JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Venue: Committee Room 1, Date: Monday, 29th January, 2018

County Hall, Matlock, DE4

3AG

Time: 3.00 p.m.

AGENDA

PLEASE NOTE

There is a Pre-meeting for Members in the Committee Room at 2:30pm.

1. Joint Health and Overview Scrutiny Agenda Pack (Pages 1 - 73) Attachments:-

Item 5 – Powerpoint Presentation.

Item 6 – Update.

Item 7 – Powerpoint Presentation.

South Yorkshire, Derbyshire, Nottinghamshire and Wakefield Joint Health Scrutiny Committee

18 January 2018

Dear Member

Joint Health Scrutiny Committee

Please attend the meeting of the **Joint Health Scrutiny Committee** to be held on **Monday 29 January 2018** in **Committee Room 1, County Hall, Matlock, Derbyshire DE4 3AG, from 3.00pm – 5.00pm.**

The agenda for the meeting is set out below.

AGENDA

- 1. Declarations of Interest (if any)
- 2. Apologies for absence
- 3. To confirm the Minutes of the meeting held on 31 July 2017 (attached)
- 4. Review of the Terms of Reference of the JHSC (report attached)
- 5. Implementation of Hyper Acute Stroke Services Reconfiguration
- 6. Children's non-specialist surgery and anaesthesia progress on implementation
- 7. Independent hospital review update
- 8. Review of Specific Hospital Services Briefing Paper (attached)

JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE Monday, 31st July, 2017

Present:- Councillor Simon Evans (Rotherham MBC) (in the Chair); Councillors Pat Midgley (Sheffield City Council), Cynthia Ransome (Doncaster MBC) and David Taylor (Derbyshire County Council)
Also in attendance:-

Scrutiny Officers:- Anna Marshall (Barnsley MBC), Christine Rothwell (Doncaster MBC), Roz Savage (Derbyshire County Council), Janet Spurling (Rotherham MBC), Emily Standbrook-Shaw (Sheffield City Council) and Andy Wood (Wakefield MDC)

NHS:- Steve Allinson (North Derbyshire CCG), Dr. Peter Anderton (Commissioners Working Together), Lisa Bromley (Bassetlaw CCG), Will Cleary-Gray (NHS England), Alison Knowles (NHS England), Kate Laurance (Sheffield CCG), Dr. Tim Moorhead (Sheffield CCG), Maddy Ruff (Sheffield CCG), Lesley Smith (Barnsley CCG), Helen Stevens (NHS England) and Professor Chris Welsh (Yorkshire and The Humber Clinical Senate)

Apologies for absence:- Apologies were received from Councillors Keith Girling (Nottinghamshire County Council), Wayne Johnson (Barnsley MBC), Andrea Robinson (Doncaster MBC) and Betty Rhodes (Wakefield MDC).

1. INTRODUCTIONS

The Chair welcomed everyone to the meeting and attendees introduced themselves.

An additional agenda item on the Hospital Services review had been agreed by the Chair, as this meeting was a good opportunity to present this information to Members at an early stage.

2. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

Two questions had been received in advance of the meeting, with copies circulated to Members, including the introductory text for each question.

(1) Nora Everitt, Barnsley Save our NHS

As we feel that this Joint Health Scrutiny Committee do not currently demonstrate either consistency in the recording of its deliberations or independence in carrying out its scrutiny functions, in order to inspire the confidence of local people that they do fulfil their Statutory functions and demonstrates their statutory powers will they change their current practice/Terms of Reference by:

 Showing a clear independence from the NHS body attendees they invite to inform their scrutiny committee

- Clarifying, rather than confusing, the respective roles of the Scrutiny Committee and of the NHS bodies attending their Committee by request
- Reverting back to the name of their committee that describes the local authorities making up the Joint Committee and to cease using the new name that describes the NHS bodies that they scrutinise
- Meeting in Town Halls as is the accepted practice for scrutiny committees
- Clearly recording their deliberations, questions and decisions
- Considering live streaming their meetings 'to allow local people, particularly those who are not present at scrutiny-hearing meetings, to have the opportunity to see or hear the proceedings' (Department of Health Local Authority Scrutiny 2014)?

Barnsley Save Our NHS were thanked for their timely question as the terms of reference were being reviewed and the points raised would be considered during the review.

(2) Doug Wright, Keep Our NHS Public Doncaster and Bassetlaw

I believe that the needs of local people are not considered when each core partner HAS to sign up to the South Yorkshire and Bassetlaw MOU, in order to receive the extra funding given to the new South Yorkshire and Bassetlaw Regional Accountable Care Systems. How can this this coercive approach be eliminated by this Committee in the proposed terms of reference to assist the core partners ensuring that the needs of local people?

Supplementary - Why are Mid Yorkshire and North Derbyshire Councils included in this terms of reference?

Keep Our NHS Public Doncaster and Bassetlaw were thanked for their question. It was clarified that the Joint Health Overview and Scrutiny Committee (JHOSC) had been established to scrutinise the Commissioners Working Together Programme that covered seven local authority areas including Wakefield and Derbyshire. The terms of reference referred to this workstream and not to the South Yorkshire and Bassetlaw (SY&B) Sustainability and Transformation Plan (STP) which had a different geographical footprint.

3. MINUTES OF THE PREVIOUS MEETINGS HELD ON APRIL, 2017

Due to membership changes the minutes of the previous meeting were noted.

4. DECLARATIONS OF INTEREST

There were no declarations of interest from Elected Members.

5. HOSPITAL SERVICES REVIEW

Professor Welsh, Independent Review Director for the SY&B Accountable Care System Hospital Services Review gave a brief verbal update on this workstream.

This was an independent review and would take ten months to April 2018. The first stage would be to define the criteria to help understand what a sustainable hospital service was. Then the review would be looking at services and defining those which were non-sustainable and advising on future models of delivery to ensure long term sustainability.

The work was at a very early stage with the team in place for four weeks. They had met with commissioners in SY&B, providers and clinical commissioning groups. A programme of public engagement would be running going into the autumn and with local Elected Members over the coming months.

Discussion and questions ensued covering the following points:-

- How would the review want to involve Elected Members and the JHOSC?
 - There was a timetable of engagement with Elected Members into the autumn and it would be expected to return to the JHOSC in the future as the work progresses.
- For it to be positive it needed the clinical requirements now and for the public to be informed about what the review was aiming to achieve.
 - It was to ensure high quality patient care in each place within SY&B. The review would make recommendations but the expectation would be that the majority of care would still be at people's local hospital, although some things were technology dependent or depended on high quality skills in the workforce.

Very specific care may mean travel elsewhere, as now for example with coronary care. It was a case of getting people as quickly as possible to the place where they would receive the best high quality care, which might not be their local hospital.

It was suggested that further discussion was needed about how scrutiny may wish to be involved, including at different stages, possibly linked in with scrutiny arrangements for the SY&B STP below.

Resolved:- That the timescales for the consultation and the work on the hospital services review be provided at the next JHOSC meeting.

6. CHILDREN'S NON SPECIALISED SURGERY AND ANAESTHESIA UPDATE

Dr. Moorhead introduced a short briefing paper summarising the key issues regarding the proposals for children's non specialised surgery and anaesthesia. Attention was also drawn to the powerpoint slides attached to the minutes of the last meeting summarising the case for change, options, travel impact, and the consultation process and outcomes.

A unanimous decision had been made by the Joint Committee of Clinical Commissioning Groups and Hardwick Clinical Commissioning Group to approve the decision making business case for children's non specialised surgery and anaesthesia on 28 June, 2017.

Approval of the preferred model enables the majority of surgery to continue to be delivered locally and the development of three hubs, Doncaster Royal Infirmary, Sheffield Children's Hospital and Pinderfields General Hospital in Wakefield.

The decision means that once implemented around one or two children per week needing an emergency operation for a small number of conditions, at night or at a weekend, will no longer be treated in hospitals in Barnsley, Chesterfield and Rotherham, and will receive their treatment at one of the three hubs.

It is very early days in terms of implementation but a mobilisation plan is under development, including the ongoing designation process and development of a managed clinical network. It has been agreed to implement within existing commissioning and contracting arrangements and it is anticipated that implementation will commence from quarter four 2017/18 onwards.

Members sought clarification on hospital capacity in the case of a major incident such as a road traffic accident involving a large number of injured children. - The major trauma centre was located at Sheffield Children's Hospital and although the hospital had finite capacity if necessary it would assume the lead for overall co-ordination across local hospitals.

It was confirmed that plans for implementation would be in place by the end of December 2017 and that a further update could be brought to the Joint Health Overview and Scrutiny Committee (JHOSC) in two to three months.

Cllr Midgley informed the JHOSC that if Members were interested visits could be arranged to see the improvements made at Sheffield Children's Hospital.

Resolved:- (1) That the current position to progress the changes to children's non specialised surgery and anaesthesia be noted.

(2) That future updates on implementation be received by the Committee.

7. UPDATE ON HYPER ACUTE STROKE SERVICES

Lesley Smith introduced a short paper setting out the current position regarding the review of hyper acute stroke services and the development of the business case.

No decision had been made yet and it was likely to be October before the final decision was taken as work was still ongoing, particularly with the region's hospitals. Although the clinical case for change was strong it was in the context of a complex set of interactions and the full implications on all partners, staff and patients needed to be understood to enable an informed decision on the future of services.

Numbers and the pathway for people with suspected strokes needed to be considered further.

It was acknowledged there were potential risks with deferring the decision to reconfigure hyper acute stroke services and work would continue with hospitals to manage these to ensure existing services were supported. For example the stroke pathway for Barnsley had for a while seen thrombolysis carried out elsewhere.

Resolved:- (1) That the current progress with the hyper acute stroke services transformation be noted.

(2) That an update be provided to the Committee in October following the meeting of the Joint Committee of Clinical Commissioning Groups.

8. REVIEW OF JHOSC TERMS OF REFERENCE

There was a brief discussion with regard to formalising arrangements for receiving and responding to questions from members of the public. For example whether a specific length of time should be incorporated in the agenda and whether they should be submitted with a few days' notice, such as by the end of the Wednesday before the meeting, in order to facilitate the response.

No other suggestions were made at the meeting with regard to the principles, membership or working arrangements but it was agreed that more time was necessary for discussion.

In light of the issues around the current remit of the JHOSC and the different geographical footprints involved for various NHS workstreams, NHS

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England highlighted the interconnectivity and commented that they would welcome one place for joint scrutiny.

Resolved:- (1) That the scrutiny officers and Elected Members work on the review of the terms of reference and amend them to take account of points made in the questions from the public.

9. DISCUSSION REGARDING SCRUTINY ARRANGEMENTS FOR THE SOUTH YORKSHIRE AND BASSETLAW SUSTAINABILITY AND TRANSFORMATION PLAN

It was suggested that it would be helpful to have or create a scrutiny committee for the SY&B footprint and that scrutiny officers could work with the Elected Members to determine when this would be appropriate.

NHS England commented that as patient flows crossed boundaries some changes would not be confined to the SY&B footprint but would also involve Mid Yorkshire and Chesterfield. They added that the current JHOSC membership would also work for the hospital services review.

This complexity might mean it would be a case of identifying the best memberships according to the workstreams.

Dr. Moorhead confirmed that 80% of the Sustainability and Transformation Plan (STP) was at a local level and there would be no need to replicate local scrutiny. The other 20% was wider and could potentially be scrutinised by this JHOSC.

Clarity was sought on the timescale for having a clear plan and programme for the STP, in particular the wider 20% beyond the individual place plans. – Proposals could be brought to the next JHOSC meeting to help identify future work.

Resolved:- (1) That this issue be discussed in conjunction with the review of the terms of reference.

(2) That the STP proposals be presented at the next meeting for Members' consideration.

10. DATE OF NEXT MEETING

Resolved:- That the next meeting of the Joint Health Overview and Scrutiny Committee be held in October 2017, date and time to be confirmed.

South Yorkshire, Derbyshire, Nottinghamshire and Wakefield Joint Health Scrutiny Committee

29 January 2018

Chairman's Report

Review of the Terms of Reference for the Joint Health Overview and Scrutiny Committee

1. Purpose of the Report

To outline the issues considered during the review of the terms for of reference for the Joint Health Overview and Scrutiny Committee that was established to consider health service changes in South and Mid Yorkshire, Bassetlaw and North Derbyshire, and to seek the Committee's approval for the recommended amendments to the terms of reference and ways of working.

2. Background Information

When health service providers develop proposals to reconfigure services they are required to inform and consult with the Health Scrutiny Committee of the appropriate local council. Frequently proposed service changes impact on a specific area and, as such, are the responsibility of a single Health Scrutiny Committee. However, where the proposed changes are substantial and affect more than one local authority area, councils are required to form a Joint Health Overview and Scrutiny Committee (JHOSC) to consider the proposals and ensure that consultation with local communities is effective.

This JHOSC was established in 2015 for the purpose of overseeing the NHS "Working Together" programme. It was set up following a formal request made by the NHS Clinical Commissioning Groups (CCGs) that provide services in the South and Mid Yorkshire, Bassetlaw and North Derbyshire. The request was made to the local authorities with responsibility for scrutinising health services across the same geographical footprint.

3. Current Situation

At the meeting of the JHOSC on 31 July, it was resolved that the local government officers supporting the Committee would meet to review the terms of reference. This was in light of:

- Health service providers indicating that future work streams may result in service reconfigurations that will impact on part or all of the geographical footprint of the local authorities represented on the JHOSC.
- Public questions seeking clarity of the Committee's, name, scope and remit
- Committee Members being cognisant of the demands placed on NHS resources and the desire to streamline attendance of NHS representatives.

 The need to ensure that the meetings are accessible to the public and that the Committee is in a position to provide appropriate and timely responses to public questions.

The proposed revised Terms of Reference are attached as an appendix to this report.

4. Recommendations

Following consideration of the issues described above, and subsequent conversations with Members, the Committee is requested to agree that:

- 1. The name of the JHOSC is revised to reflect the Local Authorities represented on the Committee. Therefore the name of the Committee will be the South Yorkshire, Derbyshire, Nottinghamshire and Wakefield JHOSC.
- 2. Future JHOSC meetings are held in the Town Hall of the local authority hosting the meeting.
- 3. Members of the public are encouraged to submit their questions three working days prior to the meeting to allow Committee Members time to consider the issues raised and provide an appropriate response at the meeting.
- 4. Public questions are included as a standard agenda item at future meetings and that the time allowed on the day of the meeting, for public questions, is managed at the discretion of the Chairperson.
- 5. Quorum for the JHOSC meetings will be three Members from geographical areas directly affected by the proposals under consideration.
- 6. As new NHS work streams and potential service reconfigurations emerge the JHOSC will determine whether it is appropriate for the committee to jointly scrutinise the proposals under development. Each local authority reserves the right to consider issues at a local level. This decision will be based on information, provided by the relevant NHS bodies, setting out the scope and timeframes of future work streams and the geographical footprint that may be affected by the potential changes.
- 7. That NHS witnesses attending the meeting will be limited to officers and/or health professionals presenting reports or information to Members, plus any additional witnesses specifically requested to attend by Members.

CIIr David Taylor (Derbyshire County Council)

(JHSC Chairman for Meeting 11 December 2017)

Appendix

Terms of Reference for the South Yorkshire, Derbyshire Nottinghamshire and Wakefield Joint Health Overview and Scrutiny Committee

The South Yorkshire, Derbyshire Nottinghamshire and WakefieldJoint Health Overview and Scrutiny Committee is a joint committee appointed under Regulation 30 of the Local Authority (Public Health, Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013/218 and is authorised to discharge the following health overview and scrutiny functions of the authority (in accordance with regulations issued under Section 244 National Health Service Act 2006) in relation to health service reconfigurations or any health service related issues covering this geographical footprint:

- a) To review and scrutinise any matter relating to the planning, provision and operation of the health service in its area, pursuant to Regulation 21 of the Local Authority (Public Health, Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013.
- b) To make reports and recommendations on any matter it has reviewed or scrutinised, and request responses to the same pursuant to Regulation 22 of the Local Authority (Public Health, Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013.
- c) To comment on, make recommendations about, or report to the Secretary of State in writing about proposals in respect of which a relevant NHS body or a relevant health service provider is required to consult, pursuant to Regulation 23 of the Local Authority (Public Health, Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013.
- d) To require a relevant NHS body or relevant health service provider to provide such information about the planning, provision and operation of the health service in its area as may be reasonably required in order to discharge its relevant functions, pursuant to Regulation 26 of the Local Authority (Public Health, Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2014.
- e) To require any member or employee of a relevant NHS body or relevant health service provider to attend meetings to answer such questions as appear to be necessary for discharging its relevant functions, pursuant to Regulation 27 of the Local Authority (Public Health, Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013.

Principles

- The purpose of the committee is to ensure that the needs of local people are an integral part of the delivery and development of health services across this geographical footprint.
- The committee's aim is to ensure service configuration achieves better clinical outcomes and patient experience.
- As new NHS work streams and potential service reconfigurations emerge, the JHOSC will determine whether it is appropriate for the committee to jointly scrutinise the proposals under development. Each local authority reserves the right to consider issues at a local level.
- All Members, officers, members of the public and patient representatives involved in improving health and health services through this scrutiny committee will be treated with courtesy and respect at all times.

Membership

- The Joint Committee shall be made up of seven (non-executive) members, one from each of the constituent authorities.
- A constituent authority may appoint a substitute to attend in the place of the named member on the Joint Committee who will have voting rights in place of the absent member.
- Quorum for meetings of the Joint Committee will be three members from local authorities directly affected by the proposals under consideration.

The 7 Committee Member Authorities are:

Barnsley Metropolitan Borough Council Derbyshire County Council Doncaster Metropolitan Borough Council Nottinghamshire County Council Rotherham Metropolitan Borough Council Sheffield City Council

Wakefield Metropolitan District Council

Covering NHS England and the following 8 NHS Clinical Commissioning Groups (CCGs):

Barnsley CCG
Bassetlaw CCG
Doncaster CCG
Hardwick CCG
North Derbyshire
CCG Rotherham
CCG Sheffield CCG
Wakefield CCG

Working Arrangements:

- The Committee will meet on an ad-hoc basis as topics require scrutiny.
- On a rotating basis for each meeting, each local authority will Chair and provide administrative support to that meeting. Meetings will take place in the Town Hall of the local authority hosting the meeting.
- Agenda, minutes and committee papers will be published on the websites of all the local authorities 5 working days before the meeting.
- There is a standing agenda item for public questions at every meeting. Time allocated for this will be at the discretion of the Chair.
- Members of the public are encouraged to submit their questions 3 working days in advance of the meeting to enable Committee Members time to consider issues raised and provide an appropriate response at the meeting.
- The Committee will identify and invite the appropriate NHS witnesses to attend meetings.

Briefing paper to the Joint Health Overview Scrutiny Committee

Meeting: 29 January 2018

Review of Specific Hospital Services

Request to the Joint Health Overview and Scrutiny Committee comprising: Barnsley Metropolitan Borough Council, Doncaster Metropolitan Borough Council, North Derbyshire County Council, Nottinghamshire County Council, Rotherham Metropolitan Borough Council, Sheffield City Council and Wakefield District Council.

Background

The JHOSC has already considered, under its health overview and scrutiny functions, proposals to change out of hours children's surgery and anaesthesia services and hyper acute stroke services across the geography of Barnsley, Bassetlaw, Doncaster, North Derbyshire, Rotherham, Sheffield and Wakefield.

The Joint Committee of CCGS, as part of the South Yorkshire and Bassetlaw Accountable Care System, is now reviewing the health services provided to our communities as part of a Hospital Services Review. This Review includes five service areas that are carried out in Barnsley Hospital NHS Foundation Trust, Chesterfield Royal Hospital NHS Foundation Trust, Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust, The Rotherham Foundation Trust, Sheffield Teaching Hospitals NHS Foundation Trust and, Mid Yorkshire Hospitals NHS Trust (the latter trust is involved but the patient numbers are very small).

The services are: urgent and emergency care; maternity services; hospital services for children who are particularly ill; services for stomach and intestines conditions (gastroenterology), including investigations (endoscopy); and stroke (early supported discharge and rehabilitation).

Request

The JCCCG expects to bring change proposals to patients and the public formally within the next year and would like to continue to share cases for change with the JHOSC before we proceed to formulate, engage and consult on any options for future service configuration. In this way, we can work with you to shape these options and the subsequent engagement and consultation so that we develop robust proposals which provide safe care for local people.

Under the Terms of Reference of the JHOSC, there is provision for the Committee to consider 'any other health related issues covering the same geographical footprint' in addition to the programmes within Commissioners Working Together. The Committee is therefore asked to continue to convene to carry out its duties under section 30 (5) of the regulations for the relevant scrutiny functions to be exercised by a joint scrutiny panel as proposals develop around the Review.

The Joint Committee may also wish to consider at this stage if it would like a joint representative of the Healthwatch bodies within the footprint to assist (in a non-voting capacity) and advise it for the purposes of the consultation process.

Review of proposals to change hyper acute stroke services in South and Mid Yorkshire, Bassetlaw and North Derbyshire

Joint Overview and Scrutiny Presentation

January 2018

Hyper acute stroke services

- the case for change

- Compelling national evidence that organised stroke care in a designated stroke unit – hyper acute stroke unit with rapid access to treatment –
 - improves outcomes
 - reduces avoidable disability
 - contributes to reduced mortality and length of stay
 - London reduced 90 day mortality by 5% (absolute reduction of 1.1%) and
 - reduced LOS by 1.4 days (London) and 2 days (Manchester)
 - and where higher patient numbers, have improved thrombolysis rates and increased adherence to guidelines, associated with improved stroke outcomes

Current variation in quality - Scope to improve

- Most SYB stroke units have improved their performance on indicators in the Sentinel Stroke National Audit Programme (SSNAP), yet significant variation persists, with several providers unable to perform well in the areas that are relate to hyper acute care.
- Barnsley and Rotherham services have a low percentage of patients who have been reviewed by a stroke specialist consultant within 24 hours (reflecting the inability to provide 7 day consultant working).
- All units have thrombolysis rates below the national average but they are particularly low in Rotherham and Barnsley (prior to redirection to other units).

Current variation in quality - Scope to improve

- There is a need to improve and ensure equity of care across SYB, the proportion of patients who
 - receive brain scanning within an hour
 - thrombolysis
 - are admitted to a stroke unit within 4 hours
 - are seen by a stroke specialist within 14 hours and
 - the timeliness of some therapy assessments, especially speech and language therapy
- It would not be possible to achieve improvements in all these areas across all existing service provision.
- The evidence base indicates that larger units are more likely to achieve quicker access to CT scans and have higher thrombolysis rates.

Workforce challenges

- The combination of a national shortage of staff for some stroke specialist disciplines and increased staffing requirements to meet national standards (eg 7 day access to stroke specialist consultants, 7 day therapy assessments) are creating increasing challenges for existing services.
- The impact of insufficient medical staff is unsustainable rotas and over reliance on locums (particularly in Barnsley and Rotherham), with services becoming increasingly fragile.
- The workforce challenges mean that it is not possible for us to meet all the requirements for hyper acute stroke care set out in the NHSE Clinical Standards for seven day services and the national standards for stroke care across all existing services.
- Consolidation of hyper acute care at fewer hospitals would enable us to meet the Clinical Standards for seven day services & national standards and thus deliver high quality care that improves outcomes for patients.

Clinical & Cost Effectiveness

- The Clinical Senate endorsed the national expert view that the total number of patients to access a hyper acute stroke service should be a minimum of 600 confirmed stroke patients a year to maintain clinical competency with a maximum of 1500 to avoid workload pressures.
- Not all existing SYB units admit above the recommended minimum threshold of admissions to ensure provision of a clinically effective unit (600 per year).
- All existing units except Sheffield fall below the number of admissions for a cost effective unit (ie the break even point based on national tariff and 100% best practice tariff is 900 patients per year).

One proposal on which we consulted:

- If you live in South Yorkshire and Bassetlaw and North Derbyshire and have a stroke, you would receive hyper acute stroke care in
 - Doncaster Royal Infirmary,
 - Royal Hallamshire Hospital in Sheffield,
 - Chesterfield Royal Hospital
- The proposal means that patients who would previously have been admitted to Barnsley Hospital or Rotherham hospital for hyper acute stroke care will in future receive care at Doncaster Royal Infirmary, Royal Hallamshire Hospital in Sheffield, or Pinderfields Hospital in Wakefield.
- After on average 72 hours of critical hyper acute care, they would be transferred to back to Barnsley or Rotherham for the remainder of their care.

Impact of the proposals

Criteria we need to take account of	What the evidence shows		
Ambulance travel - access meets 45 minutes for	Travel impact assessment and analysis		
95% of population	confirms journey times within 45 – 60		
	mins		
HASU activity levels - Clinical critical mass, of	Two (South Yorkshire and Bassetlaw)		
>600 and <1,500 stroke admissions per annum	units would be within the range		
Transformation should minimise cross-boundary	All patient flows remain within the		
impact	original planning footprint		
Is there a 7 day service being offered?	Greater opportunity to achieve through		
	organised units & consolidating activity		
	into 2 units		
Adequate workforce - performance against	As above		
SSNAP scores (case for change)			
Impact of change on visitors and carers travel	Travel impact assessment confirms		
time (pre consultation)	journey times within 45 – 90 mins		

Travel impact

- The vast majority of the population is within 30 45 minute drive-time to the proposed HASUs with cost of parking actually being less than they would currently pay at their local centres for up to 4 hours.
- 26 and 27% of Rotherham and Barnsley don't have cars (census data) and so we analysed the impact of travelling by public transport. Majority can get to a site within 90 minutes (as a visitor) on buses, trains or trams.
- For places outside this travel time, they would mostly be treated/travel to a
 different NHS region (eg, very west of North Derbyshire would likely go to
 Manchester or Stockport and Cottam (Bassetlaw) are more likely to go to
 Lincoln).
- Travel by public transport from Barnsley to Pinderfields as a visitor would mean an increased cost due to crossing the South to West Yorkshire border.

The consultation process

There were a number of ways in which all internal and external stakeholders could respond to the consultation, these were:

- Online consultation questionnaire
- Paper surveys
- Meetings and events eg, public meetings and focus groups
- Individual submissions eg, via telephone, email or letter
- Representative telephone survey
- Online poll

- Digital communications and engagement
 - o 8,318 unique visitors used the CWT website
 - 62,000 page visits to the consultation webpages
- Broadcast and print media releases
 - o 19 pieces of coverage in local, regional and national media
- Social media
 - Tweets generated more than 55,000 impressions
 - CWT's 21 Facebook posts reached 16,991 people and saw 939 users take action
- Public consultation events
- Specific interest engagement via email, hard copies of the consultation documents and meetings

Communications and engagement activity

- Seldom heard group engagement via email, hard copies of the consultation documents and discussion groups
- Stakeholder briefings including local MPs and councillors, Health and Wellbeing Board, Health Overview and Scrutiny Committees
- Staff briefings via internal communications channels, newsletters, forums and groups
- Hard copies of the consultation documents, postcards and flyers
 distributed to hospitals, GP practices, libraries and children's centres,
 dental practices, campaign groups, town halls, community venues and
 organisations and at public events. 50,000 copies of the consultation
 document were printed and distributed on request through these
 channels

The responses

- 1109 for hyper acute stroke services
 - 282 were from the online survey
 - 58 were from the paper survey
 - 740 were from the telephone survey
 - 6 individual written submissions
 - 6 from partner organisations
 - 16 public meetings/focus groups/local groups
 - 1 petition

Hyper acute stroke services

	Consultation survey respondents		Telephone survey respondents	
CCG area	Actual	%	Actual	%
Barnsley	132	39%	72	10%
Bassetlaw	14	4%	33	4%
Doncaster	52	15%	98	13%ge
North Derbyshire and Hardwick (combined)	16	5%	227	31%8
Rotherham	75	22%	106	14%
Sheffield	41	12%	139	19%
Wakefield	3	1%	65	9%
Other	3	1%	0	0%
Did not say	4	1%	0	0%
Total	340	100%	740	100%

What did people say?

Stroke

- Mixed response to the three centre option. 54% of self-selecting consultation survey respondents disagree with this option and 50% of telephone survey responses agree with it.
- The patterns of agreement are similar across both survey channels except for Bassetlaw, Sheffield and Wakefield where the majority of self-selecting consultation survey respondents disagree with the three centre option compared to the telephone survey respondents in those areas.
- There are high levels of support for the three centre option in Doncaster and North Derbyshire and Hardwick (which cover hospitals where the hyper acute stroke services are being proposed). There is low level of support for this option in the Barnsley CCG area.

Where disagreed, themes were:

- Not being able to access high quality care quickly and patient safety
- Social impact
- Other concerns (lack of funding for the NHS, wish to have a centre in local area so could access high quality care, additional pressure on the ambulance service)

Where agreed, themes were:

- Quick and easy access to high quality care
- Better quality of care and improved health outcomes
- More effective allocation of resources
- Other comments

A number of people didn't feel they could comment.

Alternative suggestions

- Almost half of the consultation survey respondents had alternative suggestions to make. The majority were making the case for Barnsley District General Hospital to have a hyper acute stroke service to make sure that local people could have quick access to time-critical care.
- The other main suggestions were to have a hyper acute stroke service in every hospital and to start investing in the right calibre of staff to make this happen.

Meetings

• The themes emerging from the meetings are the same as those from the consultation and telephone responses.

Written submissions

- 3 written submissions by individuals
- All our hospitals, except Sheffield Children's and Mid Yorkshire Hospitals
- Dan Jarvis MP
- Barnsley Save Our NHS

The themes emerging from the written public submissions mirror those in the surveys.

The themes emerging from the organisations can be summarised as:

- Support for the proposals
- Clarification on maintaining outcomes and quality of care for local populations
- Clarification on repatriation and ambulance service protocols
- Staff retention and development
- The potential adverse impact of increased activity levels (where a hospital could see more patients as a result of change)
- Financial viability/affordability

Online poll

- Mid-point analysis highlighted the complexity of the narrative on the proposals and the difficulty in engaging people on the issues.
- Recommendation from the Consultation Institute to create a short poll. At the end of the poll, respondents were directed to full details of the consultations on the CWT website.
- The questions were developed to capture people's thoughts on the proposals in a different way and were checked by a market research agency.
- The themes within the poll are the same as those within the main consultation.
- The results do not inform the main consultation survey analysis and are simply intended to provide further data on people's opinions

Concluding comments

- As with all public consultations, the public response cannot be seen as representative of the population as a whole but instead is representative of interested parties who were made aware of the consultation and were motivated to respond
- Within the analysis we cannot be clear the extent to which responses are informed by the supporting information that has been provided
- The telephone survey was undertaken with a randomly selected and representative cross-section of residents to ensure that the consultation process accurately captured the views of the wider population of South and Mid Yorkshire, Bassetlaw and North Derbyshire.
- A consistent picture there is mixed support for the proposals

- Potential changes to services, particularly where loss of services are involved, understandably cause apprehension among those who may be affected and there has been clear and vocal opposition in some areas where this is potentially the case
- The main concern highlighted across all consultation feedback is the impact on the ability for patients and families to access high quality care closer to home if the proposed changes are introduced.
- The outcomes of the consultation process will need to be considered alongside other information available

Hyper acute stroke care

The Proposed Model

The Proposed Model

- A Stroke Managed Clinical Network (MCN) to support the development of networked provision of stroke care across the South Yorkshire and Bassetlaw Accountable Care System.
- Consolidation of hyper acute stroke care at the following units
 - Doncaster Royal Infirmary
 - Royal Hallamshire Hospital
 - Pinderfields Hospital Wakefield
 - Plus the continuation of hyper acute stroke care at Royal Chesterfield Hospital.
- The hyper acute stroke model above will be supported by
 - NHS England commissioning and gradual implementation of mechanical thrombectomy
 - A review of the wider stroke pathway as part of the Hospital Services
 Review
- There is also a need to continue improvements in primary and secondary prevention of stroke risk factors.

The Proposed Model

The Stroke Managed Clinical Network will

- Support all operational aspects of delivery, ensure effective care pathways and clinical collaboration and coordination between sites.
- Facilitate cross organisational, multi professional clinical engagement and patient/carer engagement to improve care pathways.
- Fulfil a key role in assuring providers and commissioners of all aspects of quality, in addition to coordinating provider resources to secure improved outcomes for patients.

The Proposed Model - Consolidation of hyper acute stroke care

- Hyper acute stroke care will be delivered at
 - Doncaster Royal Infirmary
 - Royal Hallamshire Hospital
 - Pinderfields Hospital Wakefield
 - Plus the continuation of existing HASU care at Royal Chesterfield Hospital.
- Patients who would previously have been admitted to Barnsley Hospital or Rotherham hospital for hyper acute stroke care will in future if they present within 48 hours of onset of symptoms (the critical period for hyper acute stroke care) receive care at Doncaster Royal Infirmary, Royal Hallamshire Hospital in Sheffield, or Pinderfields Hospital in Wakefield.
- Work has been undertaken with the ambulance service to understand the new anticipated patient flows and to inform the total number of patients expected to receive their hyper acute stroke care in each of the HASUs.

The Proposed Model - Consolidation of hyper acute stroke care

- On arrival at a SYB HASU patients will receive an initial assessment and for those felt to have had a stroke a CT scan.
- After admission to a SYB HASU it is expected that patients will -
 - receive thrombolysis if clinically indicated,
 - have a consultant review (within 14 hours, 7 days a week)
 - have neurological and physiological monitoring until stable and appropriate stroke nurse assessments
 - have their swallow assessed and receive nutritional support if required
 - Have therapy assessments and therapy will be commenced while on HASU where clinically indicated (7 day therapy)
- After on average 72 hours of critical hyper acute care, patients will be transferred back to Barnsley or Rotherham for the remainder of their care and rehabilitation.

The Proposed Model – Mechanical Thrombectomy

- The hyper acute stroke care model will be supported by NHSE commissioning and the gradual implementation of mechanical thrombectomy to be delivered in neuroscience centres (Sheffield, Leeds, Hull and East Yorkshire for Yorkshire and the Humber).
- Plans are under development and it is likely that we will have a 'drip and ship' model with patients initially assessed by the HASUs, with transfer to a neuroscience centre for eligible patients.
- Further planning is required, but if current flows to neuroscience centres for other conditions are mirrored then patients admitted to Doncaster HASU will go to Sheffield and patients admitted to Mid Yorkshire HASU will go to Leeds.

The Proposed Model – Anticipated Benefits

- Delivery of an improved, more resilient and sustainable service
 - Through an established Managed Clinical Network, resulting in an enhanced ability to attract and retain a specialist stroke workforce and facilitate 7 day provision.
- A service that delivers improved clinical quality (clinical effectiveness, patient safety and patient experience)
 - All HASUs (except Chesterfield) will have the recommended patient numbers (600-1500) to provide a clinically effective service and will be above the 900 (patients a year) identified as necessary for a cost effective service
 - An enhanced ability to meet evidence based national stroke standards (NICE, RCP and STP guidelines) for HASU care eg increased proportion of patients scanned in an hour and thrombolysed.
 - It will be possible for SYB HASUs to meet all the NHSE Urgent and Emergency Care Standards for seven day care without the need to significantly increase consultant numbers.

The Proposed Model – Anticipated Benefits

- Reduced inequalities in access, patient experience, quality of care and outcomes
 - All patients across SYB will have access to high quality hyper acute stroke care that meets the national best practice standards.
- Contribution to improved health outcomes
 - A reduction in in hospital and overall mortality from stroke
 - A reduction in disability from stroke and improved quality of likfe
 - A higher proportion of people who have had a stroke able to return home to live independently and return to work
 - A reduction in the number of patients newly discharged to care homes/continuing health care
- A reduction in stroke mortality was seen after the consolidation of stroke care in London.

Themes from the Public Consultation -

Themes from the public –

- Not being able to access high quality care quickly and patient safety
- Social impact
- Other concerns (lack of funding for the NHS, wish to have a centre in local area so could access high quality care, additional pressure on the ambulance service)

The themes from the organisations were:

- Overall support for the proposals
- Clarification on maintaining outcomes and quality of care for local populations
- Clarification on repatriation and ambulance service protocols
- Staff retention and development
- The potential adverse impact of increased activity levels (where a hospital could see more patients as a result of change)
- Financial viability/affordability

Addressing themes identified in the consultation -

A number of themes were identified from the consultation, from both the public and organisations. All have been considered and informed the development of the proposed model.

Not being able to access high quality care quickly and patient safety
 Performance against SSNAP indicators is currently variable.
 The proposed new model should enable us to improve performance on key indicators and ensure equity of care.

Social Impact

The new model is about providing hyper acute stroke care (on average the first 72 hours) differently, after which patients would be repatriated for their ongoing care and rehabilitation to Barnsley and Rotherham.

The travel analysis showed most people could get to a site (as a visitor) within 90 minutes, with most journeys well under 90 minutes. Parking charges for visitors at Sheffield and Doncaster would reduce, albeit a potential increase in public transport costs for visits to Pinderfields Hospital. For people on low or no income, hospital travel reimbursement policies would apply

Addressing themes identified in the consultation -

A number of themes were identified from the consultation and all have been considered and informed the development of the proposed model.

- Clarification on maintaining outcomes and quality of care for local populations (not being able to access high quality care).
 - Performance against SSNAP indicators is currently variable.
 - The proposed new model should enable us to improve performance on key indicators and ensure equity of care.
- Clarification on 'repatriation' and ambulance service protocols

A clinical working group has been established to develop a policy. The ambulance service is involved and if the proposals are approved a plan will be developed with ambulance protocols. More work on the data shows less people will require repatriation than initially anticipated.

• Staff retention and development

A workforce group – made up of the different professions - is developing a strategy focusing on staff recruitment, retention and development. There are plans to look at joint medical posts.

Addressing the themes identified in the consultation -

The potential adverse impact of increased activity levels (where a hospital could see more patients as a result of change) All the units that would see more patients have developed plans that set out how they would manage the increase.

The implementation would be taken forward in phases. Not all the change would be made at once, making it safe for patients and manageable for would be made at once, making it safe for patients and manageable for providers and we would closely monitor it together. All the new HASUs will be $\frac{8}{3}$ below 1500 patients annually.

Financial viability

The new model is driven by a strong clinical case for change and would need investment.

If we do nothing, the variation in quality and workforce issues are likely to worsen and it may no longer be possible to deliver the existing service. If this happened, urgent and ad hoc arrangements would need to be put in place – which would require investment.

Managing Stroke Mimics

- Some patients who paramedics or A&E staff initially think may have had a stroke, turn out not to have had a stroke (stroke mimics).
- One of the concerns raised upon considering the consolidation of hyper acute stroke care was that many patients from Barnsley and Rotherham could be transferred to a HASU and found to be a stroke mimic and then need to be repatriated.
- Learning from Greater Manchester indicates that it is possible to improve the recognition and identification of stroke mimic conditions at the outset to reduce unnecessary transfer to HASUs (work with paramedics & A&E staff)
- Recent audit work in Sheffield predicts that only a small proportion of Barnsley and Rotherham patients with a stroke mimic condition will need repatriating.
 If we assume similar rates in the other two HASUs – the total estimated number of stroke mimics who are likely to need repatriation is approx 1 per week each – Barnsley and Rotherham.

Managing Risks - Mitigation Plans

Do nothing

- There is a risk that doing nothing will result in more challenges for existing services and potential deterioration in the quality and safety of provision.
- To mitigate against unplanned service change there is established dialog between providers and the ambulance service.

Stroke mimics

- There is a risk that transfer could result in their management and experience of care being adversely impacted.
- To mitigate this action will be taken to improve the identification of stroke mimics by paramedics and A&E staff and increase patient/carer input to maximise the potential to improve patient experience and minimise adverse impacts.
- There is also a risk that assumptions around their identification and flow are not fulfilled.
- To mitigate this audit work has been completed and predicts that the numbers requiring repatriation are likely to be low.

Managing Risks - Mitigation Plans

Repatriation

- There is a risk that it will not be possible to repatriate patients in a timely manner due to transport availability or bed capacity.
- To mitigate this transport requirements are included in the business case and a 'patient flow' policy will be agreed by all.

Ensuring benefit realisation

- There is a risk that it may not be possible to timely realise all the anticipated benefits and that focusing on HASU alone will not maximise the possible improvements in patient outcomes.
- To mitigate this work has been undertaken to articulate the benefits and what needs to be in place to realise them. The MCN will have a key role in benefits realisation & ensuring a pathway approach as will working with other workstreams (such as prevention) to maximise potential to improve outcomes.

Wider implications

 Acute stroke care is facing increasing challenges and as such has been included in the hospital services review.

Summary

- The proposed new model is to improve the quality of care
- Although there are risks associated with the proposed new model it is possible to mitigate these so that they are manageable
- The most significant risks that are difficult to mitigate are those associated
 with not progressing the new model, doing nothing will result in increasing
 challenges for already fragile services in Rotherham and Barnsley Hospitals and
 potential deterioration in the quality and safety of provision.
- Due to the fragility of existing services and their inability to consistently meet all national standards relating to stroke care, on balance the risks and challenges of the proposed model are less than the risks of doing nothing.
- The evidence base indicates that it will be possible to improve the quality of care, sustainability and cost effectiveness that would not be possible through continuing to try to improve and deliver hyper acute care at all current sites.

Commissioning Implications

- The business case for the reconfiguration of hyper acute stroke care in South Yorkshire and Bassetlaw has been assured by NHS England.
- The proposed new model of hyper acute stroke care requires investment from commissioners of circa £1.8M for higher average tariffs at the HASU sites, additional best practice tariffs and patient transport.
- It is recommended that the approach is to commission once with a system commissioner, a single contract for a hyper acute stroke service with a consistent approach to acute stroke care with a group of providers.
- Procurement advice confirms that there is a clear rationale for the use of a negotiated procedure without prior publication approach ahead of awarding the contract for the new model.
- Due to the scale of the change it is proposed that implementation is phased, given that arrangements are already in place to redirect patients for thrombolysis to other HASUs it is proposed that Rotherham HASU is decommissioned in the first phase, followed by Barnsley HASU.

Children's Non Specialised Surgery and Anaesthesia Update

Joint Overview and Scrutiny Committee

29th January 2018

Author(s)	James Scott, Maternity & Children's Workstream, South Yorkshire and Bassetlaw Accountable Care System Marianna Hargreaves, Transformation Programme Lead, South Yorkshire and Bassetlaw Accountable Care System Additional material provided by Prof Des Breen, Medical Director, Working Together ACC Vanguard Partnership Emma Andrews, Interim Clinical Networks, Project Consultant			
Sponsor	Will Cleary-Gray, Director of Transformation and Sustainability, SYB Accountable Care System Chris Edwards – SRO Maternity and Children's Workstream			
Is your report for Approval / Consideration / Noting				
For Noting				
Are there any resource implications (including Financial, Staffing etc)?				
N/A				

Summary of key issues

- A decision was made by the Joint Committee of Clinical Commissioning Groups and Hardwick Clinical Commissioning Group to approve the decision making business case for children's non specialised surgery and anaesthesia on Wednesday 28th June 2017.
- Approval of the preferred model enables the majority of surgery to continue to be delivered locally and the development of three hubs, Doncaster Royal Infirmary, Sheffield Children's Hospital and Pinderfields General Hospital in Wakefield.
- The decision means that once implemented around one or two children per week needing an emergency operation for a small number of conditions, at night or at a weekend, will no longer be treated in hospitals in Barnsley, Chesterfield and Rotherham, and will receive their treatment at one of the three hubs.
- Implementation is now progressing with detailed work being undertaken to agree clinical pathways through the Managed Clinical Network, and a series of designation visits (to be completed by mid-February 2018). There has been some slippage from the anticipated due date of end Q4 2017-18 however implementation is still expected in Q1 2018-19.

Recommendations

The Joint Overview and Scrutiny Committee members are asked to note the progress to enable the changes to children's non specialised surgery and anaesthesia.

Children's Non Specialised Surgery and Anaesthesia Update Joint Overview and Scrutiny Committee

29th January 2018

1. Purpose

The purpose of this brief is to update the Joint Overview and Scrutiny Committee on the progress to implement approved changes to Children's Surgery and Anaesthesia (CS&A) services. JCCCG approved the decision making business case to progress the changes in a meeting in public on Wednesday 28th June 2017. The JHOSC were able to hear and scrutinise the decision making business case at this time. This paper follows an earlier update to the JHOSC in July 2017.

2. Introduction

A decision was made by the Joint Committee of Clinical Commissioning Groups and Hardwick Clinical Commissioning Group to approve the decision making business case for children's non specialised surgery and anaesthesia on Wednesday 28th June.

Over the last three years clinical commissioners and hospital trusts providing services in Barnsley, Bassetlaw, Chesterfield, Doncaster, Rotherham and Sheffield have come together to review and improve the care and experiences of all children needing an emergency operation in our region.

By working together better across all hospitals and commissioning organisations, new ways of working have been developed which means the number of children affected by these changes reduced significantly since the launch of the consultation in October 2016 and this has given staff working in the services more opportunities to improve and enhance their skills.

Approval of the preferred model enables the majority of surgery to continue to be delivered locally and the development of three hubs, Doncaster Royal Infirmary, Sheffield Children's Hospital and Pinderfields General Hospital in Wakefield.

The decision means that once implemented around one or two children per week needing an emergency operation for a small number of conditions, at night or at a weekend, will no longer be treated in hospitals in Barnsley, Chesterfield and Rotherham and will instead have their surgery at Doncaster Royal Infirmary, Sheffield Children's Hospital or Pinderfield's General Hospital where the right staff, with the right skills, will be available 24 hours a day, seven days a week. The service at Bassetlaw Hospital will remain the same as it already does not provide acute surgery for children out of hours.

3. Implementation Progress

Implementation is progressing with the Managed Clinical Network taking a lead role. In particular progress has been made to -

- Complete the designation visits. There has been strong engagement from all the Trusts in populating teams for these visits and to date the three proposed 'hubs' visits are complete and in the process of receiving feedback, with the three non-hub visits to be complete by mid February 2018.
- **Develop and agree clinical pathways**. Working groups have been set up for each clinical pathway facilitated by the Managed Clinical Network. Through these groups good progress has been made to develop pathways or adopt existing pathways where possible and appropriate to do so. The aim is for the majority of clinical pathways to be ratified at the Managed Clinical Network meeting in February.

There remains an expectation that transfer numbers, given the adherence to the designation standards, will be low. Agreeing the necessary transport arrangements to facilitate these transfers is a key part of the plan going forward.

Overall there has been some slippage from the anticipated due date of end Q4 2017-18 however implementation is still expected in Q1 2018-19.

4. Power of Referral

The JHOSC has not yet informed the JCCCG if it wishes to use its referral power in regard to the decision on Children's non specialised surgery and anaesthesia. The JHOSC is asked to update the JCCG on its intentions.

South Yorkshire and Bassetlaw Accountable Care System

The Hospital Services Review

Presentation to the JHOSC

29 January 2018

Outline

- Aims and objectives of the review
- Services in scope and developing options

- Public and clinical engagement
- Next steps

Aims and objectives of the review

Aims and objectives of the review

 Define and agree a set of criteria for what constitutes 'Sustainable Hospital Services' for each Place and for South Yorkshire and Bassetlaw, North Derbyshire and Mid Yorkshire

- Identify any services (or parts of services) that are unsustainable, short, medium and long-term including tertiary services delivered within and beyond the STP
- Put forward future service delivery model or models which will deliver sustainable hospital services
- Consider what the future role of a District General Hospital is in the context of the aspirations outlined in the South Yorkshire and Bassetlaw Sustainability and Transformation Plan (STP) and emergent models of sustainable service provision

Definition of sustainability

A sustainable service...

- sees and treats **enough patients** to operate a safe and efficient service
- has an appropriate workforce to meet staffing needs
- has interdependent clinical services in place and in reach to operate core services safely and effectively
- is likely to be deliverable within the **resource envelope** that is likely to be available

Process

1A)

Agree systemwide approach to generating a shortlist of services 1B)

Diagnose the sustainability issues with the shortlisted services, and identify the needs of each Place; begin to develop options

2

Develop
system-wide
options and
apply
evaluation
criteria to
arrive at a
preferred
option

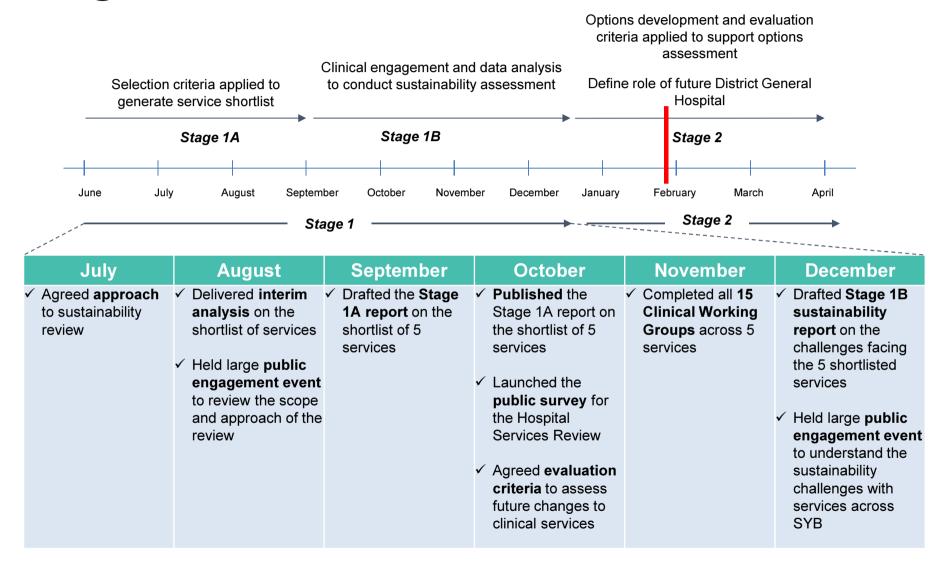
Jun-Sep 2017

Oct-Dec 2017

Jan-Apr 2018

We are here

Progress so far

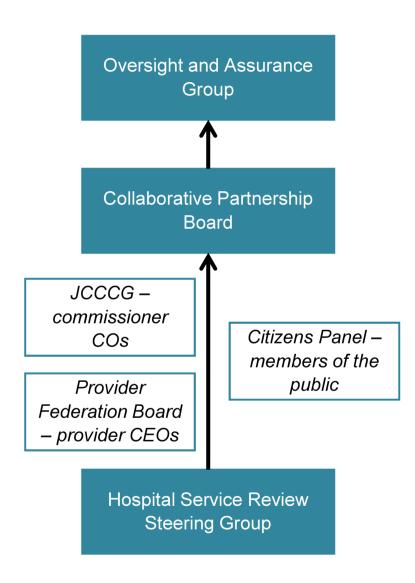


The timeline over the next few months is as follows

Jan	Feb	Mar	Apr
Publish 1B report	Modelling of options	1 March Final session of Clinical	Evaluation of options
Further work on		Working Groups	
ideas proposed in	Ongoing public		Draft and agree
the CWGs and	engagement	8 March SYB-wide session with the	report, circulated through
public engagement to develop		public	governance groups
recommendations		paone	Boromanos Broaks
		Evaluation of	Submit report to
Ongoing public engagement		options	commissioners end April

The briefing paper that members of the JHOSC have received asks that the JHOSC continue to meet in order to discuss the services included within the Hospital Services Review going forward.

Governance structure



- commissioned the Review and will receive its reports and recommendations
- Membership = Trust Chairs; HWB Board Chairs; CCG Clinical Chairs; lay members
- Has oversight of the report and feeds into it.
- Membership = Trust CEOs; local authority representatives; CCG AOs; lay members; NHSE and NHSI
- JCCG and the Provider Federation Board are not formally part of the governance but allow AOs and trust CEOS to feed into the Review each month. JCCCG will ultimately decide which of the Review's recommendations to take forward.
- The Citizens Panel provides their views and insights
- Chaired by Professor Chris Welsh (Independent Review Director) and acts as the day-to-day advisory board for the Review
- Membership = acute provider Medical Directors and other senior leads, YAS, CCG leads

Services in scope, and Clinical Working Groups

The Review is focusing on the following services:

- The services identified are those which:
 - Are facing significant difficulties with workforce and / or quality of care
 - Have a significant number of interdependencies: setting these services on a more sustainable footing will significantly help to improve the service as a whole
 - Have a significant impact on the service as a whole

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

We will also look at a very high level at some elective (nonemergency) services

The services chosen focus largely on the emergency, 24/7 services. The review team anticipate that the review will consider how elective services might be located across the system in order to improve quality and support any proposals in these services

Within this the Review is likely to have the following key themes:

Transforming care

- 1) Workforce: how Trusts can best work together to train and support their staff
- **2) Delivering the same standards of care**: how Trusts can work together to ensure that patients receive the same standard of care wherever they are
- 3) Innovation: how we draw on new technologies to support the delivery of care

Configuring services

- **4)** The 5 core services: how the services can best be configured and delivered across the 5 key services
- **5) Non-emergency services**: ways to improve the quality of non-emergency services

Supporting organisations

6) Supporting trusts to work together: what organisational structures could support collaboration between trusts

Clinical engagement

Clinician engagement through 5 Clinical Working Groups

Workshop 1:

"What are the issues and the root causes of those issues?"

Mid Oct 2017

Workshop 2:

How have other places solved these problems? What ideas should we explore?

Early Nov

Workshop 3:

Do these ideas go far enough?
What would need to change to make them happen?

Late Nov / early
Dec

Workshop 4

How do the options developed so far perform against our evaluation criteria?

March 2018

The Overarching Strategic Group pulls together the conclusions from across the five Clinical Working Groups

Public engagement

We are engaging with the public on the same issues as we are engaging with clinicians

Public engagement methods

- 3 SYB-wide events open to anyone (August, December, March)
- Face to face sessions open to residents in Barnsley, Bassetlaw, Doncaster,
 Rotherham
- Focus groups with seldom heard groups across the footprint
- Session with young people
- Online survey across the health economy
- Telephone survey of 1,000 people across the footprint to mirror demographic makeup of South Yorkshire and Bassetlaw
- Stands in receptions of some hospitals: Sheffield Children's Hospital, Chesterfield,
 Rotherham so far
- Information distributed through Healthwatches etc

Issues

- Feedback on problems with services now and public priorities for service change
- Feedback on priorities for evaluation criteria
- Feedback on emerging directions for the Review
- [In March] Applying evaluation criteria to potential models

Thank you