GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

TRUST BOARD STRATEGY SESSION – JANUARY 2020

This information is confidential. Proposals detailed within this document are subject to consultation/involvement

Report Title
Centres of Excellence – Long to Medium List Process
Sponsor and Author(s)
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Executive Summary

Purpose

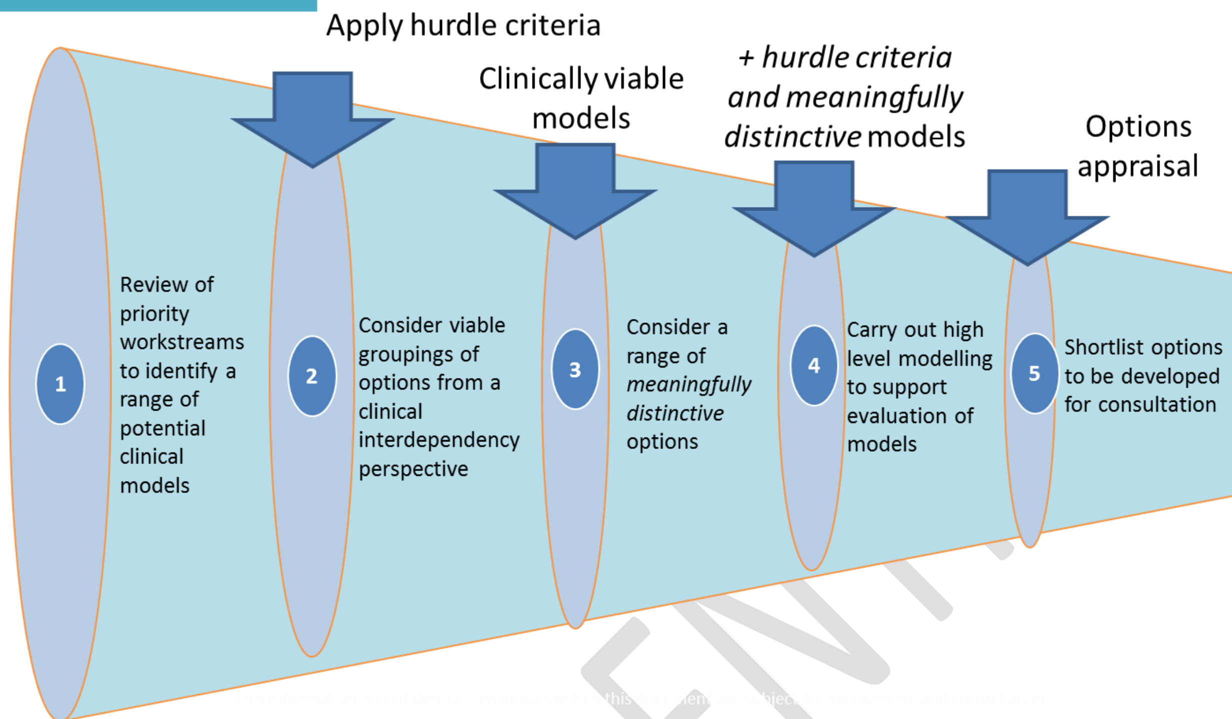
To brief the Board on activities to develop the long and medium list of solutions, prior to Solutions Appraisal on 4th and 5th February 2020.

Key issues to note

1. Fit for the Future public engagement paused in October and a draft *Outcomes of Engagement Report* and *Baseline Impact Report* were issued to programme clinical workstreams under controlled circulation during the pre-election period.
2. The General Election has delayed the programme timeline, moving the Citizens' Jury from December to January. The programme aim is still to go back out to the public with consultation options following local elections in May 2020.
3. For *centres of excellence* we engaged with the public on the following topics (as agreed at July TLT):
    a. Overall *centres of excellence* vision
    b. General surgery
    c. Emergency and acute medicine (including emergency departments and acute take)
    d. Image-guided interventional surgery hub (including interventional radiology, cardiology, vascular)
    e. All of the above relating to adult services only, outpatients excluded.
4. At the end of October, following requests to clarify the position relating to ED, it was confirmed the final consultation options will not include any proposals to change the current Emergency Department service model at Cheltenham General Hospital
5. The final *Outcomes of Engagement* and *Baseline Impact Report* will be published in early January prior to discussion at the Health and Social Care Overview and Scrutiny Committee.
6. A Citizens' Jury will be convened from 20th – 24th January 2020. This Jury is not a decision-making body, but will consider the important factors the public should be aware of in delivery of the services outlined above. Their advice will help us prepare for consultation.
7. A second Citizens' Jury will convene following a public consultation phase to make a recommendation on the preferred option for delivery.
8. The solutions development process outlined in the remainder of this paper is documented for scrutiny and debate and is subject to variation if required.
9. Appraisal of the solutions/options suggested below is due to take place on 4th and 5th February 2020, with the supporting evidence pack issued on 27th January 2020.

The Solutions Development Process

The diagram overleaf illustrates the stages of solutions development. This paper covers up to step 4.



Step 1: Developing a longlist

The longlist was developed separately by three workstreams:

- Image-Guided Interventional Surgery
- General Surgery
- Emergency & Acute Medicine

Each Workstream held workshops over a variety of pre-arranged and bespoke meetings between 30th October and 13th December 2019.

All workstreams had access to the following documents to support development of the longlist:

- the draft *Outcomes of Engagement Report* to ensure the longlist reflected feedback from the public engagement phase, including notes from the three independently facilitated *Solutions Development Workshops* with a balanced room of lay and service representation
- a modelling baseline report including protected characteristics data, benchmarking and activity
- a draft *Baseline Impact Report* to provide context on protected characteristics, inequality and travel

This led to the description of 21 separate solutions descriptions, as illustrated overleaf, where A = Emergency & Acute Medicine, B = Image Guided Interventional Surgery, C = General Surgery D= New build single hospital:

Longlist: The 21 solutions descriptions

A

1:	2:	3.	4.
ED: No change **AM: No change**	**ED: No change** **AM:** GRH >Acute Floor CGH: extended SDEC Smaller MAU Direct admit pathways	**ED: No change** **AM:** GRH >Acute Floor CGH: extended SDEC No MAU Direct admit pathways (=centralised acute take)	**ED: 24/7 CGH** **AM: No change**

B

1. No change	**2. IGIS Hub and Vascular centralised to GRH**	**3. IGIS Hub centralised to GRH Vascular remains CGH**	**4. IGIS Hub centralised to CGH**

C

1. EGS – both	**2. EGS – CGH**	**3. EGS – GRH**
4. Elective colorectal – both	**5. Elective colorectal – CGH**	**6. Elective colorectal - GRH**
7. Elective upper GI – both	**8. Elective upper GI – CGH**	**9. Elective upper GI – GRH**
10. Daycases – both	**11. Daycases – CGH**	**12. Daycases – GRH**

D

1

Single site new build hospital

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Each solution has its own supporting document setting out the clinical model, adjacencies and potential impact. There are 1297 possible variations of the solutions descriptions above.

It should be noted that the Trust intends to consult on the long-term configuration of Trauma & Orthopaedics and Gastroenterology as part of this process. These two specialties are only considered in two variants for each: continue the new configuration, or revert to the previous delivery model. These are therefore not factored in to the process until Step 4.

Step 2: Applying the Hurdle Criteria

Hurdle criteria were defined by the ICS Executives and set out in the draft Pre-Consultation Business Case approved by Trust Board in June 2019. They are as follows:

1. Address the issues identified in the Case for Change
2. Supports the delivery of high quality care across Gloucestershire, ensuring provision of a clinically safe service.
3. Achievable and able to be delivered in a timely and sustainable way.
4. Affordable and offers best value for money, making the most of the Gloucestershire pound (Is the solution within the current cost envelope (19/20 forecast outturn cost base)?
5. Supports sustainable ways of working and facilitates both recruitment and retention of our workforce.

The clinical Workstream groups were asked to review the draft longlist solutions against the Hurdle Criteria and provide recommendations about any solution which did not meet the hurdle criteria, along with supporting evidence. Their recommendations were discussed by GHFT Executive Team on 10th December and at Centres of Excellence Advisory Group for further discussion on 11th December.

Two solutions were recommended for removal due to failure to clear the hurdle criteria set:

Solution ref	Descriptor	Hurdle not cleared	Rationale/evidence
D1	Single site new build hospital	1, 3, and 4	Although 'Gloucestershire 2050' references a vision for a new acute hospital for the county, within the 10 year timeframe of this programme a new hospital is not part of the ICS or Trust vision, and the supporting capital is unlikely to be available to make it affordable and therefore achievable.
C1	Emergency general surgery on both sites (CGH and GRH)	1 and 5	High level workforce risks exist associated with continuing delivery of this 'current state' configuration. Assessed as unsustainable in the short to medium term on this basis, and therefore also does not meet Case for Change.

If accepted, this would reduce the longlist down to 19 possible solutions with 864 potential variations.

Step 3: Group into clinically viable models

The next stage was to bring the three Workstream solution descriptors together to eliminate any combinations of solutions that did not form 'clinically viable' models. This process was started by Centres of Excellence Advisory Group on 11th December, and then discussed further by the clinical Workstream groups. NB. The Image Guided Interventional Surgery group will not meet until January 2020.

There were several recommendations and suggestions from this discussion, which can be summarised in three themes:

- combinations to remove
- combinations/solutions that can be set aside to become variants on distinct models later
- other considerations

Combinations/solutions to remove

- C2 (centralise Emergency General Surgery to CGH) was incompatible with any material changes. The driver for this was the key clinical adjacency with paediatrics which cannot be factored in as a variable within the scope of this programme.
- The combination of A3 (centralised acute medical take) and B4, centralise Image-Guided Interventional Surgery to CGH, was assessed as non-viable

A3. ED: No change **AM:** GRH >Acute Floor CGH: extended SDEC No MAU Direct admit pathways (=centralised acute take)	**B4. IGIS Hub centralised to CGH**	**Reduced capacity and capability for acute medicine in CGH would make the full centralisation of the IGIS Hub on the CGH site undeliverable.**

- Solution A2 (smaller MAU in CGH) was deemed sub-optimal and not a viable alternative solution, particularly when considered alongside the only remaining viable emergency general surgery solution (centralise to GRH) and should be removed from further consideration.

Viable solutions/combinations that can be set aside as variants on preferred model(s)

- All general surgery daycase solutions (C10/11/12),as daycase surgery model can be flexed to support the preferred inpatient solution
- The following General Surgery combinations are theoretically viable, but will be set aside as variants to consider on a shorter list of options:
  - C7: Elective Upper GI split across both sites
  - C4 + C8: Elective colorectal no change, plus elective Upper GI to CGH

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- C4 + C7: Elective colorectal no change, plus elective Upper GI split across both sites
- C5 + C7: Elective colorectal CGH, plus elective Upper GI to both
- C6 + C8: Elective colorectal to GRH, plus elective Upper GI to CGH
- C6 + C7: Elective colorectal to GRH, elective Upper GI to both

Other recommendations:

- Solution A3 is not sufficiently described at present and requires further definition and adjustment to make it a viable alternative solution.
- The A1 (no change in emergency and acute medicine) and B1 (no change in image-guided interventional surgery) options do not clear hurdle criteria as they do not meet the case for change. They are retained as a comparator in the 'no change' scenario.
- A4 (re-open CGH ED overnight) was not deemed compatible with C3 (centralise emergency general surgery to GRH), the only remaining EGS solution. However, it needs to remain on the list for further evaluation due to the amount of public feedback asking for it to be considered. It is therefore shown as a variant on the 'no change' option in combination with C3 (centralised emergency general surgery to GRH). Further work will be required to assess whether this can be made to be a viable medium to long term configuration. All other A4/C3 combinations are discounted.

The effect of these recommendations would be 14 remaining solutions descriptions, of which 10 are variations on the current model. Allowing for the combinations that are held for consideration later, this leaves 29 potentially viable configurations.

Step 4: *Meaningfully Distinctive* options
At this stage the aim is to reduce the 29 variants to a medium list of options that differ sufficiently from each other to be compared and evaluated. On this basis, **nine options** are suggested and set out below, in increasing order of change. Some of these have multiple variants and so the configuration which allows the most distinction between this option and others is used to ensure the proposed change is clear. All viable variants are still available to be applied to solutions that score well in appraisal.

0. No change
1. Revert to original T&O and Gastroenterology configurations
2. Only centralise Emergency General Surgery to GRH, no other changes (option 2 is embedded in all subsequent options)
3. Re-open CGH ED fully overnight
4. Partial split of elective general surgery surgical specialties (more to CGH than current)
5. Centralise all elective and emergency gastrointestinal to GRH
6. IGIS hub to GRH, retain vascular in CGH
7. Full elective/non-elective split for general surgery with IGIS hub centralised to GRH
8. Full elective/non-elective split for general surgery with IGIS hub remaining in CGH
9. (A subset of 7 and 8 which only shows a centralised acute medical take)

These nine options are laid out in more detail overleaf:

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		Least change				More change			Most change		
Ref	**Solutions Descriptor**	**No Change**	**Option 1**	**Option 2**	**Option 3**	**Option 4 (4.4)**	**Option 5**	**Option 6**	**Option 7**	**Option 8**	**Option 9**
			Least change - revert to original Gastro/T&O configurations	**Least change - centralise EGS**	**Least change + overnight ED**	**GI partial split**	**Centralise GI (GRH)**	**IGIS hub to GRH, retain vascular CGH**	**Most change (E/NE split with hub on NE site)**	**Most change (E/NE split with hub on E site)**	**Most change - no CGH MAU**
A1	E&AM: No change	✓		✓		Variants on E&AM	Variants on E&AM	Variants on E&AM	Variants on E&AM	Variants on E&AM	
A2	CGH smaller MAU										
A3	CGH no MAU										✓
A4	CGH ED to 24/7				✓						
B1	IGIS: No change	✓	✓	✓	✓	Variants on IGIS	Variants on IGIS				Variants on IGIS
B2	IGIS hub and vascular to GRH								✓		
B3	IGIS hub to GRH, vascular CGH							✓			
B4	IGIS hub CGH									✓	
C1	*EGS both*	*✓*									
C3	EGS to GRH		✓	✓	✓	✓	✓	✓	✓	✓	✓
C4	Elective colorectal both (no change)	✓	✓	✓	✓						
C5	Elective colorectal to CGH					✓			✓	✓	
C6	Elective colorectal to GRH						✓	Variants on elective GI			Variants on elective GI
C7	Elective upper GI both										
C8	Elective upper GI CGH								✓	✓	
C9	Elective upper GI GRH (no change)	✓	✓	✓	✓	✓	✓				
Gastro 1	Centralised CGH	✓		✓	✓	✓	✓	✓	✓	✓	✓
Gastro 2	Original configuration		✓								
T&O 1	Split O=CGH/T=GRH	✓		✓	✓	✓	✓	✓	✓	✓	✓
T&O 2	Original configuration		✓								
C10	GI daycases - both	✓	Configurations to be defined								
C11	GI daycases - CGH										
C12	GI daycases - GRH										

NB. It is possible that the final shortlist will comprise variants on the options set out above.

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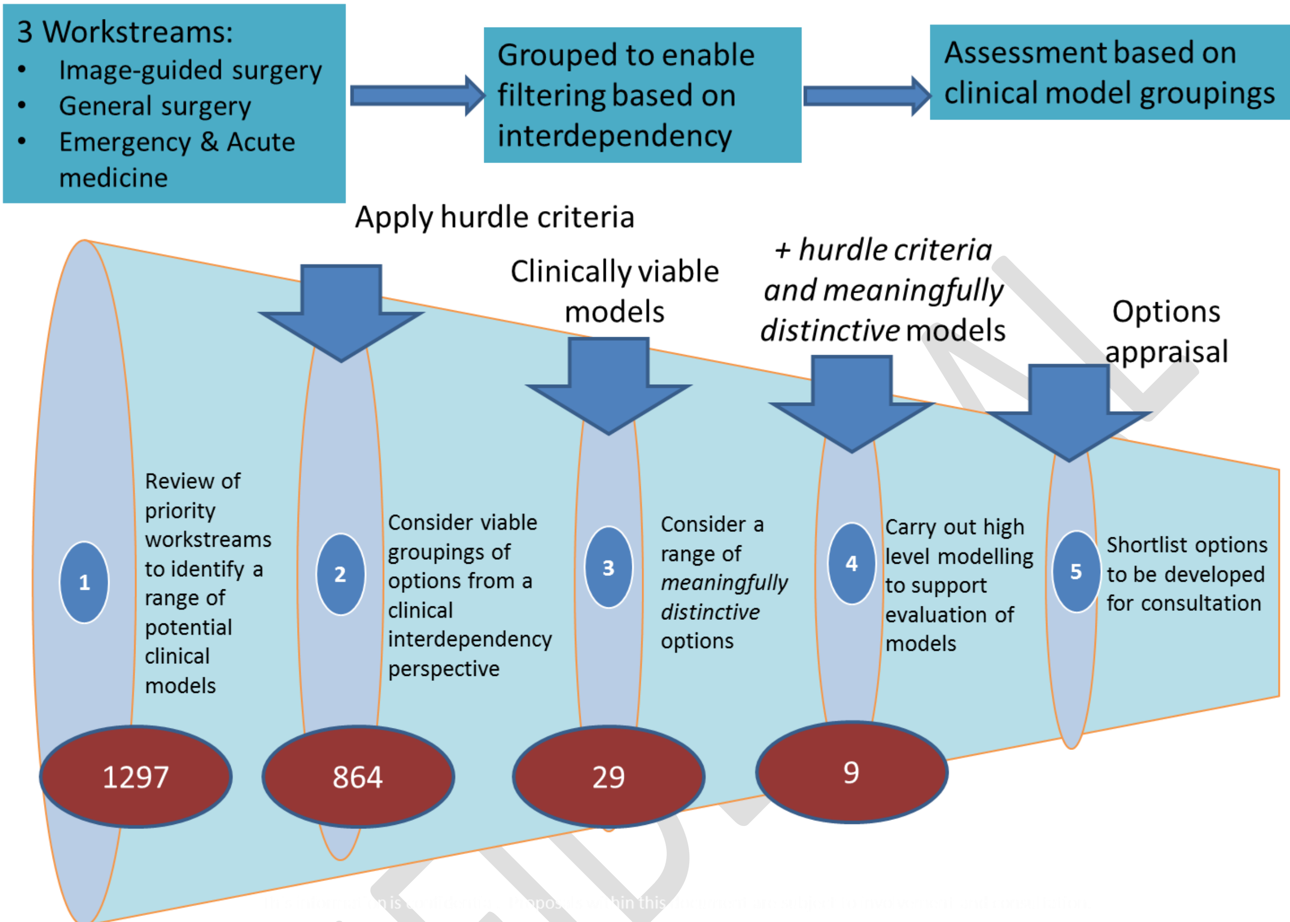
Conclusions

The cumulative impact of these recommendations is summarised in the diagram below:



Implications and Future Action Required
All of the process outlined above is documented for scrutiny and debate and is subject to variation if required.

The key next step for Board to be aware of is the requirement to develop the 'A3' solution description(s) to provide a clinically viable and supported variant on no change.

Due to tight timelines, a modelling brief was issued on 17th December based on the nine options and associated solutions descriptions set out in this paper. Any variations in options will need to be confirmed as early as possible in January in order to meet the deadline for issue of the Solutions Appraisal supporting evidence pack on 27th January 2020, ready for solutions appraisal on the 4th and 5th February.

Recommendations

Board is asked to:

1. Support the recommendation on hurdle criteria (remove D1 – build a brand new hospital, and C1, continue the current configuration for emergency general surgery).
2. Support the recommendations on 'clinically viable' solutions and combinations as set out Step 3 (page 4-5), that removes a number of possible solutions
3. Note the requirement to develop an agreed description for 'A3' (centralised acute take, no change to CGH ED)
4. Support the development of modelling for the nine proposed options, or recommend any changes

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Impact Upon Strategic Objectives
Delivers the 'Centres of Excellence' objective and supports delivery of 'Outstanding Care'
Impact Upon Corporate Risks
C2784 – Risk of formal challenge to service reconfiguration proposals: provided we follow advice, the PCBC and engagement process seek to mitigate risk of successful challenge to proposals. Deteriorating patient (safety risk): this paper supports mitigation of existing Surgical Division patient safety risk around providing a sustainable long-term model.
Regulatory and/or Legal Implications
As a clinical reconfiguration programme Centres of Excellence carries a high risk of legal challenge. This is well understood and the processes set out here are designed deliberately to ensure transparency of decision making and clarity that discussions and suggestions are subject to evaluation of impact, and public engagement and consultation where required.
Equality & Patient Impact
A comprehensive Baseline Impact Assessment report has been prepared which sets out the current equalities baseline for each of the services in scope. It also considers important factors that should be taken into account in the development and evaluation of potential solutions, such as how people travel to hospital, and the impact of physical, mental and social circumstances on access to services. The Baseline Report does not evaluate any specific options. A multi-agency Reference Group, including several patient and public representatives, was tasked with overseeing development of this report. Following agreement the medium and shortlist of options, a Pre-Consultation Report will be produced which sets out the actual impact of any options proposed. This will form part of the solutions appraisal supporting materials pack.

Resource Implications			
Finance	X	Information Management & Technology	X
Human Resources	X	Buildings	

Action/Decision Required							
For Decision		For Assurance		For Approval	x	For Information	

Date the paper was presented to previous Committees						
Quality & Performance Committee	**Finance & Digital Committee**	**Audit & Assurance Committee**	**People and OD Committee**	**Remuneration Committee**	**Trust Leadership Team**	**Other (specify)**
					8/01/20	
Outcome of discussion when presented to previous Committees						
Pending						

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