



Hospital Services Review

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

January 2018

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1 Where we are

This chapter provides a recap on the Hospital Services Review, specifically:

- An overview of the Review
- The objective of the Review
- The project timelines
- The progress made in Stage 1A

1.1 Introduction

The South Yorkshire and Bassetlaw (SYB) Accountable Care System, as well as the acute providers in Mid Yorkshire and North Derbyshire 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 around how acute services might be made more sustainable. The Review covers 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; the Rotherham NHS Foundation Trust; Sheffield Children's Hospital NHS Foundation Trust; and Sheffield Teaching Hospitals NHS Foundation Trust). The Review also includes two acute hospitals outside the ACS (Chesterfield Royal Hospital NHS Foundation Trust, and Mid Yorkshire Hospitals NHS Trust¹) since these hospitals have significant patient flows to and from SYB for some services. This report refers to South Yorkshire and Bassetlaw, Mid Yorks and North Derbyshire (SYBMYND) to capture all the trusts included within the scope of the Review, although some recommendations that the Review makes are likely to apply more to the five SYB trusts.

SYBMYND 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 to deliver care for the patients that they serve.

During the course of the Review, three reports will be published, of which this is the second. The intention of this second report is to ensure that stakeholders have access to the information and issues which have been discussed between clinicians and in the public engagement sessions, to ensure transparency and enable all stakeholders to engage with the ongoing debate.

The three reports of the Review will be:

¹Mid Yorkshire Hospitals are included because there are some patients who live in Wakefield who access South Yorkshire hospitals and vice versa. The hospital is within a different NHS region which is also looking at how it can improve services by working differently. Some of the services which the review will be looking at have already been consulted on in Mid Yorkshire and we will not be recommending changes to services which have already been the subject of consultation.

- Stage 1A Report: lays out which acute services the Hospital Services Review will focus on, and why. This was published in October 2017 and is available on the Review website (<https://www.healthandcaretogethersyb.co.uk/what-we-do/working-together-future-proof-services/looking-at-hospital-services>).
- Stage 1B Report: the current report focuses on the challenges identified in the core services by clinicians, patients and the public, and some of the key themes emerging around them. It explores a number of examples of good practice elsewhere and outlines the next steps of the Review. It does not include solutions since these will be explored in stage 2.
- Stage 2 Report: will put forward a number of recommendations about how acute hospital services might be put on a sustainable footing for the future in South Yorkshire and Bassetlaw.

Following the publication of the stage 2 report, there may need to be further work to develop and consult on options in more detail.

Alongside the analysis of options for the five individual acute services, we also need to look at what this means for the overall services that our hospitals provide and how we make hospitals sustainable more widely. As part of this, we will do some early thinking to look at elective services, identifying which of these need to be provided in patients' closest hospital, and looking at national and international learning around any services where we might improve the quality and patient outcomes by creating larger more specialised centres. This work will be discussed at the public engagement event in March.

The Review is independent and open: no conclusions have yet been reached about the possible ways forward for the South Yorkshire and Bassetlaw system.

1.2 Overview

The Review will be a ten month review looking at a range of acute hospital services in SYBMYND, which are currently facing some significant challenges.

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 urgent and emergency services at all of them. The Review will look at how services could be provided to ensure everyone in South Yorkshire and Bassetlaw has equitable access to high quality, safe hospital services. The ultimate aim of the Review is to ensure that all patients can access the services that they need, reducing inequalities in access and outcomes.

The 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.

1.3 Objectives of the Review

The objective of the Review is to put forward proposals around how acute hospital services in SYBMYND (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:

- Define and agree a set of criteria for what constitutes 'Sustainable Hospital Services' for each Place² and for SYBMYND (in the context of the South Yorkshire and Bassetlaw Accountable Care Systems (ACS));
- 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);
- Put forward a 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 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 acute hospitals into settings closer to home, including community and primary care. Whilst it is out of the scope of the Review to define how community and primary care services are delivered in each Place, the Review is built on the expectation that activity will move closer to home and it is intended to support this shift.

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 and emergency care in each of them.

1.4 The hospitals included in the Review

The Review covers 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; the Rotherham NHS Foundation Trust; Sheffield Children's NHS Foundation Trust; and Sheffield Teaching Hospitals NHS Foundation Trust). These are the 'core' hospitals for the Review and we anticipate that recommendations will be directly relevant to them.

The Review also includes two acute hospitals outside the ACS (Chesterfield Royal Hospital NHS Foundation Trust, and the Mid Yorkshire Hospitals NHS Trust). These are included in the Review footprint, even though they are not located in South Yorkshire and Bassetlaw, because of patient flows. Chesterfield sends significant numbers of patients to Sheffield for some services and is the nearest hospital for a small number of patients in South Yorkshire. Mid Yorkshire Hospitals are included because some patients who live in Wakefield access South Yorkshire hospitals and vice versa. These two hospitals have in recent years been part of the 'Working Together' footprint, in which the acute trusts in South and Mid Yorkshire, Bassetlaw and North Derbyshire have developed shared approaches to backoffice functions and efficiencies.

Both Chesterfield and Mid Yorks sit within the footprint of other Sustainability and Transformation Plans, and are affected by the strategic plans for the future of healthcare in their respective footprints. As such, we anticipate that the recommendations of the Review

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

team will be directly relevant to the five acute trusts in South Yorkshire and Bassetlaw, while Chesterfield and Mid Yorks may wish to consider which of the recommendations are most relevant to them. For example, if the Review were to make recommendations about standardising an area of clinical practice, Chesterfield and Mid Yorks would need to decide whether they wished to develop a shared approach with the SYB providers or to consider whether they wished to look at a joint approach with the other providers in their own STP footprint.

Mid Yorks have recently undertaken a number of changes to their services, including a reconfiguration of their Urgent and Emergency Care services. We do not anticipate that Mid Yorks would be included within any recommendations related to the configuration of services in which they have already consulted or made changes. For this reason Mid Yorks are not part of the workstrand on the future of Urgent and Emergency Care in SYB, and are not a member of the UEC Clinical Working Group. However some South Yorkshire and Bassetlaw residents receive services at Mid Yorks so the Review will consider at a high level what implications the recommendations of the review might have on the sustainability of Mid Yorks services in the future.

The recommendations of the Review may have implications for other providers not included within the footprint of South Yorkshire and Bassetlaw, such as North Lincolnshire and Goole NHS Foundation Trust. The modelling of options for the Review will consider these implications. The Review team will also work with colleagues in other providers and STPs who are taking forward reviews of services in neighbouring areas, to ensure that the impact of potential changes in these areas is taken into account as far as possible in the Review's recommendations.

1.5 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 due to be submitted to commissioners at the end of April 2018. It has been structured into two Stages:

- Stage 1 Assessment (June 2017 – January 2018).
 - Stage 1a: 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;
 - Stage 1b: identifying the problems with the shortlisted services in depth, and gathering ideas for solutions from clinicians and the public.
- Stage 2. Options and New Models (January 2018 – April 2018). This stage will focus on potential solutions to the issues identified and define the role of the District General Hospital in the context of these solutions.

1.6 Stage 1A

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. Accordingly, the first stage of the Review, from July 2017 to early September 2017, focused on identifying and agreeing which services to concentrate on.

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 three lenses (independent analysis, trust self-assessment and clinical services interdependencies).
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.
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.

The full process for shortlisting services is explained in greater detail in the Stage 1A report, which is available on the website of the Accountable Care System³.

It was agreed that the five services to be included on the shortlist were:

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

1.7 Section 1B

Following the Review's identification of the five core services, the Review team have taken forward work to identify the specific issues and challenges facing each of the services in detail. This stage has also begun to identify some key themes and ideas that will inform the development of options in the final stage of the Review.

To do this, the Review team has undertaken three main strands of work:

- **Working with Clinical Working Groups (CWGs)** of the clinicians across the seven hospital trusts, to understand the clinical issues and options around the five services, and to look at best practice in other places.
- **Engaging with the public and patients** to understand their main concerns around these five services, and to ask them for their ideas on good practice.
- **Developing evaluation criteria** based on the priorities of clinicians, patients and the public, and system leaders for solutions going forward. The evaluation criteria will be used to assess options going forward.

³ <https://www.healthandcaretogethersyb.co.uk/what-we-do/working-together-future-proof-services/looking-at-hospital-services>

As such, this report:

- Lays out the methodology used in each of the three workstrands.
- Describes the key challenges that have been identified by clinicians in relation to the five services, some case studies that have been discussed by clinicians in relation to the five services, and some key themes that have emerged in relation to these.
- Describes the main themes that have been received so far (December 2017) in feedback from patients and the public. We are continuing to receive feedback from patients and the public and this will continue to be fed into the development of proposals.
- Outlines the proposed approach to evaluation criteria for the Hospital Services Review. We have sought views from clinicians, system leaders, patients and the public, and people from seldom heard groups, to identify the priorities of each of these groups for the evaluation criteria. The final wording of the evaluation criteria, capturing the top priority issues from the stakeholders, will be confirmed shortly.

This report does not yet put forward any proposals around the possible solutions to the challenges. These proposals will be worked up, modelled and discussed with stakeholders during the next and final stage of the report.

2 Methodology

This chapter provides an overview of the methodology of stage 1B of the Review, in particular:

- An overview of the Clinical Working Groups, their objectives and attendees.
- An overview of the approach to public and patient engagement.
- An overview of the process to determine the evaluation criteria.

2.1 Methodology of the Clinical Working Groups

A series of three Clinical Working Groups (CWGs) were held for each of the five services between October 2017 and November 2017.

2.1.1 Overview

The purpose of the Clinical Working Groups was to bring together clinicians and other members of staff from across the seven trusts, in order to discuss the challenges facing each of the five services in scope; look at some good practice; and begin to generate ideas for how the problems might be solved.

The membership included clinicians, nurses, Allied Health Professionals, the Yorkshire Ambulance Service, and community and mental health providers. All the trusts were invited to join all of the groups, with the exception of Mid Yorkshire which was not invited to attend the Urgent and Emergency Care group because it had already completed its restructuring of UEC.

Each of the CWGs met three times, in order to discuss the problems facing each service; some practical solutions for those problems, with examples of best practice; and areas where it might be possible to go further. A write-up from each of the sessions was distributed after the meetings for attendees to discuss with their trust colleagues. The detail of the CWG meetings is laid out below.

2.1.2 CWG Objectives

The objectives for each CWG meeting were as follows:

2.1.2.1 CWG 1

- Within the group, identify and reach a consensus on what the most critical challenges are that face the current and future sustainability of the service.
- Develop hypotheses about what the underlying reasons (“root causes”) of these challenges are.
- Generate some ideas about where to look for guidance on how to address the identified challenges and root causes.

2.1.2.2 CWG 2

- Share feedback from organisations to understand how the key messages from CWG 1 have been received by staff in each trust.
- Reflect on key messages and challenges identified in CWG 1 and explore whether there are any further issues that need addressing.

- Explore potential solutions to address the issues identified.
- Understand how services are delivered elsewhere and explore the impact similar models could have on the challenges faced across the footprint.

2.1.2.3 CWG 3

- Share feedback from organisations to understand how the key messages from CWG 2 have been received by staff in each trust.
- Reflect on key messages and ideas identified in CWG 2 and further refine these.
- Understand how these ideas fit into the context of SYBMYND and its hospital sites, testing out whether they go far enough to solve the challenges discussed in CWG1, and whether any other options should be considered.
- Explore potential advantages and disadvantages of the ideas, in the context of the feedback received around the priorities for the Review's evaluation criteria.

This report describes the outputs of CWG 1, and the key level themes that emerged from CWG2 and 3. The ideas generated in CWG 2 and 3 are being developed and tested further, and will be laid out in the Stage 2 Report.

2.1.3 CWG Attendees

Membership for the CWGs aimed to strike a balance between including a range of expertise, and keeping the group small enough to be focused and to reduce the burden on staff in the trusts.

It was proposed that each CWG should consist of:

- Two representatives for each acute trust: each acute trust medical director was contacted for nominations. The nominees were a mix of clinicians, nurses, midwives, therapists and operational managers.
- One representative from the community sector and mental health respectively: the main community and mental health trusts in South Yorkshire and Bassetlaw were contacted asking them to nominate representatives.
- A primary care representative, who could also act as a link to the CCGs: Accountable Officers were asked to nominate appropriate representatives.
- A representative from the Yorkshire Ambulance Service, who as the main provider of ambulance services in South Yorkshire and Bassetlaw were asked to nominate attendees.
- The clinical lead and workstream lead for the service area within the Accountable Care System team.
- The Independent Review Director and Programme Director of the Hospital Services Review, and members of the Secretariat.

It was recognised that there was already existing work underway in a number of these areas under the Working Together Partnership Vanguard. In such cases, programme leads were engaged to identify any additional participants to partake in the CWGs. Over the course of the three meetings, some trusts identified further attendees who had particularly relevant expertise who also joined the discussions.

The meetings were Chaired by the Independent Review Director. If he was unavailable, they were chaired by the Programme Director, the Medical Director of the ACS, or by an independent clinician from the Secretariat.

The full list of attendees for each CWG is outlined in Appendix 1.

2.1.4 CWG Dates

The dates of the CWGs are outlined below:

	CWG 1	CWG 2	CWG 3
Urgent and Emergency Care	Monday 23 October, 17:30 – 20:00 Northern General Hospital	Monday 6 November, 17:30 – 20:00 Northern General Hospital	Monday 20 November, 17:30 – 20:00 Doncaster Royal Infirmary
Maternity	Tuesday 24 October, 17:30 – 20:00 Rotherham Hospital	Tuesday 7 November, 17:30 – 20:00 Rotherham Hospital	Tuesday 21 November, 17:30 – 20:00 Rotherham Hospital
Stroke	Thursday 26 October, 17:30 – 20:00 Doncaster Royal Infirmary	Thursday 9 November, 17:30 – 20:00 Rotherham Hospital	Thursday 23 November, 17:30 – 20:00 Rotherham Hospital
Care of the Acutely Ill Child	Monday 30 October, 17:30 – 20:00 Doncaster Royal Infirmary	Monday 13 November, 17:30 – 20:00 Doncaster Royal Infirmary	Monday 27 November, 17:30 – 20:00 Doncaster Royal Infirmary
Gastroenterology and Endoscopy	Tuesday 31 October, 17:30 – 20:00 Doncaster Royal Infirmary	Tuesday 14 November, 17:30 – 20:00 Rotherham Hospital	Tuesday 28 November, 17:30 – 20:00 Doncaster Royal Infirmary

2.2 Methodology of public engagement

2.2.1 Objectives of public engagement

Public engagement on the review is in three stages, in parallel with the three stages of the Review itself. The objectives of each stage were as follows:

Stage 1A: (June-August): **early engagement on the services in scope**. To begin to raise awareness of the Review, and to seek patient and public views on which

services in SYB were the most challenged and should form the focus of the Review.

Stage 1B: (September-January): **engagement on the challenges and possible solutions for the 5 core services.** To understand the public's perception of the challenges that the individual services are facing; to gather any examples of good practice that patients and the public can suggest for the core services; and to understand their priorities for the development and evaluation of options.

Stage 2: (January–April): **engagement on the emerging ideas for the Review.** To gain patient and public input into the emerging options.

2.2.2 Process of public engagement

The process at each stage is:

Stage 1A: disseminating information about the Review and inviting feedback on the criteria used to determine the services in scope, across the SYB footprint, via Healthwatches and other partner organisations. This stage included a public event open to anyone affected by the Review. This public event was held in August and the report of the event was published alongside the Section 1A report. It is available online at www.healthandcaredtogethersyb.co.uk/what-we-do/working-together-future-proof-services/looking-at-hospital-services.

Stage 1B: targeted engagement with seldom heard groups as well as with the wider public on the challenges and possible solutions. The key elements of this have been:

- **An online survey.** This invited the public to give their views on, and ideas for, the five core services. Until mid- November it also included a series of questions on people's priorities for the evaluation criteria (these priorities were highlighted to the Clinical Working Groups to inform the discussions during the last CWG.) A summary analysis of the online survey (to Nov 17) is attached at Appendix 2.
- **A telephone survey** of a random sample of the public who were selected to be as representative as possible of the demographic makeup of South Yorkshire and Bassetlaw. A summary analysis of this will be made available on the Review website shortly.
- **Sessions with seldom heard groups,** arranged with the help of partner organisations in the voluntary sector. This included face to face sessions with people from seldom heard groups such as young carers, asylum seekers and refugees, BME communities, the LGBT community, young people, and the elderly. A summary report of the outcomes of these sessions (to Nov 17) is at Appendix 3.
- **Public event open to anyone in South Yorkshire and Bassetlaw.** This event, attended by 68 people from across the footprint, took place in The Source, Sheffield on 6th December. A summary of the event is attached at Appendix 4.

- **A session with the Youth Forum** of Sheffield Children’s Hospital, to ensure that the voices of young patients are heard around services for children and young people.
- **Face to face drop-in sessions for the public in individual Places.** These were held in Barnsley on 14th November 2017; Rotherham on 12th December; Bassetlaw on 19th December, and Doncaster on 19th December. Summaries of these events will be added to the website shortly.
- **Displays in hospital reception areas.** One was held in Sheffield Children’s Hospital in December and more are planned from January 2018. Summaries of these will be added to the website shortly.

Stage 2: **engagement on the emerging ideas for the Review.** This is being designed and will provide an opportunity for patients and the public to discuss and input into the early thinking around developing the recommendations for the Review. The main event will be a region-wide public engagement session in March at which attendees will have an opportunity discuss the emerging options, consider the modelling that has been done so far, and test the options against the evaluation criteria.

2.3 Evaluation criteria

2.3.1 Purpose of the evaluation criteria

The Hospital Services Review is in the process of developing a large number of possible options for the future of the acute sector in South Yorkshire and Bassetlaw. In order to narrow down these options, and decide which ones we will include within the final report, we need to identify the most important issues that options must address, and identify how well a particular option performs against them.

In order to do this, the team has identified a number of evaluation criteria, which are effectively the essential requirements for any option, against which the option will be assessed. The team will consider how far any particular option meets the essential requirements or might realise potential benefits, in order to identify which options are recommended within the final Review.

2.3.2 How the evaluation criteria will be used

The Review will use these criteria in two ways, at two stages:

- **Gateway 1: Hurdle criteria.** This is an initial, high level analysis of whether any options fail to meet the two most essential criteria for any future system. These will be applied as the options are being developed in February. If any of the options which are being developed fail to meet one of the essential ‘hurdle criteria’ before modelling even begins, they will not be considered further.
- **Gateway 2: Full evaluation criteria.** This is the full list of five evaluation criteria which will be applied to the outcomes of the modelling of options.

The Hospital Services Review is developing recommendations for consideration by commissioners, rather than determining an agreed way forward for SYB. As such, the review against the full list of evaluation criteria will be used to identify and explore the

pros and cons of different options, rather than necessarily discarding them. For example, if an option performs well against one criterion in the longer list, but poorly against another, it might still be included within the Review for commissioners to take a view on the potential trade-offs involved.

2.3.3 Developing the evaluation criteria

The Review team has gone through a number of stages to develop the evaluation criteria. The team has sought the advice of the Consultation Institute and has followed good practice in developing the process. The full results are laid out in the separate report on the evaluation criteria which will be published on the website.

The process has been as follows:

- **Developing a longlist of possible evaluation criteria:** the Review team drew on the Terms of Reference of the Review, conversations with stakeholders, and examples from previous NHS consultations, to develop a longlist of the factors which might be relevant evaluation criteria.
- **Identifying the priorities of different groups.** The Review team asked clinicians, system leaders, patients and the public, and seldom heard groups, to identify what they considered to be the most important issues in considering options going forward, from this longlist. Clinicians and system leaders were asked to rank issues by order of priority, while patients and the public, and seldom heard groups, were asked to identify how important they thought each issue was in its own right. This was intended to ensure that patients, the public and seldom heard groups could respond freely and did not feel constrained towards giving one answer or another by having to prioritise them. The results of the ranking will be published in a separate summary report available on the website (<https://www.healthandcaretogethersyb.co.uk/>).
- **Developing the final evaluation criteria:** The final criteria were developed as follows:
 - The priority issues identified by each of the groups were used to identify the five themes for the criteria. These were workforce, affordability, access, quality and interdependencies.
 - Of these five themes, workforce and affordability were identified as hurdle criteria, which will be used to exclude clearly unfeasible options before detailed modelling takes place. The choice of hurdle criteria was based on two of the CCGs' statutory duties (around quality and safety (Health and Care Act 2012 Section 23) and delivering the financial position (Health and Care Act 2012 Section 27)).

Commissioners and providers felt that workforce and affordability were the two criteria which were most essential in delivering a safe and quality service (through having the right workforce) and in determining whether an option is feasible in practice (eg whether the capital and other investment that it would require are realistic and likely to be available).

Affordability was the criterion that was considered least important by patients and the public, and by the seldom heard groups. However it was included in

the hurdle criteria because of its importance in determining whether an option is deliverable and because delivering the financial position is a statutory duty of commissioners.

- The JCCCG also had regard to their statutory duty to reduce health inequalities. This was specifically referenced under the criterion on access. It was not included as one of the hurdle criteria because in order to assess the implications for access we first need to undertake modelling of travel times; access could thus not be used as a hurdle criterion to knock out options before the first round of modelling. However the impact on health inequalities will be considered when the Review evaluates the modelling, before the Review team decides which options to include in the final recommendations.
- The Review Steering Group, the Joint Committee of Clinical Commissioning Groups, and the Oversight and Assurance Group agreed a final set of wording that captured the key issues for each criterion.

Full details of this process are laid out in the separate paper on the evaluation criteria.

2.3.4 The evaluation criteria

The criteria that were agreed were as follows:

Hurdle criteria		
	Overarching question	Dimensions
Workforce	Does the option ensure there is a sustainable workforce that is of the right number and is suitably trained and skilled to deliver the service?	<ul style="list-style-type: none"> Number of staff required to deliver the model, compared with likely available workforce Impact on opportunities for training and skills development Impact on reliance on locum / temporary staff
Affordability	Does the option cost no more than the current service?	<ul style="list-style-type: none"> Running costs of the system compared with current Net contribution of the option to closing the financial gap identified in the STP plan Level of transition costs required by the option Level of capital costs required by the option
Other criteria		
Access	<p>Does the option ensure that patients can get to the right place, in the right time, for the right service?*</p> <p><small>* Note that 'the right time' does not automatically always mean that the shortest travel time is the best: a longer travel time may still be safe and allow a better outcome eg for specialist services</small></p>	<ul style="list-style-type: none"> Travel times to services, by blue light and normal driving times, and public transport, for patients carers and relatives* Could the option increase health inequalities across SYB by limiting access for lower socioeconomic groups, their carers and relatives Extent to which the model keeps outpatient, ambulatory and daycase activity local Extent to which the model supports shifting care out of acute hospitals closer to home, where appropriate
Quality	Does the option optimise the quality of care by promoting the delivery of national guidance and good practice?	<ul style="list-style-type: none"> Promoting the delivery of national guidance and evidence-based practice
Interdependencies	Does the option ensure that a service can run safely because the other services that are necessary to support it are also appropriately available?	<ul style="list-style-type: none"> Interdependent services which need to be provided onsite are available onsite There are formal links to interdependent services that do not have to be provided onsite

2.3.5 Applying the evaluation criteria going forward

In November, the emerging priorities from patients and the public, system leaders and clinicians were fed back to the third meetings of the Clinical Working Groups so that they could consider them as they were beginning to discuss ideas.

The hurdle criteria will be applied to options in February. The full list of five evaluation criteria will be applied to the outcomes of the modelling. The evaluation will be discussed at the next Clinical Working Group and the next SYB-wide public event in March.

Once this evaluation has been completed, the Stage 2 report will lay out the detailed assessment of options against the evaluation criteria.

3 Urgent and Emergency Care

This chapter explores the challenges facing urgent and emergency care across South Yorkshire and Bassetlaw, Mid Yorkshire and North Derbyshire. In particular, it contains:

- A recap on the rationale for including the service
- The scope of the service considered within the Review
- An overview of current performance of the service
- A deep dive into some of the key challenges and issues impacting the sustainability of the services across the Review footprint.

3.1 Rationale for inclusion

In stage 1A, emergency medicine emerged as a very unsustainable service, based on the 'sustainability score' that the team developed for each service. This was due to sustainability concerns raised in particular by three trusts (Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust, The Mid Yorkshire Hospitals NHS Trust and The Rotherham NHS Foundation Trust). There were also concerns about 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 General Medical Council (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 grade⁴ and junior grades), quality issues, and low activity levels at some sites (particularly overnight). The Care Quality Commission (CQC) also raised some very significant concerns in relation to urgent and emergency care; eight separate sites across the Review footprint were identified as 'requires improvement', meaning that five out of seven of the acute trusts had significant concerns with urgent and emergency care.

Targeted conversations with place-agnostic stakeholders highlighted that whilst the service was being explored through the ACS's urgent and emergency care workstream, it is so core to the work of the hospitals that it would benefit from additional independent review and support. In addition, the scope of the current work completed to date has been primarily focused on urgent care in primary and community care settings, and there has been limited work looking at the aspect of the service that takes place in a hospital setting.

3.2 Scope

The scope for urgent and emergency care includes the Accident and Emergency (A&E) department and the Medical Assessment Unit (MAU) (or equivalent, for example 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.

The surgical assessment unit, emergency general surgery and primary and community-based models of care are out of scope, although the Review notes the strong interdependencies with these services.

⁴ Speciality doctors, associate specialist doctors and staff grades

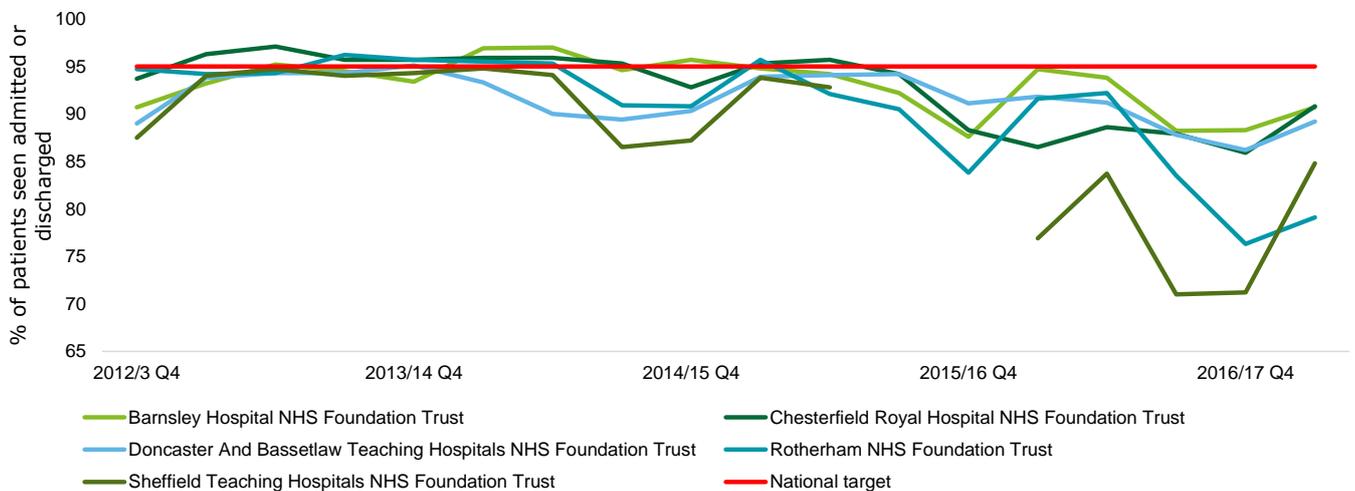
3.3 Current performance

Prior to the commencement of the CWGs, the Review team completed some analysis to understand some of the key issues with the current service. The analysis was on a combination of data provided by each trust, coupled with publicly available data.

The key messages emerging from the data analysis (completed in October 2017) were:

- Between Q4 2012/3 and Q4 2016/17, none of the trusts have met the four-hour A&E waiting time standard⁵, (although it should be noted that Sheffield Children’s NHS Foundation Trust are excluded from this analysis)⁶.

Figure 1: Proportion of patients attending A&E and seen, admitted or discharged within 4 hours: Trust-specific performance, 2012 - 2017⁷



- Most trusts have been able to reduce the proportion of patients who waited longer than four hours since the beginning of 2017, however over 5,000 patients in Q2 2017/18 waited more than four hours from the decision to admit until actual admission onto wards – 7% of all admissions⁸.
- Urgent Gastrointestinal Bleed services are key interdependent services for operating A&Es (according to the South East Coast Clinical Senate⁹) and are not fully provided on all sites.
- No trust met the seven-day standard for ensuring timely consultant review of patients on the weekend¹⁰.

⁵ HSJ Intelligence

⁶ Data not available on HSJ Intelligence

⁷ HSJ Intelligence

⁸ NHS England A&E Attendances & Emergency Admission monthly statistics, NHS and independent sector organisations in England, quarterly results

⁹ South East Coast Clinical Senate: “The Clinical Co-Dependencies of Acute Hospital Services: A Clinical Senate Review” (December 2014)

¹⁰ NHS England, Seven day service survey results, March 2017

Figure 2: Achievement of standard 2 by 7-day results, weekday and weekend - *Standard 2 - Time to first consultant review, March 2017*¹¹

	7 Results	Day Weekday results	Weekend results
	Standard 2	Standard 2	Standard 2
Chesterfield Royal Hospital NHS Foundation Trust	68%	69%	66%
Sheffield Children's NHS Foundation Trust	56%	64%	28%
Barnsley Hospital NHS Foundation Trust	67%	71%	55%
The Rotherham NHS Foundation Trust	67%	70%	61%
Sheffield Teaching Hospitals NHS Foundation Trust	60%	62%	55%
Doncaster And Bassetlaw Teaching Hospitals NHS Foundation Trust	69%	70%	65%
The Mid Yorkshire Hospitals NHS Trust	69%	73%	61%
National average ¹²	72%	73%	70%

- Overall trainee satisfaction has been below the national average since 2015 for the majority of trusts¹³. Emergency Medical Trainees across the footprint are less satisfied with their training than the UK average, particularly for Rotherham and Chesterfield, which have had scores consistently below national average for the last four years. However, trainees at Sheffield Children's and Barnsley have been consistently more satisfied with their training over the last four years than the national average.
- Urgent and Emergency Care services across the region are relatively efficient with the exception of Doncaster and Bassetlaw whose service costs are 12% higher than expected¹⁴.

3.4 Understanding the challenge in the service

The objective of the first CWG was to firstly identify the challenges and opportunities facing the service, in order to explore potential solutions in the second and third clinical working group sessions.

The group identified four main challenges that the Review should aim to address:

- Workforce.
- Managing demand.
- Flow.
- Technology and interoperability.

¹¹ Seven day service survey results, March 2017

¹² Unweighted average across 148 trusts; the standards are generally achieved when standard is met for 90% of cases;

¹³ GMC National Training Survey Results 2017

¹⁴ NHS Reference Cost Index 2015-16

These are discussed in more detail below.

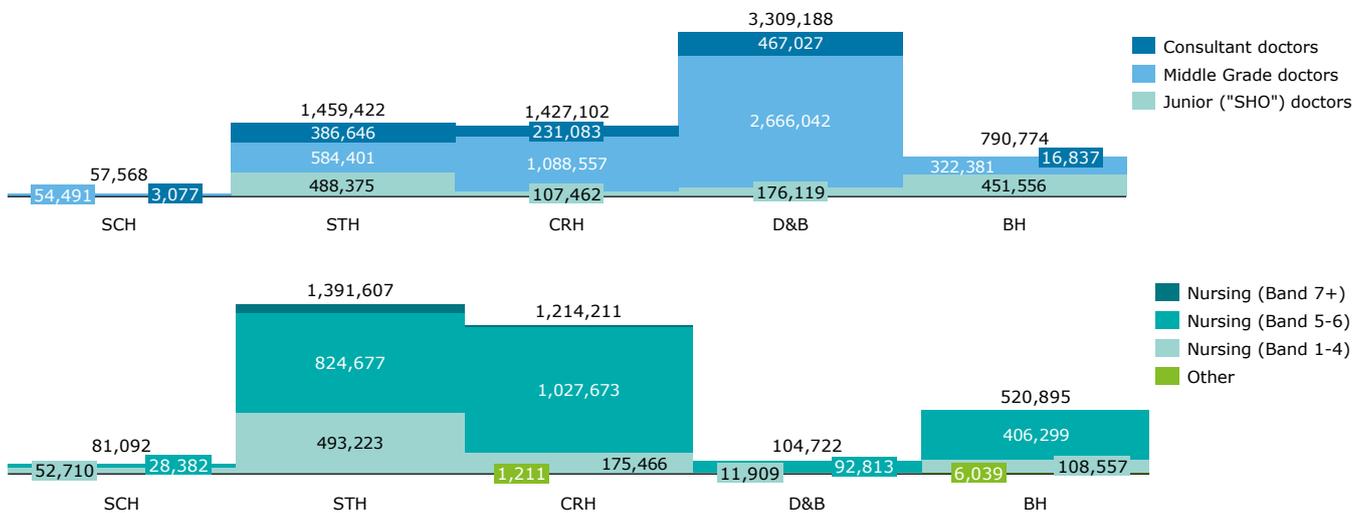
3.4.1 Workforce

The CWG felt that workforce is the single most important problem facing urgent and emergency services across the footprint. This is leading to gaps in rotas across all grades and disciplines including doctors (emergency physicians, consultant psychiatrists, middle grades, junior doctors¹⁵) and nurses.

In particular, recruitment of doctors across Yorkshire is challenging. The CWG reported that in order to alleviate staff shortages, trusts have begun to compete with each other for staff. One example of this is competition to recruit locums (particularly at middle grades) and agency staff which then consequently drives up market costs. Throughout the footprint, there is a heavy reliance on locum staff, many of whom are on short term contracts, as well as many who are working ad hoc. This also has the potential to impact the quality of care, because locum staff have a lack of local knowledge, as well as needing time to familiarise themselves with local IT systems and other operational issues. Even those trusts who which paid the highest rates are at times unable to completely fill their vacancies with locums and agency staff.

The CWG discussed analysis stating that total locum spend across trusts in FY2016/17 was c.£11.9m and is primarily on middle grade and band 5-6 nurses¹⁶.

Figure 3: Total UEC Medical, Nursing and Other Locum spend - FY2016/17 Total £¹⁷¹⁸



The CWG said that one macro issue impacting workforce is that not enough doctors and nurses are being trained. Attendees suggested that this is likely to be due to a combination of factors, including for example no significant increases in places at medical schools, and the changes to Nurse Bursaries. The abolition of Nurse Bursaries was raised in all of the

¹⁵ Qualified doctors in clinical training

¹⁶ Trust data returns

¹⁷ Trust data return

¹⁸ Use of agency / locum staff, including overtime of existing staff at additional cost to establishment. For Rotherham total spend includes agency spend for emergency (Jul-16 to Jun-17, scaled up to 12 months given March data missing) and does not include internal spend for additional sessions; for Barnsley the spend includes agency and bank costs only; other locum spend includes healthcare assistants. For Chesterfield, other locum spend is A&C support, nursing spend includes bank

Clinical Working Groups as a factor that attendees believed to be contributing to shortages of nurses, although there is as yet limited evidence of what the impact has actually been.

Some trusts are exploring new roles to fill some of the workforce gaps, for example Advanced Clinical Practitioners (ACP) and Physicians Associates (PAs) however trusts feel that these roles require further development.

CWG members felt that Emergency Medicine is a challenging speciality to work in, and the role has become increasingly pressurised as demand increases, leading to high attrition rates. This is an issue which is also recognised at a national level, and is not unique to the footprint, "... *this intense working environment of ED is well recognised to be a leading cause of medical staff dissatisfaction, attrition and premature career 'burnout', increasing the burden of the staff who remain. It also compromises the attractiveness of the speciality for the next generation of doctors who will be vital over the next decade*¹⁹" It is a priority to make the roles in Urgent and Emergency Care more attractive.

The Clinical Working Group discussed some case studies of providers who have tackled similar problems:

Developing middle grades in the West Midlands²⁰

Staff grade and associate specialist (SAS) typically have fewer opportunities for career progression compared with other senior doctors. Some specialty and SAS doctors choose to continue working as locums as they are put off by the requirements of the Certificate of Eligibility for Specialist Registration (CESR) process.

In December 2013, Health Education England (HEE) started an SAS emergency medicine "shop floor" skills training programme in the West Midlands. The twelve month programme was developed in collaboration with local providers in response to specific training needs of SAS doctors and as a basis for considering the skills mix that an SAS grade doctor requires to develop into a highly functioning middle grade doctor. The programme aims to support the development of more versatile and autonomous clinicians who are better able to manage the increasingly diverse range of conditions presenting in emergency department, improve patient care and support a key proportion of the clinical workforce.

Consequently, between 2014 and 2016 the West Midlands programme trained over 140 SAS doctors in emergency medicine shop floor skills. In 2017, following successful evaluation outcomes, the programme will be rolled out across the Midlands and London with an anticipated start date of December 2017. Plans for a national rollout will be considered for 2018/19, following successful evaluation of the programme.

The Royal College of Medicine and HEE plan to work together to provide a consistent delivery model for these schemes.

3.4.2 Managing demand

The CWG said that one of the key drivers for increased demand on hospitals is the ageing population and this, combined with an increased number of co-morbidities and longer life

¹⁹ Health Education England, NHS England, NHS Improvement and Royal College of Emergency Medicine. "Securing the future workforce for emergency departments in England" (October 2017)

²⁰ https://improvement.nhs.uk/uploads/documents/Emergency_department_workforce_plan_-_111017_Final.3.pdf

expectancy, has put pressure on services, in particular Urgent and Emergency Care where attendances and admissions have continued to rise.

Patient behaviours and public expectations have also contributed to this increase in demand. The CWG felt that there was a growing expectation amongst patients that they will be treated immediately, and in a complex landscape with a range of services (for example, NHS 111, urgent treatment centres, walk in centres) patients often turn to A&E in the first instance to seek treatment knowing that it is a recognisable service and that they will generally be seen quickly by a senior registered professional. The CWG reported that the A&E is commonly viewed as the default option that is visited when patients are unsure as to which service they need.

CWG members felt that the NHS is often reactive, and it was suggested that closer working with primary and secondary care, as well as mental health and social care services, could make demand more manageable for the acute setting. It was also raised that managing demand at different times of the day may require different solution approaches.

3.4.3 Flow

The CWG said that poor flow through the pathway can create blockages, delays and hinders the quality of care. Both internal and external problems impact issues flow within the trusts, for example, flow can be delayed internally by access to support services such as diagnostics. Externally, timely access to social care, mental health providers, and patient transfers between trusts. In all cases, flow is often hindered by the time of the week, the weekends and evenings especially.

CWG members said that it would be helpful to have clearer 'rules of engagement' between services operating within the same trust and between trusts, to ensure there are clear protocols for safely transferring and receiving patients between trusts.

The CWG members recognised that there are a number of perverse incentives which could impact behaviour, for example tariffs which incentivise admitting patients rather than seeing them in A&E.

3.4.4 Technology and interoperability

The CWG members reported that trusts within the footprint all operate different IT systems, which are not compatible. In some cases there are different systems even in the same trust. When trusts are on the same system, there is often variation in the functionality and deployment of the same software package.

CWG members said that technology solutions are not interoperable between trusts, and other partners, for example, primary, community, mental health and social care. Clinicians in the emergency department need this information to hand (including social care) when making clinical decisions.

The CWG reported that considerable inefficiency is caused by the time taken for staff to log into different computers or different programmes, and the length of time taken to record observations.

The Clinical Working Group discussed some case studies of providers who have tackled similar problems:

Integrating systems and sites across the Mayo Clinic in the United States of

America²¹

Multiple clinical systems were being used throughout Mayo Clinic, who direct care for more than 1.3 million people from all 50 states in the USA and from 137 countries in 2016.

The Mayo Clinic has designed its own app – Synthesis – which works to combine data from numerous clinical systems within the organisation. The Mayo Clinic has three major campuses in Arizona, Florida and Minnesota as well as affiliated facilities in several states. Synthesis allows clinicians to go to one place in order to find blood test results, images, medications and other patient data.

The app also includes a messaging system for within the hospital and has patient-facing videos and material to facilitate doctor–patient communication.

The app has created a user friendly, single point of access for all clinical information across a large complex provide and has led to improvements in clinical decision making and efficiency.

3.5 Key themes emerging from public and patient feedback

The patient and public feedback is laid out in more detail in the write-ups of the public session and the feedback from the public engagement event in the appendices.

Further feedback is continuing to emerge from the public engagement during January and a full report is being drafted which will draw together all the public engagement done for the Review. Alongside the feedback attached to this interim report, conclusions from the draft full report on public engagement are being used to develop the options and the final version of the full report on public engagement will be published on the ACS website as soon as possible.

The key concerns raised so far are summarised below:

3.5.1 Demand and Usage

Respondents from across all the patient and public groups, particularly the seldom heard groups, raised concerns about waiting times at A&E and the impact that this had on outcomes for patients.

Attendees of the regional public event on 6th December asked what research had been done into the reasons that people attend A&Es, and whether A&Es were being used appropriately. They questioned how far it was possible to reduce demand for A&E services within existing expectations of A&E. Like the Clinical Working Group attendees, they raised the point that A&Es are the most immediately recognisable 'gateway' into the health system. Precisely because it offers fast and easy access to care, people will use it more; we need to think through how far it is feasible to direct people elsewhere and how to make the alternatives more attractive.

²¹ <https://www.nuffieldtrust.org.uk/files/2017-01/delivering-the-benefits-of-digital-technology-web-final.pdf>
https://www.kingsfund.org.uk/sites/default/files/media/T2B_Candace_Imison.pdf

Some attendees of the regional public event suggested that the Review needed to analyse peak usage and whether all A&Es are working to capacity all of the time, or whether there are times when demand is lower and the service may not be needed in the same form.

3.5.2 Reduction in services for older people outside hospital

Attendees at the regional public event felt that one of the main reasons for increasing usage of A&Es was the reduction in support for older people in non-hospital settings, as a result of funding cuts. Increased attendance at A&E was seen as a direct consequence of the reduction in social care wardens, sheltered housing etc.

3.5.3 Links with primary care, community care and social care

Attendees at the regional public event pointed out that pressures on A&E were increased because there were not clear pathways for GPs to urgent diagnostics such as x rays. They suggested that there needed to be closer working with primary care such as a joint working group. They also felt that more work needed to be done to train care workers in nursing homes and care homes, to help them to avoid admissions.

3.5.4 Transport

All the groups raised concerns about access, and it will be essential for the Review to take travel times and transport arrangements into account in any discussions around the future of A&E. Respondents from the seldom heard groups particularly flagged issues around the difficulty of travelling from a hospital site, when there were no buses or taxis available. Attendees also suggested that there should be better communication between A&Es and ambulances, to allow them to be directed to hospitals with lower waiting times.

3.6 Moving towards solutions

The Review team recognises that this chapter sets out a number of key issues impacting the provision of the service across the Review footprint.

In January 2018, the focus of the Review will turn to identifying a number of potential solutions and recommendations for the delivery of the service going forward.

4 Maternity

This chapter explores the challenges facing maternity services across South Yorkshire and Bassetlaw, Mid Yorkshire and North Derbyshire. In particular, it contains:

- A recap on the rationale for including the service
- The scope of the service considered within the Review
- An overview of current performance of the service
- A deep dive into some of the key challenges and issues impacting the sustainability of the services across the Review footprint.

4.1 Rationale for inclusion

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'.

In stage 1A, 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.

4.2 Scope

The scope for Maternity includes antenatal and perinatal services (including relevant community settings), Early Pregnancy Assessment Clinics, Obstetric / consultant led units and Midwifery led units.

Neonatology is not considered separately from the maternity workstrand. The strong independencies between maternity, neonatology and paediatrics have been considered and will be recognised in any recommendations.

4.3 Current performance

Prior to the commencement of the CWGs, the Review team completed some analysis to understand some of the key issues with the current service. The analysis was on a combination of data provided by each Trust, coupled with publically available data.

The key messages emerging from the data analysis were:

- Not all trusts comply with the Better Birth standards²², which could be attributed to the day-to-day running of the unit.
- The neonatal mortality and stillbirth rate varies across the region over time. There were 89 stillborn children in South Yorkshire and Bassetlaw, North Derbyshire and Mid Yorkshire in FY16/17²³.

²² Trust data returns

Figure 4: Number of stillbirths and extended perinatal mortality rate by trust, 2016-17²⁴

	Barnsley Hospital NHS Foundation Trust	Chesterfield Royal Hospital NHS Foundation Trust	Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust	Sheffield Teaching Hospitals NHS Foundation Trust	Sheffield Children's NHS Foundation Trust	The Rotherham NHS Foundation Trust	The Mid Yorkshire Hospitals NHS Trust
# of stillborn babies	11	12	16	35	N/A	15	N/A*
# of antenatal stillborn babies services	8	11	13	34	N/A	15	N/A*
# of intrapartum stillborn babies	0	1	3	1	N/A	0	N/A*
# of maternal deaths	0	0	2	3 ^t	N/A	3	0
# of serious injuries during	1	N/A	N/A	4	N/A	1	4

- There is variation in service provision across trusts for Early Pregnancy Assessment Clinics and MLUs²⁵.
- Trusts struggle to fill posts across all grades and professions, in particular staff grades, nurses and trainees. Only around half of all training posts appear to be filled across the footprint²⁶.
- While overall trainee satisfaction is above national average, two thirds of trainees report higher workload pressures than their national peers²⁷.

²³ MBRRACE UK Perinatal Mortality Surveillance, 2014 & 2015

²⁴ Trust data returns

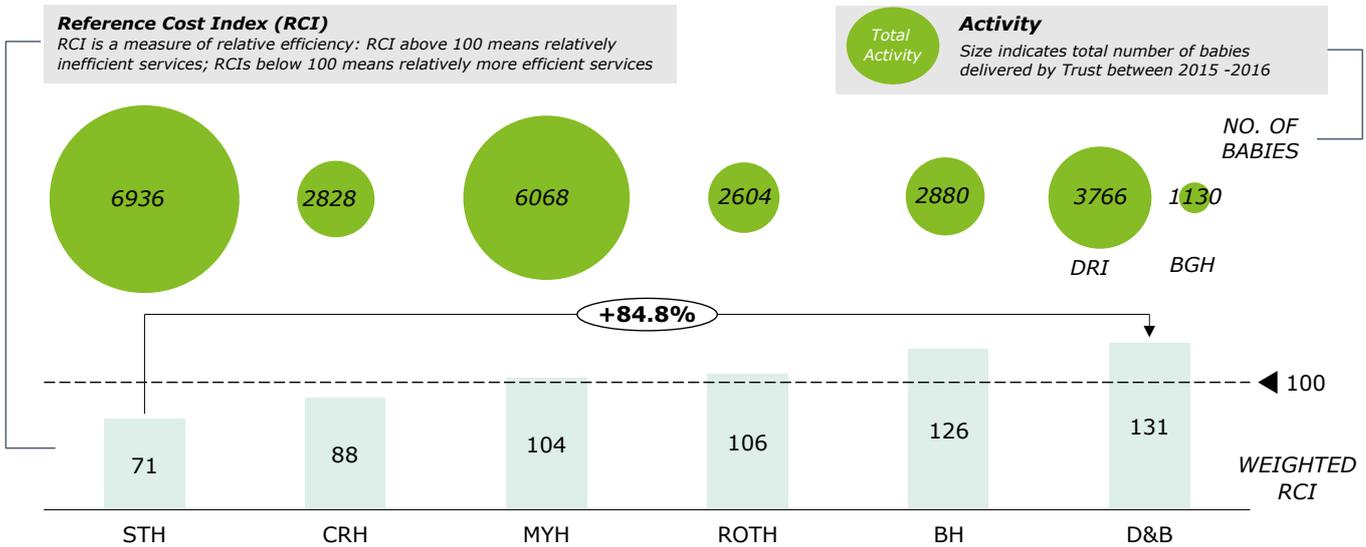
²⁵ Trust data returns

²⁶ Trust data returns

²⁷ GMC National Training Survey Results 2017

- There is an 85% difference in the efficiency of the most efficient and least efficient trust when considering weighted Reference Cost Index data²⁸.

Figure 5: Reference Cost Index compared to number of babies delivered by trust: *Weighted RCI*, Number of babies delivered, 2015-2016*²⁹



4.4 Understanding the challenge in the service

The objective of the first CWG was to firstly identify the challenges and opportunities facing the service, in order to explore potential solutions in the second and third clinical working group sessions.

The group identified five main challenges that the Review should aim to address:

- Workforce.
- Capacity and flow.
- Operations.
- Changing complexity of patients.
- Consistency of care and quality standards.

These are discussed in more detail below.

4.4.1 Workforce

The attendees of the Clinical Working Group said that the greatest challenge across all the trusts is the shortage of staff, particularly amongst middle grade and junior doctors / trainees and midwives and this was the single most important and pressing problem facing maternity services across the footprint.

Nationally, both the nursing and midwifery professions have an ageing demographic. More than half of nurses are older than 45, with a third aged between 45 and 54 and 13.6%

²⁸ NHS Reference Cost Index 2015-16; Hospital Maternity Activity 2015-16

²⁹ NHS Reference Cost Index 2015-16; Hospital Maternity Activity 2015-16

between 55 and 64. In midwifery the position is even starker, with a third of midwives over 50 and eligible to consider retirement at 55³⁰.

Attendees said that a number of staff groups providing critical clinical support services to maternity services are in short supply. These included neonatology nurses, radiologists, sonographers, paramedics and anaesthetists. The shortage in workforce supply is amplified by an ageing workforce nearing retirement, fewer than required new staff being recruited and existing staff increasingly seeking other opportunities.

The Clinical Working Group identified a number of factors that they expected would impact on recruitment more broadly, for example the discontinuation of nursing bursaries for midwives, as well as low starting salaries and high levels of responsibility, expectations and pressure making the service less attractive to join or specialise in.

CWG members said that more could be done to create a supportive environment for staff in order to improve retention. For example, in other countries there are attractive employment packages being offered which is leading to some staff relocating to these areas to take advantage of these opportunities.

Flexible working practices were considered to be important in the context of attracting a new generation of midwives and doctors to join the professions, as well as providing older staff members the opportunity to reduce their hours while remaining in the workforce, rather than exiting entirely.

CWG members said that due to significant gaps in middle grade roles, in a number of instances consultants are having to "act down" into these roles, and locums are being hired at great cost to provide significant staffing. High reliance on locums is considered to have unfavourable implications for care quality and are far from a reliable long-term solution, with some locums dropping out at short notice. In a number of instances, it is difficult to meet the locum cost cap due to patient safety concerns.

The Clinical Working Group discussed some case studies of providers who have tackled similar problems:

Midwifery Refresher Programme, Mater Misericordiae Mothers' Hospital, Australia³¹

Mater Mothers' Hospital in Australia experienced an acute shortage of midwives in the early 2000s. In response, the hospital performed a situational analysis, identifying that many midwives had left the profession and attracting them back via a midwifery refresher programme could be an effective recruitment strategy.

The Midwifery Refresher Programme comprised of 80 hours of theoretical content and a minimum of 150 hours of clinical practice. It was targeted at midwives who had been out of practice for an extended period.

The theoretical component encompassed antenatal, intrapartum, postpartum and neonatal special care and was presented by academic and clinical staff. Unpaid supernumerary

³⁰ Nuffield Trust, the NHS workforce in numbers, October 2017

³¹ European Commission, 2014 Recruitment and Retention of the Health Workforce; Nursing and Midwifery Council, The NMC register, 2017

clinical practice was provided under the guidance of an experienced midwife preceptor.

Successful participants were eligible for academic credit of two subjects towards the Master of Midwifery.

An evaluation found that during the first year of the Midwifery Refresher Programme (2002), the programme was very successful in meeting the hospital's immediate recruitment crisis whereby all participants achieved clinical competence and were subsequently offered employment. The Programme has an employment rate of c 90% following completion.

The programme has since ceased running as it appeared the market was saturated.

4.4.2 Capacity and flow

The CWG said that rising demand and increased use of transport services are pushing providers to operate at high capacity. Better coordination between trusts and transport providers is seen to be vital to ensure a continued high quality service.

Members said that transfers of new-born babies to Level 3 cots were proving particularly challenging due to the complexity of the transfer and the limited capacity. In the Yorkshire and Humber region, the Embrace transport service are delivering a specialist transport service 24/7 for critically ill children and offer a single point of access and an up-to-date view of bed availability. They are experiencing increasing demand pressures.

4.4.3 Operations

CWG members pointed to a number of issues with information technology, for example a lack of interoperability between primary care, community care and secondary care. This was said to be extremely important because information on prenatal care provided in community settings needs to be easily accessible to hospital based teams.

In the case of emergency transfers from district general hospitals to larger sites, patient information needs to be readily available to the treating clinicians at the receiving site.

The CWG said that systems are often not interoperable between trusts or between secondary and primary care, which makes shared working challenging.

4.4.4 Changing complexity of patients

Members of the CWG said that increasingly complex patient cohorts create a challenge to services, for example an increased number of consultant-led births, longer lengths of stay and patients requiring substantially more specialist medical and nursing attention.

The group highlighted the role of poor public health leading up to and during pregnancy as a key cause of the increased complexity of patients. Risk factors include smoking, low physical activity, alcohol and substance abuse as well as environmental factors such as inadequate housing or pollution. Changing demographics (for example, increasing numbers of older mothers), and co-morbidities such as poor mental health and deprivation are also potential causes.

The CWG mentioned that complex patients usually experience a longer length of stay in hospital, and tariff payments are considered insufficient in such cases.

The Clinical Working Group discussed some case studies of providers who have tackled similar problems:

Reducing smoking in pregnancy via BabyClear approach, North East England³²

In the North East (NE) of England, rates of smoking at time of delivery (SATOD) were 22% in 2010. Healthcare staff reported to be concerned about how to approach the topic of smoking and many trusts lacked the resources to monitor.

A regional approach was taken, built on cooperation between trusts and Local Authorities (LA) and a programme was commissioned by local NE tobacco control office across the region, co-funded by LAs. The intervention included a package of measures implemented in trusts and smoking cessation services such as skills training for healthcare and smoking cessation staff, universal carbon monoxide monitoring with routine opt-out referral for smoking cessation support, provision of carbon monoxide monitors and supporting materials and an explicit referral pathway and follow-up protocol.

Consequently, referral rates to local Stop Smoking Services were 2.5 times higher in month four of intervention compared to baseline. System-wide identification and referral of pregnant smokers almost doubled the probability of quitting by delivery. In addition, quitter babies were 210g heavier and almost the same weight as babies of non-smokers. Rates of smoking at time of delivery in the North East are now falling faster than England rates.

4.4.5 Consistency of care and quality standards

The CWG members reported that there is a high degree of variation in most care domains across all trusts. This includes different ways of applying national standards and guidance which can reduce the ability of staff to work collaboratively with and in other organisations. Variation in interpretation and implementation of guidance is also linked to a difference in clinical practice and outcomes.

In addition, the CWG said that there is variation in the provision of community services across the region, which contributes to delays in discharge or repatriation.

4.5 Key themes emerging from public and patient feedback

The feedback from patients and the public highlighted some key themes specific to maternity. These are laid out in more detail in the appendices.

Further feedback is continuing to emerge from the public engagement during January and a full report is being drafted which will draw together all the public engagement done for the Review. Alongside the feedback attached to this interim report, conclusions from the draft full report on public engagement are being used to develop the options and the final version of the full report on public engagement will be published on the ACS website as soon as possible.

The key points raised so far are as follows:

³² Bell et al., 2017, Evaluation of a complex healthcare intervention to increase smoking cessation in pregnant women: interrupted time series analysis with economic evaluation; Bell, 2017 Reducing smoking in pregnancy: learning from the BabyClear approach

4.5.1 Workforce

Respondents to the public survey, and from the seldom heard groups, raised particular concerns about shortages of midwives, and the impact that this had on patient care.

Attendees at the regional event and at the Rotherham public event, said that one problem with the traditional routes for training staff was that that some people might not be academic enough for a degree-based route but could still be excellent midwives or other healthcare staff. There was a suggestion that there should be more vocational routes into training for such staff.

4.5.2 Patient choice

There was discussion in the public events (particularly in Barnsley, and at the regional event) around how the system balances patient choice with patient risk. Comments focused in particular on home births and midwifery led units, with some people in favour of these and some concerned that they exposed women to higher levels of risk. Respondents from the seldom heard groups said that the most important thing was that the environment needed to be calm and relaxing in any kind of unit, and said that at the moment this was not always the experience.

4.6 Moving towards solutions

The Review team recognises that this chapter sets out a number of key issues impacting the provision of the service across the Review footprint.

In January 2018, the focus of the Review will turn to identifying a number of potential solutions and recommendations for the delivery of the service going forward.

5 Care of the Acutely Ill Child

This chapter explores the challenges facing acute paediatric services across South Yorkshire and Bassetlaw, Mid Yorkshire and North Derbyshire. In particular, it contains:

- A recap on the rationale for including the service
- The scope of the service considered within the Review
- An overview of current performance of the service
- A deep dive into some of the key challenges and issues impacting the sustainability of the services across the Review footprint.

5.1 Rationale for inclusion

In stage 1A, acute paediatrics was cited frequently in the trust interviews and was felt by some to be the area with the greatest workforce challenges across the Review footprint. Workforce shortages (felt particularly at consultant and middle grade) are an issue at national level not just in South Yorkshire and Bassetlaw, and as such the service is of concern to the local HEE leads as well as the to the individual trusts. There are also low activity levels at some sites in South Yorkshire and Bassetlaw (particularly overnight).

For both of these reasons, acute paediatrics is a service of concern to commissioners.

In addition, the CQC has raised concerns about services for children and young people at two trusts.

During stage 1A of the Review there was agreement across the stakeholders that the Review should 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.

5.2 Scope

The scope for acute paediatrics includes paediatric A&E, inpatient paediatric ward / inpatient area in A&E and children's / paediatric assessment / observation unit (CAU / PAU), including short stay PAU (SSPAU).

Maternity services are out of scope for this workstream, and considered in a workstream of its own (see chapter 4). Neonatology is not considered separately in a workstream of its own. However the strong independencies between maternity, neonatology and paediatrics have been considered and will be recognised in any recommendations.

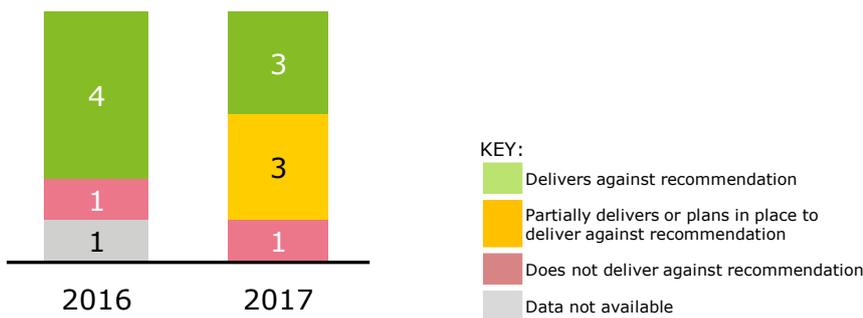
5.3 Current performance

Prior to the commencement of the CWGs, the Review team completed some analysis to understand some of the key issues with the current service. The analysis was on a combination of data provided by each Trust, coupled with publically available data.

The key messages emerging from the data analysis were:

- Trusts have taken steps to improve their sustainability evidenced by improved compliance with “Facing the Future” Standards between 2016 and 2017³³. However, there are still some standards that remain challenging for some trusts to comply with, in particular “ensuring patients are seen by a professional within four hours of admission”.

Figure 6: Compliance against the standard “child admitted is seen by a professional within four hours of admission”³⁴



- Some trusts find it challenging to provide appropriate support services 24/7 (particularly on the weekend), notably diagnostics, occupational therapy and speech and language therapy³⁵.
- There are difficulties in filling budgeted posts across all grades and professions. Only around 50% of training posts appear to be filled. Most trusts struggle to attract and maintain sufficient nurses³⁶. Staff shortages have historically been an issue and have also been identified by CQC as a matter of concern impacting patient care³⁷.

³³ Trust self-assessment against Facing the Future standards, 2017 Case for Change (unpublished)

³⁴ Trust self-assessment against Facing the Future standards, 2017 Case for Change

³⁵ Trust data returns; HSR data collection return

³⁶ Trust data returns

³⁷ Care Quality Commission

Figure 7: Care Quality Commission analysis outlining staffing concerns with acute paediatric services³⁸



Chesterfield

...met staffing guidance from the RCN ... agency usage had reduced

Bassetlaw DGH

...shortage of staff trained to care for children ... minimum of 1 trained children's nurse on each shift was not achieved

Pinderfields (MYH)

...nursing and medical staff expressed their concerns about nurse staffing numbers...

Rotherham

...medical staffing was adequate to maintain a safe service for patients as agency locums were covering the low numbers of vacancies...

Sheffield Children's

...there were vacancies in the department for 3 WTE band 5 and two WTE band 6 and none for consultants...

- Spend on locum staff varies across trusts but also across professions and is at least £1.7m across the footprint, although it should be noted that at least half of all trusts have reduced their locum spend since FY2015/16 by an average of 52%³⁹.
- Across the region, trainee satisfaction scores fluctuate year on year, but consistently fall below the national average. Perceived workload of trainees vary regionally, with half of trusts reporting higher workload than the national average⁴⁰.
- Half of all trusts run a relatively inefficient service when compared to national peers. The least efficient trust is 38% less efficient than the most efficient service delivered in a general DGH⁴¹.

5.4 Understanding the challenge in the service

The objective of the first CWG was to firstly identify the challenges and opportunities facing the service, in order to explore potential solutions in the second and third clinical working group sessions.

The group identified three main challenges that the Review should aim to address:

- Workforce.
- Training, education and capacity in the community.
- Demand on paediatric emergency departments and the interdependency with neonatology.

³⁸ Care Quality Commission

³⁹ Trust data returns

⁴⁰ GMC National Training Survey Results 2017

⁴¹ NHS Reference Cost Index 2015-16

These are discussed in more detail below.

5.4.1 Workforce

The members of the Clinical Working Group said that the greatest challenge across all the trusts is the availability and use of staff, particularly amongst middle grades, junior doctors and nurses. This is reflected in low paediatric fill rates across Yorkshire and the Humber which are also below national rates.

There are also considerable gaps in the nursing workforce and CWG members expressed concerns that this could continue to increase due to the discontinuation of the nursing bursary and issues around training provision. CWG members also felt that some nurses in District General Hospitals were put off by the expectation that they would cover a variety of paediatric specialties (as oppose to specialising in one area).

The CWG reported that middle grades and junior doctors are in particularly short supply with the footprint considered to be a "net exporter" of trainees, with already relatively lower fill rates than the rest of the country. The CWG felt that it is more difficult to attract trainees because, following changes to the HEE system, trainees now apply to the whole area of Yorkshire and the Humber; given the geography, this can mean that students are assigned to placements in areas that are geographically distant, and cannot choose whereabouts in the region they want to be based. The attendees reported anecdotally that this puts students off for applying for training places in the region and makes it less attractive. High attrition rates amongst medical students contribute to the challenged staffing position, with some trainees considering and taking up employment opportunities abroad.

There was concern amongst the members of the group that the shortage in trainee numbers has the potential to worsen the middle grade shortage, which in turn would lead to relatively lower numbers of future consultants. One impact of a shortage on numbers is an increasing reliance on locum staff, with unfavourable cost and care quality implications for the service as a whole.

While the CWG members reported that most of the consultant posts appear to be filled, locum spend remains high and roles will become harder to fill over the coming years, due to the current middle grade shortage and limited numbers of suitable candidates coming through the recruitment pipeline. In the context of compliance with Facing the Future Standards, (for example, the inclusion of a number of consultant-related targets) there may be a growing requirement for additional consultant posts across the region, although it is recognised that the financial constraints of trusts would restrict the growth of the consultant workforce.

CWG members reported variation in the use of the alternative workforce, for example, Advanced Neonatal Nurse Practitioners (ANNPs) and their use across the footprint. Some trusts include ANNPs on Senior House Officer (SHO) rotas, while others allow them to work in middle grade rotas.

The Clinical Working Group discussed some case studies of providers who have tackled similar problems:

Reconfiguration of Children's Services at Mid Yorkshire Hospitals⁴²

The Mid Yorkshire Hospital NHS Trust (MYH) has been on a multi-year transformation journey, involving reconfigurations of various services and different scales.

For hospital-based acute paediatric services, MYH has been struggling to comply with the RCPCH "Facing the future" standards. The sustainability of their paediatric services was challenged by a national reduction in registrar numbers and the need to have more consultant-delivered service. The existing service configuration, including paediatric inpatient units at two sites, meant that rotas were difficult to fill with substantive staff. Often, locum staff had to fill gaps – particularly on mid-grade rotas – which was expensive and inefficient.

The aim of the reconfiguration was to centralise available expertise, focus on admission prevention and reduce the length of stay, alongside developing community services and options for providing care closer to home.

Between 2014 and 2016, significant service changes at the two key MYH sites (Pinderfields and Dewsbury) were implemented. Dewsbury moved from having a children's ward with 18 inpatient beds as well as an assessment and rapid access clinic to become an 8 bed 24/7 Children's Assessment Unit (CAU). After a period of trialling, the CAU opening hours were changed to 12/7 in 2016, reflecting demand for these beds.

As part of this adaption at Dewsbury, the main hospital site at Pinderfields was expanded to deal with the additional demand for inpatient beds following the move out of Dewsbury. All inpatient paediatrics and neonatal activity was centralised at Pinderfields, increasing its capacity from 19 to 23 inpatient beds.

The transformation impacted the entire health economy and the service change in the hospitals was complemented by a support offer to primary care (e.g. E-consultations or GP telephone advice service, linked to hospital-based consultants).

5.4.2 Training, education and capacity in the community

The CWG members said that GPs are a pivotal link to secondary care for paediatrics. Attendees reported variation in GP training, skills and knowledge in dealing with paediatric issues: while some GPs are trained in paediatrics and are highly expert, others have had no training, and where this was the case there was a risk that it would contribute to increasing paediatric A&E workload. Ideas for supporting GPs in working with children via, for example, paediatric-related continuing professional development were discussed. Some attendees said that it was unrealistic for every GP to have full paediatric training but all GPs should know where to access support in dealing with children, either in primary or secondary care.

The CWG raised timely access to primary care as another challenge. Different opening and waiting times across the footprint were seen as having knock-on effects on acute paediatric care in hospitals.

⁴² Mid Yorkshire Hospitals NHS Trust presentation, Reconfiguration of Children's Services Mid Yorkshire Hospitals, July 2017

Similarly, attendees said that the provision of community nursing teams varies substantially in terms of hours of operation and services delivered in different Places. The community nursing offer was recognised as being vital in complementing the GP offer and where the two work well they can substantially reduce pressures in acute paediatric services in hospitals.

The Clinical Working Group discussed some case studies of providers who have tackled similar problems:

Training, education & capacity in the community in Imperial Child Health General Practice Hubs⁴³

Children make up an estimated 40% of a typical GP's workload and the Royal College of Paediatrics and Child Health estimates that in many areas in England, around half of GPs had little or no formal paediatric training. Consequently, some paediatric GP referrals to A&E for common conditions such as fever, constipation and or asthma could be more appropriately managed in primary care.

Imperial Child Health General Practice Hubs comprise groups of two or three general practices. There are three core components:

- Specialist outreach with paediatricians attending MDT team meetings with GPs, providing education sessions and delivering joint outreach clinics with the GPs
- Open access with guaranteed same-day paediatric appointment and advice; GPs also have access to specialist advice via an email and phone hotline run by consultants
- Public and Patient Engagement to educate parents and public about appropriate use of A&E and advertising self-management initiatives.

There is an efficient referral pathway with GPs being supported to refer patients to outreach clinic where consultant can see patient rather than directing to A&E, directly into relevant paediatric sub-speciality as opposed to initial general paediatric appointment and multidisciplinary team input from the wider hub team as opposed to initial general paediatric appointment.

The hub resulted in cost savings of c.£16k p.a. from seeing patients at the outreach clinic compared to the cost of equivalent hospital outpatient clinic appointments and a reduction of overall referrals to either hospital or outreach clinics and parents prefer to be seen in GP surgery as oppose to hospital.

5.4.3 Demand on paediatric emergency department and the interdependency with neonatology

CWG members reported that demand on paediatric emergency departments is growing as patient expectations rise and alternative routes to access treatment (for example, via GPs) are considered unfeasible due to long waits in some areas. Attendees felt that there is limited coordination and communication across trusts to manage or direct flow and activity from sites that are particularly busy, to those sites who have capacity.

⁴³ Kings Fund, 2014m, Imperial child health general practice hubs, available at: <https://www.kingsfund.org.uk/sites/default/files/media/imperial-child-health-general-practice-hubs-kingsfund-oct14.pdf>

The group members said that due to the workforce interdependencies between acute paediatrics and neonatology, in most District General Hospitals, staff delivering acute paediatric services also deliver neonatology services. This means that shortages in the paediatric workforce also impact the delivery of neonatology services. The group stressed that it is therefore important to consider that changes to one service and workforce model would have direct impacts on the provision of the other.

5.5 Key themes emerging from public and patient feedback

Patients and members of the public raised a number of points around paediatric services, which are described in more detail in the appendices.

Further feedback is continuing to emerge from the public engagement during January and a full report is being drafted which will draw together all the public engagement done for the Review. Alongside the feedback attached to this interim report, conclusions from the draft full report on public engagement are being used to develop the options and the final version of the full report on public engagement will be published on the ACS website as soon as possible.

The key points raised so far are:

5.5.1 Workforce

Attendees at the regional public engagement session put forward concerns and ideas around the workforce for paediatrics. There was a suggestion that paediatric training should be part of the training for all GPs, and that there should be more financial support for staff wishing to gain additional qualifications in working with children.

5.5.2 Access to services

There were different views expressed around the issues of access and quality. A number of respondents to the public survey believed that overnight paediatrics services should be available on every hospital site, with a number of responses specifically referencing the changes to paediatrics services at Bassetlaw. However some attendees at the regional public event said that quality of services was more important, and that it was "a 'no brainer'" to focus care for acutely ill children on more specialist sites.

Wherever services were based, respondents from the seldom heard groups talked about the need for paediatric units to be friendly spaces, with toys available for children to play with while waiting for care.

5.5.3 Mental health

The attendees at the regional public event raised questions around how mental health services for children would fit into the Review. Support for young people was seen as vitally important to prevent life-long mental health problems.

5.6 Moving towards solutions

The Review team recognises that this chapter sets out a number of key issues impacting the provision of the service across the Review footprint.

In January 2018, the focus of the Review will turn to identifying a number of potential solutions and recommendations for the delivery of the service going forward.

6 Gastroenterology and Endoscopy

This chapter explores the challenges facing gastroenterology and endoscopy services across South Yorkshire and Bassetlaw, Mid Yorkshire and North Derbyshire. In particular, it contains:

- A recap on the rationale for including the service
- The scope of the service considered within the Review
- An overview of current performance of the service
- A deep dive into some of the key challenges and issues impacting the sustainability of the services across the Review footprint.

6.1 Rationale for inclusion

In stage 1A, 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 not progressed because they impinge upon acute medical 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.

6.2 Scope

The scope of gastroenterology and endoscopy includes urgent and emergency gastroenterology (GI bleed services and the structure of acute rotas) as well as elective endoscopy services. The scope excludes elective gastroenterology services because it was felt the size of the scope needed to be managed in a time bound review. The review notes the strong interdependencies with emergency medicine.

6.3 Current performance

Prior to the commencement of the CWGs, the Review team completed some analysis to understand some of the key issues with the current service. The analysis was on a combination of data provided by each Trust, coupled with publically available data.

The key messages emerging from the data analysis were:

- Not all trusts operate a fully 24/7 out of hours GI Bleed service and have robust network arrangements. For example, at one trust five out of six overnight weekdays are not covered due to staffing shortages (the Gastroenterologist contributes to the General

Medical rota on a one in six basis). There is a regional agreement during the weekday overnights that patients with a GI bleed are established and referred to another Trust if a Gastroenterologist is not available⁴⁴.

- Most trusts are projecting significant increases in the future level of demand for endoscopies ranging from 4% to 15%⁴⁵. There are a number of factors which are impacting demand, including bowel cancer screening initiatives, an increase in symptomatic awareness and referrals from symptom awareness campaigns, service improvement programmes, GP direct access diagnostic test and a growing and ageing population.

Figure 8: Trust self-assessment of future levels of demand for planned endoscopies in comparison to Department of Health forecasts⁴⁶

	Barnsley Hospital NHS Foundation Trust	Chesterfield Royal Hospital NHS Foundation Trust	Sheffield Teaching Hospitals NHS Foundation Trust	Doncaster And Bassetlaw Teaching Hospitals NHS Foundation Trust	The Rotherham NHS Foundation Trust	Sheffield Children's NHS Foundation Trust
Department of Health forecasted a 10–15% year-on-year increase in demand for endoscopies ¹	<i>Data not available</i>	<i>Data not available</i>	6.50% increase p.a.	10% increase p.a.	FY17/18: 10-15% increase (due to demand from becoming Bowel scoping centre – additional 2-4 lists per week) FY18/19 onwards: 4% increase p.a.	5.17% increase p.a.

- Across trusts, there are a significant proportion of patients with waiting times of more than two weeks, the majority of which are outpatient non-cancer patients, although there are some cancer patients⁴⁷.

⁴⁴ Trust data returns

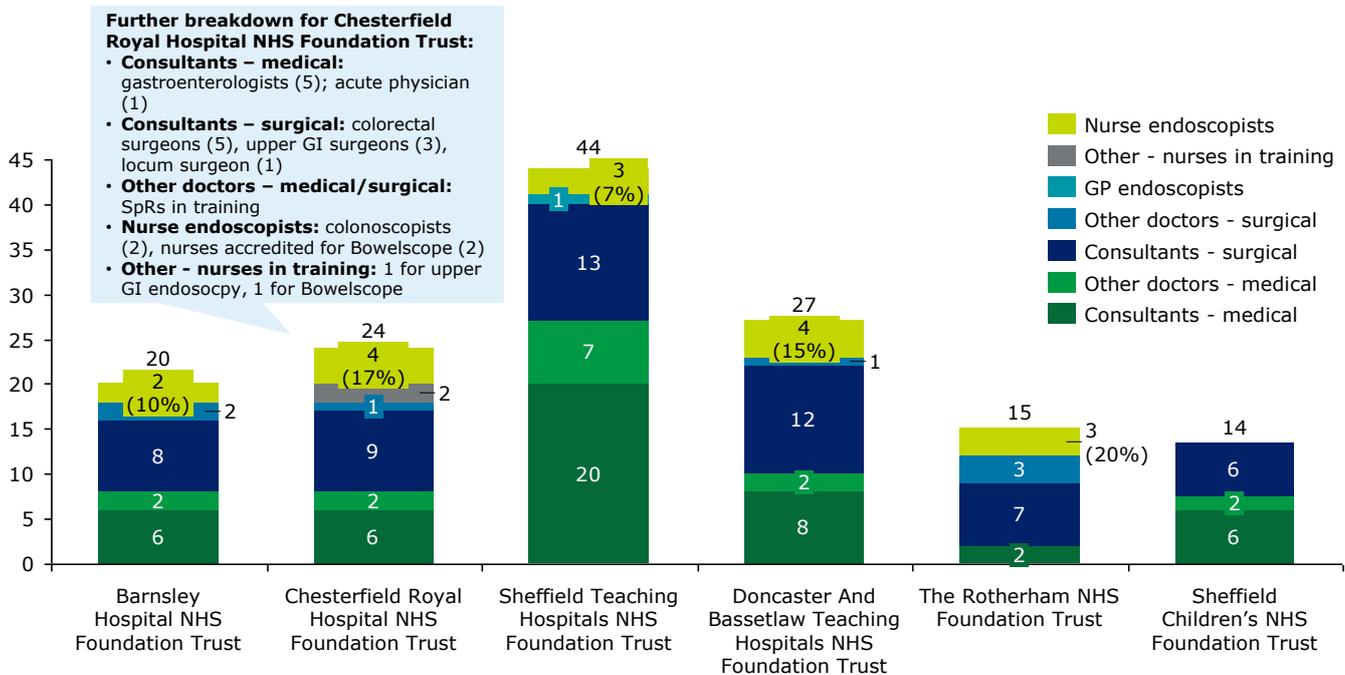
⁴⁵ Trust data returns

⁴⁶ Trust data returns

⁴⁷ Trust data returns

- Across the region, there are 16 clinical endoscopists across the trusts out of a total 144 endoscopists⁴⁸, suggesting there is greater scope for use of an alternative workforce.

Figure 9: Number of endoscopists by profession/grade (% of endoscopists that are nurse endoscopists) - Headcount FY2016/17⁴⁹



- Many trusts struggle to fill gastroenterology posts, in particular for the more senior medical grades⁵⁰. Consequently, this has resulted in high locum spend, in particular for consultant doctors and band 5 to 6 nurses.
- Overall satisfaction of gastroenterology medical trainees across the footprint has been fluctuating for the past couple of years. Trainee satisfaction is highest at Sheffield Teaching Hospitals NHS Foundation Trust and Chesterfield Royal Hospital NHS Foundation Trust, but notably, trainee satisfaction at The Rotherham NHS Foundation Trust has been steadily decreasing over the past years⁵¹.

6.4 Understanding the challenge in the service

The objective of the first CWG was to firstly identify the challenges and opportunities facing the service, in order to explore potential solutions in the second and third clinical working group sessions.

The group identified four main challenges that the Review should aim to address:

- Workforce.
- Demand.
- Inequality in access and variation in service provision.

⁴⁸ Trust data returns

⁴⁹ Trust data returns

⁵⁰ Trust data returns

⁵¹ GMC National Training Survey Results 2017

- Relationship with the independent sector. These are discussed in more detail below.

6.4.1 Workforce

6.4.1.1 Gastroenterology and endoscopy

The members of the CWG said that the greatest challenge across all the trusts is the shortage of staff, particularly amongst consultants and nurses. National shortages for these groups create difficulties for trusts in recruiting, training and retaining enough staff to cover the rotas, leading to competition for a limited pool of clinicians.

6.4.1.2 Endoscopy

CWG members pointed out that the endoscopy workforce shortage has the potential to impact on Joint Advisory Group on GI Endoscopy (JAG) accreditation and trainee numbers going forward. The groups said that there are a number of external factors that will continue to drive demand for endoscopy services (and therefore workforce) including public health risk factors (alcohol dependency and obesity); and increasing prescription and use of anticoagulant medication which necessitates a better understanding of possible side-effects and long-term impact on patients.

6.4.1.3 Gastroenterology

The group reported that as a result of workforce shortages, trusts find it difficult to cover the GI Bleeds rotas out-of-hours and over the weekend. This out of hours / on-call cover can often affect routine staffing the following day. There are also interdependencies with other services and workforce such as critical care, high dependency units and recovery units.

Group members said that GI bleed rotas needed to be staffed by experienced staff, including those trained in advancing technology (such as interventional radiology). A change in National Confidential Enquiry into Patient Outcome and Death (NCEPOD) standards which require consultants to cover the whole pathway (including lower GI bleeds such as colorectal bleeds) has resulted in a small number of consultants withdrawing from rotas as not all consultants have the necessary training or experience to work on the whole pathway, or use the more specialised technology.

The Clinical Working Group discussed some case studies of providers who have tackled similar problems:

Use of clinical endoscopists nationally and internationally⁵²

Clinical endoscopists already undertake as much of 20% of the workload in an endoscopy unit, and NHS Improving Quality initiatives estimate that up to 40% of low-risk, high-volume endoscopic procedures could potentially be carried out by non-medical endoscopists (NME).

In the United Kingdom, Ireland, New Zealand and the Netherlands, non-medical endoscopists such as nurse endoscopists are increasingly carrying out endoscopic

⁵²

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/597718/Gastrointestinal_endoscopy_workfor_ce_review.pdf

<http://www.bmj.com/content/338/bmj.b231>

procedures in collaborative multidisciplinary teams supported by medical staff. The non-medical endoscopy workforce is being developed to meet capacity challenges and Health Education England has recently endorsed the development of a non-medical endoscopy competency framework and has supported the production of a training programme for nurse endoscopists.

Clinical endoscopists work independently as autonomous and competent practitioners in performing diagnostic and therapeutic procedures.

A 2009 study into the effectiveness of nurse delivery endoscopy concluded that diagnostic endoscopy can be undertaken safely and effectively by nurses.

6.4.2 Demand

The CWG said that some of the issues around demand are common to both gastroenterology and endoscopy, and some are discrete. These are further explored below.

6.4.2.1 Gastroenterology

CWG members reported a rising demand for gastroenterology services, in particular driven by an increasing number of highly complex patients requiring specialist care and additional resource. The group felt that a focus on prevention, particularly public health interventions around alcohol and obesity is required, as well as careful consideration in the prescription of anticoagulant medication.

6.4.2.2 Endoscopy

Similarly to gastroenterology, the group said that there is a rising demand for endoscopy services, again driven by an increasing number of complex patients requiring specialist care and additional resource.

In particular for endoscopy, changes to stringent clinical guidelines (such as the two-week cancer target), the introduction of new screening programmes (such as bowel cancer screening), and the lowering of thresholds for referral for endoscopy in some areas, has caused an increase in demand for endoscopies. Some members of the group raised a concern that this is leading to increased waiting times for interval endoscopies in some cases.

The group said that one of the main drivers for referral rates is how risk averse GPs were. There was a concern that changing guidelines, with lower thresholds for referral, mean that GPs are referring more patients.

The group suggested that there is also increased public awareness of and acceptance of endoscopies as a diagnostic test, so more patients are expecting or requesting endoscopies.

6.4.3 Inequality in access and variation in service provision

Again, there are some common issues within gastroenterology and endoscopy, and some that are discrete. These are further explored below.

6.4.3.1 Gastroenterology

CWG members said that there is variation in service provision across the patch, with some trusts managing to staff a 24/7/365 Gastrointestinal (GI) Bleeds rota, with any necessary

admissions going straight to a gastroenterology ward, and others not being able to provide the same service.

In addition, attendees said that there is variation in transfer protocols, with no unified protocol used by all trusts, and sometimes poor communication across the patch. The group said that it can be challenging to transfer patients to units with 24/7 provision, and to repatriate them after treatment. This causes inequitable access to safe and sustainable gastroenterology services across the footprint.

6.4.3.2 Endoscopy

The group said that there is variation in Endoscopy equipment between trusts, with no clear standardisation of equipment making shared working difficult.

6.4.4 Relationship with independent sector

6.4.4.1 Endoscopy

The group said that a number of trusts currently draw on the independent sector to provide elective endoscopy services. Although this can help to ease waiting list pressures for trusts, there is concern that the NHS are competing with the independent sector for the same staffing pool.

6.5 Key themes emerging from public and patient feedback

The patient and public feedback on gastroenterology and endoscopy is laid out in more detail in the appendices.

Further feedback is continuing to emerge from the public engagement during January and a full report is being drafted which will draw together all the public engagement done for the Review. Alongside the feedback attached to this interim report, conclusions from the draft full report on public engagement are being used to develop the options and the final version of the full report on public engagement will be published on the ACS website as soon as possible

The key themes raised so far are:

6.5.1 Simplifying services

Attendees at the regional public event raised concerns that having services duplicated across sites was not efficient, and was confusing for patients. They specifically referenced the Royal Hallamshire and Northern General hospitals, both of which provide gastroenterology and endoscopy. There was a suggestion that it might be more efficient and less confusing to have services for gastrointestinal bleeds on a smaller number of sites.

6.5.2 Supporting patients

Attendees from the seldom heard groups were particularly concerned that proper investigations for gastrointestinal issues should be carried out, and patients should not be sent home until a full diagnosis had been found. This was felt to be particularly a concern where there were communication difficulties for patients or the family, and translators needed to be available. There also needed to be a focus on patient dignity and privacy.

6.6 Moving towards solutions

The Review team recognises that this chapter sets out a number of key issues impacting the provision of the service across the Review footprint.

In January 2018, the focus of the Review will turn to identifying a number of potential solutions and recommendations for the delivery of the service going forward.

7 Stroke

This chapter explores the challenges facing stroke services across South Yorkshire and Bassetlaw, Mid Yorkshire and North Derbyshire. In particular, it contains:

- A recap on the rationale for including the service
- The scope of the service considered within the Review
- An overview of current performance of the service
- A deep dive into some of the key challenges and issues impacting the sustainability of the services across the Review footprint.

7.1 Rationale for inclusion

In stage 1A, it was identified that for stroke services, there is difficulty in recruiting a consultant workforce. Feedback from interviewees corroborated the challenges raised in the sustainability assessment, particularly in relation to the sustainability of acute stroke services and rehabilitation at each local hospital.

At the time of the analysis, trusts said that these sustainability issues were being further compounded by the recent consultation of hyper acute stroke services (HASU), which was resulting in temporary uncertainty around the future of these services.

It was recognised that the existing work on HASU would be materially helped by taking a wider view of stroke services, and by resolving issues with transition and rehabilitation in each Place. To date, 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.

7.2 Scope

The Hospital Services Review agreed that acute stroke units (ASU), inpatient rehabilitation and Transient Ischemic Attacks (TIA) were in scope for this Review. Although Early Supported Discharge (ESD) and community rehabilitation is in scope and the Review may make recommendations, it is up to each Place to decide whether they take on board the proposal.

Hyper acute stroke services (HASU) are already subject to review, and are consequently excluded from this review, however, the interdependencies have been considered.

7.3 Current performance

Prior to the commencement of the CWGs, the Review team completed some analysis to understand some of the key issues with the current service. The analysis was on a combination of data provided by each Trust, coupled with publically available data.

The key messages emerging from the data analysis were:

- Although it is primarily associated with the provision of HASU, it should be noted that there is poor access to life saving stroke services, for example, three of the six trusts

fall below the national average of 51% for the percentage of patients scanned within one hour of clock start⁵³.

Figure 10: Percentage of patients who were thrombolysed within 1 hour of clock start (2016/17)⁵⁴

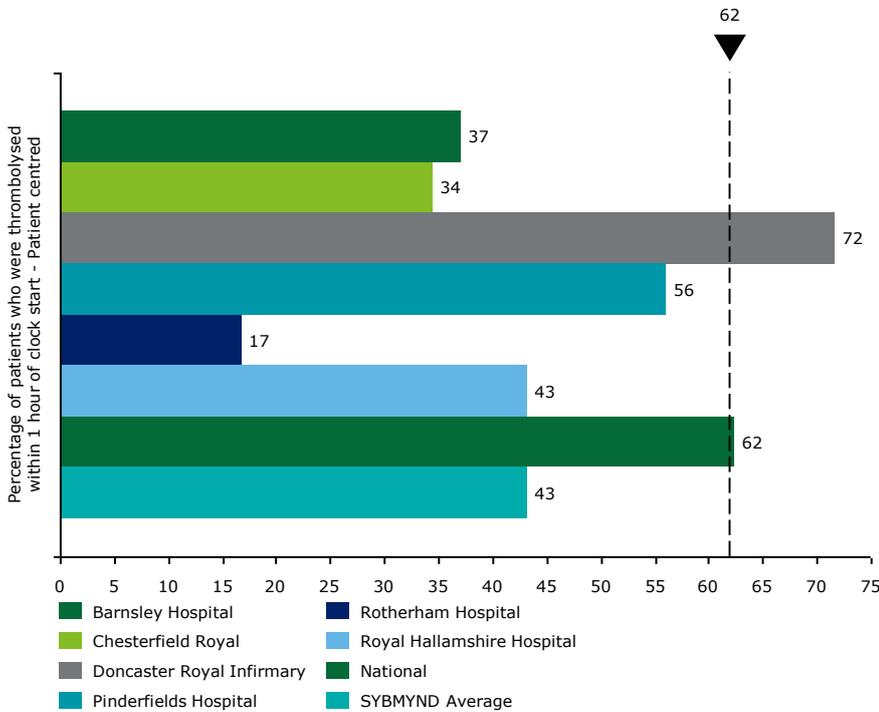


Figure 11: Number of all stroke patients given thrombolysis (April 2016 – March 2017)⁵⁵

	Barnsley Hospital	Chesterfield Royal	Doncaster Royal Infirmary	Pinderfields Hospital	Rotherham Hospital	Royal Hallamshire Hospital
Number of patients - Patient-centred 72h cohort	482	639	642	823	451	963
Percentage of all stroke patients given thrombolysis (all stroke types) - Patient centred	5.6	10	8.3	11.9	5.3	6
Number of all stroke patients given thrombolysis (all stroke types) - Patient centred ⁵⁶	27.0	63.9	53.3	97.9	23.9	57.8

⁵³ SSNAP Annual Portfolio for April 2016-March 2017 admissions and discharges / NICE

⁵⁴ SSNAP Annual Portfolio for April 2016-March 2017 admissions and discharges / NICE

⁵⁵ SSNAP Annual Portfolio for April 2016-March 2017 admissions and discharges / NICE

⁵⁶ Derived by multiplying the % of all stroke patients (all stroke types) given thrombolysis by the number of patients in a 72 hour cohort. Patient centred.

- Variation in overall trainee satisfaction is high, ranging from 87% in Doncaster and Bassetlaw to 67% at Mid Yorkshire (Geriatric Medicine) although workload is a major concern for trainees (Geriatric Medicine)⁵⁷.
- There is variation in the delivery of TIA services across the region. Not all trusts are meeting new Royal College of Physicians (RCP) guidance which states that patients with a suspected TIA should no longer be risk stratified and seen within 24 hours⁵⁸, but should be assessed and investigated within 24 hours by a stroke physician.
- There is significant variation in the commissioning and provision of services across the whole pathway in each Place⁵⁹.
- There is significant variation in access to all therapies and agreement of rehabilitation goal plans, for example there is significant variation (41%) across the region in the percentage of patients assessed by a nurse within 24 hours, at least one therapist within 24 hours, all relevant therapists within 72 hours and have rehab goals agreed within 5 days⁶⁰.
- There is a large variation in the percentage of patients treated by an ESD team⁶¹ and in some places, ESD does not happen over the weekend⁶². Moreover, there is a lack of consistency in provision of community stroke rehabilitation including duration and intensity of therapy on offer.

⁵⁷ GMC National Training Survey Results 2017

⁵⁸ Trust data return

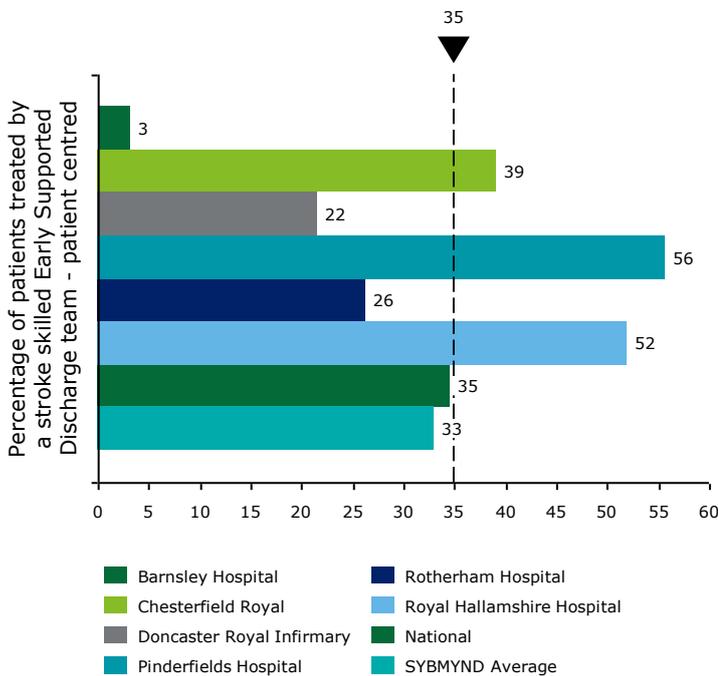
⁵⁹ Trust data return

⁶⁰ SSNAP Annual Portfolio for April 2016-March 2017 admissions and discharges / NICE

⁶¹ SSNAP Annual Portfolio for April 2016-March 2017 admissions and discharges / NICE

⁶² Trust data return

Figure 12: Percentage of patients treated by a stroke skilled Early Supported Discharge team – patient centred (2016/17)⁶³



7.4 Understanding the challenge in the service

The objective of the first CWG was to firstly identify the challenges and opportunities facing the service, in order to explore potential solutions in the second and third clinical working group sessions.

The group identified three main challenges that the Review should aim to address:

- Workforce.
- Flow.
- Inconsistency.

These are discussed in more detail below.

7.4.1 Workforce

The CWG agreed that the greatest challenge across all the trusts is the shortage of specialist stroke staff. This is broken down into four key areas:

- Difficulties recruiting and retaining nursing staff. CWG members said that caring for stroke patients is satisfying but demanding work (in particular on the ASUs where it can be physically hard work), and consequently there is a high turnover amongst staff and a high nurse vacancy rate. The group felt that the end of nursing bursaries is likely to have had a detrimental impact on nursing numbers.
- The CWG highlighted a shortage of acute stroke consultants at some trusts, and the knock-on impact this has on trainees. This has created a market for locums and

⁶³ SSNAP Annual Portfolio for April 2016-March 2017 admissions and discharges / NICE

increased the pay rate. In some cases trusts are unable to fill all their posts even if they break the pay cap for locums.

- Attendees said that acute stroke units are struggling to meet the national clinical guidelines for stroke, published by the Royal College of Physicians⁶⁴ which state that “a hyper-acute stroke unit should have continuous access to a consultant with expertise in stroke medicine, with consultant review 7 days per week... [and]... an acute stroke unit should have continuous access to a consultant with expertise in stroke medicine, with consultant review 5 days a week.”
- The group said that there is a funding shortage for therapists, although in this area it was felt that the staff would in fact be available. As a result of the funding shortages there is too little capacity available to deliver the hours of therapy required and meet seven-day working requirements with some services also reliant on locum staff. These factors limit the therapy intensity and or lead to shorter therapy time frames.

The Clinical Working Group discussed some case studies of providers who have tackled similar problems:

Exploring an alternative workforce at Salford Royal NHS Foundation Trust⁶⁵

At Salford Royal NHS Foundation Trust, there is an established advanced practice (AP) team within the stroke service which continues to grow including developing trainee advanced practitioners.

The trust is the provider of the Comprehensive Stroke Centre (CSC) for Greater Manchester and is a recognised regional centre for Major Trauma / Neurosciences and a centre of clinical excellence. The CSC assesses ~3,800 patients a year and treats ~2,100 stroke patients a year.

The trust has established two advanced nurse practitioners (ANP) who work clinically as part of the senior clinical fellow rota alongside an advanced practitioner (AP) from a paramedic background who is working as part of the junior clinical fellow rota. Both Nurses are non-medical prescribers with extensive P lists, and the trust is currently working up a patient group direction (PGD) for the paramedic advanced practitioner (AP) to work with in the emergency department. Both the two advanced nurse practitioners, and the advanced practitioner work 80:20 clinical to non-clinical.

The trust are currently training three more APs from therapy backgrounds, although there are limitations on two of these being able to prescribe.

The trust is exploring appointing a Physicians Associate (PA) in the new year and careful consideration is being given to how this role will fit into a junior fellow rota, as they will also be unable to prescribe initially.

The new roles have provided a stable, consistent input that can support rotas and new doctors and provides continuity, service development and training for new and rotating staff.

⁶⁴ Royal College of Physicians, National Clinical Guidelines for Stroke (2016)

⁶⁵ Engagement with the trust

The trust has identified a number of important lessons about how to use such roles in rotas, recognising that they are not like for like replacements and their background, interests, specific experience and prescribing abilities need to be factored in to how they are utilised in service.

7.4.2 Flow

The group members said that patient flow through the stroke patient pathway is a critical issue. Particular pinch points are transitions between the HASU and ASU, ASU to the community, inpatient rehabilitation, social care and home. Flow is also impacted by a lack of seven day working with partners, for example community rehabilitation and social care.

Within the acute setting, the CWG said that access to investigations seven days a week (for example, for TIAs) and varying waits for carotid surgery are also a contributor to poor patient flow within the hospital.

Although there is work ongoing to address delays in discharge across a range of specialties, group members said that length of stay for stroke patients is still very variable between hospitals and this consequently puts pressure on the patient pathway.

7.4.3 Inconsistency

The CWG reported that there is recognised inequity in the services being commissioned and offered to patients throughout South Yorkshire and Bassetlaw, Mid Yorkshire and North Derbyshire.

Attendees said that following recent changes to TIA guidelines, some trusts have not been able to meet the increase in demand for consultants and nurses that the new guidelines create. This has led to delays in some outpatient services, creating variation in the number of days that patients wait for an appointment in different trusts. In addition, some trusts face challenges with imaging capacity, and the vascular surgery response also varies between trusts. There are also issues as to whether patients present quickly enough for early TIA intervention, and whether TIAs are recognised: wider workforce training is required to ensure that staff are able to identify a TIA.

The group reported considerable variation in the provision of stroke rehabilitation services and Early Supported Discharge in each Place: for example, some Places do not have a stroke specific rehabilitation service specification, while others do not offer ESD. There is also variation to the degree that organisations are meeting seven day guidance.

The Clinical Working Group discussed some case studies of providers who have tackled similar problems:

Standardisation of Community rehabilitation in Greater Manchester (including Eastern Cheshire)⁶⁶

In 2015, Greater Manchester re-designed its acute care pathways for stroke patients. However, community rehabilitation for stroke services was not standardised. Throughout Greater Manchester there is a wide range of locally commissioned community rehabilitation

⁶⁶ Documents provided to Review team

services and there is inconsistency in a number of key quality metrics.

Greater Manchester identified evidence for the effectiveness of Early Supported Discharge (ESD) for those who have mild to moderate disability and the impact, with trials demonstrating that ESD can reduce long term dependency, admission to institutional care and reduce length of stay.

The region is working towards implementing a standardised model and service specification for community rehabilitation services in Greater Manchester for stroke by 2017.

The model will build on the principles and practice of ESD as well as the available evidence and guidelines, to ensure that all stroke patients discharged are seen in a timely way but a single multi-disciplinary team, regardless of their disability.

Desired outcomes from this piece of work include:

- To improve the quality and consistency of information provided on discharge.
- To improve interaction with social care to reduce delays and access to packages of care on discharge.
- To provide better support for return to work and vocational rehabilitation.
- To improve referral to community based services to support recovery, especially those provided by the voluntary sector.
- To develop a basket of suitable outcome measures for rehabilitation and implement consistently across Greater Manchester.
- To improve compliance with 6 month reviews of stroke patients.

7.5 Key themes emerging from public and patient feedback

The patient and public feedback is laid out in more detail in the appendices.

Further feedback is continuing to emerge from the public engagement during January and a full report is being drafted which will draw together all the public engagement done for the Review. Alongside the feedback attached to this interim report, conclusions from the draft full report on public engagement are being used to develop the options and the final version of the full report on public engagement will be published on the ACS website as soon as possible.

The key points that have been raised around stroke so far are as follows:

7.5.1 Access to care

Attendees at the regional public engagement event felt that more needed to be done in order to ensure access to a specialist stroke unit within 4 hours. They pointed to data suggesting that the system was not performing well against this metric.

7.5.2 Capacity

Respondents from the seldom heard groups were particularly concerned that there needed to be enough bed capacity on acute sites for patients to stay until they were well, and not be discharged too quickly since this created unmanageable burdens for families. There should be facilities for families to stay overnight.

7.5.3 Mental health

Attendees at the regional public engagement event emphasised the importance of mental health services working alongside physical health, in treating stroke. They pointed to high rates of depression amongst stroke survivors, which can in turn hamper the patient's recovery.

7.5.4 Patient transport

Attendees at the regional public engagement event raised concerns that ambulance transfers were already under strain. They suggested that it will be essential to include both travel times and the implications for the ambulance service in the analysis done for the Review.

7.6 Moving towards solutions

The Review team recognises that this chapter sets out a number of key issues impacting the provision of the service across the Review footprint.

In January 2018, the focus of the Review will turn to identifying a number of potential solutions and recommendations for the delivery of the service going forward.

8 Emerging themes from clinical engagement

This chapter explores the emerging themes from the clinical engagement within stage 1B of the review.

8.1 Emerging themes

This section summarises the discussions in the second and third CWG. The groups discussed the challenges in the services at length. Some of the challenges were unique to specific services but looking across all of the issues discussed in the five services, three main themes emerged as threads across all of the groups:

- Workforce
- Clinical standardisation
- The configuration of services

8.1.1 Workforce

It was felt that the footprint needed to become a more attractive employer and become better at retaining staff. Ideas which might contribute to doing this included:

- Enabling more flexible working.
- Exploring a single approach to training, development and career paths.
- Exploring a single approach to re-validation.
- Exploring a single approach to alternative career paths, for example for Physician Associates and Advanced Nurse Practitioners.
- Exploring a single approach to developing staff with alternative backgrounds, for example apprentices to support and complement the core workforce.

It is recognised that any approach to working multi-site working or rotations would need to be balanced with the personal circumstances and wishes of staff, for example, through an "opt in" basis, and recognising that any vacant posts would need to be backfilled to ensure service delivery.

8.1.2 Clinical standardisation

At the moment there is significant variation between the clinical approach taken on different sites and by different Trusts. Sometimes this variation is based on clinical need but much of it is 'unwarranted variation', and suggests that not all patients are receiving care in line with national best practice.

The Clinical Working Groups felt that in order for the trusts to work better together as a system, and make the most of the possibilities of the Accountable Care System, they should be aiming to develop a more standardised approach to clinical practice. This would

also simplify the experience for trainee doctors and other staff who rotate between sites and have to learn different protocols each time.

Ideas which might contribute to this included:

- Standardising the ways in which clinical protocols and guidance are interpreted and implemented differently across organisations. There is a potential need to identify and streamline a number of protocols. For example, within Maternity there are a number of guidelines that are applied differently across trusts and would benefit from standardisation, for example, induction of labour, criteria for designating expectant mothers as low / medium / high risk births, and risk escalation and action protocols.
- Agreeing patient transfer protocols so there is agreement across sites about when and how a patient is transferred between providers.

In addition, for some services there may be opportunities to standardise commissioning specifications across the footprint.

8.1.3 The configuration of services

The groups also consider whether the services were currently configured in such a way as to make the best use of the available workforce and to provide patients with access to specialised care. The groups felt that in most cases the current configuration of services was not optimal for the quality of patient care and creating a sustainable service for the future. The groups explored how it might be possible to optimise providing more care closer to their own homes, whilst ensuring that more specialised services could be fully staffed and high quality.

Ideas which might contribute to this included:

- Identifying which services need to be carried out in local providers in order to provide patients with the best care closer to home, and which need to be done at scale in order to provide better access to specialist skills and equipment
- Identifying how existing staff might best be used to support higher quality and more consistent outcomes for patients, for example by consolidating rotas.

9 Emerging themes from patient and public engagement

This chapter explores the emerging themes from the patient and public engagement. This includes in particular the online survey which, at the time of writing (December 2017), had attracted 301 respondents, including 213 members of the public and 88 members of staff; the public engagement events, particularly the regional event held on 6th December; and engagement with 96 people from seldom heard groups.

9.1 Overview of patient and public engagement

A wide range of issues have been raised in the sessions held with patients and the public, in the online survey, and in the interviews with people from the seldom heard groups.

Some key themes can be seen to be emerging around issues and potential solutions which apply across the services (the detail relating to specific services is outlined above):

- Workforce
- Access to local services
- Links to other sectors: primary care, community care, mental health and social care
- Links to the voluntary sector
- The Accountable Care System.

9.2 Summary of key themes from patient and public engagement

9.2.1 Workforce

Respondents to the survey and in the public events emphasised the importance of workforce, as being central to a positive experience of care.

The overall quality of care and service from staff is central to a positive experience. The 'soft skills' from doctors, nurses and other staff are key. One issue which was raised by some respondents from the seldom heard groups was the issue of language skills amongst the workforce, with a lack of interpreters impacting on communication with staff and therefore the quality of care. There was also an issue around the availability of sign language interpreters for Deaf patients.

The public survey included a significant number of responses which focused on the need for increased staffing levels. Attendees at the regional public engagement event, and the public engagement event at Rotherham, suggested that the NHS needed to look at non-traditional routes to recruit staff, including greater use of non-degree routes such as apprenticeships. They also suggested that NHS organisations and universities needed to work with schools and sixth form colleges to increase awareness of medical careers amongst students at the time that they were thinking about future careers.

Shortages of staff were seen as having a major impact on quality of care, and respondents to the public engagement event gave examples of occasions when staff had been too rushed and overworked to be able to provide compassionate care.

Staff shortages were also seen as exacerbating problems with waiting times. Feedback from the online survey pointed to waiting times in a wide variety of areas (diagnostics, elective, emergency and ambulance services) as impacting on the quality of care. Respondents from the seldom heard groups said that long waiting times, for example in A&E or a GP surgery, were particularly hard for patients who had mental health issues and might be agitated.

9.2.2 Access to local services

A key theme of the online survey responses related to having local services that they can easily access. The online survey included a particularly large number of responses related to the reduction in paediatrics services at Bassetlaw, with people concerned about the closure of the paediatrics ward overnight. Feedback from the seldom heard groups emphasised that access to services needed to be equitable.

Responses from the attendees at the public event in December was more mixed, with a number of attendees commenting that they would prefer to see high quality services, even if this meant travelling further because specialist expertise had been consolidated onto a smaller number of sites.

A key theme across all of the discussions around access to care was transport, particularly the importance of engaging the ambulance service and understanding the impact of any proposals on them. The impact on travel times was also highlighted as a theme in responses to the survey and in the public session.

9.2.3 Links to primary care, mental health, community sector, social care,

A major theme across all the channels of public engagement was that the Hospital Services Review cannot look at acute services in isolation. Acute services are interdependent with primary care, mental health, the community sector, and social care services. There was a strong steer in the regional public event that the Review team needed to engage with all of these sectors, particularly social care.

9.2.4 Links to the voluntary sector

Some respondents raised concerns about cuts to support for voluntary sector organisations, which they described as having knock on effects for NHS services.

9.2.5 The Accountable Care System

A number of questions were raised in the face to face public sessions about what the Accountable Care System is; what it is 'accountable' for and who it is 'accountable' to; and how it relates to the Hospital Services Review.

9.2.6 'Other' responses

In addition to the key themes outlined here, a wide range of other issues were raised as:

- The need for improved communication with patients and families, particularly where language is a barrier
- Need for improved facilities
- No car parking charges/better parking
- Improved sign-in process
- More beds needed in hospitals
- The need for improved technology and particularly IT compatibility
- The need for continuity of care
- Need to check records to ensure the right medication is given
- Need for better managerial support for staff

- Wards should be quieter and there are issues with quality of care eg bringing food
- Staff should be permanent not temporary locum staff who don't know the patients or the hospital
- Greater clarity around how the Review relates to Chesterfield Hospital
- Suggestions for strengthening public engagement going forward

9.3 Response to patient and public engagement

The majority of the points raised in the patient and public engagement will be fed into the development and evaluation of options, and will be discussed in more detail in the Stage 2 report of the Hospital Services Review. However, we have sought to address some points immediately, including:

- Clarifying in the 1b Report around how the HSR relates to Chesterfield and Mid Yorks hospitals.
- Clarifying in the 1b Report how we have engaged with primary and community care, and mental health through the CWGs.
- Engaging more closely with social care. Following the public engagement event, the Review team have set up meetings with the social care leads from each of the relevant Local Authorities to talk through the issues relevant to social care.
- Taking account of the feedback on the public engagement events as we begin to plan the next session in March.

10 Next steps

This chapter outlines the next steps of the review between January 2018 and April 2018.

10.1 Next steps

In January 2018, the review will progress into stage two where the main focus will turn to identifying options for addressing some of the concerns raised across stage one and developing a number of recommendations.

There are a number of key components to stage two of the review:

- A number of potential options will be developed, drawing on the rich inputs and insights gauged from the first seven months of the Review, and in particular the clinical input of the CWG members.
- This first longlist of options will be tested against our hurdle criteria, to rule out options which are not feasible.
- The remaining options will be modelled, at a high level, to understand the impact. The modelling will then be assessed against the full list of evaluation criteria.
- There will be a fourth CWG with clinical representatives who participated in the first three CWGs, as well as a third system-wide public engagement event. Both the CWG meeting and the public event will review and discuss system-wide options, review modelling outputs against the evaluation criteria, and identify the pros and cons of each model.
- This will then be developed into a final report outlining a number of recommendations which will be submitted to commissioners at the end of April 2018. It will be published shortly afterwards.
- There will be further public engagement to give the public and patients an opportunity to comment on the emerging ideas for the Review.

As previously mentioned, the Review is independent and open: no conclusions have yet been reached about the possible ways forward for the South Yorkshire and Bassetlaw accountable care system.

Appendix 1 CWG Attendance List

Urgent and Emergency Care

Name	Role	Organisation	CWG 1	CWG 2	CWG 3
Mike Simms	Medical Advisor	Barnsley CCG	Attended	Attended	
Shaun Garside	Director of Operations	Barnsley Hospital NHS Foundation Trust	Attended	Attended	Attended
James Griffiths	Clinical Lead for ED	Barnsley Hospital NHS Foundation Trust			Attended
Bill Bailey	Clinical Director Emergency Care and Orthopaedics	Chesterfield Royal Hospital NHS Foundation Trust	Attended	Attended	Attended
Nicholas Mallaband	Consultant	Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust	Attended	Attended	
Lesley Hammond	General Manager	Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust		Attended	Attended
Julie Thornton	Deputy General Manager	Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust	Attended		
Sewa Singh	Medical Director / Consultant	Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust	Attended		
Lorraine Grayson	Clinical Lead / Head of Audit Services	Nottinghamshire Healthcare NHS Foundation Trust			Attended
Debbie Dolan	Operational Manager	Nottinghamshire Healthcare NHS Foundation Trust	Attended		
Heather Towndrow	Integration Development Manager	Nottinghamshire Healthcare NHS Foundation Trust	Attended	Attended	Attended

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Melanie Gibbons	Service Manager	Rotherham Doncaster and South Humber NHS Foundation Trust	Attended	Attended	
Maxine Dennis	Director of Operations	Rotherham Hospital NHS Foundation Trust	Attended	Attended	
Conrad Wareham	Medical Director	Rotherham Hospital NHS Foundation Trust	Attended		Attended
StJohn Livesey	GP	Sheffield CCG	Attended		Attended
Brian Hughes	Commissioner	Sheffield CCG	Attended		
Alex Hendrie	Deputy Divisional Manager	Sheffield Children's NHS Foundation Trust	Attended		
Helen Stewart	Senior PEM Registrar	Sheffield Children's NHS Foundation Trust			Attended
Edward Snelson	Consultant	Sheffield Children's Teaching Hospital	Attended	Attended	
Avril Kuhrt	Clinical Director	Sheffield Teaching Hospitals NHS Foundation Trust	Attended	Attended	Attended
Lisa Walton	Operations Director	Sheffield Teaching Hospitals NHS Foundation Trust	Attended	Attended	Attended
Rachel Gillott	Programme Director Urgent and Emergency Care	South Yorkshire, Mid Yorkshire and North Derbyshire Working Together Programme	Attended		Attended
Jacqui Crossley	Head of Clinical Effectiveness and Governance	Yorkshire Ambulance Service NHS Trust	Attended	Attended	Attended

Maternity

Name	Role	Organisation	CWG 1	CWG 2	CWG 3
Noor Khanem	Obstetrics Clinical Lead / Consultant Obstetrician	Barnsley Hospital NHS Foundation Trust	Attended	Attended	Attended
Heather McNair	Director of Nursing	Barnsley Hospital NHS Foundation Trust	Attended	Attended	Attended
James Holloway	GP	Bassetlaw CCG		Attended	
Janet Cresswell	Consultant	Chesterfield Royal Hospital NHS Foundation		Attended	Attended

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		Trust			
Sarah Petty	Senior Matron	Chesterfield Royal Hospital NHS Foundation Trust	Attended	Attended	Attended
Janine Grayson	Head of Midwifery	Doncaster and Bassetlaw Hospitals NHS Foundation Trust			Attended
Sharon Dickenson	Head of Midwifery	Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust	Attended	Attended	Attended
Eki Emovon	Care Group Director	Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust	Attended		
Moira Hardy	Director of Nursing	Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust	Attended	Attended	Attended
Niki Sneddon	GP	Doncaster CCG	Attended		Attended
Kazia Foster	Service Improvement Manager	Nottinghamshire Healthcare NHS Foundation Trust		Attended	
Heather Towndrow	Integration Development Manager	Nottinghamshire Healthcare NHS Foundation Trust			Attended
Ngozi Anumba	GP	Sheffield CCG			Attended
Kate Laurance	Commissioning Manager	Sheffield CCG		Attended	
Claire Harness	Nurse Director	Sheffield Children's NHS Foundation Trust	Attended		Attended
Andrea Galimberti	Clinical Director	Sheffield Teaching Hospitals NHS Foundation Trust	Attended	Attended	
Paula Schofield	Nurse Director	Sheffield Teaching Hospitals NHS Foundation Trust	Attended	Attended	Attended
Elizabeth Pilling	Consultant Neonatologist / Neonatal ODN	Sheffield Teaching Hospitals NHS Foundation Trust			Attended
Audra Muxlow	Head of Midwifery and	The Rotherham Hospital NHS Foundation	Attended		Attended

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	Nursing	Trust			
Daksha Patel	Divisional Director	The Rotherham Hospital NHS Foundation Trust	Attended		Attended
Conrad Wareham	Medical Director	The Rotherham Hospital NHS Foundation Trust	Attended	Attended	Attended
Audra Muxlow	Head of Midwifery and Nursing	The Rotherham Hospital NHS Foundation Trust	Attended		Attended
Daksha Patel	Divisional Director	The Rotherham Hospital NHS Foundation Trust	Attended		Attended
Conrad Wareham	Medical Director	The Rotherham Hospital NHS Foundation Trust	Attended	Attended	Attended
Steven Dykes	Deputy Medical Director	Yorkshire Ambulance Service NHS Trust	Attended	Attended	Attended

Stroke

Name	Role	Organisation	CWG 1	CWG 2	CWG 3
Philippa Moreno	Physiotherapy Inpatient Manager	Barnsley Hospital NHS Foundation Trust		Attended	
Ursula MacFarlane	Occupational Therapy Service Manager	Barnsley Hospital NHS Foundation Trust		Attended	Attended
Terrie Fleet	Clinical Nurse Specialist	Barnsley Hospital NHS Foundation Trust			Attended
Gavin Portier	Matron	Barnsley Hospital NHS Foundation Trust			Attended
Shaun Gardside	Director of Operations	Barnsley Hospital NHS Foundation Trust		Attended	Attended
James Holloway	GP	Bassetlaw CCG	Attended	Attended	Attended
Nanthakumar V	Governing Body Member	Bassetlaw CCG		Attended	Attended

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Gary Durrant	Nursing Lead	Chesterfield Royal Hospital NHS Foundation Trust			Attended
Sunil Punnoose	Clinical Lead for Stroke	Chesterfield Royal Hospital NHS Foundation Trust	Attended	Attended	
Tina Potter	Matron	Chesterfield Royal Hospital NHS Foundation Trust	Attended	Attended	
Peter Anderton	Consultant Stroke Physician / Clinical Lead for Stroke Services	Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust		Attended	Attended
Sarah Bayliss	General Manager	Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust	Attended	Attended	
Jaimie Shepherd	Stroke Pathway Clinical Manager	Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust	Attended		Attended
Jane Douthwaite	Physiotherapist Lead	Nottinghamshire Healthcare NHS Foundation Trust	Attended	Attended	Attended
Cora Turner	Service Manager	Rotherham Doncaster and South Humber NHS Foundation Trust		Attended	Attended
Anthony Gore	Clinical Director / GP	Sheffield CCG	Attended	Attended	
Rob Ghosh	Clinical Director / Consultant Physician	Sheffield Teaching Hospitals NHS Foundation Trust		Attended	
Richard Grunewald	Clinical Director	Sheffield Teaching Hospitals NHS Foundation Trust	Attended	Attended	
Amanda Jones	Stroke Nurse Consultant	Sheffield Teaching Hospitals NHS Foundation Trust	Attended	Attended	
Chris Hayden	Pathway Manager	Sheffield Teaching Hospitals NHS Foundation Trust	Attended	Attended	Attended
Caroline Haw	Clinical Lead for Speech and	Sheffield Teaching Hospitals NHS Foundation Trust	Attended	Attended	Attended

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	Language Therapy in Stroke	Trust			
Mandy Higginbottom	Head of Primary Care and Interface Services	Sheffield Teaching Hospitals NHS Foundation Trust	Attended	Attended	
Simon Hickman	Consultant Neurologist	Sheffield Teaching Hospitals NHS Foundation Trust			Attended
Augutsin Iqbal	Consultant	South West Yorkshire Partnership NHS Foundation Trust	Attended	Attended	Attended
Lisa Wilkins	Consutant / Workstream Lead	South Yorkshire, Mid Yorkshire and North Derbyshire Working Together Programme	Attended	Attended	
Marianna Hargreaves	Programme / Workstream Lead	South Yorkshire, Mid Yorkshire and North Derbyshire Working Together Programme	Attended		
Prabal Datta	Consultant Cerebrovascular Physician / Clinical Lead	The Mid Yorkshire Hospitals NHS Trust		Attended	Attended
Jon Miles	Divisional Director	The Rotherham Hospital NHS Foundation Trust		Attended	
Louise Deakin	General Manager for Acute Intgrated Medicine	The Rotherham Hospital NHS Foundation Trust		Attended	
Jacqui Crossley	Head of Clinical Effectiveness and Governance	Yorkshire Ambulance Service NHS Trust	Attended	Attended	Attended

Care of the Acutely Ill Child

Name	Role	Organisation	CWG 1	CWG 2	CWG 3
Jamie Macinnes	GP	Barnsley CCG	Attended	Attended	Attended
Sunil Bhimsaria	Clinical Lead / Consultant Paediatrician	Barnsley Hospital NHS Foundation Trust	Attended	Attended	Attended

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Claire Stockwell	Service Manager	Barnsley Hospital NHS Foundation Trust	Attended		
Carmel Stagles	Senior Manager	Chesterfield Royal Hospital NHS Foundation Trust			Attended
Tracey Barker	Senior Matron	Chesterfield Royal Hospital NHS Foundation Trust	Attended	Attended	
Roby Matthew	Clinical Lead for Paediatrics / Consultant	Chesterfield Royal Hospital NHS Foundation Trust	Attended	Attended	
Anuja Natarajan	Clinical Director	Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust	Attended	Attended	Attended
Helen Burroughs	Deputy GM	Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust	Attended	Attended	Attended
Heather Towndrow	Integration Manager	Development Nottinghamshire Healthcare NHS Foundation Trust	Attended	Attended	
Jason Page	GP	Rotherham CCG			Attended
Julie Lodge	Associate Nurse Director	Rotherham Doncaster and South Humber NHS Foundation Trust	Attended	Attended	
Nikki Bates	GP / Children's Portfolio Holder	Sheffield CCG	Attended		Attended
Tim Moorehead	Chair	Sheffield CCG	Attended		
Craig Radford	Associate Director of Operations	Sheffield Children's NHS Foundation Trust	Attended	Attended	Attended
Sally Gibbs	Deputy Divisional Director / Consultant Paediatric A&E	Sheffield Children's NHS Foundation Trust	Attended	Attended	Attended
Nicola Jay	Clinical Lead / Consultant Paediatrician	Sheffield Children's NHS Foundation Trust	Attended	Attended	Attended
Jeff Perring	Clinical Lead / Consultant Paediatrician	Sheffield Children's NHS Foundation Trust	Attended		Attended

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Elizabeth Pilling	Consultant Neonatologist / Neonatal ODN	Sheffield Teaching Hospitals NHS Foundation Trust		Attended	Attended
Allison Grove	Consultant Paediatrician / Divisional Clinical Director	The Mid Yorkshire Hospitals NHS Trust	Attended	Attended	Attended
Daksha Patel	Divisional Director / Consultant Obstetrician	The Rotherham Hospital NHS Foundation Trust	Attended		Attended
Alison Cowie	Matron for the Special Care Baby Unit	The Rotherham Hospital NHS Foundation Trust			Attended
Faye Marshall	Service Manager	The Rotherham Hospital NHS Foundation Trust	Attended		Attended
Gill Willers	General Manager	The Rotherham Hospital NHS Foundation Trust	Attended		Attended
Sanjay Suri	Consultant Paediatrician	The Rotherham Hospital NHS Foundation Trust	Attended	Attended	Attended
Conrad Wareham	Medical Director	The Rotherham Hospital NHS Foundation Trust	Attended		
Steven Dykes	Deputy MD	Yorkshire Ambulance Service NHS Trust	Attended		

Gastroenterology and Endoscopy

Name	Role	Organisation	CWG 1	CWG 2	CWG 3
Dominic Byllas	Gastroenterology Consultant	Barnsley Hospital NHS Foundation Trust			Attended
Shaun Garside	Director of Operations	Barnsley Hospital NHS Foundation Trust	Attended	Attended	Attended
Jack Harding	Programme Manager Elective and Diagnostic Workstream	Barnsley Hospital NHS Foundation Trust	Attended	Attended	Attended

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Dawn Hadley	Senior Nurse Surgeon / Matron	Chesterfield Royal Hospital NHS Foundation Trust	Attended		Attended
Keith Dear	Consultant	Chesterfield Royal Hospital NHS Foundation Trust	Attended	Attended	Attended
Lesley Hammond	General Manager	Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust			Attended
Debi Oxley	Senior Sister in Endoscopy	Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust			Attended
Khalid Habib	Consultant Surgeon / Clinical Lead in Endoscopy	Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust			Attended
Anu Agrawal	Consultant	Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust		Attended	Attended
Julie Thornton	Deputy GM	Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust	Attended	Attended	
Prithvraji Rao	Consultant	Sheffield Children's NHS Foundation Trust	Attended		
Alex Hendrie	DDM	Sheffield Children's NHS Foundation Trust	Attended	Attended	Attended
Kumar Basu	Clinical Director	Sheffield Teaching Hospitals NHS Foundation Trust	Attended	Attended	Attended
Mo Thoufeeq	Clinical Lead	Sheffield Teaching Hospitals NHS Foundation Trust	Attended		
Marie McKenniff	Operations Director for Gastroenterology and Heptology	Sheffield Teaching Hospitals NHS Foundation Trust	Attended	Attended	
Jane Hopkins	Director of Nursing	Sheffield Teaching Hospitals NHS Foundation Trust	Attended	Attended	Attended
Faisal Abid	Clinical Lead for Endoscopy	The Mid Yorkshire Hospitals NHS Trust			Attended
Rebecca	Service Manager	The Mid Yorkshire Hospitals NHS Trust			Attended

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McGuinness					
Jeff Garner	Divisional Director	The Rotherham Hospital NHS Foundation Trust		Attended	Attended
Conrad Wareham	Medical Director	The Rotherham Hospital NHS Foundation Trust	Attended	Attended	
Louise Deakin	Associate General Manager	The Rotherham Hospital NHS Foundation Trust		Attended	Attended
Idris Griffiths	Accountable Officer	Bassetlaw CCG	Attended		
Charles Heatley	CCG Clinical Director Planned Care	Sheffield CCG	Attended		

