Public Document Pack

To all Members of the

COMMISSIONING WORKING TOGETHER JOINT REGIONAL OVERVIEW AND SCRUTINY COMMITTEE

AGENDA

Notice is given that a Meeting of the above Committee is to be held as follows:

VENUE Oak House, Bramley, Rotherham, S66 1YY
DATE: Monday, 8th August, 2016
TIME: **3.30 pm**

Items for Discussion:

Issued on: 29th July, 2016

Senior Governance Services Officer for this meeting: Christine Rothwell
01302 735682

8. Draft Consultation Documents: - 61 - 70

- Providing hyper acute stroke services in South Yorkshire and Bassetlaw and North Derbyshire; and

- Providing Children's Surgery and Anaesthesia Services in South and Mid Yorkshire, Bassetlaw and North Derbyshire.

9. Dates and Times of Future Meetings.

Members of the Commissioning Working Together Joint Regional Overview and Scrutiny Committee

Chair for this Meeting - **Councillor Rachael Blake (DMBC)**

Councillor Sean Bambrick (Derbyshire County Council),
Councillor Jeff Ennis (Barnsley MBC),
Councillor Colleen Harwood (Nottinghamshire County Council),
Councillor Pat Midgley (Sheffield City Council),
Councillor Betty Rhodes (Wakefield MDC),
Councillor Stuart Sansome (Rotherham MBC).

Commissioners Working Together Joint Health Overview and Scrutiny Committee (JHOSC)

Monday 23 May 2016 (2.00pm)

Sheffield CCG Headquarters, 722 Prince of Wales Road, Sheffield, S9 4EU

Present	
Cllr Jeff Ennis (Barnsley MBC) (Chair)	Alice Nicholson (Sheffield CC)
Anna Morley (Barnsley MBC)	Andy Wood (Wakefield MDC)
Cllr Sean Bambrick (Derbyshire CC)	Phil Mettam (Bassetlaw CCG)
Jackie Wardle (Derbyshire CC)	Lesley Smith (Barnsley CCG)
Cllr Rachael Blake (Doncaster MBC)	Jackie Pederson (Doncaster CCG)
Christine Rothwell (Doncaster MBC)	Chris Edward (Rotherham CCG)
Cllr Colleen Harwood (Nottinghamshire CC)	Maddy Ruff (Sheffield CCG)
Martin Gately (Nottinghamshire CC)	Michele Ezro (Wakefield CCG)
Cllr Stuart Sansome (Rotherham MBC)	Helen Stevens (Working Together Programme)
Janet Spurling (Rotherham MBC)	Will Cleary-Gray (Working Together Programme)
Cllr Pat Midgley (Sheffield CC)	

1. Apologies for Absence

1.1 Apologies were received from Cllr Betty Rhodes (Wakefield MDC).

2. Declarations of Pecuniary and Non-Pecuniary Interest

2.1 There were no declarations of interest.

3. Minutes of the Previous Meeting

3.1 The minutes of the previous meeting held on 12th October 2015, were approved as a true and accurate record.

4. Committee Terms of Reference

4.1 Principles

- The committee agreed to an amendment of the first 'Principle', to remove 'considered as'.
- To add a third 'Principle' 'To ensure service configuration achieves better clinical outcomes and patient experience'.

4.2 Membership

Following discussion, it was agreed that quorum for the meeting should be reviewed in 2 meetings' time to decide whether to increase this from 3 to 4 members, to ensure an attendee is present from the South Yorkshire region.

5. Commissioners Working Together Programme Briefing

5.1 Will Cleary-Gray gave an update on the programme and explained that since the previous meeting the eight CCG's have been working together to work through the potential challenges of the geographical area involved. Today's meeting focuses on two service areas: Children's Surgery and Anaesthesia; and Hyper Acute Stroke Services. Work has already been done to engage communities and providers in relation to these

services and we are going to work up an options appraisal in relation to these services to be brought to the next meeting of this JHOSC.

5.2 Concerns were raised by committee members in relation to the consistency in decision making over geographical areas in relation to stroke services, as well as ensuring the location of centres are accessible to all within the critical first hour. The committee were advised that these concerns have been taking into consideration and we are looking to make sure that services can be accessed within a 45 minute time-frame. This work is also being carried out within the context of local Sustainability and Transformation Plans (STPs).

5.3 Other concerns were raised by Elected Members in relation to them being held accountable should these services not be effective, therefore they want to be for-warned of any problems through this committee so that they can report back to their Local Authorities as appropriate. The committee were informed that NHS representatives endorsed the comments on consistency in decision making and that principles in delivering these programmes comes from ensuring effective clinical outcomes and not making health inequalities worse.

5.4 The committee were referred to its previous meeting that there are a number of challenges services in our locality face, in particular in relation to the workforce. It was also highlighted that there is best practice which services are not currently meeting; therefore we need to get agreement on taking a different approach.

6. Pre-consultation Report for Children's Surgery and Anaesthesia and Hyper Acute Stroke Services

6.1 Helen Stevens gave an update to the committee on the consultation work which had taken place between January and April 2016 including liaising with patient user groups, developments in relation to websites and social media. Hundreds of people responded to the consultation which included representatives from a variety of communities. The attached report outlines the key themes which were identified and the feedback will be used to inform the options appraisal.

6.2 The committee suggested that the services need to ensure they're giving the right information to the right people at the right time, for example in relation to carers, particularly as different schemes for them will be in place across the areas, for example in Nottinghamshire they have a carer's passport.

6.3 Commendation was given by the committee in relation to the work that had been undertaken however queried what feedback had been received from Care Homes, what information will be given to parents in relation to children's issues, also what is available for those not on social media. The group were advised that at the moment the information is deliberately strategic to get Members' views on this work, and then further work can be done to drill down in to the detail. Work has been done with our CCGs to develop the strategy and we have also worked with Healthwatch to check nothing has been missed.

6.4 The committee asked what the anticipated cost was in relation to communications given consideration for different language requirements and were advised that this had been at the forefront of concerns. The committee was advised that best practice on how consultations have been done in other areas was considered as we don't necessarily need to have printed leaflet drops but we just need to be confident that we are reaching different communities. We will put time and resources into local communications, such

as speaking to local Imams. We will also create awareness through our partner agencies and volunteers.

6.5 Queries were raised regarding how feedback will be given to those who have provided feedback on the consultation so they can continue to monitor this work and its implementation. The committee was advised that a link to the report was sent round to those who participated as well as put on social media. However it was acknowledged that the suggestion that those who participated in the consultation could be involved in measuring outcomes and the implementation of changes would be helpful. It was therefore agreed that Helen Stevens would contact Cllr Blake outside the meeting to discuss her ideas further.

7. Draft Strategy and Plans for Consultation for Children's Surgery and Anaesthesia and Hyper acute Stroke Services

7.1 Helen Stevens gave an overview of the document provided, and explained the importance of this being shared with partners and that different communities across the geographical area are engaged with.

7.2 The committee asked if any preliminary trends had been identified for specific geographical areas as a result of the consultation and were advised that the questions asked in the consultation were general, such as 'what matters to you'. As a result of this specific information on what this means for each area is not available, however the committee requested that once this is they would like an update on the trends.

7.3 The committee recommended that the main consultation should be open for a minimum of 12 weeks and also highlighted that in other areas it was helpful to have a review during the consultation so that any issues could be identified and addressed then rather than at the end when it is too late. It was therefore agreed that a meeting of this committee would be held mid-point during the formal consultation to highlight and address any issues.

The Chair thanked all for their attendance and asked if there was any other business to discuss. Doncaster Council agreed to Chair and administer the next meeting and it was agreed that nameplates for attendees would be helpful. Following this, the Chair declared the meeting closed.

Action Points

1. 'Principles' to be amended on the Committee Terms of Reference.
2. Meeting quorum to be reviewed in 2 meetings' time.
3. Commissioners Working Together representatives to bring an options appraisal in relation to the services to the next JHOSC meeting.
4. Helen Stevens to contact Cllr Blake to discuss how those consulted could be involved in measuring outcomes and implementation of services.
5. Committee to be kept updated on geographical trends identified in responses in relation to what matters to the local population.
6. Committee meeting to be held mid-point during the formal consultation so any issues can be highlighted and addressed.
7. It was agreed for Doncaster Council to Chair and administer the next meeting, and for it to be held at Bramley in Rotherham if possible.

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Date: 8th August, 2016

Commissioning Working Together Overview and Scrutiny Covering Report

TO THE CHAIR AND MEMBERS OF THE COMMISSIONING WORKING TOGETHER JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

TITLE/EXECUTIVE SUMMARY

1. The purpose of this report is to provide Members with the opportunity to be consulted on the following areas:

A. Options Appraisal:
Hyper Acute Stroke Unit
Non specialised Children's Surgery and Anaesthesia

B. Communications and Engagement

EXEMPT REPORT

2. There is no exempt information contained in the report.

RECOMMENDATIONS

3. That the Overview and Scrutiny Committee considers and comments on the information presented.

BACKGROUND

4. The Committee will be asked to give consideration to three reports as follows:

A. Agenda Item 6 - Commissioners Working Together HASU (Hyper Acute Stroke Unit) Stage 3 detailed *o*ption appraisal. A presentation will be made by Graham Venables, Clinical Lead for Stroke work stream. (Documents attached)

B. Agenda Item 7 - Joint commissioners and Provider Working Together Programmes Non-specialised Children's surgery and Anaesthesia – options appraisal. A presentation will be made by Tim Moorhead, Clinical Lead for Children's Services work stream. (Documents attached)

C. Agenda 8 - Draft Consultation Documents – Helen Stevens, Associate Director of Communications and Engagement Commissioners Working Together. (Documents attached)

- Providing hyper acute stroke services in South Yorkshire and Bassetlaw North Derbyshire; and
- Providing Children's surgery and anaesthesia services in South and Mid Yorkshire, Bassetlaw and North Derbyshire

OPTIONS CONSIDERED AND REASONS FOR RECOMMENDED OPTION

5. There are no alternative options within this report as the intention is to provide the Committee an opportunity to consider the information presented, as detailed above.

RISKS AND ASSUMPTIONS

6. There are no specific risks associated with the recommendation in this report.

LEGAL IMPLICATIONS

7. There are no specific legal implications arising directly from this report.

FINANCIAL IMPLICATIONS

8. There are no specific financial implications arising from the recommendations detailed in this report.

EQUALITY IMPLICATIONS

9. There are no significant equality implications associated with this report. Within its programme of work the Joint Overview and Scrutiny Committee gives due consideration to its Public Equality Duty and given due regard to the need to eliminate discrimination, promote equality of opportunity and foster good relations between different communities.

BACKGROUND PAPERS

10. None

REPORT AUTHOR & CONTRIBUTORS

Mandy Philbin, Transformation Programme Manager, Commissioners Working Together Programme
Kate Laurance, Senior Commissioning Lead, Commissioners Working Together Programme
Linda Daniel, Project Lead, Commissioners Working Together Programme
James Scott, Project Lead, Providers Working Together Programme
Helen Stevens, Associate Director of Communications and Engagement
Sophie Jones, Communications and Engagement Associate
The Commissioners and Providers Working Together Programme

Hyper Acute Stroke Services Options Appraisal

Summary for the OSC

1. Purpose

The purpose of this paper is to:

- Summarise the work undertaken to date, by our CCGs, in reviewing hyper acute stroke (HAS) services across South Yorkshire and Bassetlaw and North Derbyshire.

- Inform the OSC on the progress around the ongoing work and motion towards public consultation on the options for the reconfiguration for the hyper acute stroke services (HASUs).

This change is confined to the hyper acute part of the stroke pathway which is the first 72 hours of care.

2. Background and Context

Over the past eighteen months the region's CCGs have undertaken a review of hyper acute stroke services across South Yorkshire, Bassetlaw and North Derbyshire as *Commissioners Working Together.* The current model of delivery for hyper acute stroke (HAS) services is delivered from 5 units in Barnsley, Chesterfield, Doncaster, Rotherham and Sheffield.

The main drivers for considering change are outlined below and these remain. In particular, a sustainable workforce to deliver hype acute stroke services remains a significant challenge.

Key messages from the review:

- 3 out of 5 HASU centers admit less than the best practice minimum of 600 per unit
- There is a shortage of medical, nursing and therapy staffing
- Door to needle time of over 1 hour in most places

- Low thrombolysis rates across all providers
- Not achieving 1 hour scanning time
- Unsustainable medical rotas
- Gaps in early supported discharge
- Education and training required for delegated staff
- Delays in endarterectomy

Our review was shared with the Yorkshire and the Humber Senate who supported our findings. The senate also recommended that our review was considered in context of the full regional picture with any potential impact taken into account.

In June 2015, CCGs supported the case for change with a clear mandate to develop options for future service delivery and the Yorkshire and the Humber Strategic Clinical Network (SCN) took forward the development of a 'Blueprint' for HAS across Yorkshire and the Humber.

The principle of the Blueprint was to provide a high level overview of what would provide clinically safe and sustainable HAS services and ensure the best equity of access for all our local populations.

Summary of key themes from 'HAS Blueprint':

Reconfiguration in South Yorkshire and Bassetlaw should include:

- A plan to reduce the number of HAS within the South Yorkshire and Bassetlaw and move to a minimum of 2 units
- Consider the cross-boundary impact and East Midland review for Chesterfield unit
- Transformation should include a review of patients flows
- No center should exceed the maximum stroke numbers of 1500
- Best practice travel time of 45 minutes and clinical viability
- Steps to improve clinical outcomes and provide sustainable stroke services.
- Reconfigure total number of HAS (services should deliver more than 900 interventions per year) to support clinical outcomes and improve performance seen in the SSNAP reports

The SCN presented the 'Blueprint' in April 2016 and subsequently the Senate reviewed the findings.

The final June recommendations in the SCN Blueprint for hyper acute stroke now recommends that for South Yorkshire and Bassetlaw, HAS services should include consideration of the viability of reducing the number of HAS services to a minimum of 2.

3. Stakeholder engagement and pre-consultation

Commissioners Working Together have facilitated significant stakeholder engagement throughout the review process engaging in particular with providers and commissioners and other key partners via a series of workshops, engagement events and the stroke steering group between January 2015 and May 2016.

Between January and April 2016, Commissioners Working Together held an open pre-

consultation for the review of hyper acute stroke services across South Yorkshire and Bassetlaw and North Derbyshire. The question, 'what matters to you when accessing urgent stroke services' was asked with conversations held face to face and across social and digital media. Thousands of people accessed the website to read about the case for change, several hundred were involved in face to face discussions and over two hundred responses were received.

The key themes emerging were: being seen quickly when get to hospital, being seen and treated by knowledgeable staff, safety and quality of service, fast ambulance response/travel times and good access to rehabilitation services locally.

A communication and engagement strategy for consultation has been developed for the next phase of this work and to enable us to progress to consultation with the public about proposed changes to HAS in the autumn.

4. Developing options

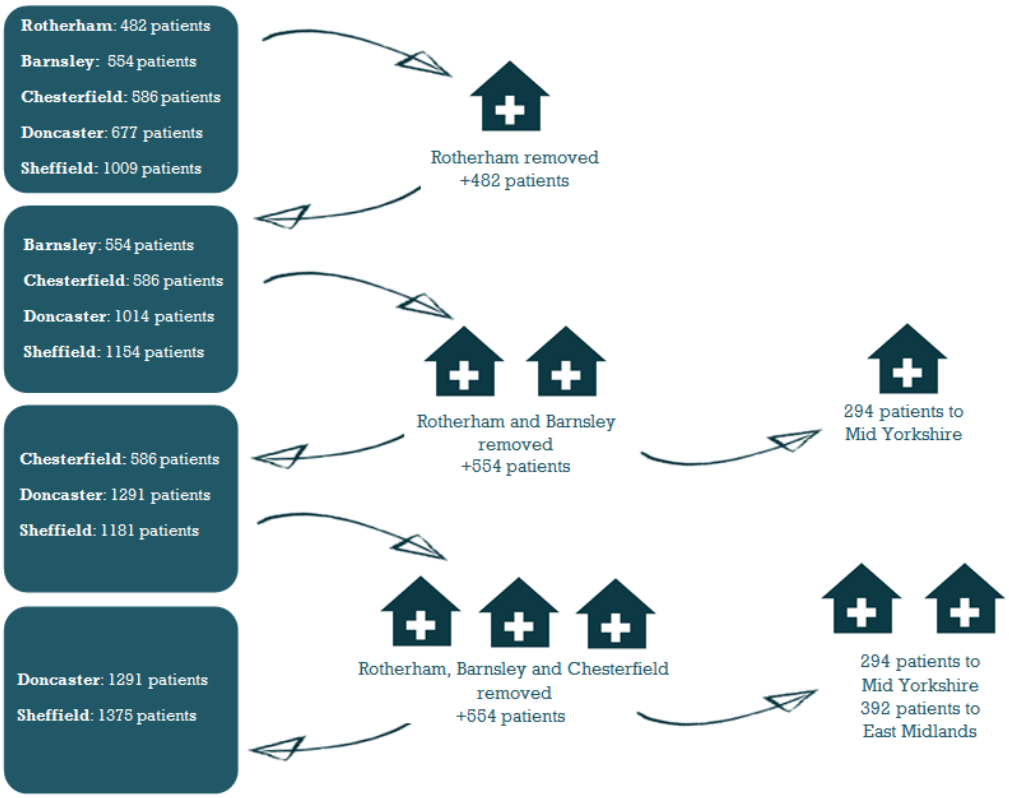
The development of the options appraisal framework to support improvements to the delivery of HASU has been undertaken working with the stroke steering group, comprising of commissioners and providers from across our Working Together partners. The steering group has also been established to support and oversee this work. The focus has been on ensuring that the appropriate outcome measures and weighting were allocated to the options appraisal matrix this was then used to review the various options and those that are most likely to impact on overall improvements to outcomes and sustainability of services.

The matrix reviewed:

- Access meets 45 mins (provided by YAS)
- HASU activity levels (and the impact from reducing a HASU)
- Cross boundary impact (recognising Mid Yorkshire and East Midlands)
- 7 day working
- Workforce
- Impact on visitors (information obtained from pre –consultation)
- Finance

This approach provided a comprehensive review and evaluation to support recommendations to improve clinical outcomes and sustainability. A full business case with detailed financial analysis is currently being developed based on the outcome of the options appraisal and will be completed in the next 2 months. The working hypothesis is that positive impact on outcomes can be achieved at null cost. This is based on change that has taken place in other parts of the country with a similar approach. We are also working with our partners in West Yorkshire and Derbyshire on the potential cross-boundary impact.

5. Summary of the outcome of the optional appraisal matrix



The outcome of the options appraisal identifies a preferred option and it is proposed that we consult the public on this preferred option from October 2016. A consultation strategy has been developed to support this process with engagement from all local communications and engagement teams.

The preferred option is that we will move from a 5 hyper acute stroke unit's model to a 3 unit model in the first stage.

The preferred option is that hyper acute stroke will be provided at Sheffield, Doncaster and Chesterfield.

Chesterfield is currently being considered as part of the East Midlands review and therefore any potential changes to the hyper acute stroke unit in Chesterfield will need to be considered in light of this review and therefore in stage 2.

The benefits of this change are that we will move to a more sustainable model of Stroke care provision for all parts of the clinical pathway and impact on the original divers for change outline in the case for change and specifically:

- Hyper acute – first 72 hours
- Acute stroke service – delivered in all 5 local sites

- Rehabilitation - delivered in all 5 local sites

Further work is required on the “do-ability” aspect which will support the operationalizing of the recommendations in the future. This is being taken forward with the stroke steering group. This work is currently taking place and will support the pre consultation business case which will be shared with NHSE to gain Level 2 assurance.

6. Assurance

Preparation work is currently being undertaken in order to submit the evidence to support Level 2 Assurance with NHSE.
This has included seeking guidance from the Clinical Senate, undertaking an Equality Impact Assessment and reviewing the viability of the current and proposed financial modeling.

7. Summary next steps

- Stage 2 Assurance for NHS England 17th August
- Financial analysis and full business case development September
- Formal consolation on preferred option 1st October for 14 weeks

8. Recommendation

OSC is asked to:

- Note progress of the work and the implications for moving forward through NHSE Level 2 Assurance and towards public consultation for the options in October.

Paper prepared by Mandy Philbin 28th July on behalf of Professor Graham Venables Clinical Director, Yorkshire and the Humber Clinical Networks.
To be read in conjunction with the full Options Appraisal

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Commissioners Working Together HASU – Stage 3 - Detailed Option Appraisal

June 2016

Title	HASU Option Appraisal		
Author	Rebecca Brown, Mandy Philbin & Stroke Steering Group		
Target Audience	Commissioner Working Together Board		
Version	V6		
WTP Reference	WTPC		
Created Date	02/04/16		
Date of Issue	28/6/16		
Document Status	FINAL		
To be read in conjunction with	Case for change Scenario appraisal document SCN HASU Blueprint for Yorkshire and the Humber Yorkshire and the Humber Senate report on the case for change Yorkshire and the Humber Senate report on the SCN HASU Blueprint		
File name and path	HASU Appraisal V6 for Boards		
Document History:			
Date	Version	Author	Details
02/04/16	1	RB	
18/04/16	2		Amends/additions from WCG/MP
10/05/16	3	MP	Matrix completed post Steering Group sign off.
02/06/16	4	W C-G	
14/06/16	5	MP	Visual added for activity and options (post board)
29th June	6	MP/WC	Consideration for 1500 based on SCN Blueprint
Approval by:	Programme Executive Group (PEG)		
Governance route:			
Group	Date	Version	Purpose
Commissioners Working Together Board	7/6/16	5	For discussion
Stroke Steering Group	8/6/16	5	For discussion
Working Together Senior Management Team	24/6/16	5	For discussion

Contents

1.0 Executive Summary

In 2007 the Department of Health published the National Stroke Strategy providing a national quality framework to secure improvements across the stroke pathway. Then in 2014, the NHS Five Year Forward View set out a positive view for future new models of care, indicating the need for rationalisation and sustainability in services in order to meet growing demands, provide high quality and remain financially viable.

A detailed baseline review across South Yorkshire, Bassetlaw and North Derbyshire demonstrated a gap analysis for the delivery of Hyper Acute Stroke Units (HASUs) within the region and formulated a “Case for Change (May 2015)” which was supported by the Commissioners Working Together partner CCGs, received positive support from the Yorkshire and the Humber Clinical Senate and was shared with acute provider Boards.

Further support and recommendations have been identified in the Hyper Acute Stroke Services Yorkshire and Humber “Blueprint” report which was undertaken by the Yorkshire and the Humber Strategic Clinical Networks.

Gaps were identified within service delivery and highlighted in both documents, difficulties in the ability to provide high quality, Sentinel Stroke National Audit Programme SSNAP performance data and sustainable services due to recurrent issues with :-

- Workforce, skills and expertise
- Capacity and demand

And being able to meet fundamental minimum numbers of stokes per HASU recognised as being key criteria required to meet national standards and enable sustainable services for the future.

All documents have been fundamental in supporting the development for this Options Appraisal.

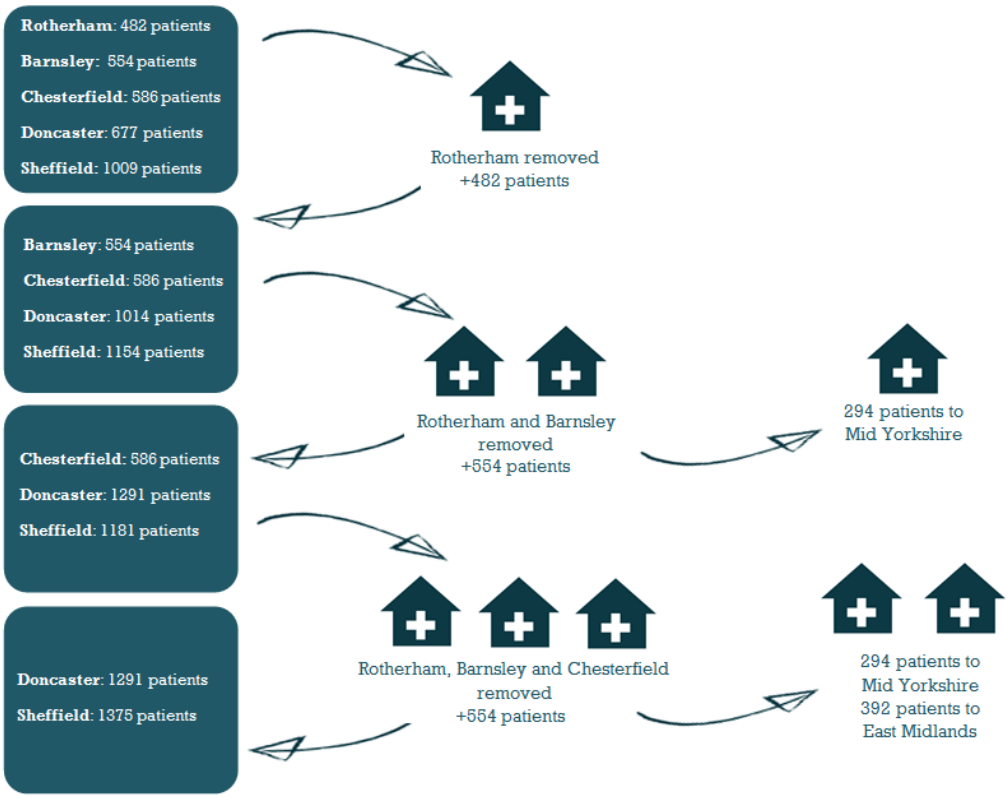
This Options Appraisal provides a comprehensive review, evaluation and proposal for a new model of care based on quantitative data for HASU activity, ambulance transfer times, SSNAP submission data (as seen in the Blueprint) and qualitative data gained through the Commissioners Working Together (CWT) engagement with service staff, clinicians and managers and pre-consultation with service users regarding potential changes to current models of service delivery.

- The outcome of the Option Appraisal supports the radical transformation and reduction of HASUs from 5 to 4, 3 or, supporting the Networks regional requirements of 2. Based on the options appraisal matrix it would be viable to reduce the number of HASUs based on true data outcomes.

- Consideration to the potential reviews/impact of any transformational changes within North Derbyshire and Mid York's given the impact on cross boundary patient flow

To be able to develop a more sustainable network for stroke care a consideration needs to be given to the following options:-

Option	Number of Units	Continue to deliver HASU services	Remove
Option 3b	4 unit delivery (Working Together Footprint)	Sheffield, Barnsley, Chesterfield and Doncaster	Rotherham
Option 3c	3 unit delivery (Working Together Footprint)	Sheffield Doncaster and Chesterfield	Barnsley and Rotherham
Option 3d	2 unit delivery (Supporting Network changes)	Sheffield and Doncaster	Barnsley Rotherham and Chesterfield



It is important to note that this Options Appraisal considers changes to the Hyper-Acute Stroke Service, not the wider service. Hyper acute stroke care is for a clearly defined period (up to 72 hours). The proposed changes refer to the first 72 hours of emergency stroke treatment, and not acute stroke care or rehabilitation.

- Further consideration is required leading to implementation of the options. This specifically related to the do ability of each option. The identified organisations need to be able to demonstrate their "do-abiity" to be able to support the increase in activity. This will mean detailed capability assessments for:-

    - Capacity and demand assessment,
    - Understand displaced activity,
    - Financial modelling
    - Pathway review, supporting repatriation/rehabilitation.

- Considerations of future impact and developments need to be kept within the sight of the developing South Yorkshire and Bassetlaw and neighbouring Sustainability Transformation Plans and regional Clinical Network recommendations (i.e. the impact on Chesterfield/ Nottingham and Sherwood Forest review).

2.0 Introduction

The way that stroke services are organised will have a major impact on a person's recovery after a stroke. We know that the most important interventions are maintaining homeostasis and preventing stroke-associated complications. We know that thrombolysis delivered quickly will reduce the chances of a disability. There is also a strong evidence base that effective prevention strategies after stroke and transient ischaemic attack (TIA) will reduce the risk of reoccurrence when supported by specialist rehabilitation both in hospital and in the community. Data from the Sentinel Stroke National Audit Programme (SSNAP) has shown that larger stroke services operate more efficiently than smaller services and they are more likely to be financially viable as well. It has been shown that levels of nurse staffing also have a direct impact on the chance of patients surviving.

To deliver the best outcomes, it is therefore vital that patients are managed in a well organised service that can deliver the best quality of care and unfortunately the SSNAP data clearly shows that there are still unacceptable variations in the quality of care across England. Given the major shortages in medical workforce that are going to increase in the coming years, the most rational solution, particularly in parts of the country with high population density, will be for providers and commissioners to work together to centralise inpatient care in a smaller number of stroke centres, as suggested in the NHS Five Year Forward View published in 2014. Where this is not possible, for

whatever reason, then telemedicine will provide at least partial solutions to existing variations in the care that a patient might expect to receive. Professor Tony Rudd CBE. National Clinical Director for Stroke, NHS England.

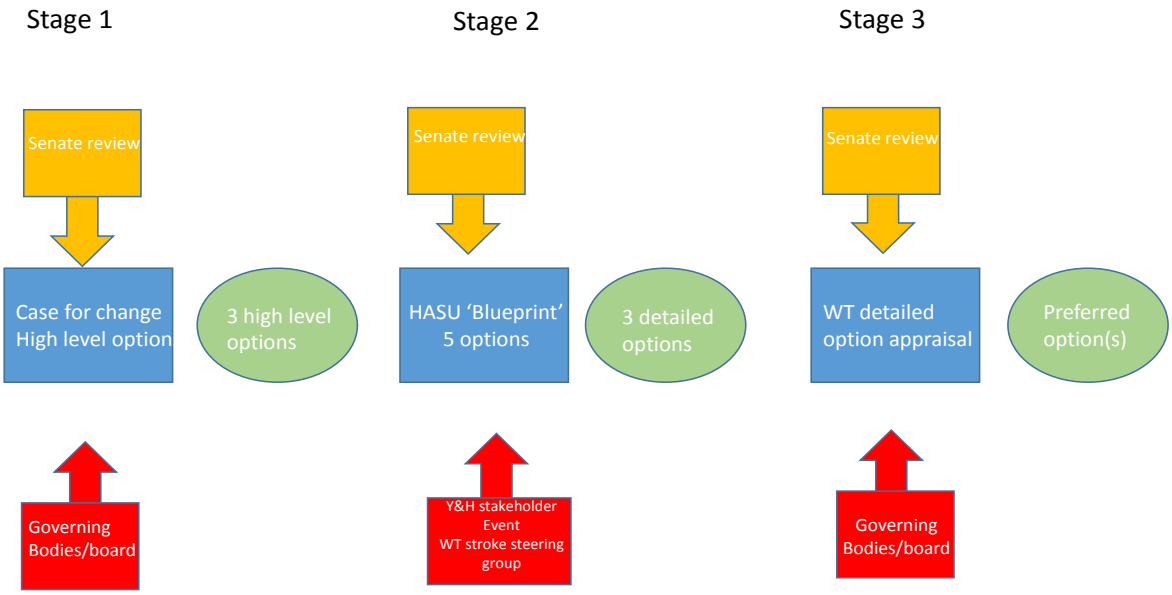
2.1 Purpose of the document

This Options Appraisal document sets out the options being considered by commissioners for the long term provision of Hyper-Acute Stroke Services within South Yorkshire, Bassetlaw and North Derbyshire and the risks and benefits with each. The purpose of this paper is to provide the information required by the Governing Bodies from each of the Clinical Commissioning Groups, along with the Commissioners Working Together programme executive group to make a decision on a preferred option/s that will be taken to public consultation in September 2016.

3.0 High level options appraisal – to date

The three sub regions of Yorkshire and Humber have identified the need to undertake an assurance review to ascertain resilience of the current HASU provision. The review has been mandated by the Yorkshire and Humber Chief Officers and is being delivered through existing sub-regional governing and accounting arrangements. For South Yorkshire, Bassetlaw and North Derbyshire, the review is being undertaken as part of Commissioners Working Together.

Figure 1 - Summary of Option Appraisal Process



In the early part of 2015 a HASU case for change and scenario appraisal document were developed with key stakeholders and taken through CWT

governance. This resulted in a clinical senate review of the aforementioned documents in July 2015.

As is clear from the phase 1 HASU case for change, the variation in quality and performance against standards across South Yorkshire, Bassetlaw and North Derbyshire, is of concern to commissioners. The key messages from the phase 1 review are as follows:

- 3/5 of HASU centres admit less than 600 strokes per annum.
- There is a shortage of medical, nursing & therapy staffing in all provider organisations.
- Door to needle times of over 1 hour in most cases
- Very low thrombolysis rates across all providers.
- Not achieving1 hour scanning.
- Unsustainable medical rotas.
- Education & training required for delegated staff.
- Gaps in Early Supported Discharge.
- Delays in endarterectomy.
- 2 units within 15 miles of each other.
- There is further work required to ensure effective use of telemedicine.

3.1 Case for Change - Stage 1 Option Appraisal

All Commissioners Working Together partner CCGs supported 'transformation' of HASUs across the CWT footprint. This decision was also supported by the Yorkshire and the Humber Clinical Senate. Stage 1 of the option appraisal outlined in the table below.

Case for Change - Stage 1 Option Appraisal	Outcome
Option 1 – Do nothing	Discounted on the basis of current quality, performance and sustainability challenges
Option 2 – Improve quality and sustainability of current configuration of 5 HASU's	Discounted on the basis of the likelihood of efforts leading to improved quality, performance and sustainability
Option 3 – Transformation of HASU's across CWT footprint	Supported on the basis of likelihood to improve quality performance and sustainability of HAS for all local population

3.2 Y&H Blueprint - Stage 2 Option Appraisal

Stage 2 involved a 'purest' approach by the SCN which ruled out/discounted keeping 5 centres on the basis of not meeting minimum recommended number of strokes for each centre. Stage 2 is outlined in the table below.

Y&H Blueprint - Stage 2 option appraisal	Outcome
Option 3a – 5 centres	Discounted on basis of 5 centres not being able to meet the minimum recommended number of stroke cases for each single centre
Option 3b - 4 centres	Option includes consideration of the North Derbyshire and Hardwick populations and the Chesterfield HASU centre
Option 3c – 3 centres	Option uses 1200 as upper limit and does not take potential services changes in East Midlands into consideration
Option 3d – 2 centres Y&H blueprint – using the 1500 metrics	To be considered on the basis of the scale of ambition required in STP development, dependant on configuration across the region
Option 3e – 1 centre	Discounted on basis of number of stokes across CWT and maximum number for a single centre

Using the principles of travel times and size of unit, the final recommendation from the SCN Blueprint for South Yorkshire, Bassetlaw region was for a minimum of 2 units for South Yorkshire and Bassetlaw.

There needs to be consideration and recognition of any transformational changes to stroke service delivery within the East Midlands Clinical Network and the potential impact in South Yorkshire and Bassetlaw. A verbal update from East Midlands Clinical Senate in May 2016 identified that the strategic review for this catchment remained outstanding.

The blueprint analysis in its early draft form did not use 1,500 as the upper limit for the size of a HASU unit; instead the clinical consensus in the SCN was to use 1,200 strokes per annum. Given the scale of ambition required in Sustainability and Transformation Plans to ensure services are sustainable for the future, the Commissioners Working Together partners have made the decision to model options on the upper threshold for size of a unit. If taken in the context of Yorkshire and Humber, and the upper limit applied, potentially there would be scope to move to fewer units across the region. This potentially could result in 2 units for South Yorkshire, Bassetlaw and North Derbyshire. It should be noted that this configuration will have the potential to increase HASU unit/s to exceed the 1200 threshold endorsed by the SCN but be supported by the ambitions of Yorkshire and Humber Senate of 1500 patient threshold.

The final recommendation from the Blueprint now recommends the use of 1500 strokes as the maximum number of strokes per unit.

3.3 Options going forward to stage 3 option appraisal

Given the outcome of the two stages of option appraisal already undertaken, the options being taken forward to stage 3 are as follows:

- Option 3b – reduce to 4 HASU centres
- Option 3c – reduce to 3 HASU centres
- Option 3d –reduce to 2 HASU centres – consideration needs to be made when supporting “do ability” given the impact of reviews ongoing in Mid Yorks and North Derbyshire.

4.0 Evaluating the options in stage 3

4.1 Learning from elsewhere

CCGs must make sure that they have a process in place for appraising and testing options. There should be a robust, documented process for sifting any long- list of options into a shortlist. There should also be a framework in place to further test shortlisted options to make sure that they are sufficiently robust and fit for purpose. This framework should also be used on any new options that emerge from the consultation. The options appraisal must include an analysis of the implications of no change. In order to arrive at such decisions, it is essential that sound, robust analysis is undertaken.

The evidence is strong that being admitted to a specialist stroke centre with access to stroke expertise 24 hours a day, seven days a week, results in better outcomes than being managed without these resources.
The improved outcomes arise from careful attention and treatment to maintain homeostasis, skilled nursing and medicine to avoid complications and early intervention to treat complications before they become life-threatening.

Reorganisation of stroke services therefore needs to take into account where the benefits lie for the population that the hyper acute stroke services are serving. High quality care, including access to intravenous thrombolysis should be available to all, with sufficient provision in place, in areas with a high population density.

However, it is important to recognise that in rural areas providing a well-staffed unit working 24/7 that is also within a 45-60 minute drive in a blue light ambulance might not be possible.

As supported by the case for change and feedback from the Clinical Senate, doing nothing and maintaining poor services for all is not an option. We need

to ensure that the greatest number of people as possible receive high quality, safe and sustainable services, for 95% of the population

4.2 Principles of Redesigning Services

Factors to consider for urban areas

The following factors should be considered when looking into redesigning stroke services in urban areas:

- Clinical and financial critical mass, of >600 and <1,500 stroke admissions per annum.
- Balance between volumes and financial viability.
- Travel time should be ideally 30 minutes but no more than 60 minutes.

Factors to consider for rural areas

The following factors should be considered when looking into redesigning stroke services in rural areas:

- Clinical and financial critical mass standards achievable in urban areas may not always be feasible in low population density areas.
- Balance between volumes, travel times and financial viability.

Standards that must not be compromised are:

- Specialist assessment on admission (24 hours a day) and daily thereafter during hyper-acute phase (the first 72 hours after having a stroke).
- Stroke unit staffed and equipped in line with best practice specification (guidance is in the development phase).
- 24-hour access to scanning.
- Access to thrombolysis, but less important than other aspects of care.
- Access to therapy.
- Door to needle time.

4.3 Option Appraisal Criteria

Commissioners Working Together have developed an evaluation criteria to use as part of the decision making process to assess potential options against criteria which have been weighted in order of importance by the Stroke Steering Group. The criteria use the principles that are set out in the Stroke Services: Decision support Guide. These have then been weighted by the CWT stroke steering group and options assessed against these.

It is agreed that quality of care should be the highest priority when it comes to decisions about service provision. However it is important to balance the other elements of the criteria to ensure that our services are maintained with the right level of skilled workforce, at locations that are accessible for patients, and in a way that uses our resources as efficiently as possible.

Agreement at the April Stoke Steering group facilitated the appropriate priority and weighting criteria to support the options appraisal matrix: Matching the criteria against the impact provides a weighted outcome measure that supports the future decision making process

Commissioners Working Together evaluation criteria

Criteria and data to support evaluation	Indicator
Access meets 45 minutes (ambulance conveyance times)	Access meets 45 minutes for 95% of population
HASS activity levels (displaced activity)	Clinical critical mass, of >600 and <1,500 stroke admissions per annum
Cross boundary impact (outside WTP footprint)	Transformation should minimise cross-boundary impact
7 day working	Is there a 7 day service being offered?
Adequate workforce	Performance against SSNAP scores (case for change)
Impact on visitors/carers (Pre consultation evaluation)	Impact of change on visitors and carers travel time

5.0 Option Appraisal

Building on the evaluation criteria the Stroke Steering Group provided clinical guidance and judgement around the importance and value on each element. This supported a weighting scoring system which when matched against a value score (1 being excellent to 5 very badly) there was clear demonstration to the capability and impact of individual organisations to deliver a HASU The evaluation of the matrix is consolidated in 5.1 with the working documentation shown in Appendix 1.

5.1 Configuration for consolidation of HASU (further working detail Appendix 1)

Option 3b Reduce to 4 units	Remove Rotherham
Option 3c Reduce to 3 units	Remove Rotherham and Barnsley
Option 3d Reduce to 2 units	Remove Rotherham, Barnsley, Chesterfield

6.0 Conclusion

6.1 Preferred Option/s

- Support option 3c as the preferred option to consult the public on and recommend to CCG commissioners. This option would result in decommissioning HASU from a Barnsley & Rotherham. Support the implementation of any future change managed through the Stroke Steering Group & SRG's.

- Give further consideration to the scale of ambition and change required to achieve Option 3d. It may be appropriate to undertake a stepped approach to this option, over a longer period of time with support and direction from the Clinical Senate pending east Midland review of HASU and transformation plans within Mid Yorks.

- It is the recommendation that option(s) 3c is for consideration by the Commissioners Working Together board and is taken forward to public consultation in South Yorkshire and Bassetlaw. In addition and as part of the consultation we would wish to raise awareness of the impact of any further potential change as part of East Midlands review of HASU services and the potential of what is described in option 3d This option and approach is now supported by the most recent recommendations from the SCN June Blueprint for HAS which recommended that a minimum of 1500 strokes should be considered in any reconfiguration of stroke services.

Appendix 1
7.1 Assessment Criteria

Criteria	Assessment (Consensious Stroke Steering Group 4.5.16)	Translation
Access meets 45 minutes Based on YAS transfer time . Optimum benchmark 45mins. Transfer time is for total stroke population Weighted as 3	5 – excellent	Access meets 45 min for 95% population (meets current model)
	4 – good	Access meets 45 min for 75 - 94% population
	3 – adequate	Access meets 45 min for 51 - 76% population
	2 – poor	Access meets 45 min for 26 - 50% population
	1 – very poor	Access meets 45 min for 25 - 0% population

Criteria	Assessment	Translation
HASU activity levels Based on a viable option of 900-1,200 as optimum delivery for all units. For 2 units to be modelled on 1500 patients Weighted as 4	5 – excellent	Ensures 2 other HASUs are viable due to transfer in activity (over 900)
	4 – good	Ensures 2 other HASUs are viable due to transfer in activity (over 600)
	3 – adequate	Ensures 1 other HASUs are viable due to transfer in activity (over 900)
	2 - poor	Ensures 1 other HASUs are viable due to transfer in activity (over 600)
	1 – very poor	Ensures 0 other HASUs are viable due to transfer in activity

Criteria	Assessment	Translation
Cross boundary impact Weighted as 2	5 – excellent	No impact
	3 – adequate	Minimal impact (affects 2 HASU, not tipping them over 1200)
	1 – very poor	Tips one centre over 1500

Criteria	Assessment	Translation
7 day working Based on accessibility and impact on clinical outcomes Weighted as 5	5 – excellent	Reduces number of non-compliant centres by 4
	4 – good	Reduces number of non-compliant centres by 3
	3 – adequate	Reduces number of non-compliant centres by 2
	2 - poor	Reduces number of non-compliant centres by 1
	1 – very poor	Does not reduce non-compliant centres

Criteria	Assessment	Translation
Adequate workforce Based on resilience and sustainability of service. Weighted as 6	5 – excellent	Removes 2 HASU who have less staffing than required in 3 of the reported SSNAP areas
	4 – good	Removes 1 HASU who have less staffing than required in 3 of the reported SSNAP areas
	3 – adequate	Removes 1 HASU who have less staffing than required in 2 of the reported SSNAP areas
	2 - poor	Removes 1 HASU who have less staffing than required in 1 of the reported SSNAP areas
	1 – very poor	Does not affect any underperforming HASUs

Criteria	Assessment	Translation
Patient experience and Impact on visitors/carers Weighted as 1	5 – excellent	Travel times are increased for 20% of the population
	4 – good	Travel times are increased for 40% of the population
	3 – adequate	Travel times are increased for 60% of the population
	2 - poor	Travel times are increased for 80% of the population
	1 – very poor	Travel times are increased for 100% of the population

Option 3b - 4 Units

HASU 2016 OPTION APPRAISAL

Step 1 - Weight the parameters

Criteria							Relative score	Weight (%)
Access meets 45 mins	30						30	**14%**
HASU activity levels	40						40	**19%**
Cross boundary impact	20						20	**10%**
7 day working	50						50	**24%**
Workforce	60						60	**29%**
Patient experience - Impact on visitors	10						10	**5%**
							210	**100%**

Step 2 - Score each option

5 = excellent
4 = good
3 = adequate
2 = poor
1 = very poor

Criteria		**Unweighted Scores** Option 3b (i) Barnsley	Option 3b (ii) Doncaster	Option 3b (iii) Rotherham	Option 3b (iiii) Chesterfield	**Weight (%)**		
	Displace							
Access meets 45 mins		5	5	5	5	14%		
HASU activity levels		4	4	3	3	19%		
Cross boundary impact		3	3	5	3	10%		
7 day working		2	1	2	2	24%		
Workforce		1	3	4	4	29%		
Impact on visitors		5	5	5	5	5%		
		20	**21**	**24**	**22**	**100%**		

Step 3 - Weighted results

Criteria		**Weighted Result** Option 3b (i) Barnsley	Option 3b (ii) Doncaster	Option 3b (iii) Rotherham	Option 3b (iiii) Chesterfield
	Displace				
Access meets 45 mins		0.71	0.71	0.71	0.71
HASU activity levels		0.76	0.76	0.57	0.57
Cross boundary impact		0.29	0.29	0.48	0.29
7 day working		0.48	0.24	0.48	0.48
Workforce		0.29	0.86	1.14	1.14
Impact on visitors		0.24	0.24	0.24	0.24
The higher the score the more positive option is for removal		**2.76**	**3.10**	**3.62**	**3.43**

Option 3c - 3 Units

HASU 2016 OPTION APPRAISAL

Step 1 - Weight the parameters

Criteria									Relative score	Weight (%)
Access meets 45 mins	30								30	**14%**
HASU activity levels	40								40	**19%**
Cross boundary impact	20								20	**10%**
7 day working	50								50	**24%**
Workforce	60								60	**29%**
Impact on visitors	10								10	**5%**
									210	**100%**

Step 2 - Score each option

5 = excellent
4 = good
3 = adequate
2 = poor
1 = very poor

Criteria		**Unweighted Scores** Option 3c (i)	Option 3c (ii)	Option 3c (iii)	Option 3c (iiii)	Option 3c (iiiii)	Option 3c (iiiiii)	**Weight (%)**
	Displace	Barnsley & Doncaster	Barnsley & Chesterfield	Barnsley & Rotherham	Doncaster & Chesterfield	Doncaster & Rotherham	Rotherham & Chesterfield	
Access meets 45 mins		5	5	5	5	5	5	14%
HASU activity levels		3	5	5	4	4	5	19%
Cross boundary impact		3	3	3	3	3	3	10%
7 day working		2	3	3	2	3	3	24%
Workforce		1	2	4	4	4	1	29%
Impact on visitors		5	5	5	5	5	5	5%
		19	**23**	**25**	**23**	**24**	**22**	**100%**

Step 3 - Weighted results

Criteria		**Weighted Result** Option 3c (i)	Option 3c (ii)	Option 3c (iii)	Option 3c (iiii)		
	Displace	Barnsley & Doncaster	Barnsley & Chesterfield	Barnsley & Rotherham	Doncaster & Chesterfield	Doncaster & Rotherham	Rotherham & Chesterfield
Access meets 45 mins		0.71	0.71	0.71	0.71	0.71	0.71
HASU activity levels		0.57	0.95	0.95	0.76	0.76	0.95
Cross boundary impact		0.29	0.29	0.29	0.29	0.29	0.29
7 day working		0.48	0.71	0.71	0.48	0.71	0.71
Workforce		0.29	0.57	1.14	1.14	1.14	0.29
Impact on visitors		0.24	0.24	0.24	0.24	0.24	0.24
The higher the score the more positive option is for removal		**2.57**	**3.48**	**4.05**	**3.62**	**3.86**	**3.19**

Option 3d - 2 Units

HASU 2016 OPTION APPRAISAL

Step 1 - Weight the parameters

Criteria							Relative score	Weight (%)
Access meets 45 mins	30						30	**14%**
HASU activity levels	40						40	**19%**
Cross boundary impact	20						20	**10%**
7 day working	50						50	**24%**
Workforce	60						60	**29%**
Impact on visitors	10						10	**5%**
							210	**100%**

Step 2 - Score each option

5 = excellent
4 = good
3 = adequate
2 = poor
1 = very poor

Criteria		Unweighted Scores Option 3d (i) Sheffield & Barnsley	Option 3d (ii) Sheffield & Chesterfield	Option 3d(iii) Sheffield & Doncaster	Option 3d (iiii) Sheffield & Rotherham	Weight (%)
	Retain					
Access meets 45 mins		5	2	5	2	14%
HASU activity levels		2	1	5	1	19%
Cross boundary impact		1	3	5	1	10%
7 day working		2	2	1	2	24%
Workforce		2	3	3	4	29%
Impact on visitors		5	5	5	5	5%
		17	**16**	**24**	**15**	**100%**

Step 3 - Weighted results

Criteria		Weighted Result Option 3d (i) Sheffield & Barnsley	Option 3d (ii) Sheffield & Chesterfield	Option 3d(iii) Sheffield & Doncaster	Option 3d (iiii) Sheffield & Rotherham
	Retain				
Access meets 45 mins		0.71	0.29	0.71	0.29
HASU activity levels		0.38	0.19	0.95	0.19
Cross boundary impact		0.10	0.29	0.48	0.10
7 day working		0.48	0.48	0.24	0.48
Workforce		0.57	0.86	0.86	1.14
Impact on visitors		0.24	0.24	0.24	0.24
The higher the score the more positive option is for retention of those services		**2.48**	**2.33**	**3.48**	**2.43**

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Children's Surgery Options Appraisal

Summary for the OSC

1. Purpose

The purpose of this paper is to:

- Summarise the work undertaken to date, by our CCGs and Providers, in reviewing children's non specialised surgery across South and Mid Yorkshire, Bassetlaw and North Derbyshire.

- Inform the OSC of the progress around the ongoing work and recommendation to go to public consultation on the options for the reconfiguration of children's non specialised surgery

2. Background and Context

2.1 As Commissioners Working Together, CCGs have undertaken a review of Children's non-specialised surgery. he first phase of work was agreed in June 2015 and following this, the case for change was agreed by CCGs and trust boards in the Working Together footprint in autumn 2015. The programme then progressed work as part of the review which included:

- A fully developed project plan
- A provider self-assessment against national standards of care
- Benefits analysis and outcomes
- Assessment of need and demand for provision
- The specified model of care including the standards to enable designation of providers of surgical care
- Undertaking procurement advice and market analysis
- Considering best practice nationally and internationally.
- Development of options to re-configure services to provide sustainable care.
- An appraisal of options for configuration to provide sustainable care

Progress reports have been considered by the Working Together Programme Team which has representatives for all CCGs and acute provider trusts, this has continued throughout the review of children's surgery. The work was phased and updates in between were taken to trust boards and CCG governing bodies. The phases included:

2.2 Phase one development January 2015 – September 2015 – included the development of the case for change including:

- Engaging with key stakeholders
- Establishment of a clinical task and finish group with representation from all trusts
- Undertaking a baseline assessment of current services
- Forming consensus of the issues
- Identifying best practice models
- Specifying the pathways that should be in place to meet standards
- Exploring strengths and benefits of potential models
- Considering our populations needs for the future
- Seeking external clinical scrutiny of the work to date (through the clinical Senate)

2.3 Phase Two October 2015 – September 2016

The development of a specification, options on a model and drafting full outline business case including:

- Implementation of communication and engagement strategy - Pre –engagement with patients and the public, key stakeholders (Health Overview and Scrutiny Committees) and staff
- Enacting procurement advice, including a provider engagement event and Prior Information Notice of Service changes
- Development of a service specification meeting national standards and gap analysis against existing provision
- Expert assessment panel advice and guidance
- Exploring demand and need, including flows in provision.
- Development of options on a service model and assessment and appraisal of options
- Consideration of the implementation plan and mechanisms to mobilise and operationalise change
- Development of full business case including activity and financial impact
- Planning for formal consultation
- Consideration of options to implement change and the impact

3. Stakeholder engagement and pre-consultation

Commissioners Working Together have facilitated significant stakeholder engagement throughout the review process engaging in particular with providers and commissioners and other key partners via a series of workshops, engagement events and the clinical task and finish group.
Between January and April 2016, Commissioners Working Together, held an open pre-consultation to inform the review of children's surgery services across South and Mid Yorkshire, Bassetlaw and North Derbyshire. Asking 'what matters to you when accessing children's surgery' the conversations were held face to face and across social media. Thousands of people accessed the website to read about the case for change, several hundreds were involved in face to face discussions and over two hundred responses were received.

The key themes emerging were: being seen and treated by knowledgeable staff, safety and quality of service, is the most important thing and that families were happy to travel for the right care services locally. It was also important to people that professionals had information on about their child and that the professionals talked to each other about the needs of the child and family.

A communication and engagement strategy for consultation has been developed for the next phase of this work and to enable us to progress to consultation with the public about proposed changes to children's surgery this autumn.

4. Developing options

The development of the options appraisal to support improvements to the delivery of children's surgery was discussed at the task and finish group, the core leaders group, and with key clinicians through a clinical reference group.
The focus has been on assessing the options and looking to the most sustainable option that provides the best outcomes in line with national standards.

It is proposed that provision is developed through a network of providers across the geography and that elective day case provision not requiring overnight care is provided at as many local sites as possible. This will be planned through a Managed Clinical Network of Providers that will work across organisational boundaries.

It is then proposed that non elective urgent care out of hours surgery is managed in fewer sites.

5. Summary of the outcome of the optional appraisal to date

The outcome of the options appraisal identifies a preferred option and it is proposed that we consult the public on this preferred option in October 2016. A consultation strategy has been developed to support this process with engagement from all local communications and engagement teams.

The preferred option is that we will move to a network of planned provision across all providers who meet the new service specification.

It is then proposed that for non-elective out of hour's surgery that provision is consolidated over fewer sites to provide 3 hubs and entry points out of hours.

The preferred option is that for these small numbers for some areas of non-specialised out of hours provision will be provided in Doncaster, Sheffield and Wakefield.

Chesterfield currently has a network in place with Nottingham so may take a view on developing these arrangements for out of hours provision.

The benefits of this change are that we will move to a more sustainable model of networked provision for all parts of the clinical pathway.

Further work is required on the detail around sub specialty areas that can be treated at local level where skills are available or maintained. Aspects of the operationalizing of the provision for the future will need development through the Managed Clinical Network. This work is currently taking place and the Managed Clinical Network is in the process of

developing a draft business case based upon these changes which will be shared with NHSE to support Level 2 assurance.

6. Assurance

Preparation work is currently being undertaken in order to submit the evidence to support Level 2 Assurance with NHSE.
This has included seeking guidance from the Clinical Senate, undertaking an Equality Impact Assessment and reviewing the viability of the current and proposed financial modeling.

7. Summary next steps

- Stage 2 Assurance for NHS England - 17 August
- Financial analysis and full business case development September
- Formal consultation on preferred option - 2 October for 14 weeks

8. Recommendation

Joint HOSC is asked to:

- Note progress of the work and the implications for moving forward through NHSE Level 2 Assurance and towards public consultation on the options in October.

Paper prepared by

Kate Laurance Head of Commissioning on behalf of Dr Tim Moorhead Commissioners Working Together Clinical Lead for the Working Together Programme
To be read in conjunction with the full Options Appraisal

Joint commissioners and provider Working Together Programmes

Non- specialised Children's Surgery and Anaesthesia – Options Appraisal

June 2016

June 2016

Title	Non- specialised Children's Surgery and Anaesthesia – Options Appraisal		
Author	Kate Laurance/ Children's Services Core Leaders Group		
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27/4/2016	1	KL	Worked up following discussion at task and finish group
28/4/16	2	KL	Options updated
29/4/16	3	KL	Data with analysis and split supported by activity data being modelled.
13/5/2016	4	KL	With feedback from Children's Core Leaders steering Group
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27/5/2016	6	KW	Re-formatted
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			assumptions, 2.8 note on status of following RAG rating for options. Changes to sections 3.2,3.3 re OA next steps
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2/6/16	10	KL	With Updates to Section 2 on matrix for scoring
5/7/16	11	HS	Amended numbers to ensure non identifiable
Governance Route:			
Group	Date	Version	Purpose
Working Together Programme Board	7th June 2016	1	For Sign off and support

Contents

Introduction and Overview

This paper has been worked up to give an overview of the potential options and impact for redesigning children's surgical services across South and Mid Yorkshire, Bassetlaw and North Derbyshire (the Working Together footprint). The paper proposes three main options, gives an early indicative assessment of those options using a 'traffic light' scoring, and suggests a systematic option scoring approach to run alongside this.

The enclosed gives an overview of the potential change in flows and impact of redesigning services to meet quality, safety and sustainability requirements.

The impact assessment also covers change in flows from a CCG population perspective which has been developed following the assessment panel and a subsequent meeting of the original task and finish group on the 14th of April 2016.

It is important that the **case for change** for Children's Surgery and Anaesthesia services within the Working Together footprint is considered to enable provision commissioned to be equitable, safe and sustainable for the future.

The case for change and subsequent Health Needs Assessment takes into consideration quality aspects of the service, draws on national and regional guidance and clinical best practice within services, and sets out the national standards for Children's surgical services.

In summary the challenges facing the future provision of children's surgery raised by stakeholders (surgeons, anaesthetists, Trust managers and commissioners) and identified as the key drivers for the Working Together Programmes (provider and commissioner) at meetings are as below.

- Providing a comprehensive range of effective and sustainable children's surgery and anaesthetic services.

  Changes in clinical practice have been influenced in recent years by guidance from the Royal College of Surgeons (RCS) and Royal College of Anaesthetists (RCoA) and an increased focus on clinical governance.
  One of the more significant changes has been to the training of general surgeons, with a reduction in the paediatric component of general surgical training. Individual general surgical trainees have been given free remit to choose any sub-specialty area, and unfortunately, the numbers training in any given sub-specialty do not always match the needs of the service. As a result, as surgeons retire, they are not being replaced by surgeons with the

same level of experience in paediatric surgery.

There is evidence, from the workforce profiling undertaken by providers, that concern about the ability to provide safe and effective surgery for children has caused some surgeons to limit the range of surgery that they offer, or limit the age range of children that they treat.

- Avoiding unplanned unmanageable changes to referral patterns for children's surgery.

  Within the region there is evidence that the issues identified above have resulted in unplanned changes to service provision and 'activity flows' away from smaller DGH's towards larger centres, leading to problems in capacity planning. There is recognition among clinicians that transformation of services may be required to make best use of clinical manpower, and that this needs to be addressed strategically.

- The need to consider clinical interdependencies

  The provision of children's surgical and anaesthetic services is dependent on the provision of other children's services and vice versa; in particular the provision of a number of children's services relies on the provision of paediatric anaesthetic services. There is also interdependency between medical paediatrics and maternity and neonatal services. Therefore, changes to individual services can have an impact on the overall 'portfolio' of services offered by individual Trusts. We are also taking into account the urgent and emergency care review and the work of the developing South Yorkshire and Bassetlaw Sustainability and Transformation Plan, and those of our neighbouring regions.

- Implementation of the Standards for Children's Surgery and Anaesthesia leads to challenges that are beyond the ability of individual organisations to solve.

  There is widespread recognition that meeting the standards in full may be a challenge for some Trusts. The view among clinicians is that there are options for addressing these (e.g. through the provision of in-reach and outreach services, joint training, education and audit), but that this would also require joint working. Alongside this, is the view that for the standards to be effective, they should be monitored by people who understand the services and who are able to make informed assessment against compliance; ideally peers. Also, that the standards will need to be reassessed in light of changes to national clinical guidance, in order to remain relevant.

In light of all the above, the overwhelming view from attendees at stakeholder meetings and engagement events was that:

- There is a need for change because 'continuing as we are is not sustainable'.
- Ensuring good quality and sustainable provision of services in future and implementation of standards would require cross-organisational working.
- There is lack of co-ordination across pathways and patient flows are not managed.
- The interdependencies of children's services are complex.
- There is a need for managerial leadership and clinical leadership across organisations.

Recently, regional CQC visits have highlighted the need to improve staffing levels which have led to the increased usage of locum/bank staff in various providers of children's surgery.

Between January and April 2016, Commissioners Working Together gathered the views of patients and the public during a pre-consultation phase. The following were the key themes identified as being important to people when accessing children's surgery and anaesthetic services:

- Safe, caring, quality care and treatment
- Access to specialist care – with a willingness to travel for specialist care
- Care close to home
- Communication – between children, parents, carers and their clinicians – and also between hospitals
- Being seen as soon as possible

Following the expert assessment panel held on 7 March 2016, which considered all aspects of the review and advised on a way forward, and the subsequent task and finish group discussion on the sustainable options for modelling services held on 14 April 2016, the options detailed in the main body of this paper emerged as requiring further consideration. This paper moves towards a formal assessment of those options, prior to them being circulated for public consultation.

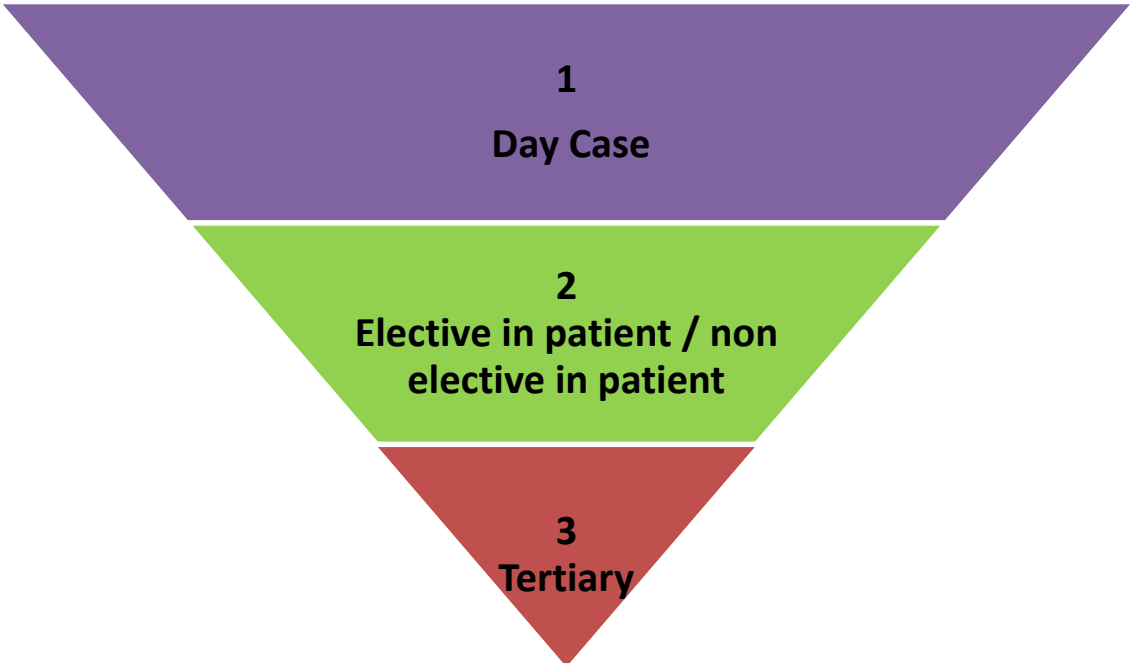
1. Proposed Model for Planned Surgery

1.1 The general principles around provision of safe and sustainable planned surgical care which providers are required to meet are outlined within the Service Specification. The intention of commissioners is to use a 'designation' approach, i.e. units meeting the specification will become designated surgical centres. This will mean designation within the tiers described within the service designation toolkit. There will also be a managed clinical network function in organising and sustaining provision across tiers within the designated centres.

Levels of care for surgery will be tiered as follows:

Tier 1 = Day Case Surgery
Tier 2 = Tier 1 + elective + out of hours non elective inpatient surgery
Tier 3 = Tier 2 + specialist (tertiary)

Surgery Tiers



1.2 This will be organised and planned at a sub specialty level, i.e. the service map for one specialty may differ from that for another specialty. The reason for this is acknowledgment of the accessibility of workforce skills in some sub specialties, which enables some aspects of surgery

to be undertaken more easily than others.

The use of outreach services to support tiers 1 and 2, as well as outpatient services will be a key function that will need to be further developed and supported from the centre hosting the expertise. Within the Managed Clinical Network (MCN) there should be a clear remit to distribute the workforce across the geography in response to need and to undertake improvement and planning activities to ensure compliant services in the designated units.

There are some common widely acknowledged procedures that have lower or higher thresholds or considerations when thinking of the models of care and specified requirements. There are some procedures, for example in general surgery where age thresholds vary, and in ENT airway management and wider support services are critical.

We also know that there are a number of time critical procedures and we must ensure we can respond and treat these effectively. The example of torsion of testes is a well-sighted example. Also the skills and expertise to respond to surgical and anaesthetic care needed within under 3 year olds is another area of great debate and one that consensus to transfer to an appropriately skilled unit has been reached across clinicians.

This means that the consideration of out of hours surgery needs a clearly defined pathway and protocols in place between centres and hospitals within the area.

2. Options and Scenario Appraisal

2.1 The proposed service model should be tested and considered alongside the current need for surgical care across the patch.

2.2 To enable a sustainable service to be established for the future, there will need to be less entry points, more critical mass of planned provision and clarity across pathways to enable out of hours, non-elective care to be directed to the most appropriate centre.

2.3 Providing the appropriately trained workforce through a managed and organised network will be critical to providing a sustainable model of care, therefore the workforce challenges, new models and skills in existence will need careful planning.

2.4 Following discussion at the assessment panel and subsequent service model discussions at the task and finish group, there was a conclusion to propose a model highlighting a range of options for the development of tier 2 hubs for surgical care, as the tier 1 and tier 3 provision are less debatable and easier to plan across the footprint.

2.5 The option needs to provide sustainability, with particular focus on sustaining care across the geography and safe management of the acutely ill child presenting non-electively out of hours.

2.6 There is also a significant interface with the acute care work stream on ensuring that paediatric 24/7 medical care is in place that may further impact on inpatient care levels in the future. As well as this, there is an acknowledged interface with acute maternity and neonatal care due to workforce interdependencies.

2.7 The criteria to assess options and impact of changes within proposals must consider as a minimum:

Criterion	Indicator	Questions
Access **Red** – High Impact negative Impact **Amber**- Some Impact and some changes minimal Impact **Green**- Changes in access but equitable timeframes	Patients would access the same standard of care; ensuring care is equitable across geography and sites. Patients would access the right care within similar timeframes. Therefore population location would not mean negative impact on access.	Will populations from across the WTP footprint access provision for urgent surgery care within critical times frames for treatment? Would populations particularly from areas of high deprivation have to travel longer distances for treatment and care? What will patients value more access to right care in a location further away, or access to substandard care but in a location need by with quicker access?

Activity and flow **Red**- Deliverability of changes in activity are challenging or workforce skill maintenance would be an issue **Amber**- Sustainability of workforce skills although challenging **Green** – Activity changes should be able to be maintained	Any changes in activity or flow can be sustained and managed between providers	Are there are sufficient activity levels to maintain workforce skills? Is there sufficient activity to be able to justify planning care for a group of patients? Will there be a mechanism in place to plan for changes between providers to meet the care needs for surgery provision across the WTP? Have the providers got the ability to deliver an increase in activity or will capacity be an issue?

Workforce sustainability, quality and best practice **Red-** Workforce sustainability still a major challenge **Amber –**possible to maintain but challenging. **Green –** Should be sustainable	That workforce skills and competencies are sustainable longer term and can be developed where needed within the proposed option.	Does the proposed option enable workforce development across a whole system? Can skills be further developed to enable future needs to be met? Will provision be able to meet specified standards? Can proposed models to develop workforce be implemented?

Cross boundary impact **Red –** Significant change, high impact on transport and care across boundaries **Amber –** Some change, some impact **Green –** Change will have minimum impact or could be managed effectively within proposal	That any changes across boundaries are managed with the least possible negative impact and the potential impact on transport is scoped, understood and assessed. Cross boundary provision is considered,	Does this change have a significant impact on transport? Will there be patients from one area travelling more to another area/site for care? If so out of the proposed options which have the most cross boundary changes? Do the proposals have an impact on provision or care across boundaries to neighboring CCG's? If so what might the negative impact of change be?

An indicative “Traffic Lighted” assessment of the models against the relevant criterion (using a “Red, Amber, Green” or “RAG” rating) is included below in sections 2.9 - 2.12. For the implementation of any recommendation it is acknowledged that further collegiate scoring methods should be undertaken in depth by a clinical sub group and by at specialty level in order to support operational delivery and change management requirements.

2.8 There has been some natural migration already within the services into a Tiered approach. This primary gap in service delivery is around paediatrics requiring overnight stay and out of hours services.

2.9 Tier 1 proposals indicate the continued delivery of day case surgery for hospitals that can do two things:-

- Firstly, meet the service specification and associated designation to provide day case surgery.
- Demonstrate enough critical mass to warrant planning and providing this level of activity given that some lists will be provided by an outreach model and at sub specialty may require specific surgical skills.

Tier 2 proposals have focused on appraising and assessing options over 2-4 centre model and will be the area that the largest level of change is needed.

For tier 3 provision this would be provided over only a few centres within the geographical boundaries of the programme.

The options appraisal is based upon current hospital sites, although we know from the needs assessment and the map of population growth rate that the need for provision falls across all areas over time.

Activity numbers associated with each of the options are based upon assumptions, i.e. taking historical patient activity levels in particular sites, and assessing, based upon the shape of each option, a) whether activity would stay at that site or leave and b) if it leaves that site, where it is likely to go to, based upon local geography, transport links, etc.

As this work proceeds, potentially to public consultation against a viable option following appraisal, it may be necessary and good practice to invite further scrutiny of those assumptions.

The following RAG rated / traffic lighted options assessments in sections 2.9-2.11 is based upon initial views of the core members of the programme team, with a focus on an option in light of its ability to meet the relevant standards and meet the intentions of the project. Section 3 will talk about the conclusions and recommendations following the RAG rating.

RAG Rating of Options:

Completed by the Working Together Programme and Project Management team and discussed and approved by members of the Children's Core Leaders Group.

Baseline Activity

The variances associated with each option should be applied to the base 2014-15 activity data which is shown here:

Base Activity 14-15	Trust	ENT	Gen Surg	Ophth	Oral Surg	Paed Dent	Paed ENT	Paed Ophth	Paed Surg	Paed T&O	Paed Urol	T&O	Urology	Grand Total
Elective 0 LoS	BHNFT	269	17	0	362	0	0	0	0	46	0	74	14	782
	CRH	258	59	53	0	0	<5	<5	<5	20	0	76	15	490
	DBH	454	57	58	182	0	0	0	0	0	0	225	26	1002
	MYH	380	45	67	448	0	0	0	0	0	0	218	98	1256
	Other	118	17	23	17	0	32	12	104	25	112	73	14	547
	SCH	0	0	0	0	0	931	271	927	553	0	0	0	2682
	STH	59	16	27	171	539	0	0	0	0	0	59	27	898
	TRFT	214	56	71	446	0	0	<5	0	0	0	109	70	967
Elective 0 LoS Total		1752	267	299	1626	539	<968	<293	<1036	644	112	834	264	8624
Elective Non-DC	BHNFT	38	<5	0	0	0	0	0	0	7	0	19	0	65
	CRH	130	<5	0	0	0	<5	0	0	6	0	23	0	163
	DBH	140	<5	0	11	0	0	0	0	0	0	48	0	203
	MYH	29	<5	0	<5	0	0	0	0	0	0	46	<5	82
	Other	36	<5	0	0	<5	24	<5	22	13	7	35	0	142
	SCH	0	0	0	0	0	407	<5	79	217	0	0	0	705
	STH	9	0	0	<5	0	0	0	0	0	0	18	<5	31
	TRFT	96	5	6	5	0	0	0	0	0	0	26	0	138
Elective Non-DC Total		478	16	6	21	<5	434	<5	101	243	7	215	<5	1529
Emergency	BHNFT	42	262	0	0	0	0	0	0	0	0	197	0	501
	CRH	34	131	<5	0	0	<5	0	<5	0	0	145	0	316
	DBH	175	195	8	12	0	0	0	0	0	0	407	20	817
	MYH	110	212	<5	37	0	0	0	0	0	0	260	108	729
	Other	39	130	<5	9	0	6	0	79	19	<5	146	14	447
	SCH	0	0	0	0	0	67	7	388	174	0	0	0	636
	STH	47	130	0	0	0	0	0	0	0	0	63	62	302
	TRFT	71	294	5	94	0	0	0	0	0	0	238	10	712
Emergency Total		518	1354	19	152	0	74	7	469	193	<5	1456	214	4460
Grand Total		2748	1637	324	1799	540	1473	300	1604	1080	123	2505	480	14613

2.10 **Option One** - **Development of 4 tier 2 hubs**:

Based upon the current providers and need across the patch, hubs would be located at Sheffield, Doncaster, Pinderfields and Chesterfield. This would site tier 2 provision over the geography evenly to meet need. There are existing arrangements between Nottingham and Chesterfield Royal these could be explored further and developed further.

Criterion	RAG	Initial Assessed Impact
Access		This would mean some cases would be transferred to the proposed Tier 2 units and not have a procedure at units providing Tier 1 care. They might be stabilised and transferred to the nearest tier 2 unit. This would mean continuation of the current configuration with most units and sites sustaining and developing full care pathways for all surgery needed. We know this is unlikely to be sustainable model of care, and from the review to date we know this will mean variation when patients access care, or pose a significant challenge in providing equitable access to care.
Activity levels and levels of change		This would mean trying to maintain the activity levels and flows with some activity in most sites, so almost status quo on activity assumptions. It is likely that there would be a level of transfer to ensure patients got the right care. This is not easy to quantify or predict.
Cross boundary impact and transport		This would mean little cross boundary impact. There would be a level of transfer needed which is not easy to quantify given the uncertainty around stabilising clinical appointments on some sites.
Adequate Workforce, safety and quality		There would not be the ability to provide the workforce to provide this cover consistently across all sites.
Impact on visitors/carers		For some care that was not planned this would mean travelling to another site.
Finance		We know the current position overall is not sustainable financially across all NHS provision and there are less resources available in the future.

Challenge in delivery	N/A	This would mean almost status quo
Total weighted score		The status quo is not an option

Option 1 : Indicative Activity Changes:

Four Hubs - Variance Impact by Selected Specialty

1. Emergency

	ENT	*Gen Surg*	*Ophth*	*Oral Surg*	*T&O*	*Urology*	*TOTAL*
Current Activity	518	1354	19	152	1456	214	**3713**
Variance by Provider							
BHNFT	-42	-262	0	0	-197	0	**-501**
CRH	-6	-26	-1	0	-35	0	**-68**
DBH	-12	75	-2	27	-27	-4	**57**
MYH	21	106	0	0	89	-2	**214**
Other	0	0	0	0	0	0	0
SCH	110	401	8	67	408	16	**1009**
STH	0	0	0	0	0	0	**0**
TRFT	-71	-294	-5	-94	-238	-10	**-712**

2. Elective with LOS >0

	ENT	*Gen Surg*	*Ophth*	*Oral Surg*	*T&O*	*Urology*	*TOTAL*
Current Activity	478	16	6	21	215	2	**738**
Variance by Provider							
BHNFT	-38	-1	0	0	-19	0	**-58**
CRH	-36	0	0	0	-5	0	**-40**
DBH	-23	0	1	-1	-1	0	**-24**
MYH	36	0	2	0	7	0	**45**
Other	0	0	0	0	0	0	0
SCH	157	6	3	6	43	0	**215**
STH	0	0	0	0	0	0	**0**
TRFT	-96	-5	-6	-5	-26	0	**-138**

2.11 **Option Two** - **Development of 3 tier 2 hubs**:

To meet need equitably across the geography these would be at Sheffield, Pinderfields and Doncaster. This would provide even distribution over the geography and stabilise the currently established outreach approach with North Lincolnshire and Goole (NLAG) provision. Chesterfield would need further consideration.

Criterion	RAG	Initial Assessed Impact
Access		This would mean some cases would be transferred to the proposed Tier 2 units and not present at units providing Tier 1 care, or be stabilised and transferred to the nearest tier 2 unit. This would mean all CCG populations would have equality of access to the same standards of surgical care, but mean further travel for procedures for some populations.
Activity levels change		This would change the activity and flow with some activity moving from existing sites to the designated Tier 2 units. Therefore a change in activity and flow from 2 existing sites.
Cross boundary impact and transport		This would mean populations from Rotherham, Bassetlaw and Barnsley travelling to Doncaster, Wakefield or Sheffield, if these sites were to be developed as the tier 2 sites. This would impact on transport services, this would need planning in, the number of new transfers overall would increase.
Adequate Workforce, safety and quality		There would need to be concentrated workforce planning throughout and across the 3 hub sites.
Impact on visitors/carers		For some care that was not planned this would mean travelling to the Tier 2 centre instead of a local hospital site.
Finance		Not known at this stage
Challenge in delivery		This option although challenging requires a substantial change could be delivered. It would need a level of additional planning for increased capacity in the proposed tier 2 centres.

Total weighted scores		This option would mean a radical change across inpatient provision and moving to a planned network across outpatient and day case surgery.

Option 2 : Indicative Activity Changes:

Three Hubs - Variance Impact by Selected Specialty

1. Emergency

	ENT	*Gen Surg*	*Ophth*	*Oral Surg*	*T&O*	*Urology*	*TOTAL*
Current Activity	518	1354	19	152	1456	214	**3713**
Variance by Provider							
BHNFT	-42	-262	0	0	-197	0	**-501**
CRH	-34	-131	-3	0	-145	0	**-313**
DBH	-12	76	-2	27	-27	-4	**58**
MYH	20	106	0	0	89	-2	**214**
Other	0	0	0	0	0	0	0
SCH	139	505	8	67	518	16	**1252**
STH	0	0	0	0	0	0	**0**
TRFT	-71	-294	-5	-94	-238	-10	**-712**

2. Elective with LOS >0

	ENT	*Gen Surg*	*Ophth*	*Oral Surg*	*T&O*	*Urology*	*TOTAL*
Current Activity	478	16	6	21	215	2	**738**
Variance by Provider							
BHNFT	-38	-1	0	0	-19	0	**-58**
CRH	-130	-1	0	0	-23	0	**-154**
DBH	-23	0	1	-1	-1	0	**-24**
MYH	36	0	2	0	7	0	**45**
Other	0	0	0	0	0	0	0
SCH	251	6	3	6	62	0	**329**
STH	0	0	0	0	0	0	**0**
TRFT	-96	-5	-6	-5	-26	0	**-138**

2.12 **Option Three** - **Development of 2 tier 2 hubs across the geography**:

These would be located at Sheffield and Pinderfields. This would provide a site for inpatient care within the geography based at a larger distance apart to the current configuration.

Criterion	RAG	Initial Assessed Impact
Access		This would mean some cases would be transferred to the proposed Tier 2 units and not present at units providing Tier 1 care, or be stabilised and transferred to the nearest tier 2 unit. This would mean all CCG populations would have equality of access to the same standards of surgical care, but mean further travel for procedures and may build in a time delay to treatment.
Activity levels – levels of change		This would change the activity and flow with some activity moving from Rotherham, Barnsley, Doncaster and Bassetlaw to the tier 2 units. The level of activity needed at the 2 sites would be challenging to provide.
Cross boundary impact and transport		This would mean populations from Rotherham, Barnsley, Bassetlaw and Chesterfield travelling and would impact on transport services as there would be a significant number of transfers.
Adequate workforce		There would be the ability to plan the workforce to provide this cover apart from the acute paediatric workforce in the future for this care
Impact on visitors/carers		For some care that was not planned this would mean travelling to the Tier 2 centre
Finance		Not known at this stage
Challenge in delivery		There would be bed capacity issues with this proposal as the shift of inpatient activity would be significant
Total weighted score		This could have a significant impact on patients access to care without a radical upgrade in transport and capacity at the 2 site proposed.

Option 3 : Indicative Activity Changes:

Two Hubs - Variance Impact by Selected Specialty

1. Emergency

	ENT	*Gen Surg*	*Ophth*	*Oral Surg*	*T&O*	*Urology*	*TOTAL*
Current Activity	518	1354	19	152	1456	214	**3713**
Variance by Provider							
BHNFT	-42	-262	0	0	-197	0	**-501**
CRH	-34	-131	-3	0	-145	0	**-313**
DBH	-175	-195	-8	-12	-407	-20	**-817**
MYH	48	163	1	1	108	3	**324**
Other	0	0	0	0	0	0	0
SCH	274	719	15	105	879	27	**2019**
STH	0	0	0	0	0	0	**0**
TRFT	-71	-294	-5	-94	-238	-10	**-712**

2. Elective with LOS >0

	ENT	*Gen Surg*	*Ophth*	*Oral Surg*	*T&O*	*Urology*	*TOTAL*
Current Activity	478	16	6	21	215	2	**738**
Variance by Provider							
BHNFT	-38	-1	0	0	-19	0	**-58**
CRH	-130	-1	0	0	-23	0	**-154**
DBH	-140	-4	0	-11	-48	0	**-203**
MYH	47	1	2	2	16	0	**67**
Other	0	0	0	0	0	0	0
SCH	357	10	4	14	100	0	**486**
STH	0	0	0	0	0	0	**0**
TRFT	-96	-5	-6	-5	-26	0	**-138**

3. Conclusions and Recommendations

3.1 Governing Bodies are asked to support the designation of Tier 1 and Tier 3 surgical care, enabling the implementation of this through the Managed Clinical Network and through commissioning and contracting teams within CCGs.

3.2 Governing Bodies are also asked to support further consideration of the options. Building upon the initial, indicative RAG scores above, and noting that (at this stage) the three-hub model appears to offer the greatest benefit and scope for feasibility, and should be appraised further.

3.3 This is likely to lead to the formal classification a “Preferred Option”, with subsequent development of a business case to examine detailed implementation aspects.

3.4 It is acknowledged from the outset and from the RAG scoring and supporting data that there will be potential capacity issues, to a greater or lesser degree, with all options, as well as potential sustainability impacts upon other services at sites not designated as Tier 2. The ‘do-ability’ of options should be a substantial factor in their appraisal.

3.5 Following the first phase of work on the Acute Care pathway in May and the STP initial modelling to be completed in June 2016, further consideration of the potential impacts of these upon surgical models will need to be undertaken. There is an acknowledged interdependency between the assessment and management of acute care within paediatric assessment and the pathway to surgical care for procedure and intervention.

3.6 At this stage, whilst the three-hub model presents the most promising initial findings, the Working Together Programmes recognise that, in addition to option scoring, all proposals will and should be subject to adequate public consultation, and that this should take place in a transparent way. It is anticipated that this consultation will start in September 2016.

Kate Laurance on behalf of Commissioners Working Together and *the Working Together Programme*
1 June 2016

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DRAFT CONSULTATION DOCUMENTS

Providing hyper acute stroke services in South Yorkshire and Bassetlaw and North Derbyshire

Following a review into hyper acute stroke services in South Yorkshire and Bassetlaw and North Derbyshire, we are now considering a number of options for the future of the service.

At the moment, depending on where people live, they will have a different experience and receive different standards of care and our local doctors, nurses, healthcare staff and clinical experts all agreed that this shouldn't be the case.

Between January and April this year, we held an open pre-consultation to ask patients and members of the public what would matter to them when accessing these two services. All feedback has been central to the development of the options which have been agreed by all our local NHS clinical commissioners and councillor health leads.

We want to know what you think. Between 3 October 2016 and 6 January 2017 we want your opinions on our options to change and improve our hyper acute stroke services.

Who are Commissioners Working Together?

Commissioners Working Together is a partnership between the eight NHS clinical commissioning groups (CCGs) in South and Mid Yorkshire, Bassetlaw and North Derbyshire. NHS clinical commissioning groups pay for local health services in their region and our aim is to provide better services for everyone by working together.

Our partners are:

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

What are hyper acute stroke services or units (HASUs)?

They are:

- Where you are cared for up to the first 72 hours after having a stroke when you need more specialist 'critical' care.

They are not:

- "Acute stroke" units/wards – which is where you are cared for after the first 72 hours of having a stroke until you are ready to go home from hospital

- Rehabilitation services, such as speech and language and physiotherapies, which help you get better once you've gone home from the hospital

Why do we want to improve these services?

- At the moment, 3 out of 5 of our critical care units (HASUs) admit less than 600 patients a year which is below the best practice minimum of 900 per year – meaning our workforce isn't being used in the best, or most efficient way, so could become deskilled

- We need more stroke doctors and nurses to run the existing services – but there aren't enough locally and nationally and this is leading to problems with medical cover in our local hospitals – and we have already seen temporary closures of some of our units.

- How quickly scans and tests are done, and reported – which help to diagnose and then treat patients – varies from hospital to hospital

- Due to this delay in the necessary tests being done, there is a delay in some treatments that should be given after having a stroke

- We currently have two units less than 15 miles away from each other which, separately, are unsustainable (and currently treat less than 600 patients a year)

Because of the reasons above, the experience and treatment our patients receive currently varies across our region and it is getting harder to provide the level and quality of safe services that we expect.

What are the options?

We are recommending that we change services by adopting a system wide solution, working together better for the benefit of every stroke patient in South Yorkshire and Bassetlaw and North Derbyshire. Based on feedback from our doctors, nurses and regional and national clinical experts, we think option one would allow us to do this, with further work being carried out to consider the second option in the future.

Option 1:

If you live in South Yorkshire and Bassetlaw and North Derbyshire and have a stroke, you would receive hyper acute stroke care in:

- Chesterfield Royal Hospital
- Doncaster Royal Infirmary
- The Royal Hallamshire Hospital, Sheffield

This would mean that Barnsley and Rotherham hospitals would no longer provide hyper acute care for people who have had a stroke.

After the first 72 hours of receiving critical care, if you live in Barnsley or Rotherham and are well enough, and want to, you would be transferred to your local hospital for the remainder of your care.

This is because we are not looking to make changes to 'acute' stroke care which is care received after the first 72 hours until you go home from hospital and this will still be provided in all our local hospitals.

Rehabilitation services, such as speech and language and physiotherapies, which help you to get better once you've left hospital, will also be provided closer to where you live.

Option 2:

If you live in South Yorkshire and Bassetlaw and North Derbyshire and have a stroke, you would receive hyper acute stroke care in:

- Doncaster Royal Infirmary
- The Royal Hallamshire Hospital, Sheffield

This would mean that Barnsley, Chesterfield and Rotherham hospitals would no longer provide critical care for people who have had a stroke.

After the first 72 hours of receiving critical care, if you live in Barnsley, Chesterfield or Rotherham and are well enough, and want to, you would be transferred to your local hospital for the remainder of your care.

This is because we are not looking to make changes to 'acute' stroke care which is care received after the first 72 hours until you go home from hospital and this will still be provided in all our local hospitals.

Rehabilitation services, such as speech and language and physiotherapies, which help you to get better once you've left hospital, will also be provided closer to where you live.

I live in Barnsley/Rotherham, where will I go if I have a stroke?

In the future, if you had a stroke, you may be taken to another South Yorkshire hospital for the first 72 hours of your care, but at the moment, nothing will change and you will be taken to and treated in Barnsley and Rotherham.

Any decision to change this is subject to public consultation.

If you want to change services, should I be worried that this means they're not safe at the moment?

No. For the reasons mentioned, we want to improve services so our patients get consistent and continued high quality and sustainable care - while avoiding care becoming unsafe in the future.

We know that to provide the best services for our patients, we could do things better and we believe that one of the best ways to do this is to work across a wider area – ensuring safe staffing levels and using skills and resources in a more efficient and effective way.

Let us know what you think!

>To include personal details questions including equal opps form (no names)<

Do you agree or disagree with our proposal to change the way we provide hyper acute stroke services?

Agree
Disagree
Don't know

If you disagree with our proposal to change the way we provide hyper acute stroke services, please let us know why:

(Comment box)

At the moment, some people have better experiences, better and faster treatment and better access to services than others – and because we want to make sure everyone has access to the same high quality care, we have developed the following options with feedback from our doctors, nurses and members of the public who took part in our pre-consultation. Which of our proposed options do you prefer?

Option 1
(Details in box)

Option 2
(Details in box)

Why do you think this is the best option?

(Comment box)

Do you think there is another option we could consider?

Yes
No
Don't know

If you answered yes, please describe this below and say why you would prefer this option

(Comment box)

What happens next?

Between 3 October 2016 and 6 January 2017, we will be asking for people living in South Yorkshire and Bassetlaw and North Derbyshire to let us know what they think about our proposals to change hyper acute stroke services.

The results of this consultation will be presented to the Commissioners Working Together (joint CCG) board and the joint health overview and scrutiny committee who will make a decision on how hyper acute stroke services will be provided in our region.

When making a final decision, we will consider:

- All patient and public feedback
- The impact on access to services, including travel times
- The impact on quality and safety of the service

We expect a decision to be made in February 2017.

Providing children's surgery and anaesthesia services in South and Mid Yorkshire, Bassetlaw and North Derbyshire

Following a review into children's surgery and anaesthesia services in South and Mid Yorkshire, Bassetlaw and North Derbyshire, we are now considering a number of options for the future of the service.

At the moment, depending on where people live, they will have a different experience and receive different standards of care. Our local doctors, nurses, healthcare staff and clinical experts all agreed that this wasn't fair – and came together to change it.

Between January and April this year, we held an open pre-consultation to ask patients and members of the public what would matter to them when accessing these two services. All feedback has been central to the development of the options which have been agreed by all our local NHS clinical commissioners and councillor health leads.

We want to know what you think. Between 3 October 2016 and 6 January 2017 we want your opinions on our options to change and improve our children's surgery and anaesthesia services.

Who are Commissioners Working Together?

Commissioners Working Together is a partnership between the eight NHS clinical commissioning groups (CCGs) in South and Mid Yorkshire, Bassetlaw and North Derbyshire. NHS clinical commissioning groups pay for local health services in their region and our aim is to provide better services for everyone by working together.

Our partners are:

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

Why do we want to change children's surgery and anaesthesia services?

At the moment, some people have better experiences, better and faster treatment and better access to services than others – and we don't think this is right. We want everyone to have access to the same, high quality services, no matter where in the region you live.

We also know:

- Some of our hospital doctors and nurses don't treat as many children as others do – which means experience and quality of services and treatment can vary depending on where you live.

- Nationally, there aren't enough health care professionals qualified to treat children.

- Changes to the numbers of hours that doctors can work means that cover is a mixture of permanent and temporary staff and this can affect continuity of care.

- The costs of services will exceed funding in the future.

- For the reasons above, the quality of the service isn't the same everywhere – all hospitals must work to the same high standards, but this is getting harder.

Which services do you mean?

If your child needed an operation under general anaesthetic (where they are sent to sleep):

- ✓ At night, or
- ✓ At a weekend, or,
- ✓ They need to stay in hospital overnight

For the following services,

- Ear, nose and throat (ENT)
- General surgery
- Ophthalmology
- Oral surgery
- Trauma and orthopaedics
- Urology

We are proposing they are done in a different way.

These are the only services we are proposing to change.

For most services, nothing would change. Children would still have operations in their local hospitals for things like:

- Tonsil removal
- Glue ear
- Setting of fractures/broken bones
- Any treatment that requires only a local anaesthetic but not being sent to sleep

We're also not looking to change specialist services for children with very complex or multiple conditions needing care from specialist doctors and nurses. For these services, you would still go to Sheffield Children's Hospital as the only specialist children's centre in our region.

What are the options for children's surgery and anaesthesia services?

We are recommending that three options for the future of children's surgery and anaesthesia services are considered during public consultation. These are:

Option 1:

If your child needed an operation under general anaesthetic (where they are sent to sleep):

- ✓ At night, or
- ✓ At a weekend, or,
- ✓ They need to stay in hospital overnight

For the following kinds of surgery, they would go to Chesterfield Royal Hospital, Doncaster Royal Infirmary, Pinderfields General Hospital or Sheffield Children's Hospital (map).

- Ear, nose and throat (ENT)
- General surgery
- Ophthalmology
- Oral surgery
- Trauma and orthopaedics
- Urology

Children's operations for these services would no longer be provided in Barnsley or Rotherham hospitals.

Option 2:

If your child needed an operation under general anaesthetic (where they are sent to sleep):

- ✓ At night, or
- ✓ At a weekend, or,
- ✓ They need to stay in hospital overnight

For the following kinds of surgery, they would go to Doncaster Royal Infirmary, Pinderfields General Hospital or Sheffield Children's Hospital (map).

- Ear, nose and throat (ENT)
- General surgery
- Ophthalmology
- Oral surgery
- Trauma and orthopaedics
- Urology

Children's operations for these services would no longer be provided in Barnsley, Chesterfield or Rotherham hospitals.

Option 3:

If your child needed an operation under general anaesthetic (where they are sent to sleep):

- ✓ At night, or
- ✓ At a weekend, or,
- ✓ They need to stay in hospital overnight

For the following kinds of surgery, they would go to Pinderfields General Hospital or Sheffield Children's Hospital (map)

- Ear, nose and throat (ENT)
- General surgery
- Ophthalmology
- Oral surgery
- Trauma and orthopaedics
- Urology

Children's operations for these services would no longer be provided in Barnsley, Chesterfield, Doncaster or Rotherham hospitals.

Which option do we prefer?

We prefer option 2. This is because with careful planning to ensure we have the most appropriate staff in each hospital, and to make sure our patients could get to one of the hospitals within XX minutes, we believe that option 2 would give all patients in South and Mid Yorkshire, Bassetlaw and North Derbyshire, access to the same quality and standard of children's surgery services.

We do not think that option 1 would be sustainable as we would not have enough doctors or nurses to provide cover across all sites meaning we would risk facing further safety and quality problems.

We also think that option 3 would be challenging in terms of the increased amount of patients going to only one of two places.

By making changes to how children's surgery and anaesthesia services are currently provided, we believe we can better run the service as one – sharing skills, knowledge and ultimately, providing a much better, equal service to every child across South and Mid Yorkshire, Bassetlaw and North Derbyshire.

I live in Barnsley/Chesterfield/Rotherham - where will I go if my child needs an operation?

In the future, you may need to travel to another hospital in South Yorkshire if your child needs a certain kind of treatment that is no longer provided at your local hospital - but at the moment, nothing will change.

All options and the decision to approve any of the options is subject to public consultation.

What if my child needs an emergency operation?

At the moment your child would go to your local hospital, where depending on their needs, they may be transferred to Sheffield Children's Hospital for specialist care. If you live in Sheffield already, you would go straight here. This won't change.

If you want to change services, should I be worried that this means they're not safe at the moment?

No. For the reasons mentioned, we want to improve services so our patients get consistent and continued high quality and sustainable care - while avoiding care becoming unsafe in the future.

We know that to provide the best services for our patients, we could do things better and we believe that one of the best ways to do this is to work across a wider area – ensuring safe staffing levels and using skills and resources in a more efficient and effective way.

Let us know what you think!

>Personal details questions including equal opps form (no names)<

Do you agree or disagree with our proposal to change the way we provide children's surgery and anaesthesia services?

Agree
Disagree
Don't know

If you disagree with our proposal to change the way we provide children's surgery and anaesthesia services, please let us know why:

(Comment box)

At the moment, some people have better experiences, better and faster treatment and better access to services than others – and because we want to make sure everyone has access to the same high quality care, we have developed the following options with feedback from our doctors, nurses and members of the public who took part in our pre-consultation. Which of our proposed options do you prefer?

Option 1	**Option 2**	**Option 3**
(Details in box)	(Details in box)	(Details in box)

Why do you think this is the best option?

(Comment box)

Do you think there is another option we could consider?

Yes
No
Don't know

If you answered yes, please describe this below and say why you would prefer this option

(Comment box)

What happens next?

Between 3 October 2016 and 6 January 2017, we will be asking for people living in South and Mid Yorkshire, Bassetlaw and North Derbyshire to let us know what they think about our proposals to change children's surgery and anaesthesia services.

The results of this consultation will be presented to the Commissioners Working Together (joint CCG) board and the joint health overview and scrutiny committee who will make a decision on how children's surgery and anaesthesia services will be provided in our region.

When making a final decision, we will consider:

- All patient and public feedback
- The impact on access to services, including travel times
- The impact on quality and safety of the service

We expect a decision to be made in February 2017.

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