

South Yorkshire and Bassetlaw, Mid Yorkshire and North Derbyshire: Working Together on Hospital Services

Strategic Outline Case Annex A:

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

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1 INTRODUCTION

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

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

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

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

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

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

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

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

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

Other stakeholders including patients and the public were invited to respond with their views on the full report by 12th July¹. The public feedback received, as well as our response, is also detailed in this report.

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

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

1.2 ENGAGEMENT WITH PATIENTS AND THE PUBLIC

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

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

2 RESPONSES FROM CLINICAL COMMISSIONING GROUPS

2.1 BARNSELEY CCG

2.1.1 Response from Barnsley CCG

The following response was received:

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

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

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

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

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

2.1.2 Response to points raised by Barnsley CCG

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

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

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

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

- The hospital services programme will model all the appropriate options, including those where some patients' next nearest trust might be outside SYB(ND). However, in parallel with undertaking the modelling, the team will undertake due diligence around understanding any quality, safety and capacity issues at the potential receiving sites. This will include dialogue with the receiving site and their commissioners, to understand the issues from their perspective, as well as consideration of publicly available data on quality, capacity etc. The team will engage with SYB commissioners in designing this process of due diligence.
- In evaluating the options, one of the existing evaluation criteria is quality, and the team will consider any implications of quality for patients receiving care from trusts outside SYB(ND). The assessment against the criterion around access will also consider the potential equality implications of some patients receiving care at sites which are not signed up to the principles of the SYB Hosted Network.

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

2.2 BASSETLAW CCG

2.2.1 Response from Bassetlaw CCG

The following response was received:

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

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

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

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

2.2.2 Response to points raised by Bassetlaw CCG

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

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

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

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

2.3 DONCASTER CCG

2.3.1 Response from Doncaster CCG

The following response was received:

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

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

In response to the recommendations, I can confirm that:

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

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

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

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

2.3.2 Response to points raised by Doncaster CCG

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

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

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

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

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

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

2.4 NORTH DERBYSHIRE CCG

2.4.1 Response from North Derbyshire CCG

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

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

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

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

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

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

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

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

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

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

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

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

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

2.4.2 Response to points raised by North Derbyshire CCG

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

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

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

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

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

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

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

2.5 ROTHERHAM CCG

2.5.1 Response received from Rotherham CCG

The following response was received:

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

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

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

I hope this feedback is helpful.

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

2.5.2 Response to points raised by Rotherham CCG

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

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

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

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

Paediatric Assessment Units - The concern raised by Rotherham CCG is noted. It is important to reiterate that any proposals for reconfiguration will be developed in close collaboration with clinicians to ensure they meet safety and quality requirements. Clinical evidence supports the safety of SSPAUs as an alternative to full-time inpatient units, particularly when there is not enough activity or resource to sustain a full paediatric inpatient unit, assuming appropriate transfer protocols are in place for those patients requiring overnight care. The Royal College of Paediatrics and Child Health support such a care model, stating that for many patients they are a more appropriate care setting than an inpatient unit, and these models are being increasingly used to deliver high quality paediatric care².

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

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

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

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

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

2.6 SHEFFIELD CCG

2.6.1 Response received from Sheffield CCG

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

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

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

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

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

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

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

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

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

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

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

2.6.2 Response to points raised by Sheffield CCG

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

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

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

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

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

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

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

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

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

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

2.7 WAKEFIELD CCG

2.7.1 Response received from Wakefield CCG

The following response was received:

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

2.7.2 Response to points raised by Wakefield CCG

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

3 RESPONSES FROM ACUTE TRUSTS

3.1 BARNSELEY HOSPITALS NHS FOUNDATION TRUST

3.1.1 Response received from Barnsley Hospitals NHS FT

The following response was received:

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

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

Transformation proposals

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

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

Potential Reconfiguration Options:

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

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

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

General points

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

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

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

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

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

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

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

3.1.2 Response to points raised by Barnsley Hospitals NHS FT

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

The ICS responds to the specific concerns raised as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3.2 DONCASTER AND BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST

3.2.1 Response received from Doncaster and Bassetlaw Teaching Hospitals

The following response was received:

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

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

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

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

3.2.2 Response to points raised by Doncaster and Bassetlaw Teaching Hospitals

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3.3 CHESTERFIELD ROYAL HOSPITAL NHS FOUNDATION TRUST

3.3.1 Response received from Chesterfield Royal Hospital

The following response was received:

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

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

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

3.3.2 Response to points raised by Chesterfield Royal Hospital

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

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

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

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

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

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

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

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

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

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

The SOC identifies the following way forward on maternity services:

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

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

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

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

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

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

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

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

3.4 MID YORKSHIRE HOSPITALS NHS TRUST

3.4.1 Response received from Mid Yorkshire Hospitals

The following response was received:

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

3.4.2 Response to points raised by Mid Yorkshire Hospitals

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

3.5 THE ROTHERHAM HOSPITAL NHS FOUNDATION TRUST

3.5.1 Response received from The Rotherham Hospital

The following response was received:

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

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

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

As a Trust Board:

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

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

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

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

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

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

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

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

3.5.2 Response to points raised by The Rotherham Hospital

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

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

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

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

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

Clinical evidence supports the safety of SSPAUs as an alternative to full-time inpatient units, particularly when there is not enough activity or resource to sustain a full paediatric inpatient unit, assuming appropriate transfer protocols are in place for those patients requiring overnight care. The Royal College of Paediatrics and Child Health support such a care model, stating that for many patients they are a more appropriate care setting than an inpatient unit, and are being increasingly used to deliver high quality paediatric care³.

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

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

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

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

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

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

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

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

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

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

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

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

3.6 SHEFFIELD CHILDREN’S HOSPITAL NHS FOUNDATION TRUST

3.6.1 Response received from Sheffield Children’s Hospital

The following response was received:

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

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

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

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

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

Addendum – further response from Sheffield Children’s Hospital

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

3.6.2 Response to points raised by Sheffield Children’s Hospital

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

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

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

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

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

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

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

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

3.7 SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST

3.7.1 Response received from Sheffield Teaching Hospitals

The following response was received:

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

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

3.7.2 Response to points raised by Sheffield Teaching Hospitals

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

4 RESPONSES FROM COMMUNITY AND MENTAL HEALTH TRUSTS

4.1 SHEFFIELD HEALTH AND SOCIAL CARE NHS FOUNDATION TRUST

4.1.1 Response received from Sheffield Health and Social Care

The following response was received:

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

4.1.2 Response to points raised by Sheffield Health and Social Care

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

4.2 SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST

4.2.1 Response received from South West Yorkshire Partnership NHS Foundation Trust

The following response was received:

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

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

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

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

5 RESPONSES RECEIVED FROM OTHER PROVIDER ORGANISATIONS

5.1 EAST MIDLANDS AMBULANCE SERVICE NHS TRUST

5.1.1 Response received from East Midlands Ambulance

The following response was received:

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

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

Following discussion, our views can be summarised as follows:

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

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

5.1.2 Response to points raised by East Midlands Ambulance

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

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

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

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

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

5.2 YORKSHIRE AMBULANCE SERVICE NHS TRUST

5.2.1 Response received from Yorkshire Ambulance Service

The following response was received:

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

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

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

5.2.2 Response to points raised by Yorkshire Ambulance Service

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

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

6 RESPONSES RECEIVED FROM LOCAL AUTHORITIES

6.1 JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

6.1.1 Action points from the JHOSC

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

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

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

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

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

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

6.2 ROTHERHAM BOROUGH COUNCIL

6.2.1 Response received from Rotherham Borough Council

The following response was received:

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

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

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

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

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

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

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

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

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

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

6.2.2 Response to points raised by Rotherham Borough Council

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7 RESPONSES RECEIVED FROM PATIENTS AND THE PUBLIC

7.1 MEMBER OF THE PUBLIC - 1

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

7.1.1 Response received from a member of the public

This is a response to four documents, listed below⁴, published on 9 May 2018, together with videos on the same website and slides presented at the Joint Health Overview and Scrutiny Committee on 12 June 2018.

1 Issues of geography

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

2 Governance, transparency and pace of change

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

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

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

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

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

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

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

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

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

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

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

3 Rationale for the review

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

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

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

The population is ageing

Victim blaming and the idea that burdensome older people are to blame for increasing pressures on health and care services has been challenged elsewhere⁵. For example, many pensioners remain active, contribute to society and do all kinds of work, paid and unpaid. At the same time, many younger people are also suffering from deteriorating health. Given this, the focus on one age group seems misplaced and ageist. It masks the crisis in social care, which has been underfunded and undermined by successive governments, and underplays chronic ill health, both mental and physical, in other age groups and simplistically juxtaposes ageing and complex needs:

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

Demand is increasing

The so-called increase in demand has existed since the early days of the NHS and is driven by many factors, including air pollution⁶, poverty, benefit ‘reforms’, failed housing policy and austerity cuts. The Director of Public Health for Sheffield, Greg Fell, stated in his 2017 report:

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

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

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

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

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

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

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

Our workforce is increasingly overstretched

This is a strangely impersonal way to refer to overwhelming pressures on staff, which have been thoroughly documented, most movingly by the Royal College of Nursing in two reports on Safe and Effective Staffing published in 2017⁸. These make heart-breaking reading, and nothing in the HSR reports comes anywhere near addressing the concerns of the RCN or of NHS Providers, who described the challenges facing our NHS in 2017 as [Mission Impossible](#), risking patient safety and creating unfair and unsustainable burdens on staff⁹. We have heard similar concerns from local union reps, dismayed by the pressures on their members. Yet the review blithely proclaims that our region will be transformed into “a place where people want to come and work”. (Doc 1, page 19)

People’s needs are changing

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

The types of healthcare that we can provide are changing

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

4 Purpose of the Review

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

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

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

⁸ RCN (May 2017) *Safe and Effective Staffing: The Real Picture* <https://www.rcn.org.uk/professional-development/publications/pub-006195>

RCN (December 2017) *Safe and Effective Staffing: Nursing Against the Odds* <https://www.rcn.org.uk/professional-development/publications/pub-006415>

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

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

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

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

5 Lack of staff involvement

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

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

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

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

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

6 Staffing shortages

Here is the HSR vision for addressing staffing issues:

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

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

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

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

It is not only about recruiting them but about the ongoing, continuing professional development that you give people that allows them to feel valued and retained within the service...

Also, as people get towards the end of their careers, rather than retiring, encouraging people to be retaining their skills within the system, within management and training is a very positive thing.

There is much more we could learn from other systems about morale more generally and how other systems maintain that.¹¹

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

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

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

7 Lack of public voice

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

A Citizens Panel has been set up, but the membership is unknown; it is said to provide an independent view and critical friendship¹², aims which seem difficult to reconcile.

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

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

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

Recommendations for the future of hospital services in South Yorkshire and Bassetlaw

9 May 2018



The majority of services should remain in all local hospitals.



All seven emergency departments should remain.



Hospitals should develop "networks of care" with each taking responsibility for one of the reviewed services.



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



Women should have more choice over their maternity care and healthcare partners should explore further options for delivering maternity care.



A Health and Care Institute and an Innovation Hub should be developed, linked with universities, colleges and schools to develop and support the workforce while also researching new developments and technologies.

Find out more: www.healthandcaretogethersyb.co.uk



- 1 The majority of services should remain in all local hospitals. We have already been asked whether this means that 51% of services will remain and 49% be cut, which may seem flippant, but highlights the mistrust provoked by the lack of transparency around the review. The above slide does not include the reconfiguration recommendations for stroke, which was understandable as a legal decision was pending. However, it also omits proposed cuts in obstetrics units and gastroenterology services. The technical/financial annex includes the possibility of cutting beds from 5,178 to 4,637 by 2021/22 ([Doc 3 slide 25](#)). This raises concerns about premature discharge as well as the possible rationing of admissions.
- 2 All seven emergency departments should remain. Should does not mean that they will remain. Perhaps in the end only some emergency services will remain. Already there is huge concern in Sheffield about proposals to shift facilities from the Minor Injuries Unit and the Walk-in Centre to an Urgent Treatment Centre at the overstretched and inaccessible Northern General Hospital.
- 3 Hospitals should develop "networks of care" with each taking responsibility for one of the reviewed services. Details of these responsibilities remain unclear, and much of the discussion about hosted networks, single service models or coordinated delivery to manage flows of resources and patients treats people are treated as units to be shifted around the system, omitting impacts on quality.
- 4 There should be an expansion of services for children in the community and short stay units, meaning less need for longer stay inpatient wards and partners should consider further work to consider a small

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

- 5 Women should have more choice over their maternity care and healthcare partners should explore further options for delivering maternity care. 'Choices' refers to a document called *Better Births*¹³, which promotes women's choices, including the choice to give birth at home. The possible over-medicalisation of childbirth by (male) consultants is one issue, but 'choosing' home births might be inadvisable, since a higher proportion of women in SYB are at high risk than the national average and only 23% of births might be eligible for safe treatment in standalone midwifery led units (pages 137-138 of HSR [Doc 1](#)). Even with the positive spin, this recommendation has begun to alarm local people: after all, 'low risk' does not mean there is no risk. Moreover, the focus on 'choice' may exacerbate existing health inequalities.
- 6 A Health and Care Institute and an Innovation Hub should be developed, linked with universities, colleges and schools to develop and support the workforce while also researching new developments and technologies. Details of the proposed Institute are tucked away in chapter 9 of the main report, with functions and faculties illustrated on pages 56-7. This seems an expensive way to address the £17m cost of temporary staff in the past year, the staffing gaps required to meet Royal College guidelines (17% in paediatrics and 18% in maternity, slide 25 of [Doc 3](#)), let alone cope with the demoralisation of staff reported by the Royal College of Nursing, nurses' recourse to food banks, the PTSD reported to us, and so on. Professor Welsh casually suggests in his video that the proposed South Yorkshire Health and Care Institute would encourage young people not in education, employment or training to join the health service. He seems unaware that many young people are not in education or training because of high student fees and debt burdens, the abolition of EMAs and nursing bursaries, though bursaries are mentioned several times in the report. How would an HCI overcome these problems? Where would it find staff and on what terms and conditions would they be employed?

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

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

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

6 Lack of resources and lack of adequate data

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

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

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

¹³ <https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf>

¹⁴ <https://www.sheffield.ac.uk/news/nr/leading-the-way-with-new-test-beds-1.543143>

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

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



HSR analysis

There are currently significant limitations to this initial financial analysis

Limitations and assumptions of this initial analysis

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

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

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

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

7 Transport issues

Chapter 22 is devoted to Transport because:

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

The report also states:

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

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

Conclusion

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

7.1.2 Response to points raised by member of the public

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

Responses to the specific points raised are laid out below:

1. Geography

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

In summary:

- **South Yorkshire and Bassetlaw:** the organisations in the Sustainability and Transformation Partnership for South Yorkshire and Bassetlaw (SYB) are now members of the Integrated Care System (ICS). For CCGs, this is Barnsley, Bassetlaw, Doncaster, Rotherham and Sheffield. For acute hospitals, it is the Foundation Trusts of Barnsley, Doncaster and Bassetlaw, Rotherham, Sheffield Children’s, and Sheffield Teaching. For mental health organisations it is the Foundation Trusts of Rotherham, Doncaster and South Humber and Sheffield Health and Social Care.
- **South Yorkshire and Bassetlaw and North Derbyshire:** these are the organisations above, plus Chesterfield Royal Hospital Foundation Trust, and North Derbyshire CCG (Hardwick CCG is engaged through North Derbyshire CCG). This area covers the Trusts which are included within scope for potential reconfiguration options.

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

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

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

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

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

2. Governance

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

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

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

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

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

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

The committee concluded that

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

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

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

3. The rationale for the Review

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

The main pressures that the HSR is aiming to address (the ageing population, rising demand etc) are well evidenced in a number of national reports. See for example Gareth Iacocobucci writing in the British Medical Journal¹⁷ and a recent report by the Health Foundation and the Institute of Fiscal Studies¹⁸.

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

4. Purpose of the review

The member of the public asks about the rationale behind choosing the five services within the HSR. In order to provide clarity around this question, the SOC includes a short summary of how the five services were selected and prioritised. A more detailed account is published in the Section 1A report of the HSR, available on the website

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

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

¹⁵ <https://publications.parliament.uk/pa/cm201719/cmselect/cmhealth/650/650.pdf> p.75

¹⁶ <https://publications.parliament.uk/pa/cm201719/cmselect/cmhealth/650/650.pdf> p.78

¹⁷ <https://www.bmj.com/content/356/bmj.i6691.full>

¹⁸ <https://www.ifs.org.uk/uploads/R143.pdf>

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

A 'sustainable' service was defined as one where:

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

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

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

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

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

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

- The ICS communications team attended a number of events at healthcare sites across the footprints, including some open sessions with nurses. Some of the hospitals invited members of the team to set up a stall in their reception areas, and the team also attended some GP surgeries. This gave an opportunity to talk directly with both patients and staff at the sites, and to distribute surveys to get their views on the issues. Copies of the survey were left at the sites for any staff who were interested and had not been able to attend.
- A number of staff were also interviewed in the telephone surveys.
- **Trades unions:** SYB ICS meets with regional union representatives in the Staff Partnership Forum every two months. Members of the Forum have been kept up to date with the Review throughout the process and have discussed the findings of the Hospital Services Review. Comments from the group have informed the development of the next stage: for example, junior doctors will be invited to become members of the Clinical Working Groups at the request of union representatives.

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

5. Staff shortages

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

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

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

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

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

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

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

8. Lack of public voice

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

Public engagement to date -

- **Face to face engagement:** Three large public events were held which were open to any member of the public, in addition to individual meetings in specific Places. Further events were held in the foyers of some of the acute hospitals, and members of the team also visited other healthcare spaces such as GP surgeries to raise awareness. Patient Participation Groups in some of the Places also ran sessions on the HSR.
- **Public survey:** In addition, the HSR published a public survey, which received 1,849 responses. 1,000 of these were from people, chosen to mirror the demographic makeup of the health economy, who took part in a telephone survey.
- **Targeted engagement with seldom heard groups:** The engagement work also includes in-depth sessions with 96 representatives of seldom heard groups (including for example BME groups, young carers, the Deaf community, older people, asylum seekers, and the LGBT community).

The results of this public engagement were used to inform the drafting of the HSR. The engagement is summarised in a report at:

https://www.healthandcaretogethersyb.co.uk/application/files/4815/2231/8192/15._HSR_Stage_1b_Engagement_Report.pdf

The detailed responses, including the responses to the surveys, the write-ups of the public sessions, and the analysis of the engagement with seldom heard groups, are all available on the website.

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

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

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

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

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

Regarding some of the specific comments raised on the proposals:

- **The majority of services should remain in all local hospitals.** This was a principle of the HSR and also underpins the Strategic Outline Case. District General Hospitals provide services along a spectrum from low acuity and complexity through to higher acuity and complexity. The SOC is based on the principle that the majority of services should remain on the sites of local DGHs or be moved closer to home if possible. Some higher complexity services (for example inpatient paediatrics) may benefit from consolidation within a network, due to concentrations of workforce and expertise.
- **The reduction in bed numbers.** It is the aim of SYBICS and its individual Places to prevent people from getting ill, and to provide care as close to home as possible, with people only staying in hospital if it is necessary. It is in this context that each Place is anticipating a shift to support closer to home wherever possible. This does not mean patients will be prematurely discharged from hospital, or that people who need to be in hospital will not be cared for there.
- **Changes to emergency departments.** The SOC says that the system will retain all six emergency departments plus the paediatric emergency department at Sheffield Children's Hospital. In response to the feedback from the respondent we have made this statement very clear in the SOC. The SOC states that emergency departments will keep their doors open 24/7, with consultant coverage appropriate to the size of the unit, guided by Royal College of Emergency Medicine guidelines. Clinical Working Groups will be asked to consider what staff presence is appropriate in A&Es at different times of the day and explore how we can use staff in different ways. Alternative staff roles, such as advanced nurse or medical practitioners, or support from GPs, could help to address workforce challenges in our urgent and emergency care services.
- **Home births.** Better Births laid out a strategy to increase the choices available to women, including more midwifery-led services and more home births for mothers who are at low risk of complications. Home births and Midwifery Led Units were discussed by the public at public events, with members of the public expressing different views on how the system should balance patient choice with patient risk. Some people were in favour of home births and midwifery led units, and some were concerned that they exposed women to higher levels of risk.

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

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

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

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

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

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

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

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

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

9. Lack of resources and a lack of data

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

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

Quality assurance was conducted on the modelling and included:

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

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

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

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

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

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

10. Transport

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

7.2 MEMBER OF THE PUBLIC – 2

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

7.2.1 Response received from a member of the public

GOVERNANCE

1. *At Barnsley CCG Board meeting (14/6/18) Professor Welch (Independent Review Team Lead) accepted, when asked by a public question, that the financial section in the Technical Annex was estimated and based on the information given by only one hospital, no data being received from the other hospitals. He said further work was needed over the next nine months which would require data from all the hospitals to allow a full financial analysis.*

Both Professor Welch and Lesley Smith (System Reform Lead and Barnsley CCG Chief Officer) stated that none of the HSR recommendations are driven by the financial analysis.

It is disturbing to hear that:

- a) *The recommendations cannot be said to 'not make the financial situation worse' which was the agreed position of the review as a full financial analysis has not been possible.*
- b) *The answer to Q.9 in the Question and Answer Sheet part of the report is therefore not true.*
- c) *That only one hospital provided the data required in the ten months since the Review began and before the Report was published, despite the claim that these hospitals had worked together in a collaborative partnership for about five years.*

- d) *This non-co-operation does not demonstrate a strong collaborative or bode well for future partnership working.*
 - e) *That a decision will be made to approve a review's recommendations that cannot be guaranteed as cost neutral, as required.*
 - f) *This is not sound business practice and is not ethical given the business is a public service funded from the public purse.*
2. *The Report states that each public body partner will retain their responsibility for meeting their own statutory duties should the Hospital Service Review Report recommendations be implemented. However the Report assumes that individual statutory duties can be delegated to the Integrated Care System, when statutory duties cannot legally be delegated. Also to do so would not be compatible with the statement that each public body partner retains responsibility for their statutory duties.*
- Some examples include:*
- a) *The duties of CCGs for commissioning functions, including service specifications, and protocols, cannot just be assumed by the Hosted Networks that are managed by a Trust as implied in Section B Transformation.*
 - b) *The duty of each Trust to develop, support and recruit its own workforce cannot just be assumed by the hosted networks that are managed by another Trust.*
 - c) *There is an assumption that responsibilities that are laid down in statute can just be transferred across organisational boundaries without affecting staff employment status, and individual organisational statutory responsibilities.*

ACCOUNTABILITY

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

"14Z2 Public involvement and consultation by clinical commissioning groups

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

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

- (3) The clinical commissioning group must include in its constitution—
(a) a description of the arrangements made by it under subsection (2),
and
(b) a statement of the principles which it will follow in implementing those arrangements.*
- (4) The Board may publish guidance for clinical commissioning groups on the discharge of their functions under this section.*
- (5) A clinical commissioning group must have regard to any guidance published by the Board under subsection (4).*
- (6) The reference in subsection (2)(b) to the delivery of services is a reference “*

In all the plans for transforming services 1422 CCG Public Involvement Duty applies. This is clarified by the [Statutory Guidance for Patient and Public Participation in Commissioning](#) published in April 2017 by NHS England (the Board).

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

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

7.2.2 Response to points raised by member of the public

1. Governance

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

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

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

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

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

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

2. Statutory duties

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

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

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

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

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

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

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

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

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

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

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






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

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

7.3.1 Response received from Save Our NHS

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

The Review's recommendations were as follows

A&E	Maternity	Acutely ill children	Stroke	Gastroenterology
				
<ul style="list-style-type: none"> • Maintain 6 consultant led A&Es (plus the consultant led paediatric A&E at Sheffield Children's) 	<ul style="list-style-type: none"> • Increase choice: home births, Midwifery Led Units • All hospitals have midwifery led services for low risk women • Higher risk women cared for in larger consultant led units • Could replace 1 or 2 obstetric units with MLUs 	<ul style="list-style-type: none"> • More care for children at home / in community • Seriously ill children cared for in units with more specialists • Explore focusing 24/7 paediatric units on fewer sites: 1 or 2 could become Paediatric Assessment Units open 14/7 	<ul style="list-style-type: none"> • Standardised approach to Early Supported Discharge, TIA and rehab services • Consultants on Sites which will have a Hyper Acute Stroke Unit support services on those sites which have Acute Stroke Unit 	<ul style="list-style-type: none"> • Explore consolidating evening and weekend cover onto 3 or 4 sites: so that all sites have formal access to 24/7 GI bleed cover at all times, if necessary on another site

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



A Health and Care Institute and an Innovation Hub should be developed, linked with universities, colleges and schools to develop and support the workforce while also researching new developments and technologies.

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

What do you think is good about hospitals?

- 1 When admitted at 9 years old, it was good they let my mum stay overnight.
- 2 Whenever I've needed the NHS, they've been there.
- 3 Access for acute patients to therapeutic services, i.e. activities that are engaging, creative and promote physical activity. Well done, Occupational Therapy!!
- 4 Commitment of staff.
- 5 Blood testing service at the Hallamshire is speedy and efficient.
- 6 Great care and repair for my grandson (cleft lip and palate).
- 7 Been in hospital at Hallamshire and everything was good, from surgeon to cleaning staff!
- 8 Friendly, helpful nurses – how do they do it when they're so overworked?
- 9 It's good to see some welcoming entrances and child-friendly waiting areas.
- 10 Congrats NH's 70's. Its good service and maintenance.
- 11 They are good because they are local to communities
- 12 Quality of some of the services. Range of specialist services. Their apparent willingness to work together.
- 13 Sheffield hospitals are linked to the medical school, which is good.
- 14 SY - outpatients / theatre /
- 15 Sheffield hospitals are linked to the medical school, which is good.

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

What could be better?

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

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

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

What do you think about A&E Services?

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

What do you think about maternity services and proposals?

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

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

What do you think about Services for Acutely Ill Children?

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

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

What do you think about Stroke Services?

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

What do you think about Gastroenterology Services?

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

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

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

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

16 Quite a good idea.

What do you think about creating an Innovation Hub?

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

Do you have any more comments?

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

7.3.2 Response to the survey conducted by Save Our NHS

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

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