



Health and Care Working Together in South Yorkshire and Bassetlaw

The Hospital Services Review

Public engagement event

8 March 2018



Welcome and introductions

Helen Stevens

Associate director of communications, Health and Care
Working Together in South Yorkshire and Bassetlaw

10.00 – 10.10



Agenda

10.00	Welcome and introductions	Helen Stevens
10.10	Introduction to the Shadow Integrated Care System & Questions	Prof. Des Breen
10.20	Why we are having the Hospital Services Review & Questions	Prof. Chris Welsh
10.30	Overview of the Hospital Services Review:	Alexandra Norrish
	<ul style="list-style-type: none"> • Workforce issues • Clinical variation • Innovation • Governance 	
11.00	Questions	All
11.20	Approach to developing our configuration options	Alexandra Norrish
11.35	Vision and options – 10 minutes on each service:	
	<ul style="list-style-type: none"> • Maternity 	Dr Karen Selby
	<ul style="list-style-type: none"> • Paediatrics 	Dr. Nicola Jay
	<ul style="list-style-type: none"> • Urgent and Emergency Care 	Dr. Nick Mallaband
	<ul style="list-style-type: none"> • Stroke 	Dr Caroline Haw
	<ul style="list-style-type: none"> • Gastroenterology and endoscopy 	Dr Mo Thoufeeq
12.25	Elective care	Prof. Chris Welsh
12.35	Lunch	
13.00	Group discussions: each group has 20 minutes to discuss each service	
14.40	Plenary	Group facilitators
14.55	Summary and close	Helen Stevens, Prof. Chris Welsh



Introduction to the Shadow Integrated Care System

Des Breen

Medical Director, Health and Care Working Together in South Yorkshire and Bassetlaw

10.10 – 10.20



Who are we/what is an Integrated Care System?

- We are Health and Care Working Together in South Yorkshire and Bassetlaw. A partnership of 25 NHS, local authority, voluntary and independent organisations responsible for looking after the health and care of the 1.5 million people living in Barnsley, Bassetlaw, Doncaster, Rotherham and Sheffield.
- Through working together, we have been chosen by NHS England as one of the first areas of the country to become an accountable care system – giving us more freedom to have a local system for local people.
- The Hospital Services Review also includes Mid Yorkshire Hospitals and Chesterfield Royal Hospital, although they are not part of the Shadow Integrated Care System.



Further information about the ICS is available in the slides that were sent to today's participants as pre-reading.

Workstreams

- The Shadow Integrated Care System covers primary care, mental health, community care and social care
- At the last public session in December we had presentations by colleagues from mental health, primary care and community care. Since the session, we have also met with the Directors of Adult Social Services across the system.
- Today we are focusing on the Hospital Services Review's recommendations on acute care so all of our presenters are from the acute sector.





Questions

10.10 – 10.20



Why we are having the Hospital Services Review

Chris Welsh

Independent Review Director

10.20 – 10.30



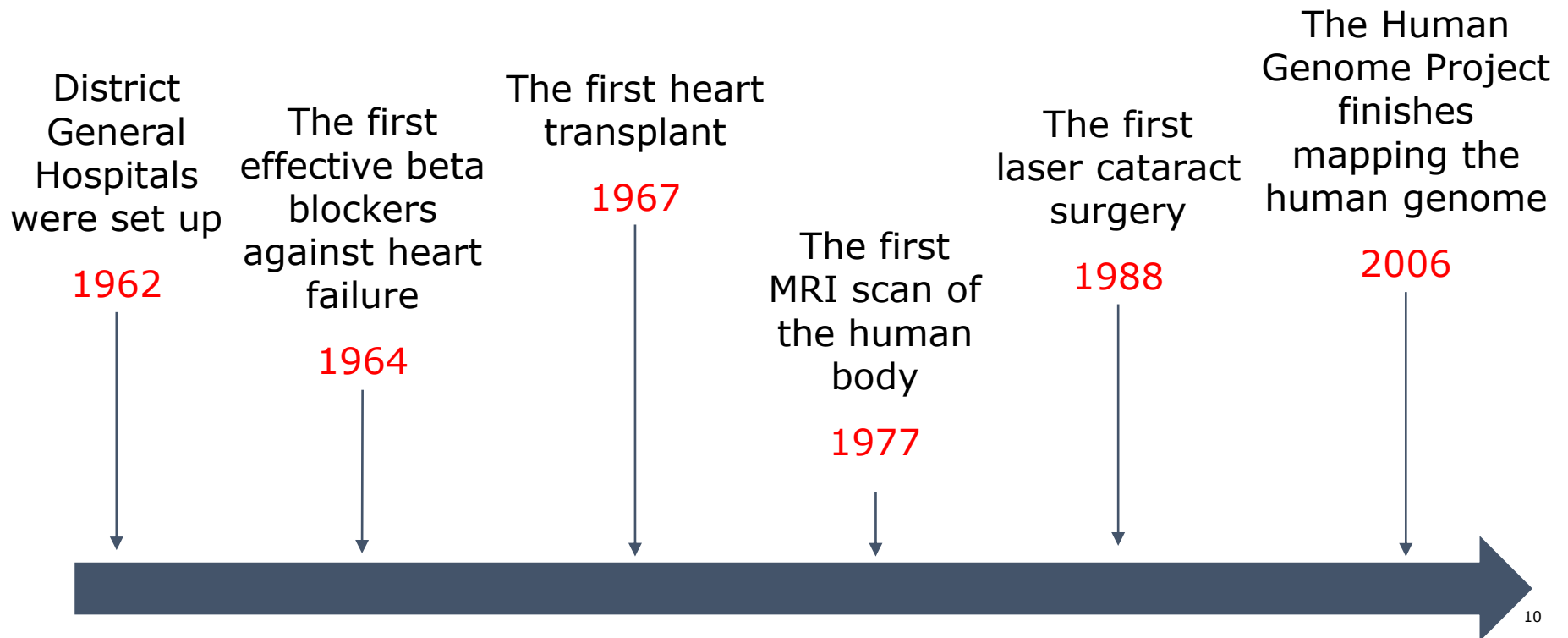
Why are we having a Hospital Services Review?

- South Yorkshire and Bassetlaw has some excellent hospitals and some great care
- But healthcare has changed since the NHS was set up, and the NHS has to change with it
- At the same time we are facing challenges we have never faced before, and we are struggling to provide good care for everyone
- We need to look at how we provide care in order to safeguard the future of the NHS.

The NHS needs to change – because healthcare has changed

The way that the NHS is organised now was designed in 1962, when District General Hospitals were proposed.

So when the NHS took its current form much of the healthcare that is commonplace today did not exist



At the same time we are facing challenges that the NHS has never had to face before

Our population is ageing

In 1901 baby boys were expected to live for 45 years and girls for 49 years.

In 2012, boys could expect to live for 79 years and girls for 83 years.

By 2032, this is expected to increase to 83 years and 87 years respectively*.



This is good news – but it means that the number of very elderly and frail people with multiple health needs is growing

At the same time there are shortages of trained staff across the country

There are shortages of staff across the country in many specialties. Last year, for the first time ever, fewer people applied to train as nurses than there were places available nationally.

In some services in South Yorkshire and Bassetlaw, more than half the posts are vacant.

Even when we pay high additional costs for temporary staff, there are often just not enough trained people to fill the posts.

We need to find ways to retain our workforce – but also to make better use of the staff that we have



The Hospital Services Review has been set up to look at ways to make healthcare in South Yorkshire and Bassetlaw sustainable

The review is independent and has been commissioned by all the organisations in the SYB system working together.

Over the last 8 months we have been talking to patients, the public, clinicians and system leaders to understand the issues and look at possible options.

Today we are bringing our ideas and findings back to you, and asking for your thoughts about them.





Questions

10.20 – 10.30



Overview of the Hospital Services Review

Alexandra Norrish

Review Programme Director

10.30 – 11.00

The Review has had three stages

Identify services the Review should focus on

Stage 1a

June – Sept 2017

Identify the main challenges in these services

Stage 1b

Sept – Dec 2017

Develop ideas and options for recommendations

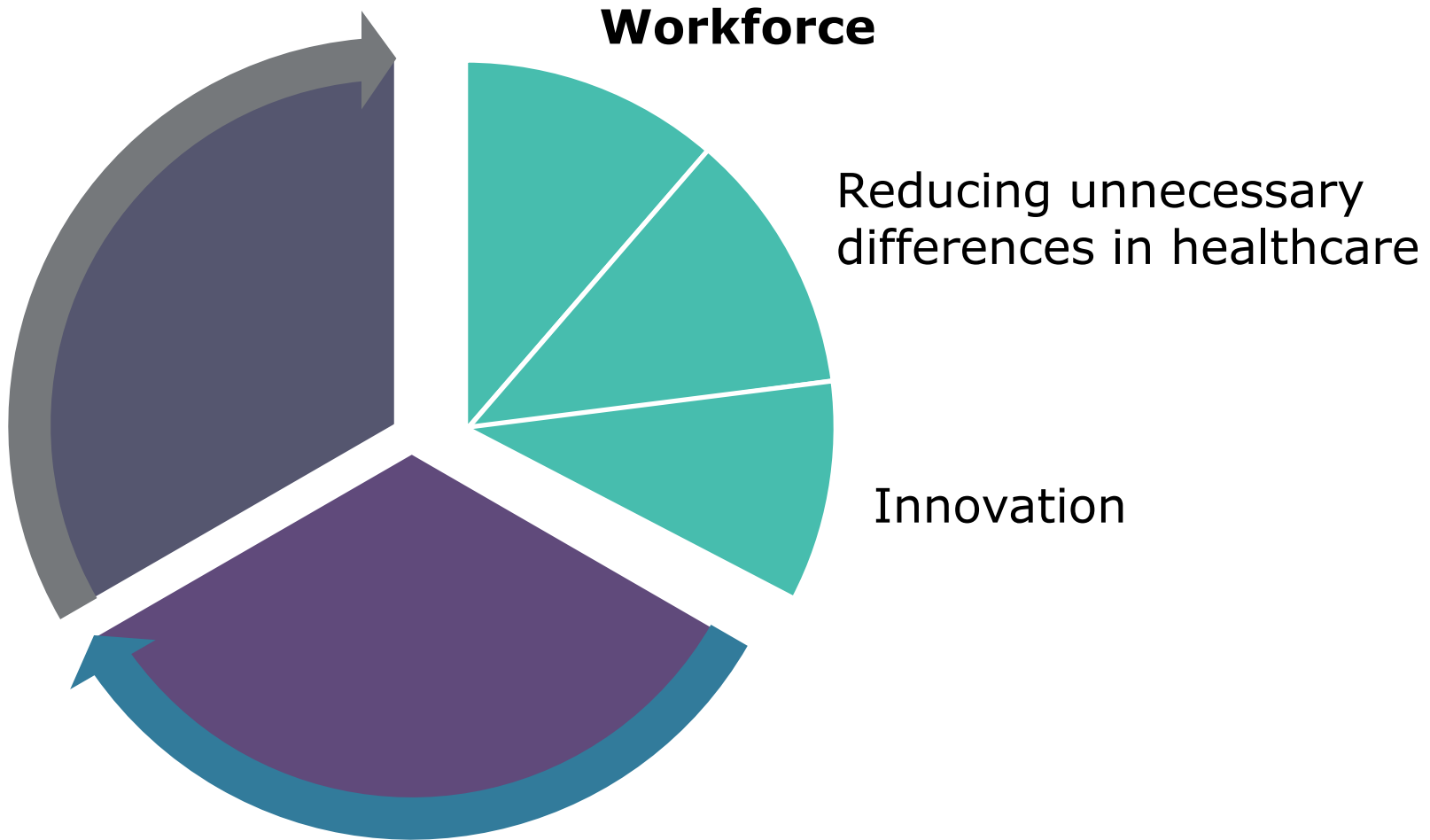
Stage 2

Jan – April 2018

- Maternity
- Care for children who are acutely unwell
- Urgent and emergency care
- Stroke
- Stomach and intestinal conditions



Improving the ways services work: three main themes have emerged





We need to do more to address the workforce challenges

Our staff told us...



- We do not do enough to make the roles attractive: we need to offer more flexible working
- Our trusts compete against each other for the same staff
- It is too difficult to work across different sites

Patients and the public told us...



- We need to do more to attract people by non-traditional routes
- There should be better communication between staff in different hospitals
- Staff need to be properly trained, have opportunities to develop their skills, be caring and compassionate

We are developing a range of workforce proposals

- We are **making it easier for staff to work across sites** eg by developing a staff passport
- We are **encouraging more young people to enter careers** in healthcare eg by working with the Universities, and developing Apprenticeships for non-degree students
- We are **developing alternative professions** to support the traditional consultant and nursing roles
- We are looking at ways that **employers can work together** to make the most of their expertise. E.g. a trust which is particularly good at one service might be responsible for training all the staff in that area.





Reducing unnecessary differences in healthcare



A second big challenge is differences in care

Our staff told us...



- Some differences in care are justified by the needs of the individual patient, but some are not
- We often have different ways to interpret and implement identical guidance, meaning that not all patients get access to best practice

Patients and the public told us...



- The quality of care and your likelihood of a good outcome should not depend on where you live or where you go to hospital.



We intend to describe in our report an approach to make care more standardised

- By bringing together clinicians and managers from each organisation, we can address unwarranted variation between clinicians and organisations to help patients get better and more consistent outcomes

- 1) **Identify** and prioritise processes that currently have unwarranted variation and affect outcomes
- 2) **Agree** on the standard way of carrying out each process
- 3) **Implement** the standard way of doing things in each member organisation
- 4) **Monitor** to measure the impact protocols have on care outcomes and ensure we are always improving the standard





There are some areas in particular which we need to focus on

Maternity

- Ensuring expectant mothers are risk assessed in a consistent way and are able to access the right care dependent on their risk

Paediatrics

- Making sure the clinical assessment of ill children is in line with best practice and consistent across all organisations

Urgent and Emergency Care

- Using the best practice method to assess patients' conditions (triage) so that they can receive the right care as quickly as possible

Stroke

- Following best practice to treat stroke along the whole pathway from acute stroke to rehabilitation

Gastroenterology and endoscopy

- Using the same endoscopy referral criteria so that patients only receive an endoscopy when necessary
- Ensuring access to urgent gastrointestinal bleed treatment is equitable for all patients



Innovation



And a third issue is how we make the most of new technologies and approaches in care

Our staff told us...



- The problems we are facing are not going to go away – the population will continue to age and demand for care will continue to go up
- We need to find different ways of delivering care that are not just 'more of the same'.

Patients and the public told us...



- People are at the heart of health services – no technology can replace that
- But many patients now have smart phones and are used to using technology and accessing information; they want to be actively involved in their care



We are looking at ways in which innovation can support each of our five workstreams

Urgent and emergency care

- Smartphone apps allowing patients waiting in A&E to submit data about their symptoms with doctors & nurses to help reduce waiting times.

Maternity

- Smartphone apps can provide reminders about healthy nutrition or direct access to midwives and help expecting mothers improve their pregnancy experience.

Paediatrics

- Wireless sensors that monitor vital signs such as heart and breathing rate of paediatric patients and send alarms directly to doctors and nurses can help improve care

Stroke

- Virtual assistants in stroke rehab wards allows patients to make requests for water, snacks, or help going to the toilet without using a nurse call button

Gastroenterology and endoscopy

- A computer programme in the hospital can read referrals from GPs for endoscopies and automatically book in patients for their procedures and send out reminders to them

We will also look at how organisations could work together





We are looking at ways in which organisations can support each other

In order to be able to make these changes, organisations are going to need to be able to

- Reach joint decisions quickly
- Collaborate on a range of issues
- Fulfil the legal requirements around accountability of their own Boards.

We are exploring structures that could help provider organisations to do this.

E.g. at present the provider organisations form a 'Committees in Common' which allows them to make some decisions jointly.





Questions

11.00-11.20



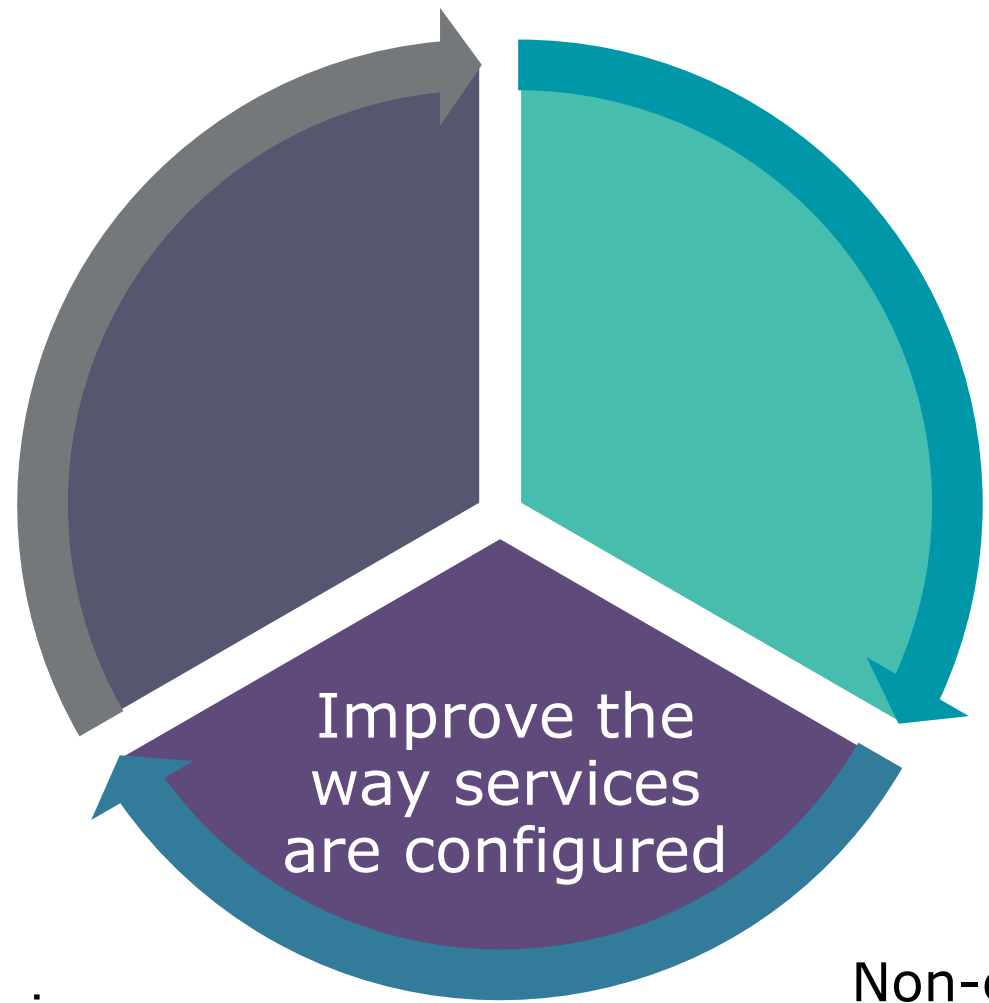
Reconfiguration options: the approach we have taken, and the vision for South Yorkshire and Bassetlaw

Alexandra Norrish

Programme Director, Hospital Services Review

11.20-11.35

We are looking at ways to improve the way services are configured



Emergency services

Non-emergency services

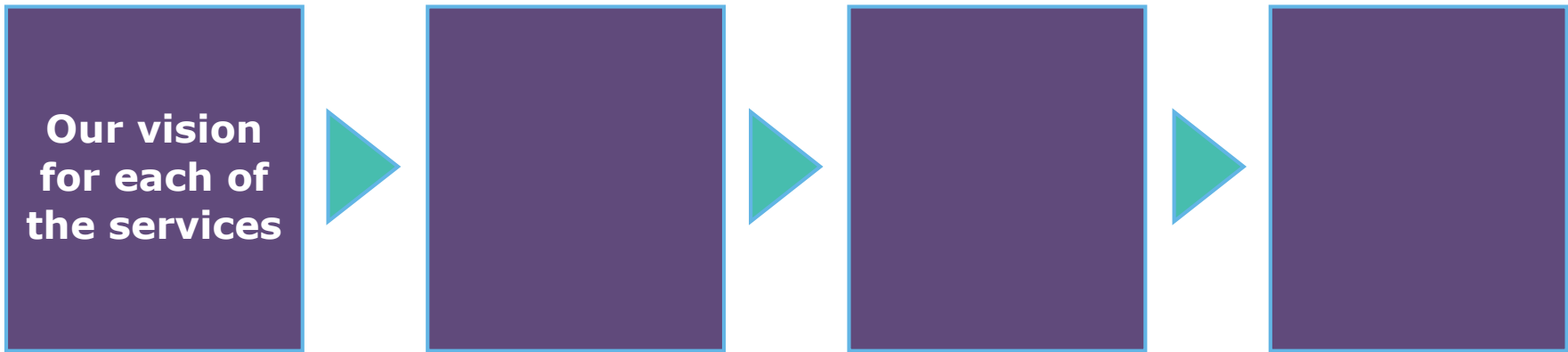


The April report will not identify sites: we want to take your views on the proposed models first

- We are talking in principle today – not about specific hospitals
- For the rest of the day we will talk about:



- We will then break into groups and ask you to discuss what you think of the options and how they perform against the evaluation criteria.





We have asked the views of patients, the public and staff

Our staff told us...



- We can deliver much more care close to people's homes than we used to
- We also need to take advantage of more specialised care. We cannot do this in small services
- We do not have, and cannot recruit, enough staff to support all the units we currently have, for all our services

Patients and the public told us...



- It is important to be able to access care close to home
- Some people are worried about whether having services further away is safe
- Other people have said they would rather receive the best care, wherever it is



Our commitments in the Hospital Services Review

- We have said from the beginning that:
 - **We are not closing any hospitals.**
 - **Most people will receive most of their hospital based care at their local hospital**
 - **We need more staff, not fewer, so we do not anticipate any job losses**

GUARANTEE



We anticipate that the majority of care will remain local

- **The Review team is thinking of proposing that every local hospital should provide:**
 - Access to urgent care services
 - Access to maternity services (subject to consultation with the public about whether they support midwife led units)
 - Access to services for children
 - Rehabilitation for people recovering from a stroke
 - Access to diagnostic services, including X-rays and CT scans
 - Outpatient clinics

This would mean that the majority of patients would be unaffected by any changes

We would like your views on this in the group session



But the patients with the most serious needs might travel elsewhere for more specialised care

- Some people would travel to places that can provide more specialist care
- For each of the services, our clinicians will describe our proposed vision for each of the services and how this might work
- **In the group session, we would like your views on whether the vision is right**







In deciding our approach to reconfiguration we asked for views on which issues were most important



Patients and the public

were invited to give their views via a survey - online or at a face to face event



Seldom heard groups

eg young carers and BME groups answered the survey at focus groups / interviews



Clinicians

were represented by our Steering Group



System leaders

voted through our Oversight and Assurance Group

The views of all these groups were sought and compiled in order to identify their priorities for assessing the options for the new system



The 5 most important issues identified by our stakeholders were:

Workforce

In the future, will we have enough staff to deliver the option? Will the option help to support training and skills? Will the option reduce our reliance on temporary staff?

Affordability

Can we afford the costs of changing the system to the new option (eg new staff costs, new buildings etc)? Will the option increase costs, once it is set up? Will the option help to manage the financial pressures on the system?

Access

How long does it take to get to sites, by ambulance, and for patients and families / carers to travel? Is there a risk that the option will increase health inequalities? Does the option keep care close to home, and keep frequently used services on the local hospital site?

Quality

Will the option help to ensure that services deliver what we know to be good practice?

Interdependencies

Are supporting services available - on the same site where necessary, or through proper links to other sites?

Access and transport are a particularly important issue:

Access and transport were very important issues for our stakeholders.

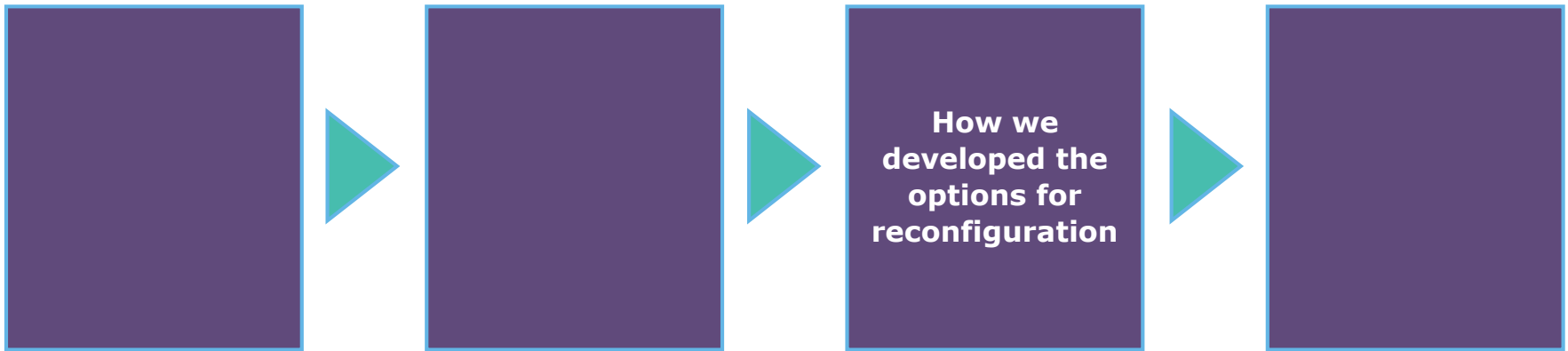
Going forward, we will need to agree:

- What is a safe **transfer time by ambulance**, for emergency services?
- What is a desirable maximum travel time for patients, families and carers, by **public transport** or by **private car**?



We would like your thoughts about this in the group discussions later.

Over the summer we will set up a travel and transport group involving patients, carers, the public, clinicians and the ambulance service.



We used the 5 evaluation criteria to develop and narrow down the options

Staff told us that the way that our services are currently designed does not meet the requirements of modern healthcare, and that, in the long term, we cannot provide high quality services if we carry on trying to provide them in the same way.

To look at what options might work, we took the following steps:

We looked at the workforce we will have available over the next 5-10 years

We identified

- how many staff we have now
- how many staff we would have, if we got our share of new staff at national level
- what impact the changes that we are proposing in the Review might have on our numbers of staff
- how many units we could potentially staff to the levels required by national guidelines, in the future



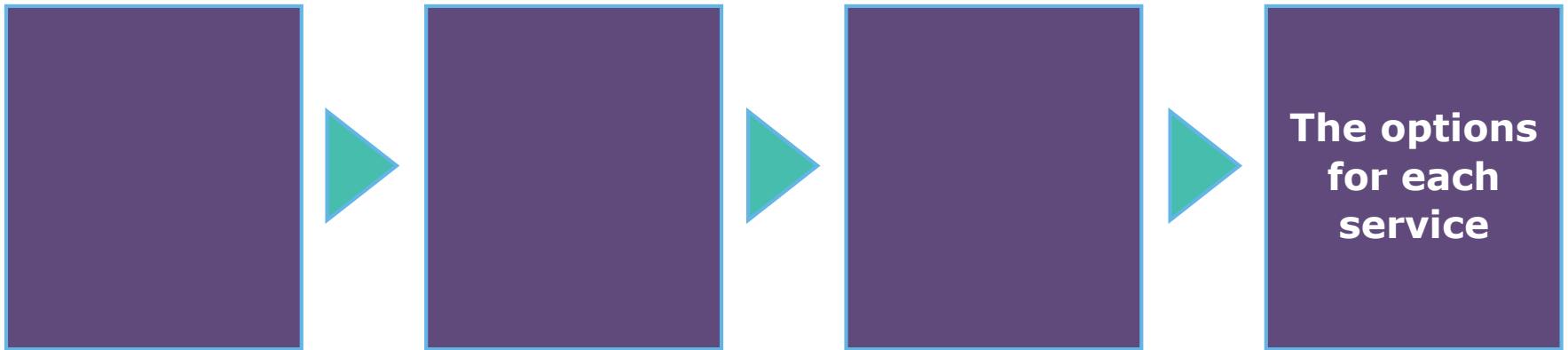
We looked at how many people would be affected by any change, and therefore the affordability of making any changes

We identified

- the maximum and minimum number of people who might receive services in a different place
- whether we would need to build more space to provide care on other sites, and the cost of this
- We looked at whether moving care out of hospital could help



We are looking at what each option would mean for access, quality and interdependencies





The options for each service

Clinical leads

11.35-112.25



Care of the Acutely Ill Child

Dr Nicola Jay

Consultant Paediatrician

ICS Clinical Lead for Care of the Acutely Unwell Child

11.35-11.45



The challenges with care for acutely ill children are....

- Children are very different from adults. They tend to get ill quickly, but get better quickly as well. This means several things:
 - Children should be looked after by people who are trained in caring for children, wherever possible
 - Most children don't need to stay in hospital for long – most for less than a day. And more and more children with chronic illnesses can be treated in their home
 - But children who are really sick need quick access to specialised paediatric care
- There are national shortages of paediatricians and we rely on locums to staff our rotas. This means we worry about our ability to provide really good care for children, across all our hospitals, 24 hours a day





Based on this, we think that the vision for a high quality service would suggest...

- To give children the best quality care we should:
 - Ensure that every hospital can receive children, and observe them, in a unit that has consultants available during the day. This is called a Paediatric Assessment Unit.
 - Ensure that really sick children are transferred to fully staffed, inpatient paediatric units, particularly overnight





Vision for Maternity Services

Dr Karen Selby

Deputy Clinical Director for Maternity Services

11.45 – 11.55



The challenges with maternity services are...

- We have a shortage of obstetricians. This means that some of our consultant led units struggle to provide the level of consultant presence that would meet national guidelines.
- We have a shortage of midwives.
- We do not currently offer as wide a range of choices to women as we would like to. The national guidance, Better Births, emphasised the need to offer women more choice in where to have their babies. This includes more midwife led units and more support to have a baby at home.
- At the moment South Yorkshire and Bassetlaw, and North Derbyshire, mostly offer units which are headed up by consultants. Many women cannot choose a unit led by a midwife.





Based on this, we think that the vision for a high quality service would suggest...

- We want to be able to offer women the chance to have their baby close to home wherever possible, but also to make sure that their birth is as safe as possible
- For women whose pregnancies are lower risk:
 - we will continue to support births at home.
 - we would like your views on whether we should have a midwife-led unit on DGHs which don't have a consultant-led unit
- For women with higher risk pregnancies, we think that we should move to having fewer, larger obstetric units which have consultants present at least 98 hours a week. This meets national guidelines around safety and quality for mothers and babies.





Vision for Urgent and Emergency Care

Dr Nick Mallaband

Emergency Care Group Director and Consultant Acute
Physician

11.55-12.05



The challenges with urgent and emergency care services are...

- Urgent care is the front door to healthcare, and probably the most recognised way to access healthcare.
- More and more people are using A&E as a quick way to get healthcare, often going to A&E for minor issues, rather than wait for a GP appointment. This makes it more difficult for hospitals to deal with real emergencies.
- There is a national shortage of staff to work in A&Es.
- A&Es are the 'front door' to the healthcare system, but they can have many different services behind them. We need to get better at identifying which services need to be on the same site as an A&E, and how to ensure patients get quick, safe access to any care they might need.





Based on this, we think that the vision for a high quality service would suggest...

- We think that every Place should have access to urgent care.
- We intend that the majority of patients would be treated in their local hospital. Some sites would offer a smaller range of other services alongside, with patients taken to more specialist sites by ambulance if necessary.
- We are looking at different models nationally around which services are offered. The options range from Urgent Treatment Centres which provide care for minor injuries, up to highly specialised A&Es with major trauma units attached





Vision for Stroke

Dr Caroline Haw

Lead Speech and Language Therapist for Stroke

12.05-12.15



The challenges with stroke services are...

- We have already agreed a business case to consolidate our Hyper Acute Stroke Units (HASU) (the intensive services that people need in the first 72 hours after a stroke) onto Sheffield, Doncaster, and Mid Yorkshire Hospitals.
- But HASU only deals with the first 3 days. After this, a patient is cared for in an Acute Stroke Unit (ASU), or is moved into rehabilitation in an inpatient unit or in the community.
- Different Places currently offer different levels of rehabilitation services, some don't offer Early Supported Discharge, and some don't have enough specialist stroke therapists.
- We are struggling to recruit stroke consultants, particularly on the smaller sites.





Based on this, we think that the vision for a high quality service would suggest...

- People who have just had a serious stroke would be cared for in a HASU for the first three days
- After that, depending on their needs, they might be discharged to
 - An acute stroke unit on the same site, or on their own local hospital site. Smaller sites might pair with a larger site to provide consultants to run their ASU
 - Rehabilitation, either in the community or as an inpatient
 - We think that every site should have Early Supported Discharge and a consistent offer for community rehab





Vision for Gastroenterology and endoscopy

Dr Mo Thoufeeq

Consultant Gastroenterologist

12.15 – 12.25



The challenges with gastroenterology and endoscopy services are...

- We have a significant shortage of gastroenterologists
- At the moment one of the main risks is that we don't have consistent access to specialist input on all sites if an emergency happens overnight, and a patient has a serious gastrointestinal bleed
- Gastroenterologists also support wider general medicine services, so they need to be in place on most sites during the day





Based on this, we think that the vision for a high quality service would suggest...

- We think that all DGHs should have gastroenterology services onsite during the day
- But overnight, we would ensure that a small number of sites were responsible for providing an emergency rota. If a patient has a real emergency, there would be a formal agreement to transfer them to a consultant at one of the lead sites. At the moment there is no formal agreement so transferring the patient is often delayed.





Elective care

Professor Chris Welsh

12.25 – 12.30

We could improve quality for some non-emergency services

- Most of our work is looking at emergency services.
- But there is national and international evidence that the quality of some elective care can be improved by creating larger, specialist centres. Examples include orthopaedic services (hips and knees) and ophthalmology (eyes).
- At the moment some elective care is sent outside the NHS to the private sector because the NHS doesn't have capacity to provide it.
- In the next stage of work, after April, we would like to explore the options for elective care.



We would like your views during the group discussion later



Outline of Group Session

Alexandra Norrish

12.30 – 12.35



After the break, please go to your group rooms as below

Blue

Red

Green

Yellow

Silver

When you signed in, you were given a colour. Please go to the room which is signed with your colour.

Each group will have an opportunity to discuss each of the issues with each of the clinical leads

We will ask you to discuss the evaluation criteria: workforce, affordability, access, quality and interdependencies

Your group will have a facilitator and a scribe, who will write down the points raised. These will inform the April report.

During lunch, please think about any points you would like to raise



Lunch

12.35 – 13.00



Group sessions

Clinical leads

13.00 – 14.40



Each group will be asked to discuss each subject in turn

	Blue	Red	Green	Yellow	Silver
13.00 – 13.20	Maternity	Gastroenterology and endoscopy	Stroke	Urgent and emergency care	Care of the Acutely Ill Child
13.20 – 13.40	Care of the Acutely Ill Child	Maternity	Gastroenterology and endoscopy	Stroke	Urgent and emergency care
13.40 – 14.00	Urgent and emergency care	Care of the Acutely Ill Child	Maternity	Gastroenterology and endoscopy	Stroke
14.00 – 14.20	Stroke	Urgent and emergency care	Care of the Acutely Ill Child	Maternity	Gastroenterology and endoscopy
14.20 – 14.40	Gastroenterology and endoscopy	Stroke	Urgent and emergency care	Care of the Acutely Ill Child	Maternity
14.40 – 14.50	Elective	Elective	Elective	Elective	Elective



Introduction by facilitators

- Each group has a facilitator and a scribe.
- They will provide you with some more detailed information on how the conclusions above were reached, and will take the group through these.
- Your scribe will write down the points that you raise, particularly points about the evaluation criteria
- The write up of the event will be used to inform the development of the April report of the Hospital Services Review



The Hospital Services Review has developed five evaluation criteria to assess the options

The five evaluation criteria are:

1. Workforce
 2. Affordability
 3. Access
 4. Quality
 5. Interdependencies
- } *used as hurdle criteria*

Each **criteria is framed as a question** and the following slides will set these out and how they apply to each of the services under review.



For each of the core services, we will ask you to discuss questions around the evaluation criteria

- 1. Workforce:** Do you think that the options will help to ensure that we have enough staff and the right staff? Which option is best?
- 2. Affordability:** Do you think that the options are affordable? Which option is best?
- 3. Access:** What are the issues around transfer by ambulance, public transport and private cars? How do we ensure equity of access? Which options perform best?
- 4. Safety:** Do you think the options will help to make sure that we can implement national guidance and make care as good as it can be?
- 5. Interdependencies:** Do you think the options will help us make sure that we have the right supporting services on site or in reach?



For elective care, we will ask you to answer the following questions:

- 1. Do you agree** that we should look at moving some services into larger specialist centres, where this brings a specific quality improvement?
- 2. If we did this,** what would be the important issues for you?



Summary of Next Steps and Close

Helen Stevens, Head of Communications, SYB
Accountable Care System

Chris Welsh, Independent Review Director

14.50-15.00

We will be engaging with patients and the public as we develop ideas for the Review

March - April: we will be working to develop the ideas that have been put forward by the public and clinicians, and will engage with the public as we do this.

End April: we will submit the Hospital Services Review to commissioners, and publish it shortly afterwards

May onwards: we will develop the options further, with public engagement, and will publish the Business Case with options for consultation later in the year





Thank you