

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

Strategic Outline Case Annex B:

Case for Change

This annex provides an outline of the Case for Change using performance metrics from the most recently available data, an update of the original analysis performed by the Hospital Services Review. A more detailed review of the Case for Change can be found in the Hospital Services Review Stage 1B report:

https://www.healthandcaretogethersyb.co.uk/application/files/9615/1809/8702/Hospital_Services_Review_1b_report.pdf

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1 CHALLENGES WITH WHOLE-SYSTEM PERFORMANCE

1.1 PERFORMANCE AGAINST NATIONAL STANDARDS

Since the HSR's initial assessment of performance, there continues to be variation in performance in some trusts.

1.1.1 A&E Performance

The national standard requires 95 per cent of patients who attend Type 1 A&E to be discharged, admitted or transferred within four hours of arrival.

In line with national trends, the hospitals in SYBMYND have struggled to meet this target for some time, with many not having achieved this target since Q2 2015/16. The graph below shows declining performance against this target across the trusts since 2015/16¹.

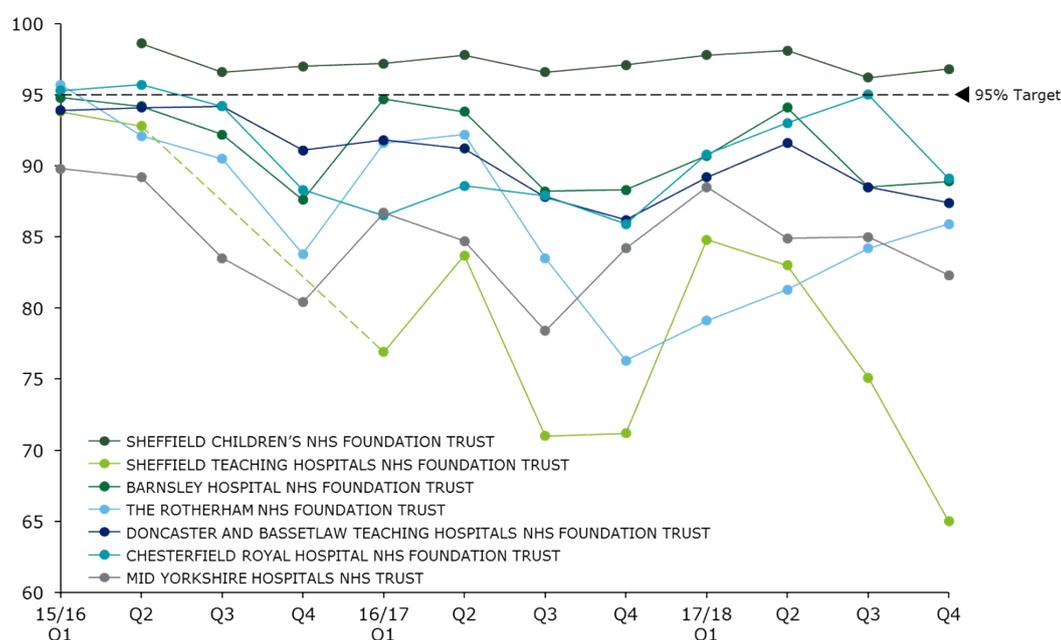


Figure 1: Per cent of Type 1 A&E attendances admitted, discharged or transferred within four hours of arrival, by trust

1.1.2 18 Week Consultant-Led Referral to Treatment Target

The NHS Constitution states that patients should wait no longer than 18 weeks from GP referral to treatment for consultant-led services. The national standard is for at least 92 per cent of patients to be seen within this time frame. As with A&E performance, hospitals across the country have been struggling to meet this.

Performance against this metric varies across the SYBMYND trusts, from 85.1 per cent in Q4 2017/18 at Mid-Yorkshire Hospitals NHS Trust to 94.8 per cent at Sheffield Teaching Hospitals NHS FT. The below chart shows this².

¹ NHS Statistics, A&E attendances and emergency admissions, 2015/16 – 2017/18

² NHS Statistics, Consultant-led referral to treatment (RTT) waiting times, 2015/16 – 2017/18

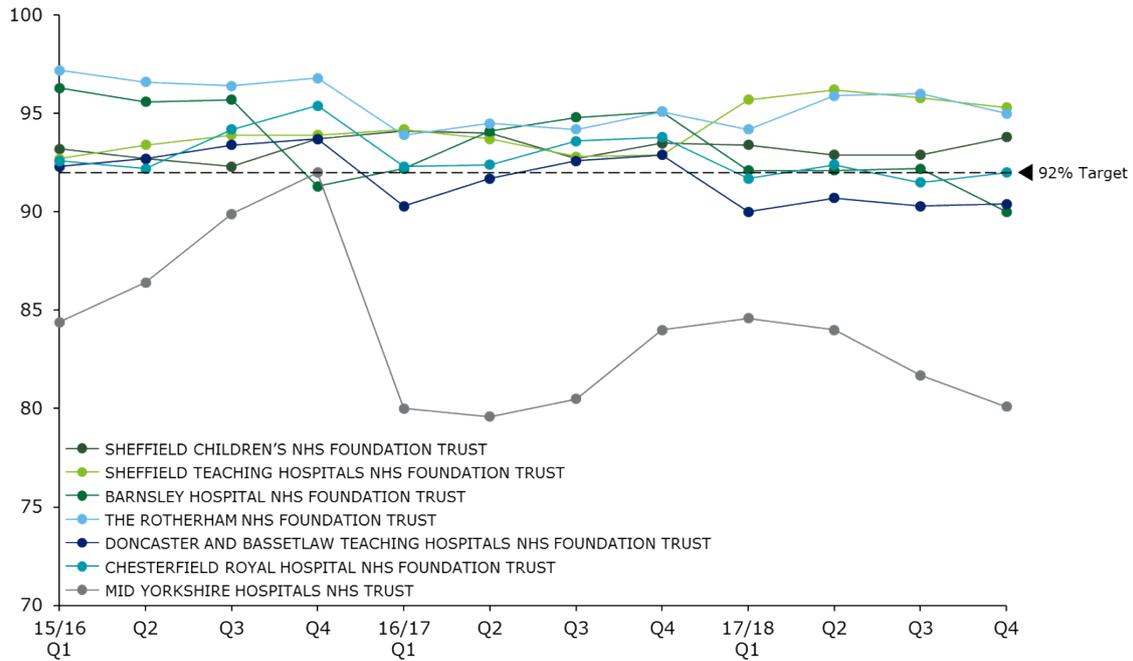


Figure 2: Per cent of referral to consultant-led treatment waiting times for incomplete pathways within 18 weeks, by trust

1.1.3 Cancer 62-Day Wait Target

NHS guidelines stipulate a target of at least 85 per cent of patients waiting no longer than two months (62 days) from GP urgent referral to first definitive treatment for cancer.

Performance in SYBMYND against this target again is varied, ranging from 78.8 per cent at Sheffield Teaching Hospitals NHS FT to 90.5 per cent at Barnsley Hospital NHS FT³.

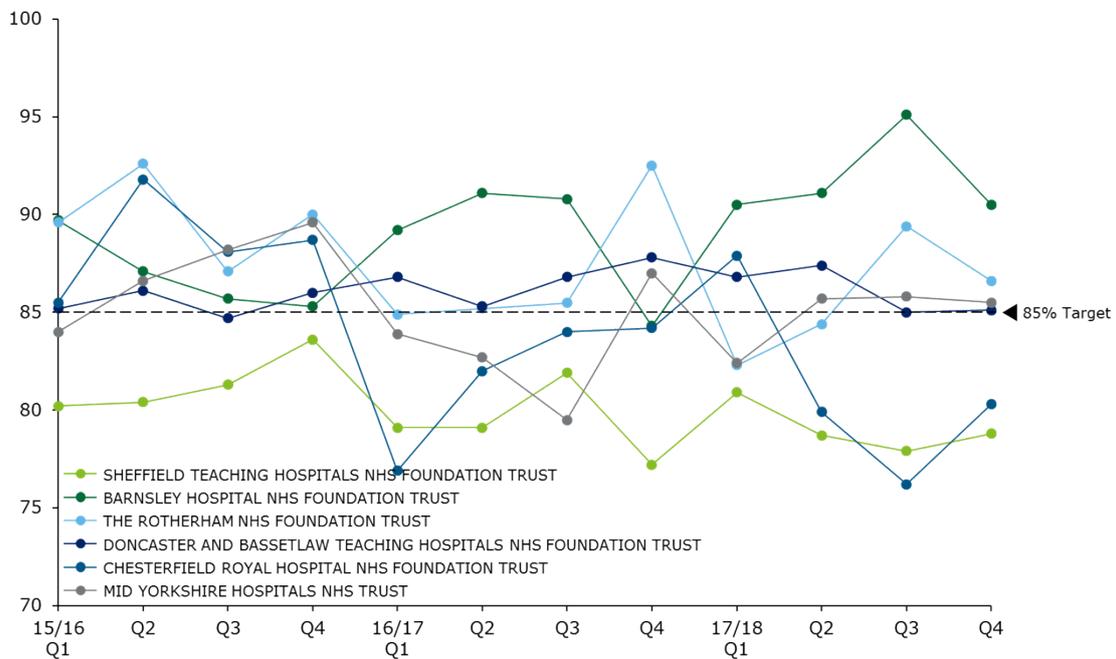


Figure 3: Per cent of patients who start cancer treatment within 62 days following urgent GP referral, by trust

³ NHS Statistics, Cancer waiting times, 2015/16 – 2017/18

1.2 CQC FEEDBACK

Several clinical services across the SYBMYND trusts are now less resilient to pressures. Shortages in key workforce are undermining the ability to provide consistently high quality care in every hospital.

The Care Quality Commission observed this in their latest inspections, and their findings for each service area and trust are summarised below⁴. The Care Quality Commission reports looks at each core service area within a hospital and provides a summary of its current position against 5 criteria, judging whether a service is safe, effective, caring, responsive and well-led. The scores from these 5 criteria produce a score per service, and the scores per service feed into an overall hospital score.

Three of the seven trusts in the SYBMYND footprint are rated overall as Requires Improvement. This is an improvement upon the previous position with Barnsley Hospital NHS FT having been reclassified as Good in March 2018. Within these trusts, seven out of 13 individual hospital sites are also classified as Required Improvement. With regards to the HSR core services, several sites are flagged as Requires Improvement in their urgent and emergency care, as well as maternity and gynaecology.

⁴ Care Quality Commission

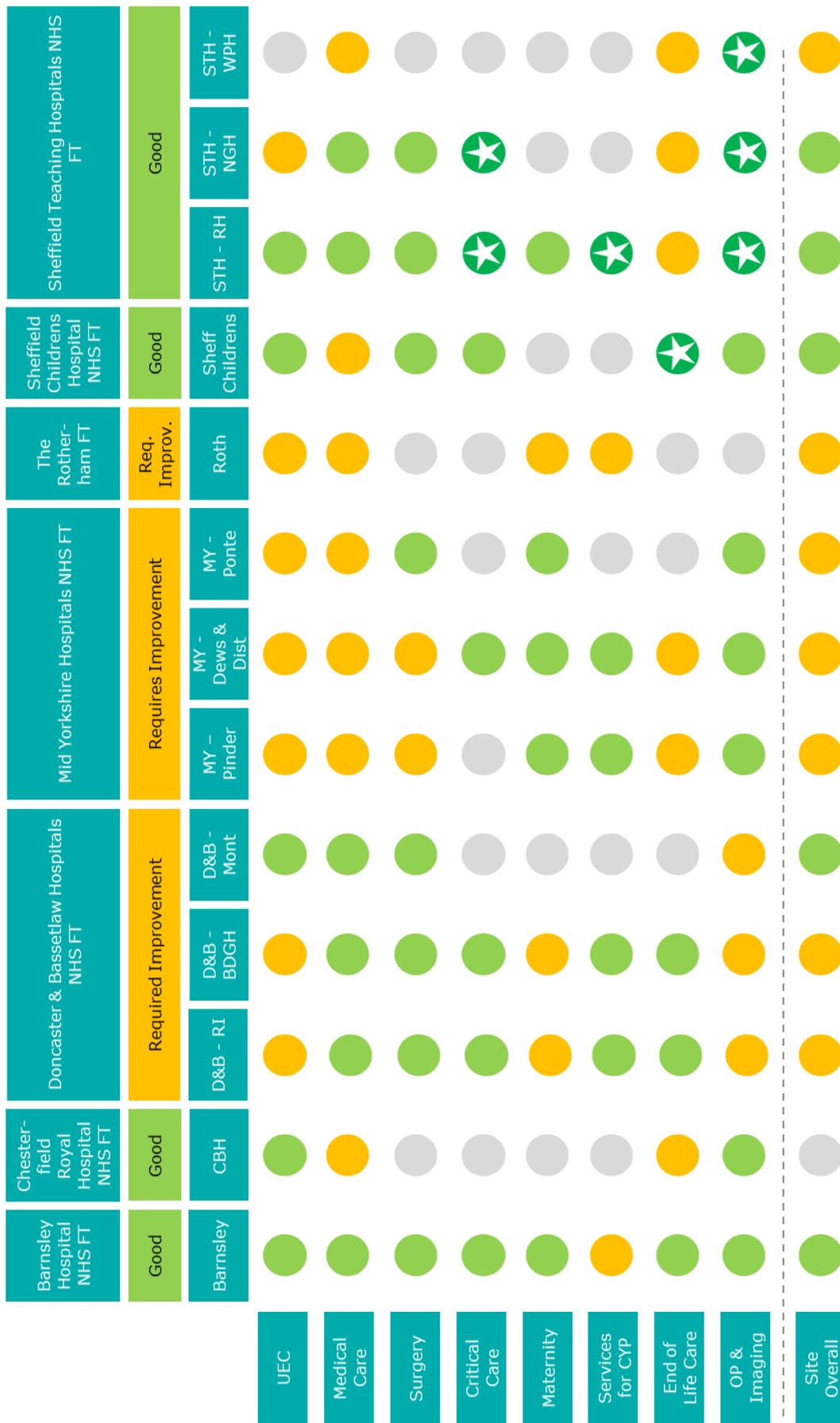


Figure 4: CQC rating by site, service area and trust

2 ANALYSING THE 5 CORE SERVICES

The Hospital Services Review focused on five core specialties, following a prioritisation exercise with the system. These services are:

- Urgent and Emergency Care
- Acute Paediatrics (Care of the Acutely Ill Child)
- Maternity
- Stroke
- Gastroenterology and Endoscopy

Five Clinical Working Groups, one for each of the core services, were convened and invited to take part in a series of workshops to identify the challenges in their service and ideate potential solutions:

- Workshop 1 asked attendees to identify the main challenges facing their respective services;
- Workshop 2 asked attendees to identify possible solutions to the challenges;
- Workshop 3 asked attendees to reflect on whether the solutions suggested so far would meet the scale of the challenge; and if not, to consider more radical options;
- Workshop 4 brought together all the 5 CWGs in a shared session. The HSR team fed back the options which they had developed using the input from workshops 1-3. They shared an early draft of the recommendations for the HSR, with attendees being asked to comment on the proposed recommendations for their service;
- Workshop 5 was a short session shortly before the publication of the independent report, to give the CWGs early sight of the likely recommendations in the final Report.

Summary notes of workshops 1-4 were produced, capturing the key points, and were shared with staff in trusts. Members of the CWGs were asked to lead discussions on the key points that had emerged from the workshops, and to relay these views back to the CWGs at the beginning of the next meeting.

Many of the key themes emerging from discussions were common across all of the CWGs. Themes which were mentioned in most or all of the groups included workforce, innovation and clinical variation. These three themes were selected as being three of the most frequently mentioned themes, and ones which the HSR was likely to be able to address.

Other issues were raised during the sessions and these are outlined in the notes of the meetings published online (available via the links in section **Error! Reference source not found.**) Some of these, such as the increasing complexity and acuity of patients, were identified as very important across multiple specialties but were excluded from the HSR because they were outside the direct ability of the HSR to address them.

2.1 WORKFORCE CHALLENGES

Workforce was the issue most frequently mentioned across all five of the Clinical Working Groups.

Specific issues that were mentioned included:

- **Difficulties with recruiting staff:** A number of different causes were cited, including national shortages; a failure to capitalise on those strengths that SYB does have in attracting applicants (such as the brand value of Sheffield Children's Hospital); for nurses, the end of

the nursing bursary; for junior doctors, the requirement for junior doctors to apply to the wider Yorkshire and the Humber region which was thought to put applicants off. There were also specific issues that were believed to make particular services unattractive, such as the physically hard nature of stroke nursing, or the high pressure and long hours in A&E units.

- **Difficulties with retaining staff:** Causes identified included workloads, particularly in units which were heavily understaffed; working conditions (e.g. lack of car parking); limited access to flexible working or planned rotas. Clinicians flagged that attrition rates amongst junior doctors can be particularly high, as high as 40 per cent for specialist trainees in obstetrics.
- **Retirement:** Upcoming retirement of large numbers of staff was flagged as a future challenge in particular areas of the workforce. Over 30 per cent of midwives are over 50, implying that over the coming decade a large number will retire, leaving significant gaps in the workforce should recruitment not be increased.
- **Training and development:** There was perceived to be significant variation in the breadth and scope of training received at different sites in SYB, leading to a variation in the relative attractiveness of each site as a workplace. Smaller DGHs are perceived to offer a less varied case mix of patients, limiting the exposure to complex cases; they also tend to offer fewer opportunities to participate in research.
- **Competition for workforce between sites:** Variation in staff contracting arrangements between sites was reported, for example around pay and benefits, affecting the relative attractiveness of trusts as a workplace. This, compounded by an overall shortage of specialists in the system, was perceived to have led to competition for the same workforce between trusts, leading to escalating costs and grade inflation to attract talent. Such issues were reported both for substantive and locum positions. Competition between public and private sector organisations was also reported as an issue.

These difficulties were reported as affecting the majority of the grades, in most of the specialties, although the CWGs did identify a few professional groups, such as obstetricians, which were under less pressure.

Following the CWGs, the HSR team undertook more detailed modelling of current and projected staff availability, and found that in general the empirical evidence supported the self-reported staffing issues.

The two tables below summarise the workforce challenge insights garnered from the engagement with CWGs and workforce data analysis. Note, due to data limitations, not all staffing groups and services were modelled.

Table 1: CWG observations on current and projected staff availability by service and staff type

	Nurses	Mid Grades / Junior Doctors	Consultants	Allied Health Professionals
UEC	Nursing staff shortage recognised, particularly following changes to nurse bursaries	Significant gaps in CT4 doctors and above, in particular specialist registrars given high number required	Shortage in senior decision makers	Shortage in consultant psychiatrists flagged
Paediatrics	Considerable gaps in nursing workforce, due to discontinuation of nursing bursary and limited development opportunities	Middle and junior-grade doctors in particularly short supply, thought partly to be due to perceptions of the specialty	Consultant posts mostly filled but locum spend high. Many qualified consultants work as locums.	Variation in use of alternative workforce, such as Advanced Neonatal Nurse Practitioners, reported
Maternity	Midwifery and nursing gaps variable across trusts	All trusts have middle-grade gaps, with the problem recognised nationally, leading to high locum spend	Consultant posts mostly filled but upcoming retirements and lack of succession planning seen as an issue	Shortages in neonatology nurses and sonographers flagged
Stroke	High nurse turnover and vacancy rate reported, given demanding nature of stroke care	Lack of consultants had knock on effect on mid-grades	Shortage in specialist consultants. Trusts not able to fill all their posts even with locums	No problem recruiting therapists but budget too low to pay for sufficient numbers
Gastroenterology and endoscopy	Nursing shortage, along with consultants, considered to be significantly challenging	Not enough trainees in post to meet service demand	Consultant gaps flagged as particular issue, especially for out of hours and weekend rotas, considered to be at "breaking point"	Issues with supply of radiologists, with a 50% shortage nationally

Table 2: Insights from quantitative modelling on current and projected workforce availability relative to forecast requirements by service and staff type.

	Nurses	Mid Grades / Junior Doctors	Consultants
UEC	N/A	124 middle grade WTEs currently; 119 WTEs forecast in 2021/2022 64 WTEs required to meet guidelines in 2021/22	60 consultant WTEs now; 70 forecast in 2021/2022 Gap of 5 FTEs for 2021/22
Paediatrics	N/A	3% decrease in available middle grade WTE complement in 2021/22	47 consultant WTEs currently; 53 forecast in 2021/2022 10 WTEs required to meet guidelines
Maternity	552 nurses at present across SYB(ND) 150 Band 5 and 6 midwives required to meet Royal College guidelines	4% decrease in available middle grade WTE complement in 2021/22	69 WTEs currently; 72 WTEs forecast in 21/22 Sufficient to staff current 60 hour units, but shortfall if increase to 98 hour cover

2.2 CLINICAL VARIATION

The Clinical Working Groups also raised concerns around clinical variation. This manifested itself in a number of different ways:

- **Variation in transfer protocols:** CWGs raised concerns around the variation in transfer protocols, with no consistent, unified approach taken by trusts. There was a concern about lack of communication between trusts, which often led to lengthy waits for patients being transferred, with staff having to negotiate with receiving trusts on behalf of their patients. Clinicians expressed a desire for clear “rules of engagement” to align behaviours regarding patient transfers.
- **Variation in clinical protocols:** The adoption of different standards and clinical protocols at different trusts, and different approaches to implementing national guidance, has led to different patients receiving different care at different hospitals for the same condition. Each CWG flagged multiple conditions and pathways for which treatment protocols varied between trusts and Places. Variation in approaches taken also impedes the flexible working of staff across sites, given often significant differences in ways of working.
- **Variation in commissioning specifications:** Clinicians raised concerns around certain conditions for which the commissioning specifications varied significantly. For example post-acute rehabilitation services packages ranged from 3 to 12 months across SYBMYND. Available of pre- and post-natal support for mothers was also reported as being subject to variation across the region. This reinforced perceptions of a “postcode lottery” for certain services across the different Places in SYB.
- **Variation in equipment:** CWG attendees flagged the variation in medical devices and equipment found at different sites. For example, variation in endoscopy equipment between trusts limits clinicians’ ability to work across multiple sites with ease, as additional training is required for them to operate the different equipment found on each site.

2.3 INNOVATION

A further theme was around innovation. Key points raised were:

- **Incompatible information technology:** CWGs raised concerns around the variation in electronic health record technologies. SystemOne, Rio, Lorenzo and Meditech are just some of the examples of software used across the region. In places there were different systems being used in different specialties in the same trust. Even where trusts were nominally on the same system, there was variation in the functionality and deployment of the same software packages. This amounts to barriers to the ease in patient record transfer and continuity of care, sometimes within the same hospital. Systems were also said to be different across secondary and primary care, again making shared working more difficult.
- **Outdated IT systems:** As well as systems not being interoperable between sites, clinicians flagged that many systems were outdated, slow to use and were not fit-for-purpose, requiring updating or replacing.
- **Slow adoption of new technologies across the region:** CWG attendees flagged that best practice and innovation was not always shared across the SYB trusts. Opportunities for improvement were identified where innovations in one trust could usefully have been rolled out across others in the system, sharing learning and advancements; but this was rarely the case.