JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Venue: **Barnsley Town Hall** **Date:** **Monday, 22nd October, 2018**
Time: **1.00 p.m.**

A G E N D A

PLEASE NOTE

There is a Pre-meeting for Members in the Committee Room at 11:00 a.m.

1. Agenda and Report Pack (Pages 1 - 42)

Public Document Pack Agenda Item 1

MEETING:	South Yorkshire, Derbyshire, Nottinghamshire and Wakefield Joint Health Overview and Scrutiny Committee
DATE:	Monday, 22 October 2018
TIME:	1.00 pm
VENUE:	Reception Room, Barnsley Town Hall

AGENDA

Administrative and Governance Issues for the Committee

1 Apologies for Absence

To receive any apologies for absence.

2 Declarations of Pecuniary and Non-Pecuniary Interest

To invite Members of the Committee to make any declarations of pecuniary and non-pecuniary interest in connection with items on this agenda.

3 Public Questions

To receive questions from Members of the Public, which will be managed at the discretion of the Chair.

4 Minutes of the Previous Meeting (Pages 3 - 10)

To approve the minutes of the previous meeting of the Committee held on 12th June 2018 (Item 4 attached).

Overview and Scrutiny Issues for the Committee

5 South Yorkshire and Bassetlaw (SYB) Integrated Care System (ICS) (Pages 11 - 30)

To consider a Cover Report of the Executive Director Core Services at Barnsley Council (Item 5a attached) in respect of a report on the South Yorkshire and Bassetlaw (SYB) Integrated Care System (ICS) (Item 5b attached).

6 Hospital Services Programme (Pages 31 - 42)

To consider a Cover Report of the Executive Director Core Services at Barnsley Council (Item 6a attached) in respect of a report on the Hospital Services Programme (Item 6b attached).

Enquiries to: Anna Marshall, Scrutiny Officer, Barnsley Council via scrutiny@barnsley.gov.uk

Witnesses

Lesley Smith, South Yorkshire and Bassetlaw (SYB) Integrated Care System (ICS) Deputy System Lead and Lead for Strategy, Planning and Transformation Delivery as well as Chief Officer at Barnsley Clinical Commissioning Group (CCG)

Will Cleary-Gray, Chief Operating Officer, SYB ICS

Helen Stevens, Associate Director of Communications and Engagement, SYB ICS

Alexandra Norrish, Programme Director, SYB Hospital Services Programme

SOUTH YORKSHIRE, DERBYSHIRE, NOTTINGHAMSHIRE AND WAKEFIELD JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Tuesday, 12 June 2018

Present: Councillors Mrs E Rhodes Chair (Wakefield MDC), P Midgley (Sheffield City C), A Robinson (Doncaster MBC), J Ennis (Barnsley MBC), D Taylor (Derbyshire CC), and S Evans (Rotherham MBC)

Scrutiny Officers:- Christine Rothwell (Doncaster MBC), Jackie Wardle (Derbyshire CC), Janet Spurling (Rotherham MBC), Emily Standbrook-Shaw (Sheffield City C), Anna Marshall (Barnsley MBC) and Andy Wood (Wakefield MDC)

NHS:- Jackie Pederson (Doncaster CCG/SYB ACS), Lesley Smith (Barnsley CCG), Sue Cassin (Rotherham CCG), Will Cleary-Gray (Programme Director), Priscilla McGuire (JCCCCG), Philip Moss (JCCCCG), Helen Stevens (JCCCCG), Marianna Hargreaves (SYB ICS), T Moorhead (Sheffield CCG/JCCCCG), Alison Knowles (NHS England) and Alexandra Norrish (SYB ICS)

Observer:- Councillor Mrs C Ransom – Doncaster MBC

7 members of the public were in attendance at the meeting

1. DECLARATIONS OF INTERESTS

No declarations of interest were made.

2. MINUTES - 29 JANUARY 2018

Resolved – That the Minutes of the meeting of the South Yorkshire, Derbyshire, Nottinghamshire and Wakefield Joint Health Overview and Scrutiny Committee held on 29 January 2018 be approved as a correct record.

3. QUESTIONS FROM MEMBERS OF THE PUBLIC

The following public questions had been submitted and the responses below were provided.

Questions from Deborah Cobbett

(1) Will Scrutiny Members please consider the health needs of South Yorkshire communities set out in the Appendix of the Hospital Services Review (Annex D: Place Definitions)?

Response – The JHOSC would take into account all communities within the scope of the review. Local Health OSCs would also have an important role to play in addressing any local proposals.

(2) Do they feel that making cuts to services is the best way to address the health inequalities, diseases of poverty and conditions associated with the post-industrial communities they were elected to serve?

Response – Health scrutiny is outcome focused, looking at cross-cutting issues, including health improvement, wellbeing and how well health inequalities are being

addressed, as well as specific treatment services.

(3) Why did the Scrutiny Committee feel the need to be "developed" by NHS managers when your role is to scrutinise their activities, not to be directed or developed by them?

Response - The JHOSC session is to help further develop its understanding of the South Yorkshire and Bassetlaw, North Derbyshire and Mid Yorkshire Health and Care Partnership, as outlined in paragraph 5.4 Agenda item 9 – JHOSC future Work Programme.

The session's primary purpose is to develop a forward work programme for the JHOSC. Joint development sessions are outlined as good practice in statutory guidance issues by the Department of Health. Overview and Scrutiny Committees and JHOSCs must have regard to any guidance issued by the Secretary of State, in exercising, or deciding whether to exercise, any of their functions.

(4) Will you note the importance of Scrutiny, as set out by the House of Commons report on the effectiveness of Local Authority Overview and Scrutiny Committees?

Response - Each individual Authority will determine if and how it responds to the Select Committee report.

(5) Why should the JHOSC "add value" as stated on page 25, paragraph 5.6? What does this mean?

Response - This is good practice as identified by the Centre for Public Scrutiny and others, not specifically in relation to the Integrated Care System but all scrutiny reviews. To "add Value" is to ensure that any scrutiny review is focused and targeted on the key issues in order to avoid duplication and maximise member and officer resources.

Question from Leonora Everitt

(6) I have shared with you the information, as requested, about my experience as a member of the public, of the Calderdale and Kirklees Joint Health Overview and Scrutiny Committee. I was treated with respect with my verbal evidence heard, and my more detailed written evidence received, both as part of one regular meeting I attended and in a meeting dedicated to receiving evidence, verbal and written, from members of the public and from groups representing members of the public.

The Calderdale and Kirklees Joint Health Overview and Scrutiny Committee met regularly with a clear programme outlining the focus of each meeting and the relevant witnesses to be called. This programme covered all aspects of the substantial change proposed, and was adjusted to include any additional issues identified during the process.

Committee members deliberated together after each meeting and published their decisions and the reasons for them in brief shortly afterwards. They decided to make some recommendations regarding the NHS proposals and when these were not suitably responded to by the NHS they made a report to the Secretary of State. He referred it to the Independent Reconfiguration Panel which endorsed the Calderdale and Kirklees Joint Health Overview and Scrutiny Committee members' concerns.

Will you consider a similar approach to ensure that you take account of the views of the people you are accountable to and whose interests you serve, and that you also ensure that you carry out your full statutory scrutiny function as effectively as the Calderdale and Kirklees Joint Health Overview and Scrutiny Committee have done for their population?

Response – There was a fundamental difference between the Calderdale and Kirklees Joint Health Overview and Scrutiny Committee and the South Yorkshire, Derbyshire, Nottinghamshire and Wakefield Joint Health Overview and Scrutiny Committee in that Calderdale and Kirklees had agreed the proposals were a substantial variation to services – a much advanced position to where we are at the moment in relation to the Hospital Services Review. As such, they laid out a programme of meetings to deal with each aspect of the review, including a specific meeting for public involvement, which included submissions as opposed to questions. The South Yorkshire, Derbyshire, Nottinghamshire and Wakefield Joint Health Overview and Scrutiny Committee may replicate this process should it decide that any proposals (which are some way off yet) involve a substantial variation to services or require a more detailed review.

A number of questions were asked that it was deemed inappropriate for the Committee to address.

4. HYPER ACUTE STROKE SERVICES

The Committee received an update on the proposals to change Hyper Acute Stroke Services in South and Mid Yorkshire, Bassetlaw and North Derbyshire.

A decision was made by the Joint Committee of Clinical Commissioning Groups and Hardwick Clinical Commissioning to approve the decision making business case changes to hyper acute services in November 2017.

The proposed model included a Stroke Clinical Network to support the development of networked provision and the consolidation of hyper acute stroke care at Doncaster Royal Infirmary, Royal Hallamshire Hospital (Sheffield) and Pinderfields Hospital (Wakefield), plus the continuation of existing provision at the Royal Chesterfield Hospital. It would be supported by the gradual implementation of Mechanical Thrombectomy commissioned by NHS England.

In February 2018, a challenge was made of the decision from a resident seeking a Judicial Review. It was confirmed in early May that permission for a Judicial Review had been refused. A renewal notice (appeal) had now been initiated and a hearing to determine if a substantive hearing was necessary was expected in June 2018. The Clinical Commissioning Groups had been advised that they could continue to plan but could not take any irreversible steps. The Hyper Acute Stroke Services Update providers were strengthening contingency planning to ensure continuation of existing provision pending an outcome of the Judicial Review.

Resolved – That the report be noted and further information be provided following the outcome of the appeal.

5. CHILDREN'S NON-SPECIALIST SURGERY AND ANAESTHESIA

An update was provided on the progress to implement approved changes to Children's Surgery and Anaesthesia Services.

A 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 in June 2017.

Approval of the preferred model would enable the majority of surgery to continue to be delivered locally at three hubs at Doncaster Royal Infirmary, Sheffield Children's Hospital and Pinderfields General Hospital at Wakefield. Once the proposals were implemented it would mean around one or two children per week needing an emergency operation for a small number of conditions, at night or at the weekend, would no longer be treated in hospitals in Barnsley, Chesterfield and Rotherham, and would receive their treatment at one of three hubs.

Implementation continued to progress with most clinical pathways having been agreed by the Managed Clinical Network and many designated visits had been completed in early 2018.

It had been anticipated that implementation of the changes would progress after designation in quarter 1 2018/19. However, through the designation process it was identified that further work was required with hub centres to enable them to deliver all aspects of the service and this would be prioritised ahead of implementation. It was now the aim that the changes would be enacted in quarter 3 2018/19. This approach had been agreed with the Joint Committee of Clinical Commissioning Groups in March 2018.

Resolved – (1) That the report be noted.

(2) That a briefing summary of the planning process reports (feedback on designation process and action plans, together with progress on patient pathways) sent to the Trusts be provided to the Joint Health Overview and Scrutiny Committee in the next four weeks.

(3) That the Joint Heath Overview and Scrutiny Committee consider the information requested at their next meeting.

6. HOSPITAL SERVICES REVIEW

The Committee received a detailed presentation on the Hospital Services Review. The objective of the review was to identify ways in which acute hospital services in South Yorkshire, Bassetlaw, Mid Yorkshire and North Derbyshire, can be put on a sustainable footing, in the face of significant challenges. The review had identified that the population was ageing, demand was increasing, the workforce was increasingly overstretched, people's needs were changing and the types of healthcare that can be provided are changing. However, the NHS has not changed to keep up.

The reviewed focused on some of the most challenged services and highlighted services which were facing significant difficulties with workforce and quality and have a significant impact on the service as a whole. Specifically these services included:

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

These issues had been discussed with the public through a range of events. An online and telephone survey had also been used to consult and engage with a wide range of individuals. A number of clinical working groups had been held to find out the views of staff. The Members felt that much greater consultation was required with the public. It was explained that activities had been arranged with the Chamber of Commerce. Toddler groups and GPs surgeries would also be targeted.

Clinicians, patients and the public identified three main areas of challenge. There were significant shortages of staff, across the workforce. Shortages mean that staff work long hours and don't have time for training and in worst cases they leave the organisation. Patients had made comments that care often felt rushed. Every trust had its own way of doing things, even when there were supposed to be national standards. This makes joint working difficult and impacts on patients. IT often doesn't work across organisations, and the system is not good at making the most of new technologies. Whilst there are some excellent new ideas emerging, these are usually in isolation of other trusts.

In developing solutions to these problems the review was guided by three main principles:

- There will continue to be a hospital in every place: we are not closing any District General Hospitals.
- Most patients will receive most of their hospital-based care at their local District General Hospitals.
- We need the staff we have – we do not expect that the review will lead to any redundancies, although some staff might have to work differently.

A solution identified was to ensure the hospitals worked better together through shared working on hosted networks. A single approach to recruitment, retention and training could be established. This could be further enhanced by the establishment of standardised clinical protocols. This would create a much greater degree of accountability. If working together was not enough, changing the way services were configured could be considered and how services could continue in a sustainable way.

For the services identified the review tested the possible options for each of the services against five criteria; workforce, affordability, access, quality and interdependencies. The review provided specific recommendations regarding delivery in the services identified.

The Hospital Services Review had been published 10 May 2018. There would be a public Joint Committee of Clinical Commissioning Groups discussion of 26 June 2018 regarding the review. These views would then be discussed at Trust Boards and Governing Bodies during June and July. Public responses to the recommendations, and the views of trusts and commissioners, would inform the drafting of a Strategic Outline Case. This would then be signed off by the Joint Committee and Clinical Commissioning Groups and the Collaborative Partnership Board.

Final comments on the report were required by 12 July 2018 and every effort would be made to publicise this to ensure a wide range of people were engaged with. It was stressed that the original report was an independent consultant's report and that no decisions had been made. The appropriate people would be invited to future meetings to discuss the finding and potential recommendations. The JHOSC was concerned

regarding the deadline for comments on the HSR report and how this would be publicised to the general public. It was suggested that existing routes would be used to advertise the deadline.

The JHOSC felt the HSR report was a complex document consisting of 180 pages together with a large number of technical annexes, which was not very reader friendly. The Committee requested that an easy read summary document is produced specifically for a public audience, and that a copy is sent to the JHOSC for comment.

In terms of general comments, the JHOSC considered that there may be a significant risk that the proposed workforce proposals would not go far enough over the next few years, leading to a further review around options for reconfiguration, particularly in relation to Emergency Departments.

With regard to maternity services, the HSR report suggests that in line with the requirement for mothers to be offered greater choice of birth options closer to home, the system should consult with the public on whether stand-alone Midwife-led Units (MLUs) are an option that they would support, and should further develop the home births service in each Place. Given that 71% of all deliveries in South Yorkshire, Bassetlaw and North Derbyshire (SYBND) are medium to high risk the JHOSC questioned the viability of standalone MLUs.

The HSR report recommended that SYB(ND) should establish a Transport Reference Group (TRG) with a remit to develop a system-wide transport strategy and the specific functions to support and deliver it. The JHOSC felt that it was important the TRG had sufficient powers and that its recommendations would be given sufficient weight in the decision-making process.

Notwithstanding these general comments, the Chair re-emphasised that the HSR report was an independent report commissioned by the JCCCG and at this stage should be viewed as such. The JHOSC will carefully consider the outcome of discussions at the JCCCG and constituent Trust Boards during June and July and will prioritise its own work programme to coincide with the decision-making process.

Resolved – That the JHOSC note the report at this stage and determine any future scrutiny activity to coincide with the decision-making process and in accordance with the Committee's agreed work programme.

7. JHOSC FUTURE WORK PROGRAMME

A report was submitted which provided an opportunity for Members to consider and agree the priorities for developing its future work programme.

The 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 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.

Since the formal establishment of the JHOSC, a number of issues / work streams have been considered by the Committee, including:

- Hyper Acute Stroke Services
- Children's non-specialist surgery and anaesthesia
- Hospital Services Review

At the JHOSC meeting held on 31 July 2017, Members were asked to consider the wider implications of the South Yorkshire and Bassetlaw Sustainability and Transformation Plan and that patient flows would also involve Mid Yorkshire and Chesterfield. It was noted that the current configuration of the JHOSC would work for the hospital services review. It was confirmed that 80% of the 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 the JHOSC.

In order to further develop the understanding of the South Yorkshire, Bassetlaw, North Derbyshire and Mid Yorkshire Health and Care Partnership, the JHOSC held a development session to consider:

- Current and future governance and decision-making arrangements of the Partnership, including the position of the JHOSC within the wider arrangements of an Accountable Care System.
- The Partnership's approach to public engagement and involvement.
- To have a fuller appreciation of the various programmes of the Partnership.
- To identify priority areas and an outline forward plan for the JHOSC including a timeline.

The outcome of the development session, particularly the various programmes and timeline would help to assist Members in developing the JHOSC forward programme of work, based on identified priorities and an agreed schedule of meetings. The work programme would require a level of flexibility in order to deal with any issues that arise throughout the year on a local, regional and national level.

Resolved – (1) That Members note the information provided and give future consideration to the matters detailed to develop the Joint Committee's work plan.

(2) That NHS colleagues provide a timeline and forward plan of topics, together with assigned officers to the JHOSC within four weeks.

8. DATE AND TIME OF NEXT MEETING

Resolved – That the next meeting of the South Yorkshire, Derbyshire, Nottinghamshire and Wakefield Joint Health Overview and Scrutiny Committee be held in early October 2018 at Barnsley Council. Date to be confirmed.

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**Report of the Executive Director Core Services,
Barnsley Metropolitan Borough Council (BMBC),
to the South Yorkshire, Derbyshire, Nottinghamshire and Wakefield,
Joint Health Overview and Scrutiny Committee (JHOSC),
on Monday 22nd October 2018**

South Yorkshire & Bassetlaw (SYB) Integrated Care System (ICS) – Cover Report

1.0 Introduction and Background

1.1 The purpose of the attached report (Item 5b) is to provide an overview and update to the Joint Health Overview and Scrutiny Committee (JHOSC) in relation to the South Yorkshire and Bassetlaw (SYB) Integrated Care System (ICS) known as 'Health and Care Working Together'.

1.2 In October 2014 the NHS published the 'Five Year Forward View (FYFV)' which provided a collective view from patient groups, clinicians and independent experts on how the health service needed to change over the next five years to close the widening gaps in the health of the population, quality of care and the funding of services.

1.3 In December 2015, the 'NHS Shared Planning Guidance' outlined a new approach to help ensure that health and care services are built around the needs of local populations. To do this, every health and care system in England (a total of 44), produced a multi-year Sustainability and Transformation Plan (STP) (published in November 2016), showing how local services would evolve and become sustainable over the coming five years – ultimately delivering the FYFV.

1.4 Over time, in line with national changes, the SYB STP has evolved to become the SYB ICS. The organisations involved reflect the geographical area which the SYB ICS covers. However due to patient flows, it is important to be mindful of National Health Services (NHS) services within neighbouring areas.

1.5 The attached report (Item 5b) provides:

- the background to the SYB ICS;
- the current position in relation to SYB ICS' 15 areas of focus including primary care, urgent and emergency care, cancer, mental health and learning disabilities, living well and prevention, elective and diagnostics, children's and maternity, digital and information technology (IT), medicines optimisation, workforce, corporate services, one public estate, finance, communications and engagement, and leadership and organisational development (OD);
- the future plans and challenges; and
- the implications for local people

2.0 Invited witnesses

2.1 At today's meeting, the following representatives will be attending to answer questions from the JHOSC regarding this work:

- Lesley Smith, South Yorkshire and Bassetlaw (SYB) Integrated Care System (ICS) Deputy System Lead and Lead for Strategy, Planning and Transformation Delivery as well as Chief Officer at Barnsley Clinical Commissioning Group (CCG)
- Will Cleary-Gray, Chief Operating Officer, SYB ICS
- Helen Stevens, Associate Director of Communications and Engagement, SYB ICS

3.0 Possible areas for discussion

3.1 Members may wish to ask questions around the following areas:

- What are the biggest challenges in relation to the SYB ICS and which would have the greatest impact on improving the local population's health if resolved?
- How effective are working relationships amongst the partner agencies involved? Are all partners engaged and involved equally?
- What are the main benefits of an ICS and how will this impact upon the patient experience of services?
- What is in place to ensure appropriate governance and transparency in decision making within the SYB ICS?
- What investment is being made in the prevention of ill health amongst the population as a result of establishing the SYB ICS?
- How do you foresee piloting the new National Engagement Framework will improve patient, public and workforce engagement and involvement?
- How do you ensure good practice in one area is shared and replicated where possible in other areas?
- What performance management arrangements are in place and how will you know if working as a system benefits all partners?
- To what extent do neighbouring STPs/ICSs impact on the SYB ICS?
- How can Elected Members help support improved health outcomes for local residents?

4.0 Background Papers and Links

- Item 5b (attached) – Update on 'Health and Care Working Together' – the SYB ICS
- South Yorkshire and Bassetlaw STP: https://smybndccgs.nhs.uk/application/files/1514/8037/0832/South_Yorkshire_and_Bassetlaw_Sustainability_and_Transformation_Plan.pdf
- NHS Five Year Forward View: https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

5.0 Glossary

CCG	Clinical Commissioning Group
FYFV	NHS Five Year Forward View
ICS	Integrated Care System
JHOSC	Joint Health Overview and Scrutiny Committee
NHS	National Health Service
STP	Sustainability and Transformation Plan
SYB	South Yorkshire and Bassetlaw

6.0 Officer Contact

Anna Marshall, Scrutiny Officer, 12th October 2018

Update on 'Health & Care Working Together' - the South Yorkshire & Bassetlaw Integrated Care System

1.0 Introduction

1.1 The purpose of this report is to provide an overview and update to the Joint Health Overview and Scrutiny Committee (JHOSC) in relation to the South Yorkshire and Bassetlaw (SYB) Integrated Care System (ICS) known as 'Health and Care Working Together'.

2.0 Background

2.1 NHS, local authority, voluntary and community sector organisations already have a history of working together to deliver high quality services in Barnsley, Bassetlaw, Doncaster, Rotherham and Sheffield.

2.2 In 2016, NHS organisations and local councils were asked to come together to form 44 sustainability and transformation partnerships (STPs) covering the whole of England, and set out their proposals to improve health and care for patients.

2.3 In some areas, the partnerships evolved to form an integrated care system, a new type of even closer collaboration. In an integrated care system, NHS organisations, in partnership with local councils and others, take collective responsibility for managing resources, delivering NHS standards, and improving the health of the population they serve.

2.4 South Yorkshire and Bassetlaw Integrated Care System is one of 10 Integrated Care Systems which has been nationally chosen to test a new way of working together locally.

2.5 Most of the partnership work between the NHS, councils and the voluntary sector takes place at a local level in each of the five places covered by the arrangements: Barnsley, Bassetlaw, Doncaster, Rotherham and Sheffield. The ICS supports this work and addresses issues that are best delivered through collaboration across the whole of South Yorkshire and Bassetlaw.

2.6 In South Yorkshire and Bassetlaw, all the partners have been working together for nearly two years. First as a Sustainability and Transformation Partnership, then as a first wave Accountable Care System and then formally as an Integrated Care System from October 2018.

2.7 Throughout this time our goal has remained the same: For everyone in South Yorkshire and Bassetlaw to have the best possible start in life, with support to be healthy and live well for longer.

2.8 The South Yorkshire and Bassetlaw Integrated Care System has a shared responsibility for the way health and care services are run and delivered to the 1.5 million people in the region. Made up of health and care organisations, it has more local ownership over local services to ensure the continued provision of services that our populations really need and deserve.

2.9 The new way of working means closer links across the region to improve people's life chances, employability and career aspirations, speed up care and treatments, make

stronger links between physical and mental healthcare, social care and the NHS and GPs and hospitals.

2.10 Nationally the vision for ICSs is that they will:

- Enable local services to provide better and more joined-up care for patients when different organisations work together in this way
- Support improved collaboration to help to make it easier for staff to work with colleagues from other organisations
- Enable systems to better understand data about local people's health, allowing them to provide care that is tailored to individual needs
- Work alongside councils, and draw on the expertise of others such as local charities and community groups, to help people to live healthier lives for longer, and to stay out of hospital when they do not need to be there
- Make faster progress than other health systems in transforming the way care is delivered, to the benefit of the population they serve

2.11 The development of ICSs reflects a need for services to be better joined-up around the needs of local populations. People are living longer with multiple, complex, long-term conditions and increasingly require long-term support from many different services and professionals. Fragmentation of services and a lack of co-ordination and communication between them can lead to a poor experience for people receiving care.

2.12 Integrated care system leaders gain greater freedoms to manage the operational and financial performance of services in their area (in ways that are consistent with their individual legal obligations).

2.13 The ICS does not replace any legal or statutory responsibilities of any of the partner organisations. It is simply an agreement to work together better.

2.14 The partnership includes:

Commissioners:

- NHS Bassetlaw Clinical Commissioning Group (BasCCG)
- NHS Barnsley Clinical Commissioning Group (BarCCG)
- NHS England (NHSE)
- NHS Doncaster Clinical Commissioning Group (DCCG)
- NHS Rotherham Clinical Commissioning Group (RCCG)
- NHS Sheffield Clinical Commissioning Group (SCCG)

Healthcare providers

- Barnsley Hospital NHS Foundation Trust (BHFT)
- Chesterfield Royal Hospital NHS Foundation Trust (CHFT)
- Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust (DBTH)
- East Midlands Ambulance Service NHS Trust (EMAS)
- Sheffield Children's Hospital NHS Foundation Trust (SCFT)
- Sheffield Teaching Hospitals NHS Foundation Trust (STHFT)
- The Rotherham NHS Foundation Trust (TRFT)
- Sheffield Health and Social Care NHS Foundation Trust (SHSCT)
- Rotherham, Doncaster, South Humber NHS Foundation Trust (RDaSH)
- Yorkshire Ambulance Service NHS Trust (YAS)

Heath Regulator, Assurer, Education and Training

- NHS England (NHSE)
- NHS Improvement (NHSI)
- Health Education England (HEE)
- Public Health England (PHE)

Local Authorities

- Barnsley Metropolitan Borough Council (BMBC)
- Doncaster Metropolitan Borough Council (DMBC)
- Nottinghamshire County Council (NCC) / Bassetlaw District Council (BDC)
- Rotherham Metropolitan Borough Council (RMBC)
- Sheffield City Council (SCC)

3.0 Current Position

3.1 On October 1st South Yorkshire and Bassetlaw Integrated Care System was officially launched. This means the ICS will start to take on more responsibilities for system performance, and invest transformation funds in priority areas in the public sector.

3.2 In September 2018, in preparation for the launch, Chief Executive System Leads officially joined the ICS. Their appointment provides additional leadership in the ICS and, together with all the Chief Executive and Accountable Officers who are supporting the workstreams, enables the priorities to move forward at a faster pace. The leads are continuing in their current, substantive roles, whilst also taking on part time roles within the ICS. The leads are:

- Lesley Smith, Chief Officer of NHS Barnsley CCG will be the Deputy System Leader as well as taking responsibility for Strategy, Planning and Transformation Delivery
- Richard Jenkins, Chief Executive of Barnsley Hospital NHS Foundation Trust will take responsibility for NHS Provider Development
- Richard Parker, Chief Executive of Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust will take responsibility for Integrated Assurance and Improvement (for NHS Providers)
- Maddy Ruff, Chief Officer of NHS Sheffield CCG will take responsibility for Population Health and Primary Care
- Chris Edwards, Chief Officer of NHS Rotherham CCG will take responsibility for Estates and Capital
- Idris Griffiths, Chief Officer for NHS Bassetlaw CCG will take responsibility for Integrated Assurance and Improvement (for NHS Commissioners)
- Kevan Taylor, Chief Executive of Sheffield Health and Social Care NHS Foundation Trust will take responsibility for Workforce

3.3 In delivering the wider priorities for the ICS, the partnership has 15 areas of focus, the workstreams and their enablers (finance, estates, leadership & organisational development (OD), communications and engagement). The workstreams and some of their achievements to date and their priorities going forwards include:

3.4 **Primary Care -** key work to date includes the establishment of Local Care Networks/Primary Care Networks in all 5 areas across SYB which, when further developed, will work together to develop resilience through sharing estates, data and IT at network and system level. Where possible, and in collaboration with staff, this could also include workforce.

3.5 The primary care workstream priorities are now to:

- Put in place the national plan to help struggling GP practices, reduce workload, expand a wider workforce, invest in technology and estates and speed up transformation of services - the GP Forward View
- Further develop digital 'interoperability' between practices, including access to records and data sharing agreements in place; ability for patients to access on-line booking, repeat prescription requests and access to health records and test results; and implementation of GP WiFi

3.6 **Urgent and emergency care (UEC) -** key work to date includes showcasing successful UEC initiatives to partners; improved relationships between senior colleagues across organisations resulting in open discussions about successes and challenges; implementation of (partial to date) a system for tracking live where in SYB UEC services are most under-pressure at any one time; development of an Integrated Urgent Care (IUC) model for SYB used to inform and influence the procurement of a new IUC Service (111 and clinical advice) across Yorkshire and Humber.

3.7 The UEC workstream priorities are now to:

- Conclude the IUC procurement by November 2018
- Develop and co-produce a transport improvement plan with a focus on increasing the number of patients being seen and treated by ambulance medical professionals and as a result not needing taking to a hospital, and standardising pathways across SYB
- Focus on reducing the amount of time people spend in hospital unnecessarily

3.8 **Cancer -** key work to date includes the Cancer Alliance Board agreeing a mutual accountability model, testing new ways of working (governance) further and faster as part of the SYB ICS; an inter-trust messaging pilot initiated to improve working across trusts to ensure patients are seen by the right person in the right place at the right time; a campaign launched to improve awareness of signs and symptoms; a series of primary care education events undertaken with each Clinical Commissioning Group (CCG).

3.9 The cancer workstream priorities are now to:

- Continue to deliver the National Cancer Taskforce recommendations. The taskforce looked at how cancer services are currently provided and set out a vision for what cancer patients should expect from the health service. The report included 96 recommendations to help transform the care that the NHS delivers for all those affected by cancer.
- Implement rapid pathways by March 2019 (colorectal, lung, and prostate cancer pathways) and deliver the 28 day faster diagnosis standard.
- Continue work to support all partners to meet the 62 day standard (this refers to the urgent referral for suspected cancer to a patient's first treatment)

3.10 **Mental health and learning disabilities -** key work to date includes securing targeted suicide prevention funding of £555,622, to reduce our suicide rate by 10%; securing £881,000 for targeted perinatal mental health funding, to provide a specialist community perinatal mental health service across Doncaster, Rotherham and Sheffield; supporting the successful commissioning and procurement of the health led trial "Working Win" which is helping people stay in and get back to work - with 1,000 referrals to the trial already achieved across Sheffield City Region since May.

3.11 The mental health and learning disabilities workstream priorities are now to:

- Support the implementation of the suicide prevention plans in each place

- Continue to support implementation of specialist community perinatal mental health service across Doncaster, Rotherham and Sheffield
- Continue to work collaboratively on a definition for out of area placements with the ultimate aim of reducing these across SYB

3.12 **Living well and prevention -** key work to date includes gaining support from the hospital chief executives for a hospital wide quit smoking programme; being recognised by NHS England as having the most comprehensive social prescribing offer of all ICSs/STPs and being featured as a case study in their new social prescribing guide to be published later this year; supporting voluntary sector partners to bid for national funding for social prescribing - with two successful partners.

3.13 The living well and prevention workstream priorities are now to:

- Start to develop hospital based implementation plans for the quit programme and to identify clinical champions
- Develop an action plan and a social prescribing strategy

3.14 **Elective and diagnostics -** key work to date includes, as a result of establishing the SYB Radiography Academy, we now have a first cohort of eight radiographers who are able to report (this is starting to ease some of the pressure on this staff group across SYB); the development of a radiology system-wide work plan and draft workforce strategy; a capital bid for networked radiology developed and prioritised; significant improvement in system performance on delivery of echocardiograms (a scan used to look at the heart and nearby blood vessels).

3.15 The elective and diagnostics workstream priorities are now to:

- Identify longer term resource for the radiology programme
- Identify ways in which we can improve hospital outpatient services for people

3.16 **Children's and maternity -** key work to date includes setting up networks of health professionals from across primary and secondary care organisations (Managed Clinical Networks); securing significant transformation funding to plan the design and delivery of maternity services as set out in the national *Better Births* plan (in Maternity Place Plans); making good progress towards implementation of the Children's Surgery and Anaesthesia's new service specification.

3.17 The children's and maternity workstream priorities are now to:

- Support the development and delivery of Maternity Place Plans – including development of effective local Maternity Voices Partnerships (MVP) in each of our places. MVPs are a team of women and their families, commissioners and providers (midwives and doctors) working together to review and contribute to the development of local maternity care
- Continue to implement the Children's Surgery and Anaesthesia Service Specification

3.18 **Digital and IT -** key work to date includes the development of a digital plan through partnership working which will empower patients and support new ideas. We are a member of the Yorkshire and Humber Local Health and Care Record Exemplar group, and one of five areas in the country to successfully bid for resources to explore, consult and design the health and care record sharing. We have installed WiFi in 41% of the 288 GP practices in our area, the work to reach 100% coverage continues.

3.19 The digital and IT workstream priorities are now to:

- Complete remaining GP WiFi work for Doncaster (43 sites), Barnsley (57 sites), Rotherham (45 sites) and Bassetlaw (16 sites)
- Design the health and care record sharing computer system

3.20 **Medicines optimisation -** key work to date includes the recent establishment of the workstream, with clear membership and remit; and delivery of savings.

3.21 The Medicines optimisation workstream priorities are now to:
- Reduce unnecessary NHS spend by using lower cost medicines; reducing the volume of inappropriate medicines prescribed
- Support the delivery of shared campaigns with partners to standardise prescribing practice
- Maximise efficiencies between primary and secondary care

3.22 **Corporate services -** key work to date in the corporate services workstream has focused on trusts taking a collective approach to corporate services so that they can reduce waste and improve efficiency and effectiveness. This means that they can focus resources on improving patient care and services. The work includes the development of a joint procurement workplan delivering savings of around £2.5m with a further £1m to be delivered e.g. electronic rostering, salary sacrifice, training - with up to £3.6m efficiencies enabled across trusts over the last three years; delivery of a joint medical staff bank pilot; a digital pathology event which attracted 140 attendees, provided local staff with the opportunity to see and hear about the technology and operational processes, and raised the profile of SYB pathology.

3.23 The corporate services workstream priorities are now to:
- Deliver existing in year procurement schemes
- Complete live bank / agency management initiatives
- Complete Human Resources (HR) streamlining projects
- Define options for pathology operational model and complete data collection to inform evaluation, complete risk analysis of procurement options and agree preferred option

3.24 The continuation of a Hospital Services Programme (see separate JHOSC paper) and work with commissioners to consider how they can best work together to improve services for all populations in SYB are also priorities for the ICS for 2018/19.

3.25 **Workforce -** workforce issues are a key driver for much of the work of the Integrated Care System. A workforce team supports the ICS workstreams, and has already supported the establishment of the workforce hub in the ICS and the successful recruitment of 96 trainee Advanced Nurse Practitioners and 160 trainee Nursing Associates to support workforce. Advanced Nurse Practitioners carry out duties such as interpreting the results of many different assessments and investigations in order to make a diagnosis, and plan and deliver care; prescribe and work with individuals to manage their medicines; plan and provide care to meet a patient's health and social care needs involving or referring on to other members of the healthcare team as appropriate. The Nursing Associate is a new role currently being trialled to help build the capacity and capability of the nursing workforce in England. The role aims to bridge the gap between health and care support workers, who have a care certificate, and registered nurses.

3.26 Going forwards the workforce team is looking to improve engagement with partners at a Place level, through establishing Place based workforce leads who can ensure co-ordination between organisation, Place and ICS. The workforce team is also looking to

develop a strategy for the whole region in relation to schools engagement and widening participation. They will also be supporting workstreams to pilot models with the aim of resolving some workforce issues through innovative workforce transformation.

3.27 **Communications and engagement -** The SYB ICS Communications, Involvement and Equality and Diversity Strategy is currently being refreshed to enable the partnership to publically renew our commitment to involving, communicating and consulting with citizens, staff, stakeholders and partners in the development and implementation of our work, as we want the future of local health and care services to be shaped by the people who need, use and work in them.

3.28 An ICS Citizens' Panel has been recruited and has now been in place for over a year. The Citizens' Panel provides an independent view and critical friendship on matters relating to the ICS. In particular the group ensures engagement opportunities are created for citizens, patients and carers and that they are meaningful, targeted and relative to the changes suggested. The panel ensures its work and the issues reflected by citizen engagement are given equal importance to the work of the professional health and care partners. Minutes from the Citizens' Panel meetings are made available on the ICS website: http://www.healthandcaretogethersyb.co.uk/index.php/get-involved/meet-citizens-panel/meeting-minutes The panel has been involved in assuring ICS engagement approaches to the Hospital Services Review, 111 procurement, and medicines optimisation campaigns.

3.29 The ICS communications and involvement team has supported the Hospital Services Review (HSR) and ensured there are opportunities throughout for the views of the public to influence emerging thinking. This has included regional events, online opportunities, local community events, and targeted community focus groups and deliberative events (with a particular focus on seldom heard communities) on the back of emerging equalities data and a gap analysis. All of the opportunities have been widely promoted via media relations and using all the partners' communication networks (see separate JHOSC paper for more information on the HSR). The Consultation Institute have been supporting and assuring the HSR involvement activity.

3.30 The ICS is currently working with the national patient participation and involvement (PPI) team to further strengthen our patient/ public engagement approach, having been selected as one of two ICSs nationally to pilot the new national engagement framework. A workshop in November involving members of the ICS' senior team, and partners from across South Yorkshire and Bassetlaw will support us to benchmark our engagement work and develop an action plan to address any gaps.

3.31 Staff and clinical engagement includes through the speciality specific networks, where groups of clinicians from the same speciality meet regularly to address needs in their field. This is through the Clinical Working Groups established by the Hospital Services Review; via targeted events, such as a discussion with Professor Don Berwick (one of the world's leading healthcare experts and former advisor to Barack Obama), which was predominantly attended by primary care clinicians; a nursing roadshow, in which we visited five hospital sites across the five places in one day with a national NHS Chief Nurse; and two events for Allied Health Professionals (AHPs). Examples of the types of AHPs who attended include dietitians, radiographers and occupational therapists. The ICS also meets monthly with the Staff Partnership Forum, which has regional representation from all of the Unions. We will also embark on a clinical engagement project with support from the national team, which will involve establishing a network of clinicians who are involved in ICS developments.

3.32 The communications and involvement team also meets monthly with the CCG lay representatives, and over the past year have held a Trust Governors event and an event for CCG lay members and Non-Executive Directors (NEDs) from Trusts. We are now embarking on establishing a 'guiding coalition' of lay members, NEDs, Trust governors and elected members from Local Authorities.

3.33 To support the launch and address concerns that the ICS is still an unknown quantity to many in South Yorkshire and Bassetlaw, the communications team is embarking on a series of activities to raise the profile of the partnership. This will include a series of media releases, new materials explaining who the ICS are and what we do and attending partners' staff and public events (such as Annual General Meetings [AGMs]).

3.34 **Finance -** Since South Yorkshire and Bassetlaw ICS came together as a Sustainability and Transformation Partnership (formerly) the evolution of the financial arrangements have mirrored the evolution of the partnership. The financial team has been working hard to ensure taking a system position is to the benefit of all partners (and therefore their patients). The team has negotiated a strong position for the ICS, so that in 2018/19 the benefits of working as an ICS benefits the partnership.

3.35 In addition to negotiating a strong financial position for 2018/19, the ICS finance team also ensured the system financial targets were met in 2017/18; completed a five year ICS financial model and one year system plan; and secured national capital funding, only available via STP systems. The capital funding will develop CT (computerised tomography) scan capacity at Doncaster and Bassetlaw Teaching Hospitals Trust (£4.9m), support the Yorkshire Ambulance Trust to develop an urgent and emergency care hub in Doncaster (£7.1m), support the co-location of the children's emergency department and assessment unit at Barnsley hospital (£2.5m) and support the reconfiguration of the hyper acute stroke unit at Sheffield Teaching Hospitals.

3.36 The key priority for the finance team, alongside continuing to manage the system financial progress is to work with the NHS England and NHS Improvement teams to help shape the development and then agree the new ICS financial framework.

3.37 In addition to our progress outlined above, our performance on our NHS Constitution commitments to patients and the public as five Places over the last year has also strengthened. The attached scorecards (see **Appendix 1**), which show our collective position at July 2018 as compared with other areas in the North of England and also the other ICSs, show that while we have work to do in some areas, our collective performance nationally is strong. The scorecards are currently health focused only (due to data that is available) but we are working on a wider scorecard, one which highlights the work we are doing to tackle the wider socio-economic determinants of health.

3.38 As we prepare for the next stage of our ICS development, a key priority for the system is to review its governance and ways of working arrangements. The independent review is currently underway and is expected to conclude with recommendations consistent with organisations' individual legal obligations that also ensure all our stakeholders shape and are involved in the work. (**Appendix 2** shows a diagram of the system-wide governance including the local 'Places'. **Appendix 3** shows the ICS governance specifically).

3.39 The South Yorkshire and Bassetlaw ICS is one of eight first wave ICSs to feature recently in an independent report by The King's Fund 'A year of integrated care systems – reviewing the journey so far': https://www.kingsfund.org.uk/publications/year-integrated-care-systems

3.40 The King's Fund report summarised that:

- Most ICSs are making progress in developing their capabilities to work as systems, and organisations are working more collaboratively to manage finances and performance in a way that was not happening previously
- There are some early signs of progress in delivering service changes, particularly in relation to strengthening primary care, developing integrated care teams and reviewing how specialist services are delivered. It is early days, and more time is needed to embed these changes and determine their impact
- The challenge now is to build on the foundations that have been laid by removing barriers and providing time and support to ICS leaders to take their work to the next stage of development. As this happens, the understandable desire to see change happen quickly needs to be married with realism about the scale and complexity of what is being attempted

4.0 Future Plans & Challenges

4.1 Currently NHS England is developing the national Long Term Plan (engagement upon this is currently taking place: https://www.engage.england.nhs.uk/consultation/developing-the-long-term-plan-for-the-nhs/) and in South Yorkshire and Bassetlaw we are taking into account the long term planning of all partners as we revise our plan in line with the national one. We are expecting the national plan to be published late in 2018 and will then work with our lay members, Citizens' Panel, and wider partners and stakeholders on our plan.

4.2 Supporting the system to meet national targets, such as those for cancer waiting lists and Accident and Emergency (A&E) waiting times, will be a key priority to ensure patients across South Yorkshire and Bassetlaw receive the best possible care, as well as ensuring we can access the system-wide transformation fund financial incentives which are dependent upon meeting the targets. The targets sit within the remit of the workstreams, and their priorities include the implementation of initiatives to ensure these targets are met. The emerging governance arrangements will ensure the system holds itself to account for any un-met targets.

4.3 Workstreams have also undertaken work to identify their perceived challenges and mitigating actions, common themes include:

- Ensuring 'Place' and 'system' function effectively and don't work against each other - the Chief Executive system leads will help ensure Place and system complement rather than compete
- Securing whole system partner support for initiatives and supporting a culture of mutual support – continuous and ongoing staff and clinical engagement will support this, as will strong system leadership
- Governance that supports change and doesn't delay it – the governance review will address this
- Digital, information governance and IT limitations – the digital workstream is clear about their important role enabling the wider workstreams
- Workforce – a key focus for most of the workstreams, to be underpinned by the workforce hub
- Where potential changes are particularly sensitive – strong and continuous engagement with patients/ public/ staff and stakeholders will help ensure people's views are taken into account and changes are the right changes for the patients of South Yorkshire

5.0 Implications for Local People

5.1 The goal of the ICS is for everyone in South Yorkshire and Bassetlaw to have the best possible start in life, with support to be healthy and live well for longer.

5.2 By bringing together the region's public services we have more opportunities to tackle shared issues that affect people's life chances, join up health and care and improve health and wellbeing across the region.

5.3 Around 80% of health problems can be prevented and the partnership are promising to focus on keeping people well, slowing or stopping ill-health developing and support some of the most vulnerable in our communities to live healthier, more fulfilling lives.

5.4 In all this it is envisaged that the largest implications on local people and the local community will be positive.

5.5 Inevitably some of the proposed changes that may emerge as a result of the work of the partners within the five places that make up the ICS (for example proposed reconfiguration in the Hospital Services Review [see separate JHOSC paper]) will have more immediate impacts on the local population. The approach of the partners within the ICS is to continue to ensure a robust approach to involvement by working effectively and efficiently as a partnership while meeting their statutory duties. Equality and diversity assessments will ensure any potential impacts are always taken into consideration before any decisions are made (in line with the legal requirements on our partner statutory organisations).

6.0 Conclusions

6.1 As per the findings of the national King's Fund review 'There are some early signs of progress in delivering service changes, particularly in relation to strengthening primary care, developing integrated care teams and reviewing how specialist services are delivered. It is early days, and more time is needed to embed these changes and determine their impact.' Locally we feel this also accurately summarises the progress of the South Yorkshire and Bassetlaw ICS, in our evolution from STP to ICS we have started to make some great in-roads and also to develop some innovative and exciting plans for how integrated care can truly improve the lives of the people in South Yorkshire and Bassetlaw.

7.0 Background Papers and Useful Links

7.1 The following links have been used in the preparation of the report and may be useful for further information:
http://www.healthandcaretogethersyb.co.uk/
https://www.engage.england.nhs.uk/consultation/developing-the-long-term-plan-for-the-nhs/
https://www.kingsfund.org.uk/publications/year-integrated-care-systems

8.0 Glossary

8.1

BDC	Bassetlaw District Council
BHFT	Barnsley Hospital NHS Foundation Trust
BMBC	Barnsley Metropolitan Borough Council
CCG	Clinical Commissioning Group
CHFT	Chesterfield Royal Hospital NHS Foundation Trust

DBTH	Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust
DMBC	Doncaster Metropolitan Borough Council
H&CWT	Health & Care Working Together (the name of the ICS)
HEE	Health Education England
ICS	Integrated Care System
IUC	Integrated Urgent Care
JCCCG	Joint Committee of Clinical Commissioning Groups
JHOSC	Joint Health Overview and Scrutiny Committee
MOU	Memorandum of Understanding
NCC	Nottinghamshire County Council
NHSE	NHS England
NHSI	NHS Improvement
PHE	Public Health England
RDaSH	Rotherham, Doncaster, South Humber NHS Foundation Trust
RMBC	Rotherham Metropolitan Borough Council
SCC	Sheffield City Council
SCFT	Sheffield Children's Hospital NHS Foundation Trust
SHSCT	Sheffield Health and Social Care NHS Foundation Trust
STHFT	Sheffield Teaching Hospitals NHS Foundation Trust
SYB	South Yorkshire and Bassetlaw
TRFT	The Rotherham NHS Foundation Trust
UEC	Urgent & Emergency Care
YAS	Yorkshire Ambulance Service NHS Trust

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How are we doing? An overview

September 2018
(July data)

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How are we doing? An overview

September 2018
(July data)

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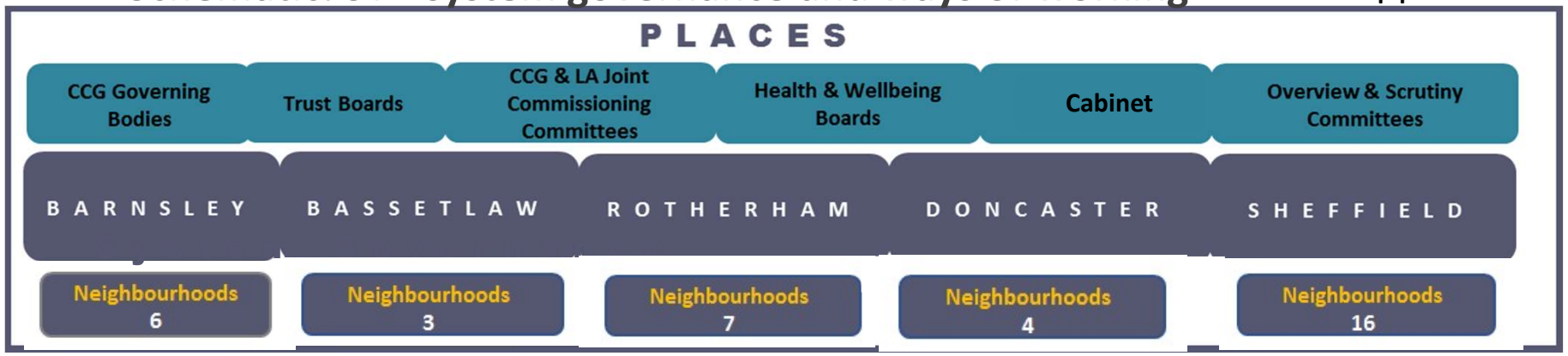
Schematic: SYB system governance and ways of working

5b-Appendix 2



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System governance and ways of working
(note: under review)

5b-Appendix 3

The ICS **oversight and assurance group** includes chairs from clinical commissioning groups, hospital trusts and health and wellbeing boards. The meetings are attended by their chief executives and accountable officers. It provides oversight and assurance, via set of key principles, on the process and quality of decisions affecting South Yorkshire and Bassetlaw.

Oversight & Assurance Group

Collaborative Partnership Board

Executive Steering Group

Committees
Cancer Alliance
Programme Boards

The ICS **collaborative partnership board** includes chief executives and accountable officers from acute and mental health hospitals, primary care, commissioning groups, local authorities, voluntary action groups, Healthwatch organisations, NHS England and other arm's length bodies. Clinical chairs from commissioning groups are also represented on the board. It is responsible for setting the overarching strategic vision and plan for the South Yorkshire and Bassetlaw health and social care system.

The ICS **executive steering group** includes chief officers and chief executives, directors of strategy, transformation and delivery and directors of finance. Its role is to secure delivery on behalf of the Collaborative Partnership Board and give an executive steer to the range of transformation and enabling programmes which underpin the SYB plan.

There is also a range of **programme boards** responsible for delivering the workstreams. These are led by a chief executive and senior responsible officer (an accountable officer from a clinical commissioning group) and supported by a director of finance and a project manager / workstream lead. The boards drive the delivery of the programmes / workstreams.

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**Report of the Executive Director Core Services,
Barnsley Metropolitan Borough Council (BMBC),
to the South Yorkshire, Derbyshire, Nottinghamshire and Wakefield,
Joint Health Overview and Scrutiny Committee (JHOSC),
on Monday 22nd October 2018**

Hospital Services Programme – Cover Report

1.0 Introduction and Background

1.1 The purpose of the attached report (Item 6b) is to provide an overview and update to the Joint Health Overview and Scrutiny Committee (JHOSC) in relation to the South Yorkshire and Bassetlaw (SYB) Independent Hospital Services Review (HSR) (published in May 2018).

1.2 Since the JHOSC last met in June 2018, a Strategic Outline Case (SOC) document has been developed, which outlines how the system intends to take forward the recommendations in the HSR. The three main principles of the SOC (as with the HSR) are:

1. There will continue to be a hospital in every Place: no District General Hospitals (DGH) will be closed;
2. Most patients will receive most of their hospital-based care at their local DGH;
3. The staff in place are needed; therefore it is not expected that the work of the Review will lead to any redundancies, although staff may need to work differently.

1.3 The SOC outlines three main workstreams which are:

1. Shared Working – this includes the development of Hosted Networks to support co-operation between Trusts and improve conditions for staff. Also, support for the workforce and innovation through a Health & Care Institute and Innovation Hub;
2. Transformation - moving activity from the acute (e.g. hospital) sector to primary (e.g. GPs) and community care, where appropriate. Also, transforming the workforce (e.g. by changing job roles);
3. Reconfiguration - exploring options around how maternity, paediatrics and gastroenterology services are configured.

1.4 The attached report (Item 6b) provides:

- the background to the Hospital Services Programme;
- the key challenges in the 5 services included in the HSR which are urgent and emergency care (UEC), care of the acutely ill child, maternity, stroke, and gastroenterology & endoscopy;
- an outline of the proposed changes;
- information on clinical and public engagement; and
- a summary of the next steps

2.0 Invited witnesses

2.1 At today's meeting, the following representatives will be attending to answer questions from the JHOSC regarding this work:

- Lesley Smith, South Yorkshire and Bassetlaw (SYB) Integrated Care System (ICS) Deputy System Lead and Lead for Strategy, Planning and Transformation Delivery as well as Chief Officer at Barnsley Clinical Commissioning Group (CCG)
- Will Cleary-Gray, Chief Operating Officer, SYB ICS
- Helen Stevens, Associate Director of Communications and Engagement, SYB ICS
- Alexandra Norrish, Programme Director, SYB Hospital Services Programme

3.0 Possible areas for discussion

3.1 Members may wish to ask questions around the following areas:

- Public, patient, workforce and organisational engagement are critical to the Hospital Services Programme; therefore how will you ensure that engagement with each of these stakeholders is effective and influences the decisions made?

- What are the key risks in relation to the Hospital Services Programme and what plans are in place to mitigate these?

- How are local Health and Wellbeing Boards involved in plans to move care from hospitals into communities?

- How will you ensure reconfiguration options do not negatively impact health inequalities, particularly given the makeup of the local population and challenges in relation to transport?

- What positive opportunities does the Hospital Services Programme present which otherwise would not be realised?

- How confident are you that the plans can be delivered within the timescales and resource envelope?

- How will you ensure that actions taken to improve poor performing services will not be to the detriment of areas which are performing well?

- To what extent do reviews of hospital services in neighbouring areas impact on the plans in this Hospital Services Programme?

- What key changes are residents likely to see as a result of the plans in the SOC and over what timescales will these be undertaken?

- How can Elected Members help support the improvement of hospital services for local residents?

4.0 Background Papers and Links

- Item 6b (attached) – Update on the Hospital Services Programme
- Hospital Services Programme SOC: http://healthandcaretogethersyb.co.uk/application/files/4115/3683/6060/2018-08-24_3_SOC_-_FINAL_with_Annex_A-E.pdf

5.0 Glossary

CCG	Clinical Commissioning Group
DGH	District General Hospital
HSR	Hospital Services Review
ICS	Integrated Care System
SOC	Strategic Outline Case
SYB	South Yorkshire and Bassetlaw

6.0 Officer Contact

Anna Marshall, Scrutiny Officer, 12th October 2018

Update on the Hospital Services Programme
for the Joint Health Overview and Scrutiny Committee

1.0 Introduction

1.1 This paper describes the issues and options laid out in the Strategic Outline Case (SOC) on Hospital Services that has been developed by the providers and commissioners of South Yorkshire and Bassetlaw, Mid Yorkshire and North Derbyshire (SYBMYND). It lays out the background to the SOC; the key challenges relating to the long term sustainability of acute services; the proposals described in the SOC; the clinical and public engagement that has been undertaken so far and which will be delivered going forward; and the next steps.

2.0 Background

2.1 One of the workstreams within the Integrated Care System (ICS) is focused on the sustainability of acute services. The challenges facing the ICS around acute care (care concerned with short term or severe illness that requires treatment at a hospital) were identified in the 2016 Sustainability and Transformation Plan (STP). SYBMYND, like systems across the NHS, is facing increasing demand for acute care, due in part to an ageing population; changes in healthcare are rapidly changing the ways and places in which care can be provided; there are significant shortages of workforce; and there are financial pressures.

2.2 In response to the STP, the system launched an independent Hospital Services Review (HSR) in June 2017 to look at the issues around the sustainability of acute services. The recommendations of that Review were published in May 2018. The system's response and statement of intent around how it will take forward the recommendations of the HSR is published in a Strategic Outline Case (SOC) which is being signed off at the time of writing by CCG Governing Bodies.

3.0 The geographical areas and organisations covered

3.1 The independent Review, and now the SOC, covers the footprint of the original Working Together Vanguard. This consists of the commissioners and providers in SYB (Barnsley, Bassetlaw, Doncaster, Rotherham and Sheffield) as well as the providers Mid Yorkshire NHS Hospitals NHS Trust, and Chesterfield Royal Hospital NHS Foundation Trust, and their commissioners.

3.2 These organisations are included because the flows of patients mean that the providers are interconnected. However Mid Yorkshire and Chesterfield are also members of other STPs, and of networks outside SYB. As such, some of the SOC proposals do not apply to them: Mid Yorkshire is not included in the recommendations around reconfiguration, and is considering how far it wishes to be engaged in the recommendations around closer working; Chesterfield is included in all recommendations, but would not in the first stage be a full Host for a Hosted Network.

4.0 Identifying unsustainable services

Definition of sustainability

4.1 The STP said that SYB faces a number of challenges around the sustainability of its acute services. Sustainability was defined by the independent Hospital Services Review (HSR) as meaning:

- There are enough patients to operate a safe and efficient service;

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

Assessing the sustainability of services

4.2 The HSR began by looking at the sustainability challenges across all the acute services provided in SYBMYND. Services were reviewed through three 'lenses': their performance according to publicly available data such as delivery of national targets; concerns raised by providers themselves; and the degree of interdependency with other services. Each service was given a sustainability score. The sustainability score indicated that a number of services in SYBMYND were facing significant challenges. In order to reach a final list from the 15 most unsustainable services the HSR sought views from commissioners, NHS England and Health Education England.

4.3 The services which were finally identified as the focus of the HSR were not simply the top scoring services, although all but one appeared in the shortlist of the 15 most unsustainable. They were selected as being services where there was significant potential to improve acute services more widely, if that one service was strengthened. Maternity, which was not in the top 15, was added because of its interdependencies with paediatrics, and concerns raised by the CQC in some services.

The services which the Review focused on

4.4 The Review chose to focus on Urgent and Emergency Care, Care of the Acutely Ill Child (paediatrics), maternity, stroke, and gastroenterology and endoscopy.

5.0 Challenges

5.1 The STP identified challenges across the whole system, such as increasing demand, financial pressures, changes in ways of providing care. In addition, the HSR looked at specific challenges in the five services, and worked with the Clinical Working Groups (CWGs) to explore the underpinning reasons for these challenges.

Challenges in Urgent and Emergency Care (UEC)

5.2 The Clinical Working Group identified the following key challenges in UEC:

Workforce

- Significant gaps in rotas across all clinical grades and disciplines, including medics and nurses, and in particular at mid-grade level.
- Over-reliance on agency and locum members of staff, in particular Band 5-6 nurses.
- High rates of staff leaving and increased competition for limited workforce. This was attributed to the demanding nature of the job, which particularly affected mid-grade doctors; members of the group suggested that medical students were put off applying for a specialty in UEC because of the demanding hours.

Managing demand, capacity and flow

- Historical trend of providers not meeting the four-hour Accident & Emergency (A&E) waiting time standard.
- Ageing population and changing disease profile, leading to increased demand for emergency services.

- Rising attendance and admission rates.
- Increasing awareness of performance targets and growing patient expectations.
- Complex patient pathways often requiring multi-disciplinary working.

Challenges in Care of the Acutely Ill Child

5.3 The Clinical Working Groups identified the following key challenges in paediatrics:

Workforce

- Low fill rates, below the national average, across Yorkshire and the Humber. This particularly relates to middle grade, junior doctors and nurses. Members of the CWG pointed out that there are shortages at national level, and that the problem affects some trusts much more than others, with Sheffield Children's Hospital finding it easier to recruit owing to its reputation and specialism.
- High rates of trainees leaving the region. A number of reasons for this were explored including the competitiveness of roles in for example London.
- Significant workforce gaps in paediatrics impact negatively on other services, e.g. neonatology.

Training, education and capacity in the community

- Inequitable access to and availability of paediatric primary care services across the region.
- Substantial variation in the service provision and operating hours of community nursing teams.

Demand on paediatric emergency departments

- Rising patient expectations and increasing waiting times for routine appointments have resulted in growing demand for emergency departments.
- Limited co-ordination and communication across sites to manage demand / capacity

Challenges in Maternity

5.4 The data gathered from the participants in the Clinical Working Groups identified the following key challenges in maternity:

Workforce

- High proportion of unfilled posts across the footprint, due to difficulties in recruiting and retaining staff. This is applicable to all grades and professions, in particular staff grades, midwives and trainees; half of all training posts were vacant in the region. A specific issue about training posts (which was also raised in other CWGs) was SYB's position within Yorkshire and the Humber. A number of group members said that medical students were put off applying to Y&H, since their placements could be distributed across a wide geographical area, which made it difficult to settle in one place during training.
- Unsustainable and costly reliance on locum / agency clinicians.
- Ageing demographic of nursing and midwifery professionals, presenting a challenge to longer term sustainability.

Changing complexity of patients

- Increased number of highly complex patients requiring specialist care and additional resource.
- Reduced threshold for referrals into acute services is increasing demand, as are public health factors.

Consistency of care and quality standards

- High degree of unwarranted variation across trusts, in both process and outcomes
- Significant variation in neonatal mortality and stillbirth rates across the region

Challenges in Stroke

5.5 Recent reviews on the safe provision of care at hyper-acute stroke units has led to the proposed consolidation of hyper-acute and acute services across SYB. The HSR did not re-visit the work that had already been done around the size of units and the availability of workforce for the HASU transformation, since a commitment had already been given to retain Acute Stroke Units.

5.6 The data gathered from the participants in the Clinical Working Groups identified the following key challenges in stroke:

Workforce

- Shortage across the network of specialist stroke staff.
- Difficulties in recruiting and retaining, leading to gaps in the workforce. Stroke nursing in particular was identified as being physically demanding, since it involves moving and lifting patients, which contributes to a high rate of staff leaving.
- Funding shortage for therapists.
- Challenges in providing fully staffed rotas, despite exploring paying above cap for locum cover.

Access to service and flow

- There were a number of points during the stroke patient pathway where patients were transferred between services, which could result in delays, or breakdown of information transfer.
- Significant variation between Places / Trusts in the provision of services out of hours and on weekends.
- Cross-site variation in length of stay for comparable patients.
- Recognised inequity in the services commissioned and offered throughout the region, for example rehabilitation.
- Considerable variation in sites' ability to meet the required national standards.

Challenges in Gastroenterology and Endoscopy

5.7 The data gathered from the participants in the Clinical Working Groups identified the following key challenges in gastroenterology and endoscopy:

Workforce

- Significant workforce gaps, particularly in consultants and nurses, resulting in unsustainable out-of-hours and weekend rotas. Some group members raised concerns that some of the work, particularly in endoscopy, involved less variety than some nursing roles and so led to higher turnover of staff with people looking to gain new experience.
- Increased competition with private sector for limited workforce, since endoscopy in particular is now provided by a number of private sector providers.

Demand

- Increased number of highly complex patients requiring specialist care and additional resource.

- Reduced threshold for referrals into acute services is increasing demand, as are public health factors.

Inequality in access and variation in service provision

- Disparity in the provision of a robust, out-of-hours gastrointestinal (GI) bleeds rota.
- Difference in patient transfer protocols, including acceptance and repatriation.
- Variation in the standard of equipment available across the system.

6.0 Developing proposals based on the case for change

6.1 The information laid out above highlights the scale of the challenges that the SYBMYND trusts are facing, particularly in relation to workforce. Based on the nature of the challenges, and the issues that were identified in the Clinical Working Groups and public sessions, the Strategic Outline Case identifies three sets of proposals:

- Strengthening shared working across the trusts through Hosted Networks and innovation and workforce, to strengthen the ability to recruit, develop and retain staff, and to provide more consistent patient care.
- Transformation to make better use of the workforce and ensure that patients receive care in the best setting.
- Reconfiguration of some services (paediatrics, maternity and gastroenterology) if transformation alone cannot tackle the issues.

7.0 Proposals: Hosted Networks (HNs)

7.1 During the HSR, clinicians and executive teams described a wide range of challenges that result from Trusts not working together closely enough, and the inequalities in patient care and patient experience that result from this. A number of staff described work that they have done collaboratively through existing mechanisms such as the Working Together Vanguard, Managed Clinical Networks and Operational Delivery Networks. A common theme was that current shared working, which was based on voluntary collaboration, had limited traction.

7.2 The SOC therefore proposes a structure of Hosted Networks, which will bring the Trusts together to work jointly on specific services. The Hosted Networks are being designed at present. The intention is that there will be three levels of HN: level 1 will cover clinical standardisation and alignment of approaches to workforce such as use of the alternative workforce; level 2 will look at managing capacity more effectively across Trusts; and level 3 would involve a lead trust helping to support delivery of a service at one or more other sites in the area, at their invitation. The intention is that the HNs will be backed by more organisational levers to ensure that the decisions they reach are implemented.

7.3 The Hosted Networks are being developed in a series of workshops during the Autumn and the aim is to begin implementing them in April 2019.

8.0 Proposals: the Innovation Hub

8.1 The engagement with clinicians and the public found that while individual Trusts were often developing innovative approaches, these did not spread widely across the system. An Innovation Hub is being designed that will aim to identify major problems that could be solved by innovation; work with the Academic Health Science Network (AHSN) to find solutions; and support rollout to Trusts. The aim is to begin development and implementation of the Hub by April 2019.

9.0 Proposals: the Health and Care Institute

9.1 Much of the work across the system will require support on workforce planning and workforce development. In order to support this, a Health and Care Institute will be established that will draw together functions for workforce support across the system, and provide support to Trusts. The Institute will have a particular focus on working with schools across SYB to encourage young people to consider a career in the health service.

10.0 Proposals: Transformation

10.1 In order to make the system more sustainable in the long run, we need to address the challenges of rising demand and workforce shortages. We need to ensure that patients are being treated in the most appropriate place, rather than spending unnecessary time in acute hospitals; and that we are making the best use of our existing and available staff. This will be the focus of work initially by the Clinical Working Groups and ultimately by the Hosted Networks.

10.2 Care in the most appropriate setting: The STP said that SYB would focus on caring for people as close to home as possible. There is already a major workstream focused on this across the Places of SYB. The Hospital Services work will contribute to this through work in the Clinical Working Groups to assess, for the 5 services in the HSR, which activity needs to be delivered in an acute setting; what could be moved elsewhere; and what would be required to support such a move.

10.3 Workforce: given the existing and future pressures on the healthcare workforce, we need to ensure that we are making the best use of the staff that we have available to us, and that we are thinking creatively about new roles. The Clinical Working Groups will be asked to consider existing best practice / guidance, and to develop new thinking, about how SYB might make the best use of new roles such as Advanced Medical Practitioners to meet and alleviate workforce pressures.

11.0 Proposals: Reconfiguration

11.1 The aim of the Hospital Services programme will be to put existing services onto a sustainable footing wherever possible. However, in some services, the independent Hospital Services Review came to the conclusion that transformation and shared working alone would not be enough to meet the challenges, and in some cases that there were also potential quality gains to be made by changing the configuration of services.

11.2 The Strategic Outline Case lays out how the system is planning to take forward work to develop and test reconfiguration options. The modelling suggests that the existing number of A&Es and acute stroke units is sustainable so changes in these specialties will focus on developing the clinical model.

Urgent and Emergency Care

11.3 The SOC states that South Yorkshire and Bassetlaw and North Derbyshire (SYBND) will retain all of its A&E departments. This is based on the future availability of consultants: if SYB gets its fair share of trainees available at national level, there will be sufficient consultants to meet national standards around consultants in the current configuration.

11.4 Significant challenges will remain in mid-grades and the transformation work will address this. There will also be work to consider what the staffing model should look like in A&Es, and the implications of any other reconfiguration changes for A&E.

Stroke

11.5 The SOC states that, once the reconfiguration of Hyper Acute Stroke Units has completed across SYBMYND, all the existing sites which have Acute Stroke Units should retain them. However we will explore options to support staffing these with consultant teams working to support HASU and ASU-only sites, and to standardise the rest of the stroke pathway.

Care of the Acutely Ill Child

11.6 The SOC states that there are significant challenges to the sustainability of inpatient paediatric units in SYBND. The workforce challenges, as identified above, are significant and are not likely to be addressed in the medium term, as there is a national shortfall of paediatricians. The shortage of paediatricians also puts significant pressure on neonatology, since paediatricians at District General Hospitals tend also to cover neonatology.

11.7 The SOC therefore says that SYBND will look at options for paediatrics going forward. This includes changes to the clinical model, including looking at changing 1 or 2 Paediatric Inpatient Units into Paediatric Assessment Units, which would be open during the day. The early modelling suggested that this would strengthen the ability of all units to meet national standards, with 2 units coming close to the standards while minimising service change as far as possible. Further work will be undertaken to model the service models, workforce roles, and options in more detail at a site-specific level.

Maternity units

11.8 The SOC states that there are two main challenges to maternity services going forward: a shortage of midwives, and interdependencies with paediatrics.

11.9 Obstetric services and paediatrics are interdependent: if a site does not have 24/7 paediatrics, and thus the capacity to provide 24/7 neonatology, this has implications for whether it can provide obstetrics. A site could still provide Midwifery-Led maternity services, even without neonatology on site, since the babies and mothers in a Midwifery-Led Unit (MLU) are lower risk.

11.10 The SOC says that the Clinical Working Groups will be asked to look at a range of models, from national and international examples, to test whether there are other ways of addressing the interdependency between obstetrics and paediatrics. The modelling will consider a range of options, including moving to an MLU on the 1 or 2 sites which would move to having a Paediatric Assessment Unit.

11.11 The HSR noted that reconfiguration will not address challenges with shortages of midwives, since the number of midwives needed is linked to number of births; therefore this does not change significantly even if the configuration of services changes. Any growth in midwife numbers between now and 2021/22 would help to close the current gap, but the focus will need to be on improving recruitment levels through the Hosted Networks.

Gastroenterology and endoscopy

11.12 The SOC says that the current cover for emergency gastrointestinal bleeds, out of hours, is inconsistent and patchy. Some trusts are able to run GI bleeds rotas 24/7 independently, while others are unable to provide an adequate level of cover independently whilst also maintaining their general medical rotas.

11.13 Based on this the SOC proposes to consolidate the emergency out of hours GI bleed rota onto 3 or 4 sites, with transfer for patients to those services as required.

12.0 Timeline for reconfiguration workstrand

12.1 The aim over the next 12 months is to develop options and clinical models by the end of 2018; agree a preferred set of options to go to NHS England in early summer 2019; and go out to public consultation in autumn 2019. This timing may be subject to change as external events could affect the timing.

13.0 Clinical engagement

13.1 In addition to public engagement, there is a clear requirement laid out in NHS England guidance for clinical engagement in any changes to health services. The HSR established five Clinical Working Groups which provided the clinical input into the HSR, and the membership of these has now been refreshed and enlarged for the next stage of work. Each specialty CWG will consist of the clinical and nursing leads from each Trust; other clinicians as required e.g. a neonatologist or a therapist; a junior doctor; representatives from the mental health and community Trusts, and the two Ambulance Services; and up to three representatives from primary care.

13.2 In addition, the ICS communications team and the Hospital Services team have worked with staff, both via Trust communications teams and directly, to disseminate messages and to invite staff to comment e.g. through the online survey or events. Staff are engaged through monthly meetings of the Staff Partnership Forum.

14.0 Public engagement

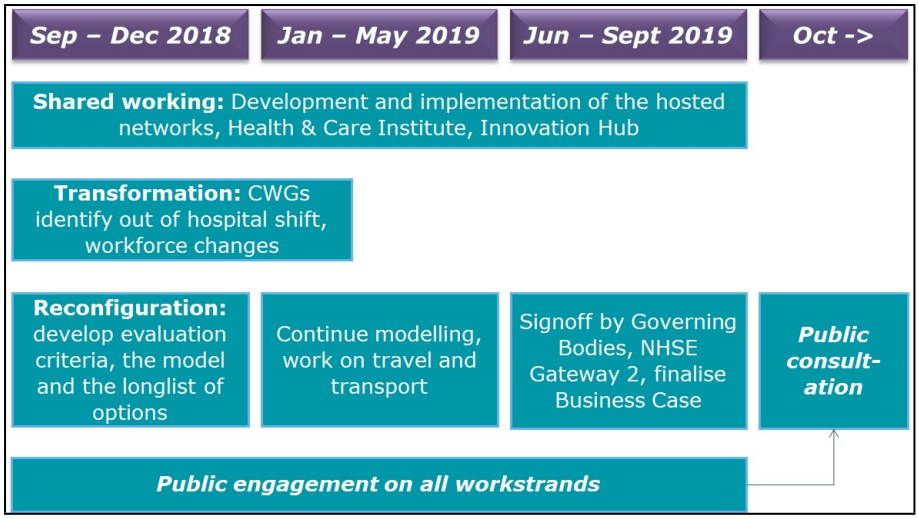
14.1 Public engagement is crucial and has been ongoing throughout the first stage of the Review and going forward. The reports of engagement up to now, including with people from the seldom heard communities, and an account of how the feedback has helped to shape the recommendations, are available on the ICS website. The communications strategy for the next stage will be published shortly and will include further engagement with seldom heard groups where there has been limited engagement up to now, as well as a programme of deliberative workshops with the wider public, and regular communications to stakeholders. Should any proposals for reconfiguration be taken forward, this would be subject to public consultation.

15.0 Next steps

15.1 The immediate next steps, over October and November: are

- Submit the SOC to the Collaborative Partnership Board on 19 October and publish it.
- Further develop proposals on the Innovation Hub and Health and Care Institute.
- Begin work via Clinical Working Groups from mid-October, focused on the transformation work and inputting into the development of options for the reconfiguration workstream.
- Develop the specification for the model and agree it in October, and begin building the model from November. The clinical models which are developed by the Clinical Working Groups will be modelled from December onwards.
- Develop the framework for the Hosted Networks, to be in a position to appoint Hosts after Christmas.

15.2 The 12 month timeline for the workstreams going forward is as in the figure below:



15.3 The JHOSC will be invited to oversee and scrutinise the process at each stage. At the request of the Committee, since the last meeting we have provided a summary of the key decision points to the Committee to ensure that the JHOSC has the opportunity to fully exercise its scrutiny function.

16.0 Glossary

A&E	Accident and Emergency
AHSN	Academic Health Science Network
ASU	Acute Stroke Unit
CLU	Consultant Led Unit
CQC	Care Quality Commission
CWG	Clinical Working Group
GI	Gastro-intestinal
HASU	Hyper Acute Stroke Unit
HN	Hosted Network
HSR	Hospital Services Review
ICS	Integrated Care System
MLU	Midwifery Led Unit
PAU	Paediatric Assessment Unit
SOC	Strategic Outline Case
STP	Sustainability and Transformation Plan
SYB	South Yorkshire and Bassetlaw
SYBMYND	South Yorkshire and Bassetlaw, Mid Yorkshire and North Derbyshire
UEC	Urgent and Emergency Care
Y&TH	Yorkshire and the Humber

17.0 Background papers

The documents for the HSR can be found online at:
https://www.healthandcaretogethersyb.co.uk/index.php/what-we-do/working-together-future-proof-services/looking-at-hospital-services.
Specific documents referenced in this paper can be found as follows:

HSR: Report 1A Analysis of the sustainability of services in SYB and process for shortlisting them	https://www.healthandcaretogethersyb.co.uk/application/files/7515/0903/4254/Hospital_Services_1a_Report.pdf

HSR: Report 1B Summaries of the key challenges for each service identified by the Clinical Working Groups	https://www.healthandcaretogethersyb.co.uk/application/files/9615/1809/8702/Hospital_Services_Review_1b_report.pdf
HSR: Final report Recommendations	https://www.healthandcaretogethersyb.co.uk/application/files/2515/2845/1016/25._HSR_Stage_2_Report.pdf
HSR: Final report technical annex Modelling of workforce shortages now and in the future; modelling of activity levels; modelling of capital costs of different options.	https://www.healthandcaretogethersyb.co.uk/application/files/5515/2845/1105/27._HSR_Stage_2_Report_Technical_Annex.pdf
HSR: Report on public engagement Summary of the public engagement and its findings. Individual writeups of the public sessions, sessions with the seldom heard groups etc are also on the website.	https://www.healthandcaretogethersyb.co.uk/application/files/4815/2231/8192/15._HSR_Stage_1b_Engagement_Report.pdf
Strategic outline case Agreed proposals for the system going forward. At the time of writing, available on CCG websites prior to public discussion in Governing Bodies; not yet formally agreed and published.	http://www.sheffieldccg.nhs.uk/Downloads/About%20US/CCG%20Governing%20Body%20Papers/2018/September%202018/PAPER%20A%20Independent%20Hospital%20Services%20Review%20FULL%20DOC.pdf