

# South Yorkshire and Bassetlaw, Mid Yorkshire and North Derbyshire: Hospital Services Programme

## **STRATEGIC OUTLINE BUSINESS CASE**

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# CONTENTS

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1	Executive Summary .....	4
1.1	Shared working between acute providers.....	4
1.2	Transformation of services .....	5
1.3	Reconfiguration .....	5
1.4	Governance.....	5
2	Strategic Context .....	7
2.1	Vision .....	7
2.2	Integrated Care Systems.....	7
2.2.1	The SYB ICS .....	7
2.2.2	The SYBMYND Collaborative.....	7
2.3	The Hospital Services Review (HSR).....	8
3	Challenges in Acute Services .....	9
3.1	Introduction.....	9
3.2	Unsustainable Services .....	9
3.3	The Main Challenges Facing the Five Core Services .....	11
3.4	Future work on other services.....	11
4	Recommendations of the Hospital Services Review.....	12
4.1	The Recommendations in the Final Report .....	12
4.2	Responses to the HSR Recommendations.....	13
5	The Agreed Way Forward .....	14
5.1	Shared working between acute providers.....	14
5.1.1	Hosted Networks .....	14
5.1.2	Health and Care Institute & Innovation Hub .....	15
5.2	Service Transformation.....	15
5.2.1	Moving care out of hospital into primary care and community care .....	15
5.2.2	Transformation of clinical models and workforce roles .....	16
5.3	Reconfiguration .....	16
5.3.1	Urgent and Emergency Care .....	16
5.3.2	Care of the Acutely Ill Child.....	16
5.3.3	Maternity .....	17
5.3.4	Gastroenterology.....	18
5.3.5	Stroke.....	18
5.4	Considerations in Relation to Reconfiguration .....	19
5.4.1	Sites in Scope .....	19
5.4.2	Trusts outside the ICS .....	19

5.4.3	Transport .....	20
5.4.4	Equalities Impact Assessment.....	21
5.4.5	Affordability .....	21
6	Capital Funding .....	23
7	Next steps .....	25
7.1	Service Level Collaboration.....	25
7.2	System Level Collaborative Working .....	25
7.3	Service Transformation.....	25
7.4	Reconfiguration .....	25
7.5	Moving care into the community (out of hospital).....	26
7.6	Public consultation and engagement .....	27
7.7	Assurance of the proposals.....	28
7.8	Governance.....	28
8	Timeline for delivery .....	31
8.1	High level timeline .....	31
8.1.1	Agreed way forward .....	31
9	Glossary .....	33

**Annex A – Responses to HSR Feedback**

**Annex B – Case for Change**

**Annex C – SYB ICS Collaborative Partnership Board**

**Annex D – Details of CCG Governing Body and Trust Board Discussions on HSR, Post-Publication**

**Annex E – Addendum to HSR Financial Modelling**

# 1 EXECUTIVE SUMMARY

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Health and care organisations in South Yorkshire and Bassetlaw, Mid Yorkshire, and North Derbyshire (SYBMYND) have formed strong partnership working over a number of years with a reputation for delivering long term improvement to health and care for all of our local populations.

This joint working covers primary care, community care, mental health, acute and specialist care and our thinking starts with where people live, in their neighbourhoods, focussing on people being enabled and supported to stay well. Our ambition is to introduce new and improved services, to develop better coordination between those which already exists, to provide support for people who are at most risk and to adapt our workforce so that we are better meeting people's needs.

Prevention will be at the heart of everything we do, and investing in and reshaping primary and community services and integrating mental and physical health will ensure people are supported as close to home as possible. At the same time we have an ambition that everyone should have improved access to high quality care in hospitals and that no matter where people live they should receive the same standards of care. Key to this success will be developing innovative models of care building on the work of the Working Together Acute Care Vanguard.

Following the publication of the South Yorkshire and Bassetlaw system plan the South Yorkshire and Bassetlaw Health and Care Partnership, through its Partnership Board, voluntarily initiated an independent review of Hospital Services. The Hospital Services Review (HSR) was published in May 2018 and it made a number of recommendations including ways in which acute trusts could work together more effectively to meet the needs of patients and how services are designed across SYBMYND.

Partners, including all health commissioners and acute providers across SYBMYND, have now considered the report and provided feedback on its recommendations. The independent review together with its recommendations was well received and broad support was given from system partners to take the work to the next stage.

This Strategic Outline Case (SOC) describes how SYBMYND partners will take the review and its recommendations forward to support realisation of shared ambitions set out in the System Plan published in November 2016.

Below is a summary of the key recommendations which will be taken forward and which the system will build on in the next stage.

## 1.1 SHARED WORKING BETWEEN ACUTE PROVIDERS

- **Acute, community and primary care providers should continue to work together**, at Place level, to ensure that services are delivered as close to patients' homes as possible. This should be supported by standardisation of which services are being provided nearer to where people live rather than in acute hospitals.
- **The acute hospitals should work together more closely**. 'Hosted Networks' should be established, initially for the 5 services included in the Independent Review. They will drive collaboration, improve workforce planning development and deployment, standardise clinical protocols to improve outcomes, and identify and roll-out cost-effective quality-improving innovations across the system.

- **System partners should establish a Health and Care Institute and an Innovation Hub** to provide a system-wide central support for workforce and innovation across the system.

## 1.2 TRANSFORMATION OF SERVICES

- **Moving care into primary care and community care.** The individual Places within SYB and ND are developing an Out of Hospital Strategy to enable people and patients to be cared for outside a hospital setting where this is appropriate, and as close to home as possible. To support this, the Clinical Working Groups will work jointly with colleagues in primary care and community care to identify care pathways and services which could be delivered in non-acute settings.
- **Transformation of clinical models and workforce roles.** In order to ensure that we are making the best use of our staff, and providing care as efficiently as possible, we will ask the Clinical Working Groups to develop new workforce models and new clinical service models. The reconfiguration modelling will take account of these new clinical workforce and clinical service models, to ensure that reconfiguration options are fit for the future and sustainable.

## 1.3 RECONFIGURATION

- **District General Hospitals will be maintained in every place**, each with its own service portfolio comprising a core and specialist offer, working in a networked way across the region.
- **Providers and commissioners will consider consolidating** some services onto fewer sites, in order to improve the quality of care that can be provided to patients and make the best use of available workforce:
  - **All Emergency Departments** should remain open and continue to provide 24/7 care
  - **Paediatrics:** The system will consider the consolidation of full-time inpatient paediatric units from six sites onto four or five, maintaining part-time short stay paediatric assessment units in those places that consolidate their paediatric inpatient units.
  - **Maternity:** the system will consider service models that can support changes to the paediatric services available onsite. This should include the possibility of maintaining standalone Midwifery Led Units on sites which do not have inpatient paediatrics. However we will also look at other options that can address the interdependencies between inpatient paediatrics and obstetric services.
  - **Gastrointestinal bleeds:** Given the difficulty in sustaining out-of-hours rotas for GI bleeds, the system will model consolidating its services from five (currently not all full-time) rotas to three or four full-time out-of-hours rotas.
  - **Stroke:** Hospitals should adopt a paired approach to collaborative working to deliver stroke services, whereby sites with a combination of Hyper Acute Stroke Unit (HASU) and Acute Stroke Unit (ASU) services work with sites that have only ASU/in-patient rehabilitation services, to allow rotation of staff and exposure to more development opportunities.
- The system will establish a transport reference group with a remit to develop a system-wide transport strategy and the specific functions to support and deliver it

## **1.4 GOVERNANCE**

- Commissioners, providers, NHS England and NHS Improvement and the Arms-length-Bodies have been developing a collaborative approach to shared working which they will build on. Commissioners and providers recognise that the current arrangements for decision making will need to evolve to support the scale of change that is included in this report.
- As the ICS develops, SYBMYND will review current governance arrangements in context of the existing legal framework and ensure these enable appropriate decision making to support the successful implementation of the recommendations in this report so that partners can improve outcomes and accessibility to services for people and patients.

This report sets out the case for change behind these agreed directions of travel, and how the system will take them forward.

## 2 STRATEGIC CONTEXT

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### 2.1 VISION

This Strategic Outline Case recognises that South Yorkshire and Bassetlaw, Mid-Yorkshire and North Derbyshire (SYBMYND) are on a journey, which began several years ago with providers and commissioners choosing to work collaboratively, the publication of a system plan outlining the strategic ambition for health and care and which continues with the Hospital Service Review recommendations. We recognise that ways of working and approaches to collaboration will continue to evolve, as South Yorkshire and Bassetlaw (SYB) develops its role of becoming one of the first, and one of the largest, Integrated Care Systems (ICS) in the country.

Our vision focuses on people staying well in their own neighbourhoods, by integrating health and care services and developing a workforce that best meets people's needs.

The SYB ICS brings together commissioners, and acute, mental health, community, social care and primary care providers from our five places to work together to improve health and care services and outcomes to benefit our population.

Our vision for acute hospitals is to work together within networks rather than as individual, standalone providers. By working more closely together, we believe that we will provide better and more equitable care for our patients. We believe that we should have agreed standards and a shared way of doing things so that people can access the most appropriate care, no matter where they live.

In most cases, we anticipate that the majority of patients will continue to receive their care in their local hospital. We confirm our commitment to maintaining all of our local District General Hospitals.

Where patients have more complex needs, we anticipate they may access specialist care and treatment at another site within the network.

The networked approach will include Mid Yorkshire and Chesterfield hospitals, which are associate partners to the SYB ICS but have a long history of shared working with the SYB hospitals due to well established patient flows from the border areas of SYB.

### 2.2 INTEGRATED CARE SYSTEMS

Integrated Care Systems (ICSs) are systems in which NHS commissioners, providers, NHS England and NHS Improvement and other Arm's-Length-Bodies, working closely with GP networks, local authorities and other partners, agree to take shared responsibility (in ways that are consistent with their individual legal obligations) for how they use their collective resources to improve quality of care and health outcomes. ICSs are expected to make faster progress than other health systems in transforming the way care is delivered, to the benefit of the population they serve.

#### 2.2.1 The SYB ICS

The SYB system is large and complex, comprising of five places: Barnsley, Bassetlaw, Doncaster, Rotherham and Sheffield. Within the SYB system are 208 GP practices, five local authorities, five clinical commissioning groups, five acute Foundation Trusts (two with integrated community services), four mental health providers and one ambulance service. The system is served by 72,000 staff and a health and care budget of £3.9bn each year. There are also two associate partner trusts: Chesterfield Royal Hospital NHS Foundation Trust and Mid Yorkshire Hospitals NHS Trust, and two associate CCGs: North Derbyshire CCG and Wakefield CCG.

#### 2.2.2 The SYBMYND Collaborative

The five 'core trusts' are the members of the South Yorkshire and Bassetlaw Integrated Care System:

- Barnsley Hospital NHS Foundation Trust;

- Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust;
- Sheffield Teaching Hospitals NHS Foundation Trust;
- Sheffield Children’s Hospital NHS Foundation Trust; and
- The Rotherham NHS Foundation Trust.

In addition to this, the neighbouring acute trust of Chesterfield Royal Hospital NHS Foundation Trust was fully included within the recommendations of the Review, and recommendations relating to shared working (though not to reconfiguration) also included the Mid Yorkshire Hospitals NHS Trust.

Their inclusion was due to a long history of joint working and clinical networks which support patient services, and the formal collaboration which has existed between the seven SYBMYND acute providers since 2014, when the Providers Working Together acute national Vanguard Programme was established.

However, going forward, work with Chesterfield will need to take account of Chesterfield’s position within the Derbyshire Sustainability and Transformation Plan as well as its links to South Yorkshire and Bassetlaw.

### **2.3 THE HOSPITAL SERVICES REVIEW (HSR)**

In 2017 the system commissioned a review of its acute services, recognising they faced significant sustainability challenges.

The HSR was undertaken over a 10-month period phased in three stages:

- June – August 2017: Identifying the services in scope for the Review
- September – December 2017: Detailed analysis of the issues facing the 5 core services
- January – May 2018: Development of options for the core services.

The Review was informed by a process of clinical engagement, through a series of Clinical Working Groups each of which met five times; and a public engagement programme which included both face to face and online communications. Concerted effort was made to engage seldom heard groups.

The Review team has published the notes of the clinical meetings, the reports of all the public engagement events, the findings of the Review and the detailed evidence for these at each stage of the Review. The reports and the supporting annexes can be found, along with the full set of Review documentation, at:

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

This Strategic Outline Case outlines the system’s agreed way forward following the receipt of the HSR recommendations. It draws on the HSR report, and on the responses to that Report (attached at **Annex A**).

## 3 CHALLENGES IN ACUTE SERVICES

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A full case for change for the system is published as part of the HSR's website online. An updated analysis of the performance metrics of the Trusts in the system, and an overview of the challenges identified in the five services in scope of the review can be found in **Annex B – Case for Change**.

### 3.1 INTRODUCTION

The partners and associates of the South Yorkshire and Bassetlaw ICS commissioned the HSR in response to the challenges identified in the SYB Sustainability and Transformation Plan (STP) or System Plan.

SYBMYND has some of the best acute hospital services in the country, some of which have national and international reputations, including a specialist cancer centre, children's hospital and numerous high quality services in many locations. It also has one of the country's busiest accident and emergency departments. However, the system is under pressure from mounting demand and workforce pressures, both of which impact on the quality of care that patients receive. In addition there are inequalities of access and health outcomes across SYBMYND.

The current and future context will continue to challenge the system, as Trusts continue to respond to increasing demand and to national requirements around quality of care, equity of access and efficiency. The Review offered a unique opportunity to fundamentally change the way care is delivered in the system, and to consider options to transform the way trusts work together to sustain services.

Through tackling the challenges together, and considering the Report recommendations, SYBMYND aims to become one of the most innovative, safe, caring, responsive, effective, well led and efficient health and care systems in the country.

### 3.2 UNSUSTAINABLE SERVICES

The HSR spent the first three months of the Review assessing performance across all acute specialties in SYBMYND.

The findings of the assessment are published in the Stage 1A Report of the HSR, available at:

[https://www.healthandcaretogethersyb.co.uk/application/files/7515/0903/4254/Hospital\\_Services\\_1a\\_Report.pdf](https://www.healthandcaretogethersyb.co.uk/application/files/7515/0903/4254/Hospital_Services_1a_Report.pdf)

The HSR found that a number of acute services across SYBMYND were facing significant sustainability challenges. The HSR undertook a methodical prioritisation process to identify those services which were facing the most acute challenges, and from these it selected five significantly challenged services as the focus of the Review.

Details of how the services were identified are laid out in the 1A Report which is available on the website. In summary, the HSR considered a range of published metrics to provide an independent analysis; worked with Trusts to identify the services that they thought most unsustainable; and identified the level of interdependencies with other services.

The below table identifies the acute services identified as the most unsustainable. A high score indicates that not only was the service of high concern to individual Trusts across the system, but that this assessment was backed up by evidence, and that the service was critically interdependent in maintaining other hospital services.

Rank	Service	Independent analysis	Trust self-assessment	Degree of clinical co-dependencies	Sustainability Score
1	Emergency Medicine	13.6	16.0	16.0	15.2
2	Gastroenterology	10.8	13.0	15.0	12.9
3	Urology	13.5	12.0	13.0	12.8
4	Stroke - HASU	10.8	16.0	11.0	12.6
5	Critical Care	13.0	12.0	12.0	12.3
6	ENT	11.9	12.0	13.0	12.3
7	Cardiology	14.3	11.0	11.0	12.1
8	Radiology	11.8	12.0	12.0	11.9
9	Acute Medicine	11.2	11.0	12.0	11.4
10	Dermatology	14.3	18.0	0.0	10.8
11	Paediatric Medicine	9.4	11.0	11.0	10.5
12	Orthopaedics	14.3	8.0	8.0	10.1
13	Endoscopy	6.7	10.0	12.0	9.6
14	Ophthalmology	14.4	14.0	0.0	9.5
15	Neonatology	7.6	10.0	10.0	9.2

Table 1: Assessment of service sustainability. Services taken forward for inclusion in the Hospital Services Review are highlighted

In order to agree which of these very challenged services the Review should focus on, the HSR team invited input from the HSR Steering Group (including Medical Directors of all the trusts); patients and the public; and national organisations such as NHS England.

From the Steering Group, the following five services were identified for Review:

- Urgent and Emergency Care
- Acute Paediatrics (Care of the Acutely Ill Child)
- Maternity
- Stroke (the acute pathway, supporting HASU)
- Gastroenterology and Endoscopy

Four of these scored in the top fifteen most unsustainable services in SYBMYND (highlighted in orange in the table above). The fifth, maternity, was added because its interdependencies with paediatrics make it difficult to consider paediatrics in isolation, as well as its significance whilst considering the role of the District General Hospital (which was part of the HSR's terms of reference). Endoscopy and Gastroenterology were included together for the same reason.

### 3.3 THE MAIN CHALLENGES FACING THE FIVE CORE SERVICES

The main challenges facing each of the five services were identified through the Clinical Working Groups, engagement with patients and the public, and performance and workforce data provided by the Trusts.

The main challenges that emerged in relation to the five services are as follows:

- **Workforce** – As is the case across the country, SYBMYND has a significant shortfall in the number of substantive staff in the system, with problems in both the recruitment and retention staff. The remaining workforce is therefore overstretched and there is a significant reliance on costly agency staff. Gaps in the workforce mean that staffing levels can fall below those required to provide a safe service for patients.
- **Unwarranted Clinical Variation** - Lack of standardised clinical protocols across the region means that patients with the same condition can receive different packages of care. This results in variation in clinical outcomes, both between and within Trusts. Reducing unwarranted variation is a key priority for the NHS nationally and was identified as a key challenge in the SYBMYND region.
- **Innovation** – Technology and digital infrastructure were flagged as being problematic. Outdated systems that were incompatible with one another, and slow adoption of new technologies across the region were hindering progress that could support the work of clinical healthcare staff.

Further detail on the challenges faced by the system and those faced by the five services in question is provided in **Annex B – Case for Change**.

A full report of the challenges identified by the HSR is available in the Stage 1B Report available at:

[https://www.healthandcaretogethersyb.co.uk/application/files/9615/1809/8702/Hospital\\_Services\\_Review\\_1b\\_report.pdf](https://www.healthandcaretogethersyb.co.uk/application/files/9615/1809/8702/Hospital_Services_Review_1b_report.pdf)

### 3.4 FUTURE WORK ON OTHER SERVICES

The five services identified above have formed the first wave of services. In the work over the next twelve months, neonatology will be included in the work on paediatrics because its interdependencies with maternity and paediatrics mean that it needs to be considered as part of any potential reconfiguration. In South Yorkshire and Bassetlaw and North Derbyshire, most neonatologists also work in paediatric units. This point has been raised frequently in feedback from stakeholders across the system including the maternity and paediatric Clinical Working Groups.

## 4 RECOMMENDATIONS OF THE HOSPITAL SERVICES REVIEW

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### 4.1 THE RECOMMENDATIONS IN THE FINAL REPORT

Following an assessment of the sustainability of acute services in the SYBMYND, which involved significant clinical and public engagement throughout, the HSR made the following recommendations:

- **Acute, community and primary care providers should continue to work together**, at Place level, to ensure that services are delivered as close to patients' homes as possible. This should be supported by some standardisation across the acute services: there should be a defined range of services that will be moved out of an acute hospital setting, to be delivered in primary or community care, or patients' own homes.
- **All of the existing District General Hospitals should be maintained**, each with its own service portfolio, working in a networked way across the region.
- **The acute hospitals should work together more closely**. 'Hosted Networks' should be set up, initially for the 5 services included in the Review, with each capable provider taking the lead on one of the services. There will be three tiers of Hosted Networks. At the minimum, they will aim to drive collaboration and improve workforce planning, development and deployment; standardise clinical protocols to improve outcomes; and identify and roll-out cost-effective, quality-improving innovations across the system. For some specialties, the Host of the Hosted Network will co-ordinate capacity and workforce; and in the most developed model the Host may potentially support delivery of a service on other site(s).
- **System partners should establish a Health and Care Institute and an Innovation Hub** to provide a system-wide central support for workforce and innovation across the system. A Health and Care Institute should provide a central resource to support the recruitment, training and development of staff; the development of standardised clinical protocols; and the analysis and monitoring of trust performance, acting as a central intelligence function. An Innovation Hub should provide the capabilities to identify and roll-out cost-effective innovations across the system, working with local, regional and national partners.
- **Providers and commissioners should consider consolidating some services onto fewer sites**. Given the magnitude of the workforce challenge, both now and forecast in the do-nothing future scenario, collaborative working will not go far enough. As such, the HSR recommended that providers and commissioners should consider the consolidation of some services onto fewer sites, in order to make the most out of the available workforce and improve the quality of care that can be provided to patients.
  - **All Emergency Departments** should remain open and continue to provide 24/7 care
  - **Paediatrics**: The system should consider the consolidation of full-time inpatient paediatric units from six sites onto four or five, maintaining part-time short stay paediatric assessment units in those places that consolidate their paediatric inpatient units.
  - **Maternity**: The system should consider the consolidation of consultant-led birthing units from six sites onto four or five, maintaining standalone midwifery-led birthing units in those places that consolidate their CLU.
  - **Gastrointestinal bleeds**: Given the difficulty in sustaining out-of-hours rotas for GI bleeds, the system should consider consolidating its services from five (currently not all full-time) rotas to three or four full-time out-of-hours rotas.

- **Stroke:** Hospitals should adopt a paired approach to collaborative working to deliver stroke services, whereby sites with a combination of Hyper Acute Stroke Unit (HASU) and Acute Stroke Unit (ASU) services work with sites that have only ASU/in-patient rehabilitation services, to allow rotation of staff and exposure to more development opportunities.
- **Elective:** The system should develop models for the transformation and reconfiguration of elective services to support an improvement in quality of elective services, as well as to support changes to non-elective services, given unsustainability challenges in this area.
- **Access:** The system should establish a transport reference group with a remit to develop a system-wide transport strategy and the specific functions to support and deliver it
- **Governance:** Current arrangements between providers are unlikely to be fit for purpose when considering the scale of change that is included in this report. SYBMYND should review current governance arrangements and ensure these enable rapid decision making at pace to support the successful implementation of the recommendations in this report.

Full details of how the HSR developed these options are available in previous Stage 1A, Stage 1B and Stage 2 HSR Reports.

Final recommendations themselves can be found at:

[https://www.healthandcaretogethersyb.co.uk/application/files/2515/2845/1016/25.\\_HSR\\_Stage\\_2\\_Report.pdf](https://www.healthandcaretogethersyb.co.uk/application/files/2515/2845/1016/25._HSR_Stage_2_Report.pdf)

## 4.2 RESPONSES TO THE HSR RECOMMENDATIONS

Since publication of the final HSR in May 2018, its recommendations have been shared with CCG Governing Bodies and Trust Boards. Public engagement has also been ongoing to inform the public of developments while continuing to capture their thoughts.

There was broad support for the findings and recommendations of the Review, and as such this Strategic Outline Case outlines the Governing Bodies' intention to take on board the recommendations and commit to further work on the sustainability of acute services.

The feedback received to the HSR proposals is detailed in **Annex A – Responses to Feedback**, along with detailed responses to the individual points raised. This document outlines the system's agreed way forward following the receipt of these responses.

## 5 THE AGREED WAY FORWARD

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CCGs, Trusts, Local Authorities and members of the public have given responses to the HSR recommendations (see **Annex A – Responses to HSR Feedback**), and as a system we have developed our agreed way forward.

Overall, the South Yorkshire and Bassetlaw Integrated Care System, with Mid Yorkshire and North Derbyshire, agrees with the recommendations of the HSR. However, as a health system, the most vital focus for us going forward will be around developing shared working across the trusts, and transforming services, including through developing new workforce models. Only when we have understood the impact of both of these things will we consider changing the configuration of our services.

### 5.1 SHARED WORKING BETWEEN ACUTE PROVIDERS

Going forward, the acute providers will work together closely. We will set up Hosted Networks, as well as an infrastructure of a Health and Care Institute to support a shared approach to workforce and innovation.

#### 5.1.1 Hosted Networks

- The system will work to establish a set of Hosted Networks across the five specialities identified in the HSR.
- The approach to Hosted Networks will consist of three tiers of Hosted Networks, with increasing levels of collaboration:
  - A basic Hosted Network will be responsible for standardising the approach to workforce functions; reducing clinical variation through setting agreed protocols; and rollout of specific identified innovations. It will be backed by agreed delegated decision making powers, accountability and monitoring.
  - A Co-ordinated Delivery Network will have the functions of a basic Hosted Network, with the Host having an additional co-ordinating role in identifying shortfalls in capacity and staff, and allocating resources to meet demand.
  - A Single Service Model will be explored, for some trusts and some specialties, whereby the Host may play a role in supporting the delivery of services on other sites. This arrangement is unlikely to cover every site in the network and would only occur if the support was requested by the receiving site.
- It is recognised that services are continually developing and evolving. As such, whilst we will work with service providers to determine the most appropriate level of network for each specialty, we acknowledge that this is dynamic and may change over time.
- The first step will be to work with providers and commissioners to develop a central framework on the networks' purpose, function and form that can be tailored to each service. The framework will outline the proposed form of the Hosted Networks and the lines of accountability between the Hosted Network, member trusts and the ICS. This will also lay out the responsibilities of both Hosts, and network members. An implementation plan will be drawn up to support this.
- The programme will engage providers and commissioners in developing a robust approach to equitably assigning Host organisations for each of the Hosted Networks. This will include developing criteria around what a Host must be able to provide, and the requirements that it must meet, in order to be eligible to host a service. This will ensure that whilst lead roles

are shared across the system, all Hosts have the resources and ability to perform the role of Host.

- Engagement will also be conducted to ensure staff have the opportunity to get involved and shape ways of working across the various organisations.
- The development of Hosted Networks will be alongside that of the Health and Care Institute and Innovation Hub, which will provide centralised analytical and human resource expertise for the Hosted Networks.

### **5.1.2 Health and Care Institute & Innovation Hub**

- We will progress the work to establish a Health and Care Institute and Innovation Hub to support the transformation themes: workforce, unwarranted clinical variation and innovation.
- We will engage with both NHS and non-NHS partners, such as local universities and industry, to develop the detail of the model.
- We will also consider funding implications and any interdependencies or overlap with other ICS workstreams.
- We will work with Health Education England to develop the workforce function of the Health and Care Institute. The approach to developing the Health and Care Institute and Innovation Hub should also include social care and the third sector to enable the appropriate innovation in care pathways.
- The Institute and Hub are likely to be one organisation, rather than two separate structures, but this will be agreed in work going forward

## **5.2 SERVICE TRANSFORMATION**

We will ensure that services are working together as well as possible.

In order to do this, we will ensure that care takes place in the right place, and that only care which needs to happen in acute hospitals is provided there.

We will also look at ways in which we can use our existing workforce better, through different workforce models.

### **5.2.1 Moving care out of hospital into primary care and community care**

The NHS England Five Year Forward View, and subsequently the Sustainability and Transformation Plans of both SYB and North Derbyshire (SYBND), have focused on the importance of ensuring that care is delivered in the right place. In many cases, patients are currently receiving care in acute hospitals where this could be better and more efficiently provided in primary or community care, or in their own homes.

The individual Places within SYBND are developing their own strategies for reducing admissions to hospital, and making sure that patients receive care outside hospital wherever possible. The six CCGs have agreed to develop this into a single strategy.

In order to support this, we will ask the Clinical Working Groups to look at care pathways, and identify from the services under review which would be better delivered in settings other than the acute settings. The CWGs will work with colleagues in primary care and community care to understand what workforce and investment in primary care and community care would be necessary to make this happen. The Clinical Working Groups have already had some discussions of this, and this will build on this work.

### **5.2.2 Transformation of clinical models and workforce roles**

The HSR describes the need to develop new workforce roles, in particular the roles of the alternative professions, such as Physicians' Associates and Advanced Nurse Practitioners. The HSR envisages that developing the approach to these would be part of the role of the Hosted Networks.

Providers and commissioners, in responding to the HSR recommendations, have highlighted the importance of ensuring that we do not simply base reconfiguration options on current workforce models. Therefore, before we model the impact of reconfiguration on our workforce, we will ask the Clinical Working Groups to develop new workforce models and new clinical models to ensure that we are making the best use of our staff.

The reconfiguration modelling will take account of these transformed approaches to the workforce, to ensure that the reconfiguration options are based on the new approach rather than simply replicating the status quo.

## **5.3 RECONFIGURATION**

The HSR proposed that, where transformation options do not go far enough, we should consider reconfiguring services.

Leaders in the healthcare organisations have agreed with the majority of the HSR proposals for further work. The exception is maternity, where a number of responses raised concerns about the sustainability of Standalone Midwifery Led Units. As a result, the work going forward will include SMLUs but will also investigate other ways to address the interdependencies with paediatrics.

South Yorkshire and Bassetlaw, with North Derbyshire (SYBND)<sup>1</sup>, have agreed to model the following options:

### **5.3.1 Urgent and Emergency Care**

One member of the public asked for confirmation that the system intends to retain all 6 Accident and Emergency departments, plus the paediatric A&E at Sheffield. We confirm that we will do this.

The South Yorkshire and Bassetlaw Integrated Care System, with North Derbyshire, agrees:

- We will retain all 6 accident and emergency (A&E) departments plus the paediatric emergency department at Sheffield Children's Hospital. This includes emergency departments staying open 24/7, with consultant coverage appropriate to the size of the unit, guided by Royal College of Emergency Medicine guidelines.
- We will consider what staff presence is appropriate in A&Es at different times of the day and explore how we can use staff in different ways. Alternative staff roles, such as advanced nurse or medical practitioners, or support from GPs, could help to address workforce challenges in our A&E departments.

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<sup>1</sup> Note, Mid-Yorkshire has recent undergone reconfiguration with other trusts in its STP, as such is not a part of the reconfiguration proposals. Chesterfield is included within the scope of the reconfiguration proposals, but we will need to engage closely with Derbyshire commissioners to ensure consistency with the development of the Derbyshire Sustainability Plan, since Chesterfield sits within Derbyshire STP as well as having patient flows to SYB.

### 5.3.2 Care of the Acutely Ill Child

Some concerns were raised around whether Short Stay Paediatric Assessment Units (SSPAU) were an appropriate way forward for system partners.

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

However, clinical evidence supports the safety of SSPAUs as an alternative to full-time inpatient units, particularly when there is not enough activity or resource to sustain a full paediatric inpatient unit, assuming appropriate transfer protocols are in place for those patients requiring overnight care. The Royal College of Paediatrics and Child Health support such a care model, stating that for many patients they are a more appropriate care setting than an inpatient unit, and are being increasingly used to deliver high quality paediatric care<sup>2</sup>.

The South Yorkshire and Bassetlaw Integrated Care System, with North Derbyshire, agrees:

- We will model the impact of changing one or two inpatient paediatric units (from the existing units in South Yorkshire and Bassetlaw and North Derbyshire) into SSPAUs.
- Where an SSPAU is proposed, we will ensure that it is supported by robust referral and patient transfer protocols to ensure children are able to access the care they need out-of-hours.
- If changes are being proposed to paediatrics services, this will be mirrored by appropriate changes to maternity and neonatology services on the site. We will continue to test out a range of models that meet the required interdependencies between obstetrics and paediatrics, and will assure the safety of any such models with the Clinical Senate.
- We will continue to model transformation options, such as using mid-grade staff, and advance nurse and medical practitioners in different ways, and changing job roles, to address workforce challenges.

### 5.3.3 Maternity

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

The SYB system is working to deliver the recommendations of the Better Births report. This includes providing women with greater access to choice of where to have their babies, including home births and Midwifery Led Units.

The HSR recommended that the system should provide a MLU on every acute site, and that one or two sites should look at having Standalone Midwifery Led Units, supporting a part-time Paediatric Assessment Unit, with obstetric, neonatology and specialist paediatric services being provided at another linked site. This is a model that is used in a number of places in the NHS.

Some respondents raised concerns about the safety and in particular the sustainability of Standalone Midwifery-Led Units (SMLUs). The hospital services programme will continue to work with local obstetricians, midwives, nurses, sonographers, neonatologists and other healthcare professionals in the development of any specific proposals in the next phase of work, and this will involve a thorough assessment of the clinical evidence on SMLUs.

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<sup>2</sup> Royal College of Paediatrics and Child Health, Standards for Short-Stay Paediatric Assessment Units, March 2017.

Available at: [https://www.rcpch.ac.uk/sites/default/files/SSPAU\\_College\\_Standards\\_21.03.2017\\_final.pdf](https://www.rcpch.ac.uk/sites/default/files/SSPAU_College_Standards_21.03.2017_final.pdf)

In addition, the maternity workstrand will be asked to explore alternative clinical models, both locally and internationally, which allow of greater flexibility around the co-location of maternity and paediatric services, recognising the clinical interdependency that exists between these and neonatology services. We will test out other models that might allow for obstetric-led services remaining on a site without 24/7 paediatrics being present, and vice versa.

Any such options will be developed in close collaboration with expert Clinical Working Groups and submitted to the Clinical Senate for scrutiny, to ensure that they are safe and appropriate.

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

The need to fully consider the interdependencies between maternity, neonatal and paediatric services was also flagged in responses from Boards and Governing Bodies. The system has agreed to add neonatologists to the Clinical Working Group on Care of the Acutely Ill Child, and to include neonatology in any reconfiguration modelling in order to address this.

The South Yorkshire and Bassetlaw Integrated Care System, with North Derbyshire, agrees:

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

#### **5.3.4 Gastroenterology**

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

One respondent raised concerns about the safety implications of moving to full out of hours services on three or four sites; however, we note that the system does not currently provide out of hours services on all of these sites.

One respondent suggested that staff should move to the patient rather than vice versa. However, this was discussed in the Clinical Working Group and was thought to be a less safe option, given the

risk that a consultant called to an emergency on one site could not then support an emergency at another site.

The South Yorkshire and Bassetlaw Integrated Care System, with North Derbyshire, agrees:

- At present we do not have five full out-of-hours areas, therefore, going forward as a system we will model moving to three or four rotas, and engage with our clinicians to ensure the concerns raised above are covered.

### **5.3.5 Stroke**

The HSR did not propose any reconfiguration proposals for stroke services, as changes were already underway through the work on hyper-acute stroke units. The South Yorkshire and Bassetlaw Integrated Care System, with North Derbyshire, agrees:

- We will further develop proposals for the collaborative working of stroke services through paired sites, between sites with a HASU and an ASU. Such a collaborative way of working could be supported through the stroke Hosted Network.
- We will develop standardised commissioning specifications for early supported discharge, inpatient rehabilitation, and transient ischaemic attack services.

## **5.4 CONSIDERATIONS IN RELATION TO RECONFIGURATION**

### **5.4.1 Sites in Scope**

The HSR's reconfiguration recommendations were site agnostic, based on the collective availability of workforce and capacity across the South Yorkshire and Bassetlaw, and North Derbyshire (SDYBND) region relative to forecast activity levels and care quality requirements. Some organisations have wished to outline concerns about service change at an early stage.

At this point, the principles around potential reconfiguration require that all the possible options must be considered equally. As an immediate next step, we will lay out the approach that the system will take to defining the sites and options which will be modelled, in line with national guidance and statutory requirements around options development and options appraisal.

We confirm that the hospital sites included in the baseline for the reconfiguration modelling (i.e. sites where services might change) are:

- Barnsley Hospital
- Bassetlaw District General Hospital
- Chesterfield Royal Hospital
- Doncaster Royal Infirmary
- Northern General Hospital
- Royal Hallamshire Hospital
- Sheffield Children's Hospital
- Rotherham General Hospital.

The South Yorkshire and Bassetlaw Integrated Care System, with North Derbyshire, agrees:

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

- As we take the work forward, all Trusts will be considered in the context of the site-specific modelling; and we have an open mind in relation to how they are included. The system may wish to designate some fixed points, based on permissible criteria and in line with guidance and precedent. There would be an agreed approach to determining any fixed points, with full engagement from system leaders, patients and the public.
- Refreshed hurdle and evaluation criteria will be used to assess these options to ensure that any proposals that are taken further meet robust quality and safety requirements, and provide equal access to care for patients across the region. We will engage with system leaders, patients and the public in refreshing and agreeing weightings for the evaluation criteria.
- We recognise the need to work closely with Derbyshire CCGs around the impact of any proposals affecting Chesterfield on the Derbyshire STP.

The options modelled will be in line with the approaches agreed above.

#### **5.4.2 Trusts outside the ICS**

It is possible that under some reconfiguration scenarios the nearest service for some of our patients will be outside of the SYBND footprint.

Sites that could potentially receive additional patients from the SYBND region include, but are not limited to:

- Calderdale Royal Hospital
- Dewsbury and District Hospital
- Huddersfield Royal Infirmary
- King's Mill Hospital
- Leeds General Infirmary
- Lincoln County Hospital
- Pinderfields Hospital
- Pontefract Hospital
- Scunthorpe General Hospital

In addition, some STPs outside SYBND are undertaking reconfigurations or service changes of their own, so some of the hospitals on our borders may be making changes which could themselves impact on the SYBND sites.

The system agrees the following:

##### *Patients moving outside SYBND:*

- We will model all the appropriate options, including those where patients might move to trusts outside SYBND.
- However, as we do this we will undertake due diligence around understanding any quality, safety and capacity issues at the potential receiving sites.
- In evaluating the options, one of the existing evaluation criteria is quality, and we will consider any implications of quality for patients receiving care from trusts outside SYBND. In the assessment of equalities, we will also consider the potential equality implications of

some patients receiving care at sites which are not signed up to the principles of the SYB Hosted Networks.

#### *Proposed changes in neighbouring STPs*

- The Review team is already in contact with the leads on reconfiguration in neighbouring STPs, and contacts with these leads will continue.
- As we develop the modelling for the SYBND reconfiguration options, we will include the implications of potential patient flows into SYBND caused by potential reconfigurations in our neighbouring health economies, where these are known.

#### **5.4.3 Transport**

Feedback from members of the public raised concerns around transport, and asked in particular that we ensure that we link to strategic planning around travel and transport across the footprint. We will invite the leads on transport issues in the key organisations responsible for designing transport across the region to our travel and transport group, so the transport strategy will be a focus going forward.

The South Yorkshire and Bassetlaw Integrated Care System, with Mid Yorkshire and North Derbyshire, agrees:

- We will model the potential impact on travel times due to reconfiguration. Within the travel time modelling we will look at blue-light emergency transport, and journeys through both private transport and public transport means.
- We will also conduct a postcode-level analysis to look at the impact on different socio-economic groups based on indices of deprivation data, to ensure that no groups are disproportionately affected by change.
- We will engage local partners to set up a strategic travel group as a priority. This group will comprise representation from local acute trusts, commissioning bodies, ambulance services (both Yorkshire and East Midlands Ambulance services), local authorities, patients and the public, and other relevant local travel and transport stakeholders (such as local public transport providers). The programme will engage this group regularly as options are developed and assessed. Clinical Working Groups will be engaged in a similar capacity to understand the safety implications of increased travel times in emergencies. In such a way the acute sustainability programme will ensure that options taken forward seek to minimise and mitigate any increase in travel. It will consider the issues around public transport, in both urban and rural areas.

#### **5.4.4 Equalities and the Equalities Impact Assessment**

Ensuring equitable access to high quality care has been raised as an issue by patients and the public, and is a priority for the programme. A core aim of the Review was to address health inequalities, and this will be at the heart of modelling, and assessing our options, going forward.

The South Yorkshire and Bassetlaw Integrated Care System, with Mid Yorkshire and North Derbyshire, agrees:

- We will ensure the completion of an equalities impact assessment to inform any future proposals.
- This will be supported by quantitative modelling that seeks to identify any potential impact on patients, broken down into demographic groups, to understand and assess the impact on different groups in society. We will look at the impact on the protected groups (as identified

in the Equalities Act), as well as issues around socioeconomic inequalities which we will identify through postcode analysis.

- The programme will continue to engage with a wide range of stakeholders, including a particular focus on seldom heard groups, to hear and understand their views and concerns to ensure that their feedback is taken into consideration.
- The evaluation of options against evaluation criteria will include an assessment of impact on equalities, through the access criterion, as well as the separate Equalities Impact Assessment.

#### **5.4.5 Affordability**

Financial analysis was undertaken to understand the cost-benefit and affordability of any of the high-level reconfiguration options. Consideration was made of both any impact on trust operating expenditure and any capital cost requirements. Transition costs were also taken into account. The financial impact of each option was considered as one of the evaluation criteria in the HSR, and will continue to be so in any future appraisal of site-specific options.

More detailed modelling to fully understand financial impacts on providers and commissioners of site-specific reconfiguration options will be conducted in the next phase of work.

One response from the public raised concern about the level of modelling done to date querying whether data from all trusts had been used in the modelling, and cited the 'limitations' section in the financial annex of the report. We confirm that data from all trusts (reference costs and STP forecasts) was used to inform the analysis that underpins the HSR. The 'limitations' point relates specifically to the fact that at the time of writing only Barnsley had contributed service line reporting (SLR) data; not all trusts collect SLR data. A detailed response to the concerns raised by the member of the public is provided in **Annex A – Responses to HSR Feedback**.

The financial analysis published alongside the HSR used the data available at the time that the modelling was developed. Several trusts made more detailed data on activity available shortly before publication, and this was used to update workforce projections. However the updated data was made available too late to be included in the capacity and financial data, so an updated analysis is attached as an Annex to this Strategic Outline Case in **Annex E – Addendum to HSR Financial Modelling**. The changes are marginal (the greatest change to cost implications in any scenario is £1.3m, with most changes being £0 to £300,000) so the updated data made no impact on the final recommendations.

##### **5.4.5.1 Operating costs analysis**

Baseline trust provider costs for 2021/22, before any configuration changes, were taken from STP (now ICS) plans, which included assumptions around the impact of cost improvement programmes (CIPs), out-of-hospital schemes, and other service changes.

Various financial impacts were analysed:

Workforce efficiencies were quantified, whereby savings could be realised from the reduction in locum usage, given the decreased requirement for certain groups of staff following consolidation. Another key source of workforce efficiencies was that it might be possible to increase service coverage with fewer additional full time equivalents, relative to the current configuration. Changes to service models might also result in financial impacts: for example, new delivery models such as urgent treatment centres could be used to take activity out of A&E. Shifting additional care out-of-hospital, where appropriate, was another driver of cost impact.

Fixed cost savings were quantified to recognise a partial offset for new build costs. This was linked to changes in bed capacity when any activity shift led to new build costs.

These reductions in operating expenditure were balanced against any increased capital expenditure, with the revenue cost of any required capex phased equally over a 10-year period. More detail on the approach to quantifying capital costs is set out below.

Future stages of modelling will use more accurate trust costing data and work with commissioners and providers to quantify any associated impact on operating income.

#### *5.4.5.2 Capital costs analysis*

Capital costs were quantified on the basis of requirements for additional bed build at sites receiving additional activity. If the receiving site has no spare space, the incoming bed would be by necessity a new build. If the receiving site has spare space but not in the same department, the spare bed would need to be refurbished, for c. 50% of new build cost. If the receiving site has spare space in the same department, the incoming bed could be accommodated for no cost.

## 6 CAPITAL FUNDING

As part of the national process for prioritising STP/ICS capital, the ICS has completed a draft Estate Strategy and associated capital bids which include a range of schemes designed to deliver clinical, estate, patient quality and experience and workforce benefits across the system as a whole; including identifying an estimated future capital requirement associated with the final report of the HSR published on 9 May 2018.

HSR modelling on capital costs focused on the cost of moving activity and associated bed build. However, more detailed modelling in the next phase of work may draw out more granular capital needs, such as for technology and digital infrastructure, costs of which were accounted for in the capital bid.

At the point at which the system was required to submit bids for the next five years, HSR had not yet been fully considered by the system, and this Strategic Outline Case was still in development. On the advice of NHS England, therefore, South Yorkshire and Bassetlaw included a placeholder bid for capital related to the HSR, using a mid-range scenario from the modelling undertaken from the HSR. This bid will, obviously, only be pursued in the event that the system agrees to take forward reconfiguration, following public involvement and, if needed, consultation, and therefore the capital is required.

The ICS's total capital bid is comprised of five component workstreams as follows. The HSR reconfiguration element is 1e below. Note that, rather than including either the highest or the lowest level of costs identified in the HSR modelling, the scenario used here is a middle range which involves changes to one large and one small site for maternity and paediatrics.

ICS Initiative/ Clinical Workstream	Physical assets obtained:	Phasing of workstreams:	Capital Required:
1a System Sustainability – Primary and Community investment	Creation of additional capacity for delivering primary and community care services, training and development	Phase 1: Primary Care, Community, Mental Health, Digital and Linked Acute schemes can be delivered ahead of the HSR Strategic investment. As schemes are worked up and where change is considered significant, the ICS would be subject to NHS assurance processes, including potential public consultation and we would carry out our statutory duties.	£57m
1b – System Sustainability – Mental Health Investment	Creation of community crisis centre and reprovision of co-located services into new community hubs		£43m
1c – System Sustainability – Digital Investment	Introduction of a single, SYB-wide shared digital platform across a number of key services		£35m
1d System Sustainability – Linked Acute Schemes	Range of updated and improved clinical facilities across all acute providers (including removal of Nightingale wards, co-location of emergency services and the expansion of critical diagnostic services and key acute services)		£71m

ICS Initiative/ Clinical Workstream	Physical assets obtained:	Phasing of workstreams:	Capital Required:
1e System Sustainability – Strategic elements of HSR	<p>Reprovision of 208 new beds across existing sites, to support the reconfiguration of key acute services across the ICS (subject to consultation).</p> <p>The scenario of 208 beds was identified as a mid-point between the maximum and minimum scenarios identified within the Hospital Services Review. It is an indicative figure at this point.</p>	Phase 2: the HSR implementation could be completed alongside the Phase 1 workstreams. As the scheme is subject to NHS assurance processes, including potential public consultation, it is anticipated that a number of the Phase 1 schemes would already be completed if the scheme went ahead.	£99m

In addition, two further capital bids have been submitted around ensuring the sustainability of facilities that support acute services at Doncaster and Bassetlaw Hospitals and an ICS-wide Cancer Strategy.

The Doncaster and Bassetlaw work predominantly looks at improvement of emergency care services and improvement of services at Doncaster Royal Infirmary. We will work with the Trust on any areas that might impact or be impacted by the hospital services workstream.

In relation to the ICS-wide Cancer Strategy, the capital bid would cover potential improvements to sites and facilities across South Yorkshire and Bassetlaw. As with the HSR, any changes would be subject to engagement and, if necessary consultation with the public.

## 7 NEXT STEPS

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This Chapter outlines the next steps being undertaken by the system to deliver the recommendations of the HSR, as per the agreed way forward detailed earlier in this Strategic Outline Case.

### 7.1 SERVICE LEVEL COLLABORATION

#### Developing Hosted Networks:

- Agree a framework for all the Hosted Networks, at a system-wide level;
- Establish criteria as to what responsibilities a trust must be able to meet in order to be a host;
- Define the responsibilities of the Hosts and Members;
- Agree how this links to the ICS structures;
- Agree which trusts will lead on each of the Networks; and
- Establish the Hosted Networks

### 7.2 SYSTEM LEVEL COLLABORATIVE WORKING

#### Develop Institute of Health and Care: covering Workforce

- Agree the objectives, structures, funding and governance of the Institute; and
- Agree how it will relate to the trusts and how it will support the work of the Hosted Networks
- Establish the Institute of Health and Care

#### Develop Innovation Hub: covering Innovation

- Agree the geographical footprint of the innovation hub, who are its members, and how it relates to the Institute of Health and Care (whether it is part of the same organisation or a separate one);
- Agree the objectives, structures, funding and governance of the Institute; and
- Agree how it will relate to the trusts and how it will support the work of the Hosted Networks
- Establish the Innovation Hub

### 7.3 SERVICE TRANSFORMATION

#### Transformation of clinical models and workforce roles:

- Engage Clinical Working Groups and Health Education England, and other workforce committees, to develop new clinical models and new workforce models to ensure that we are making the best use of our staff; and
- Ensure that any reconfiguration modelling takes account of these new clinical models.

#### Supporting the out-of-hospital strategy:

- The strategy for Out of Hospital care is being developed in the ICS in partnership with its five places identifying pathways in the core acute areas which would shift into primary or

community care, and the workforce / capital / financial implications of this shift of activity whilst the acute sustainability work develops.

## **7.4 RECONFIGURATION**

### **Develop specification for modelling:**

- Develop the specification of what the modelling needs to be able to model for financial, activity, workforce and access data;
- Agree what data sources, at what levels, are required for this; and
- Agree how the modelling will relate to the requirements of the Equalities Impact Assessment.

### **Agree evaluation criteria:**

- Refresh the existing evaluation criteria to ensure that they are still fit for purpose and to address any gaps; and
- Engage the public and stakeholders on the weighting of evaluation criteria

### **Agree shortlist of options to be modelled:**

- Develop the shortlist of options around the modelling, including identifying any 'fixed points' i.e. sites or services which would self-evidently not change, and all the possible combinations of the remaining sites.
- Engage clinicians on the proposed shortlist of options for modelling; and
- Engage patients and the public on the proposed shortlist of options for modelling

### **Model shortlisted options:**

- Collect the relevant data, build the model using information around the transformed workforce developed by the Clinical Working Groups, and run the agreed options through the model. This will be iterated multiple times to ensure that the data is genuinely robust and reliable.

### **Agree preferred option(s) to be considered for consultation:**

- Evaluate the outcomes of the modelling against the evaluation criteria: this will need to involve patients and the public as well as stakeholders across the system; and
- Identify a shortlist of preferred option(s) which are likely to be included within the Pre-Consultation Business Case, based on the outcomes of the evaluation process

### **Produce Pre Consultation Business Case:**

- Engage with the Joint Health Overview and Scrutiny Committee to confirm if any elements of the proposed changes require formal public consultation (see below);
- Draft Pre-Consultation Business Case;
- Submit to NHS England for assurance (see below)

## **7.5 PUBLIC CONSULTATION AND ENGAGEMENT**

The development of the HSR has included a significant level of public and clinical engagement. Going forward, we will build on this to ensure that clinicians, members of staff, patients and the public have as many opportunities as possible to be involved.

Respondents acknowledged the engagement that had been done to date, with clinicians, nurses, midwives, other healthcare professionals, the public and patients. However, several respondents felt more should have been done. Some respondents felt that the HSR had not yet engaged sufficiently with local authorities, and specifically their elected members.

Engagement with seldom heard groups was acknowledged as positive of the work to date and the acute sustainability programme will continue to do so in any future phases of work.

Future next steps include:

- **A detailed Engagement Plan**, to include the approach to involvement, will be developed by the ICS Communications team, in collaboration with the PMO for the acute sustainability work. It will be shared with the SYB ICS Citizens' Panel and Joint Health Overview Scrutiny Committee for comment and signed off by the Sustainable Acute Services Steering Group, and by the Collaborative Partnership Board. This will ensure that patients and the public have their say on proposals at all stages of development and will seek to engage people from all areas of the region.
- **Clinicians**, other healthcare professionals and other staff groups within services will continue to be engaged through the reconstitution of the Clinical Working Groups (see below). These will meet on a regular, scheduled basis and will be a key forum in which the programme will shape and develop any options for modelling and evaluation, actively seeking their expertise in the subject and knowledge of SYBMYND and its population.
- **Engagement with patients and the public:** The approach will be outlined in the engagement strategy. In summary, the acute sustainability programme will continue to engage regularly through the ICS Citizen's Panel, CCG Engagement Groups (including Patient and Partnership Groups), provider Trust Engagement groups and other relevant forums, such as Healthwatch, voluntary sector groups, local Maternity Voices Partnerships.

Several large engagement events will also be held throughout this next phase of the Review, which will be specific to this programme of work. As respondents have pointed out, as proposed modelling work progresses, the nature of engagement will become more specifically related to changes to individual sites and services, whereas it has tended thus far to relate to broader discussion of concepts. Involvement will be frequent and regular to ensure clarity and transparency around proposals as they develop. We will also build upon the learning from previous consultations undertaken by our and other systems, to ensure relevant experience informs our work.

- **On travel and transport:** a specific patient and public group will be convened to focus on the transport and travel implications of any service change proposals. This will support a clinical and operational group on transport and travel.
- **Engagement with Local Authorities:** Whilst the HSR engaged with the Joint Health Overview and Scrutiny Committee, and will continue to do so, the programme will seek to strengthen moving forward. The Review team will engage with Directors of Public Health and Health and Wellbeing Boards on the hospital services workstreams, such as working with them as the modelling is developed to ensure that population data is accurate. More generally, the system partners will engage with Local Authorities, including Leaders, around the development of shared working across the system.
- **Formal Public Consultation:** If required, a formal public consultation plan will be developed and published alongside any pre-consultation business case, detailing plans to consult with all of the stakeholders in the SYBMYND health economy. We will actively seek comment on proposals from commissioners, trusts, healthcare staff, patients and the public, local authorities and others in order to inform any service change decision.

## 7.6 ASSURANCE OF THE PROPOSALS

As well as significant engagement with system stakeholders, patients and the public, proposals will undergo regulatory assurance processes with national NHS bodies:

### Clinical Senate sign-off of proposals:

- The North West Clinical Senate will be asked to formally review options which require clinical changes to ensure that they are robust

### NHS England assurance of proposals:

- The system will submit all proposals to NHS England for formal assurance as required

## 7.7 GOVERNANCE

The HSR was an independent review. Therefore, while its governance aimed to ensure that all the member organisations were closely involved in and sighted on the work, its governance reflected its Terms of Reference.

Going forward, the HSR ceases to be an independent review, and will become one of the workstreams of the ICS. The name of the programme, and its governance, need to reflect this.

Going forward, the health and care economy as a whole is going to need to develop appropriate governance to support the ICS and its partners. This will need to respect the existing statutory framework, while allowing for streamlined decision making in the integrated structure.

The HSR made a recommendation around ensuring that the governance is appropriately streamlined going forward, within the current statutory framework:

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

One member of the public raised a question around whether the governance was appropriate, and cited the point made in the review about the current arrangements between providers. They also expressed a query about the maintenance of statutory duties and lines of accountability in the any arrangements. It should be clarified that all commissioners will retain and perform their statutory duties, with providers and associated bodies held to account through any contracts held with the CCG(s).

Going forward, the workstream taking forward the recommendations of the HSR will be known as the Hospital Services programme (subject to agreement from our Citizen’s Panel and other public stakeholders that this phrase is easily understood).

The governance will continue to recognise the need to involve all trusts and CCGs, and other core stakeholders, and the need for strong leadership. All relevant organisations should continue to be equitably and appropriately represented in the governance of the programme.

The governance will be formally laid out in, and signed off as a part of the Terms of Reference for the sustainability of acute services work going forward. However in summary we propose the following arrangements.

### Programme Governance:

- **A Hospital Services Steering Group.** Stakeholder organisations agreed (in the Joint Committee of Clinical Commissioning Groups (JCCCG) and Collaborative Partnership Board) that we should maintain and expand the HSR Steering Group. The Steering Group will be a dedicated clinical and operational group at executive level, which will oversee the

development of the hospital services work and be accountable for delivery of the work programme within organisations. It will play a key role in the evolution of Review process, including the development of reconfiguration options and robust evaluation and appraisal frameworks.

The Steering Group (SG) is likely to bring together Medical Directors and operations executives from acute trusts, CCG Accountable Officers, senior leads from the community and mental health trusts and the Yorkshire Ambulance Service, and NHS England.

Moving forward, it is proposed that there should be designated sub-committees under the SG, such as a strategic travel group and a data and modelling group. Respondents were keen to ensure that they were represented on these groups and the membership of these groups will be confirmed in the Terms of Reference.

- **Clinical Working Groups (CWGs)** will bring together clinicians, nurses, and operations directors, and other healthcare professionals from the acute trusts, to advise on the development and evaluation of any proposals. Community and mental health services, primary care and commissioning representatives will also sit on CWGs to ensure the perspectives of the different clinical sectors are heard.
- **The Collaborative Partnership Board (CPB)** will have formal oversight of the programme for the ICS.

#### **Statutory and Delegated powers:**

- **The Boards and Governing Bodies of the trusts and CCGs** will be responsible for formal sign-off of proposals, since at this point they are the organisations which are statutorily accountable. These groups include Non-Executive Directors.

Ultimately, statutory powers around decision making on service change rest with the CCGs, who will sign off and lead any consultation on service change.

- **The Joint Committee of Clinical Commissioning Groups (JCCCG), Committees in Common (CIC) for the acute trusts, and the ICS Executive Steering Group** do not currently have any formal delegated powers around this workstream but will continue to oversee and advise on direction.

However, as part of work to develop the Integrated Care System, we are seeking to develop the governance of the system, within the existing statutory framework. The arrangements above may therefore evolve during the course of the programme if any changes are agreed to the delegated powers of the JCCCG and CIC.

#### **External scrutiny:**

- **The Joint Health Oversight and Scrutiny Committee (JHOSC)** will continue to exercise its formal powers of scrutiny. Further governance arrangements involving Local Authorities may evolve.
- **NHS England:** The programme is committed to adhering to formal NHS England Gateway processes, and will undertake these in a managed and scheduled way. There will continue to be NHS England representation at SG. The ICS will also submit developing proposals to the Northern England Clinical Senate for feedback on emerging proposals at the appropriate time.

## 8 TIMELINE FOR DELIVERY

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The following section lays out the timeline for delivery of the work programme above, as well as the proposed arrangements for public engagement and governance.

### 8.1 HIGH LEVEL TIMELINE

The next phase of work, including the development and evaluation of site-specific options, will commence in earnest in October. Engagement with staff, patients and the public will be ongoing throughout the timeframe of the review, with plans aiming to launch a formal consultation on detailed, developed options in the early autumn of 2019 (if required).

Both Trust Boards and CCG Governing Bodies flagged the timeline of the next stage of work as something on which they would like further assurance. Organisations emphasised that decisions on change need to be made and delivered with enough pace to not prolong uncertainty for staff, while allowing sufficient time to fully consider the implications for staff, patients, and the public.

#### 8.1.1 Agreed way forward

The timeline for delivery will be partly dependent on external factors, over which the health system has limited control. However, the intention is that we should follow the following timeline for reconfiguration work:

- September 2018: SOC discussed in public session at Trust Boards and CCG Governing Bodies. Governing Bodies sign off SOC under their statutory responsibilities for service change
- October 2018: Sign-off SOC at the Collaborative Partnership Board
- October – February 2018: prepare and model site-specific options; engagement with Clinical Senate and JHOSC, and ongoing public engagement
- February – October 2019: agree preferred option(s) for the pre consultation business case, if required, with public engagement; NHSE assurance process; engagement with JHOSC; draft PCBC;
- October 2019 – January 2020: public consultation on options, if required
- December 2020 onwards: Develop a Decision Making Business Case if required

Shared working plans for the establishment of Hosted Networks will be advanced alongside reconfiguration works, with a proposed timetable as follows:

- September – October 2018: Set up a programme to design and oversee implementation; agree the framework for a Level 1 network, its priorities and scope
- November – December 2018: Agree principles of engagement; appoint leads / hosts for the networks
- December 2018 – January 2019: Agree detailed requirements (including SLAs) of the leads / host
- February – March 2019: Design accountability framework; design governance and contractual arrangements
- 1<sup>st</sup> April 2019: Launch Hosted Networks

Alongside these streams of work there will be a parallel stream on transformation to develop new ways of working across the system, in conjunction with Health Education England, various groups of healthcare professionals, patients and the public.

An indicative timetable laying out the key milestones for the programme is detailed below.

Workstream	Activity	2018												2019				
		Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	
Governance																		
Strategic Outline Case	Drafting & Feedback																	
	Sign-Off Engagement																	
Shared Working																		
Hosted Networks	Define																	
	Develop & Set Up																	
	Launch HNs																	
Health & Care Institute	Review, Refine, Iterate																	
	Define, Develop, Set Up																	
	Define, Develop, Set Up																	
Transformation																		
Develop New Workforce Models	Define, Develop																	
	Iterate																	
Reconfiguration																		
Evaluation Criteria	Socialise																	
	Refresh Engagement																	
Options Development	Approach																	
	Longlist																	
	Shortlist																	
	Preferred Option Engagement																	
Transport and Travel	TAG Set-up																	
	Data Collection & Modelling																	
	Analysis & Assessment																	
	Engagement																	
Reconfiguration Modelling	Specification																	
	Build																	
	Employ																	
Out-of-Hospital Strategy																		
PCBC Drafting	Draft																	
	Sign-off																	
Equalities Impact Assessment																		
External Assurance	Clinical Senate																	
	NHS England																	
	Finalise																	

## 9 GLOSSARY

Term	Definition
<b>A</b>	
A&E	An accident and emergency department provides acute care for patients who arrive without prior appointment either by their own means or by ambulance and who have medical or surgical conditions that are likely to need hospital admission. They are typically open 24 hours a day, seven days a week.
Acute Care	Urgent short-term treatment - usually in a hospital - for patients with a new injury or illness or for patients with an existing condition that is worsening.
Acute Stroke Unit (ASU)	An acute neurological ward providing specialist services for people who have had a stroke. Patients are cared for in an intensive model of care with continuous monitoring and high nurse staffing levels. Typical length of stay may be up to 7 days. Patients are typically admitted to a Hyper-Acute Stroke Unit (HASU) for immediate emergency treatment before transfer for an ASU for ongoing care.
Acute Trust	NHS acute trusts manage hospitals. Some are regional or national centres for specialisms. Others are attached to universities and help to train clinicians. Some may also provide community services.
Advanced clinical practitioner (ACP)	An experienced, registered health and care practitioner with a Master's level award or equivalent that encompasses the four pillars of clinical practice, leadership and management, education and research, with demonstration of core capabilities and area specific clinical competence. ACPs undertake a level of practice characterised by a high degree of autonomy and complex decision making. Specific roles include Advanced Nurse Practitioner (ANP) and Advanced Therapy Practitioner (ATP). Delegating responsibilities to these roles reduces the burden on other clinicians.
Alternative workforce	This general term refers to roles for healthcare professionals that are 'non-traditional' and generally support or augment the work done by clinicians such as doctors and nurses. It encompasses Physician Associates, advanced clinical practitioners and support roles.
Antenatal Care	Care of women during pregnancy up to their going into labour by various healthcare professionals to ensure that mother and baby are as healthy as possible during pregnancy. This care also includes education, advice and support to make sure the mother is ready for labour.
<b>C</b>	
Care outside hospital	Care that takes place in a community setting. This could be a patient's home or community health centre.
Clinical Commissioning Groups (CCGs)	These are the health commissioning organisations that replaced primary care trusts (PCTs) in April 2013. CCGs are led by GPs and represent a group of GP practices in a certain area. They are responsible for purchasing healthcare services in both community and hospital settings.

Clinical governance	A framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.
Clinical interdependencies	Where some clinical services need other clinical services to be based on the same site for particular types of care to be successfully and safely delivered.
Clinical pathway	A clinical pathway is a template or blueprint for a plan of care for a specific speciality or condition. It is a guide to best practice treatment patterns, but does not replace the need for clinical judgement in meeting an individual's needs.
Clinical protocol	The detailed outline of the steps to be followed in the treatment of a patient with a particular condition.
Clinical Reference Group (CRG)	A group of clinicians and healthcare professionals convened to agree on and develop a specific clinical process, protocol or standard. The group is typically governed by a Terms of Reference and is part of a wider framework such as a Hosted Network.
Clinical Working Group (CWG)	A group comprised of clinicians, nurses, allied health professionals and other healthcare professionals from a specific service in the scope of the HSR. The primary purpose of the CWGs was to bring together members of staff from across SYB(MYND) to discuss service challenges, best practice and potential solutions, as well as to provide input and feedback into the review process.
Committees in Common (CiC)	A sub-committee of multiple committees with an agreed level of delegated decision-making rights on behalf of each committee. There must be clear terms of reference and reporting lines back to each committee.
Community Midwifery-led Unit / Birth Centre	A form of standalone midwifery-led unit providing prenatal, midwifery and postnatal services to predominantly low-risk mothers (see SMLU).
Community services	A wide range of non-emergency services provided closer to home at community facilities including local health centres and GP practices. Some may be provided by social care services.
Consultant-led obstetrics units	An obstetric unit with consultant presence, providing maternity and obstetric care to mothers, with the capacity to deal with a broader range of complications and conditions than a midwifery-led unit.
<b>D</b>	
District General Hospital (DGH)	Typically, the major healthcare facility in its locality with services that may include maternity, ED, acute medicine, surgery and a range of outpatient care. It may also provide some specialist facilities for care such as specialist surgery but does not cover all specialist services.
<b>E</b>	
Early supported discharge (ESD)	An intervention for adults after a stroke that allows their care to be transferred from an inpatient environment to a community setting. It enables people to continue their rehabilitation therapy at home, with the same intensity and expertise that they would receive in hospital.

Elective care	Treatment that is planned in advance because it does not involve a medical emergency.
Emergency care	Treatment for acute medical and surgical emergencies that may need admission to hospital. This includes severe pneumonia, diabetic coma, bleeding from the gut, complicated fractures that need surgery, and other serious illnesses.
Emergency Department	An acute hospital department responsible for the delivery of emergency medicine and care, providing treatment to patients arriving at hospital with an immediate care requirement. Accident and Emergency is a form of ED.
Engagement	The measurable degree of a stakeholder or patient's positive or negative involvement with the NHS, which influences their willingness to take part in NHS issues. In the context of the HSR, it refers to the involvement of different stakeholders to gather views, feedback and recommendations.
Evaluation criteria	A series of questions and factors to test options against to determine whether they are suitable and optimal for their intended purpose. Evaluation criteria have been agreed and used in the HSR to test service reconfiguration options.
<b>F</b>	
Facing the Future	<i>Facing the Future: Standards for children with ongoing health needs</i> <sup>3</sup> are a set of standards that focus on ensuring prompt and correct diagnosis, improving the long-term care and management of children in healthcare services. These standards were developed jointly by the Royal Colleges for Paediatrics and Child Health, General Practitioners, Nursing, Physicians and Psychiatrists.
Flexible working	The ability for clinicians and other healthcare professionals to work across multiple sites in networked system of care.
Foundation Trusts	NHS foundation trusts (FTs) are NHS organisations that run acute, community or mental health hospitals. They differ from non-foundation trusts in that they have greater financial autonomy and therefore more freedom to decide their own plans and the way local services are run. Foundation trusts have members and a council of governors.
Function	In the context of the HSR, 'function' refers to specific operational and management processes and is used as a generic term. It does not refer to statutory functions of NHS bodies (such as commissioners) unless explicitly stated.
<b>H</b>	
Hospital Services Review (HSR)	The programme to review the shape and nature of acute hospital services across SYB(MYND), culminating in this report. The HSR was commissioned by SYB commissioners on behalf of the partners in the SYB STP.
Hosted Network	A clinical network between acute trusts where a host trust provides leadership and coordination to support a system-wide approach to: workforce deployment and development; the adoption of standardised clinical guidelines; and the spread and adoption of innovation and best practice.

<sup>3</sup> Facing the Future, Royal College of Paediatric and Child Health, available online at <https://www.rcpch.ac.uk/sites/default/files/page/Facing%20the%20Future%20Together%20for%20Child%20Health%20final%20web%20version.pdf>

Hub	A setting for care outside hospital where patients are brought together for treatment also serving as a base for local healthcare teams. The services offered will vary depending on local needs and will range from bases for multidisciplinary teams to 'one-stop' centres for GP services, diagnostic and outpatient appointments.
Hyper Acute Stroke Unit (HASU)	Hospital wards that specialise in treating people who have had a stroke. A dedicated unit that gives all stroke patients access to the most up-to-date treatments and latest research breakthroughs during the first 72 hours after a stroke: swift action can reduce levels of disability and, in some cases, may even eradicate symptoms completely. Patients will typically be transported to a Hyper Acute Stroke Unit for initial emergency treatment before later being transferred to an ASU for ongoing care and therapy.
<b>I</b>	
Integrated Care System (ICS)	A partnership of NHS organisations, including providers and commissioners that collaborate to provide healthcare in a region in a close and coordinated manner. Member organisations take collective responsibility for managing resources, delivering NHS standards and improving the health of the population they serve.
<b>J</b>	
Joint Committee of Clinical Commissioning Groups (JCCCG)	A collective committee made up of representation from clinical commissioning groups (CCGs) in SYB.
<b>L</b>	
Lead / prime provider	A trust within a Hosted Network from which services are commissioned, which then sub-contracts service delivery to other trusts within the network. The lead / prime provider holds other providers to account for outcomes and for adoption of clinical protocols and pathways.
<b>M</b>	
Midwifery	The profession which leads on normal pregnancy and birth and provides expert care to mother and baby during pregnancy, childbirth and the postnatal period within a family centred environment.
Midwifery Led Units	Units run by midwives that can either be run alongside a main hospital maternity unit (AMLU) or completely standalone from hospital (SMLU). MLUs are ideal for handling births with no complications. Women facing complications may be advised to give birth at a consultant-led maternity unit.
<b>N</b>	
Neonatal Unit	A unit of a hospital that provides care and treatment of new-born babies who are too sick to be cared for by their mothers.
Networked services	The coordinated provision of care within a particular specialty across a number of providers or sites in a region. Different elements of care may be provided at different sites, requiring patient transfer to the appropriate care location.

Nurse Practitioner	An Advanced Practice Registered Nurse who has completed graduate-level education (either a Master of Nursing or Doctor of Nursing Practice degree). Nurse Practitioners treat both physical and mental conditions independently including prescription of select medications.
<b>O</b>	
Obstetrics	The medical speciality dealing with the care of pregnant women and their babies during pregnancy, childbirth and the postnatal period.
<b>P</b>	
Pairing	Two trusts working closely together to deliver an agreed set of joint functions. This may include coordination of staff and resources across the two sites, supported by appropriate contractual arrangements.
Physician Associate (PA)	Physician associates are medically trained, generalist healthcare professionals, who work alongside doctors and provide medical care as an integral part of the multidisciplinary team. Physician Associates work with a dedicated medical supervisor, but are able to work autonomously with appropriate support.
Place	The term used in the SYB STP plan for the main areas and their healthcare organisations that make up the SYB footprint. These are Barnsley, Bassetlaw, Doncaster, Rotherham and Sheffield. They encompass health and social care providers, in acute and community settings, as well as commissioners, local authorities and other key stakeholders in an area based around key population centres.
Place Plans	Statements that set out the vision, ambitions and proposed direction of travel for the design and delivery of health and care services in a Place. These plans are generally produced by commissioners of health and care services, usually in cooperation with service providers.
Primary care	Primary care services provide a first point of contact in the healthcare system for many patients, acting as the 'front door' of the NHS. Primary care includes general practice, community pharmacy, dental, and optometry (eye health) services. Patients may be treated in this setting or referred for onward treatment in a different setting (such as secondary or tertiary care).
<b>R</b>	
Reconfiguration	The rearrangement of the location and type of clinical service provided across a given area. It may include transferring the provision of different service components between acute providers, as well as transfer of some care to alternate settings such as the community.
Referral	The process whereby a patient is transferred from one professional to another, usually for specialist advice and/or treatment.
Rotations	The formalised process of organising for staff to work across multiple sites or services in a routine way. It may be used to facilitate provision of services in multiple locations or to support staff development and training.

Royal Colleges	The Royal Colleges are professional organisations for doctors, nurses and allied health professionals. In general, they have a vision of improving, maintaining and promoting standards of care within the specialist area which they cover. They work jointly to develop policy on some issues and work closely with other organisations and associations that have similar objectives. They promote education and research in their respective fields.
<b>S</b>	
Secondary care	Specialist healthcare usually provided in hospital after a referral from a GP or other health professional.
Seldom heard groups	‘Seldom heard’ is a term used to describe groups who may experience barriers to accessing services or are under-represented in healthcare decision making. Traditionally, some of the groups identified in engagement activities include rural communities, black and minority ethnic (BME) groups, gypsies and travellers, lesbian, gay, bisexual and transgender, asylum seekers and refugees and young carers. However, teenagers, employees, people with mental health issues and many others may also be considered as seldom heard, since they may not find it easy to engage with traditional methods of public engagement.
Sentinel Stroke National Audit Programme (SSNAP)	The Sentinel Stroke National Audit Programme (SSNAP) aims to improve the quality of stroke care by measuring both the structure and processes of stroke care against evidence based standards. These standards are informed by the National Clinical Guideline for Stroke, and national and local benchmarks.
Short Stay Paediatric Assessment Unit (SSPAU)	A facility within which children with acute illnesses, injuries or other urgent referrals (from GPs, community nursing teams, walk-in centres, NHS Direct and emergency departments) can be assessed, investigated, observed for a short period of time and treated without recourse to in-patient areas. May be co-located with ED.
Single service model	A network where care is delivered directly by the lead trusts and responsibility for patient care and clinical governance rests with that lead trust. Staff and resources are paid for and managed directly by the lead trust and activity is commissioned directly from the lead trust.
South Yorkshire and Bassetlaw (SYB)	SYB refers to the more specific region within SYB(MYND) that covers acute trusts which will be members of the SYB shadow Integrated Care System, as well as the footprint of SYB Sustainability and Transformation Plan.
South Yorkshire and Bassetlaw and North Derbyshire (SYB(ND))	SYB(ND) refers to the area within scope of this review (see SYB(MYND)), excluding Mid Yorkshire. It may be used to refer to recommendations on reconfiguration of services, in which Mid Yorkshire Hospitals NHS Trust is not included.
South Yorkshire and Bassetlaw Integrated Care System (SYB ICS)	SYB is one of the first and largest Integrated Care Systems. An ICS brings partner organisations closer together, taking further responsibility for finances in return for greater flexibility in delivering NHS services. ICSs are in shadow form and due to go into operation at the beginning of 2018/19 financial year. The shadow period refers to the period before the full operation of the ICS, during which the system will develop and gradually implement the governance, structural and financial arrangements required to ‘go live’ as an integrated care system.

South Yorkshire and Bassetlaw, Mid Yorkshire and North Derbyshire (SYB(MYND))	SYB(MYND) refers to the area serviced by acute trusts within the scope of this review. There are seven acute trusts in SYB(MYND): Barnsley Hospital NHS Foundation Trust, Doncaster and Bassetlaw Hospitals NHS Foundation Trust, Rotherham NHS Foundation Trust, Sheffield Children's NHS Foundation Trust, Sheffield Teaching Hospitals NHS Foundation Trust, Chesterfield Royal Hospital NHS Foundation Trust, and Mid Yorkshire Hospitals NHS Trust.
Standalone Midwifery Led Units (SMLU)	Maternity units that are led and staffed by midwives without consultant presence, in a setting that is unattached to a hospital. They generally provide prenatal, midwifery and postnatal care to lower risk mothers. They may be in community settings and are sometimes called Community Birth Hubs or Centres.
Sustainability and Transformation Plan (STP)	Five-year plans covering all aspects of NHS spending within a given geographical footprint. STPs have a broad scope in planning healthcare, including: improving quality and developing new models of care; improving health and wellbeing; and improving efficiency of services. STPs are developed by Sustainability and Transformation Partnerships, made up of NHS organisations and local councils. The SYB STP has now become an Integrated Care System (see ICS).
<b>T</b>	
Tertiary care	Highly specialised treatment such as neurosurgery, transplants and secure forensic mental health services.
<b>U</b>	
Unwarranted clinical variation	Variation that cannot be explained by the condition or the preference of the patient; it is variation that can only be explained by differences in health system performance
Urgent Treatment Centre (UTC)	Urgent care centres designed as an alternative to ED departments for patients with less severe, non-emergency conditions. Often co-located with EDs with patients triaged and streamed at the front door, and equipped to diagnose and deal with many of the most common patient conditions. May also be standalone at sites without an ED.
<b>W</b>	
Whole-time equivalent (WTE)	Whole-time equivalent is a unit that indicates the workload of an employed person (or student) in a way that makes workloads or class loads comparable across various contexts. For medical staff, it generally refers to 10 programmable activities per week of resource.