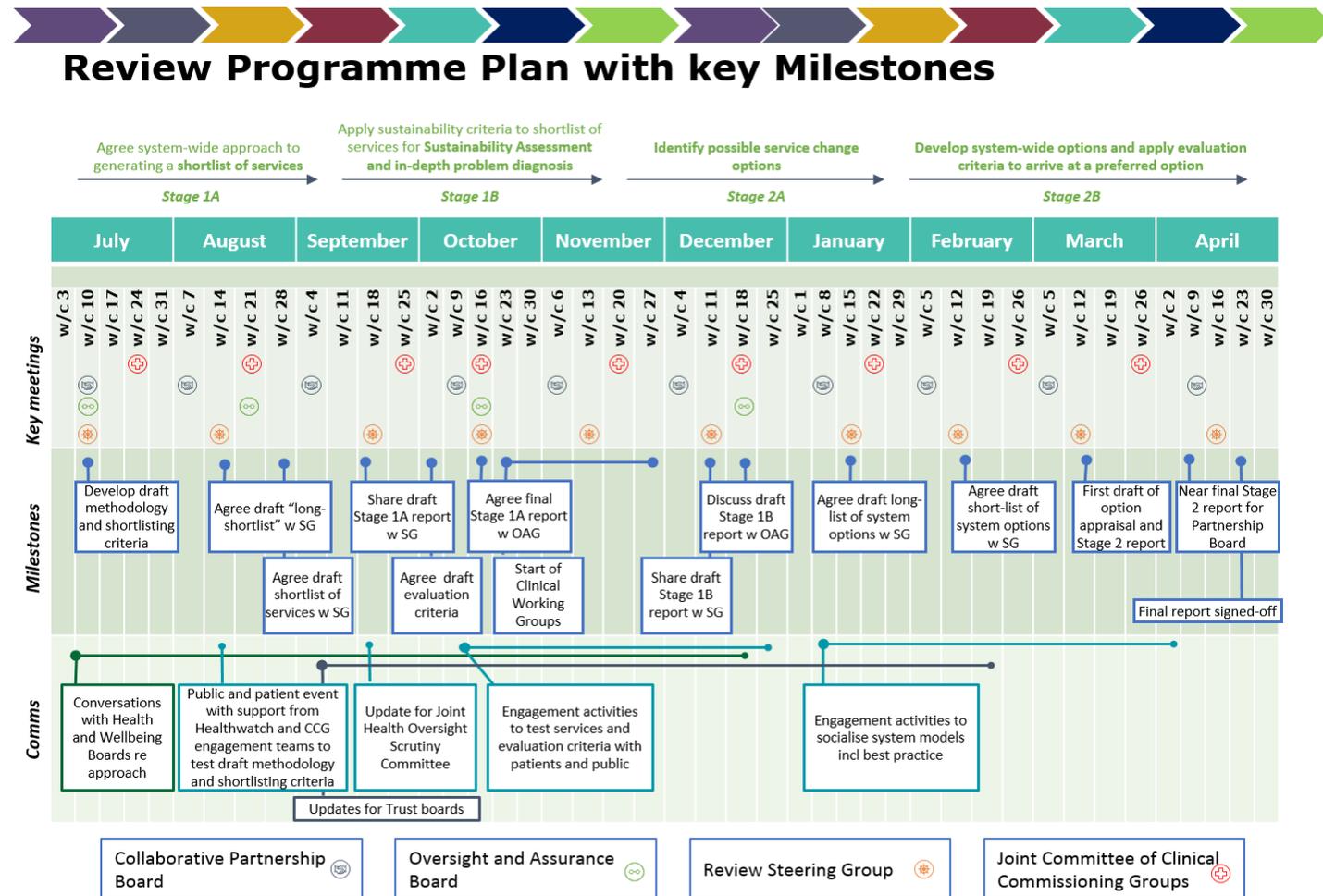
Table 8: Review Steering Group Representatives

Name	Organisation
Lesley Smith, Chief Officer	Barnsley CCG
Lisa Bromley, Executive Lead, Service Development	Bassetlaw CCG
Eric Kelly, Elected GP	Bassetlaw CCG
Simon Enright, Interim Medical Director	Barnsley Hospital NHS Foundation Trust
Karen Kelly, Director of Operations	Barnsley Hospital NHS Foundation Trust
Bob Kirton, Director of Strategy and Business Development	Barnsley Hospital NHS Foundation Trust
Tony Campbell, Chief Operating Officer	Chesterfield Royal Hospital NHS Foundation Trust
Gail Collins, Medical Director	Chesterfield Royal Hospital NHS Foundation Trust
Emma Challans, Deputy Chief Operating Officer	Doncaster and Bassetlaw Hospitals NHS Foundation Trust
David Purdue, Acting Chief Operating Officer	Doncaster and Bassetlaw Hospitals NHS Foundation Trust
Marie Purdue, Acting Director of Strategy & Improvement	Doncaster and Bassetlaw Hospitals NHS Foundation Trust
Sewa Singh, Medical Director	Doncaster and Bassetlaw Hospitals NHS Foundation Trust
Gareth Harry, Chief Commissioning Officer	Hardwick CCG
Peter Taylor, Deputy Postgraduate Dean	Health Education England (Yorkshire and Humber)
Matt England, Associate Director Planning and Partnerships	The Mid Yorkshire Hospitals NHS Trust
Karen Stone, Medical Director	The Mid Yorkshire Hospitals NHS Trust

David Black, Medical Director, and Deputy Clinical Director Specialised Commissioning	NHS England
Richard Cullen, Chair	Rotherham CCG
Chris Edwards, Chief Officer	Rotherham CCG
Ruth Brown, Director of Strategy and Operations	Sheffield Children's NHS Foundation Trust
Derek Burke, Medical Director	Sheffield Children's NHS Foundation Trust
Prasad Godbole, Clinical Director, Division of Surgery and Critical Care	Sheffield Children's NHS Foundation Trust
Helen Kay, Associate Director - Strategy and Transformation	Sheffield Children's NHS Foundation Trust
Brian Hughes, Director of Commissioning and Performance	Sheffield CCG
Zak McMurray, Medical Director	Sheffield CCG
Tim Moorhead, Chair	Sheffield CCG
Maddy Ruff, Accountable Officer	Sheffield CCG
Kirsten Major, Deputy Chief Executive	Sheffield Teaching Hospitals NHS Foundation Trust
David Throssell, Medical Director	Sheffield Teaching Hospitals NHS Foundation Trust
David Hughes, Deputy Medical Director	Sheffield Teaching Hospitals NHS Foundation Trust
Des Breen, Medical Director	Working Together Partnership Vanguard
Andrew Cash, Chief Executive Lead for Working Together	South Yorkshire and Bassetlaw Accountable Care System (Working Together)
Will Cleary-Gray, Director of Sustainability and Transformation	South Yorkshire and Bassetlaw Accountable Care System (Working Together)
Helen Stevens, Associate Director of Communications and Engagement	South Yorkshire and Bassetlaw Accountable Care System (Working Together)
Janette Watkins, Programme Director	South Yorkshire and Bassetlaw Accountable Care System (Working Together)
Chris Holt, Deputy Chief Executive and Director of Strategy and Transformation	The Rotherham NHS Foundation Trust
Conrad Wareham, Medical Director	The Rotherham NHS Foundation Trust

Pat Keane, Deputy Chief Officer, Chief Operating Officer	Wakefield CCG
Steven Dykes, Deputy Medical Director	Yorkshire Ambulance Service

# Appendix 3: Project Plan Figure 3: Project plan



NB: dates for Oversight and Assurance Board meetings in 2018 have not been agreed (as of 9 October 2017)