NHS
South West
Clinical Senate

**Fit for the Future (Centres of Excellence): Clinical Senate Desktop Review**

**Sponsoring Organisation: Gloucestershire ICS**

**Clinical Senate: South West**

**Date: 9th March 2020**

## Background

As part of the NHSE assurance process for large scale service change, it is normal for the regional Clinical Senate to undertake a Clinical Review of proposals to consider the clinical evidence base and clinical model behind proposed changes ahead of public consultation.

A formal clinical review panel is normally set up ahead of, and to inform, the stage 2 NHSE assurance meeting around the clinical model and evidence base for it, along with assessing the bed test (tests 3 and 5). Prior to setting up a full panel, and broadly in line with the stage 1 assurance meeting, a desktop review panel considers draft PCBC documentation (to include the case for change) to highlight any key concerns early on in the review process and inform the development of a robust PCBC prior to sign off to consult publicly. The desktop review panel is normally a smaller grouping of the final panel which reviews documentation virtually rather than through a face to face panel.

## Prior Clinical Senate input;

In July 2017, the Senate undertook a Clinical Review of Gloucestershire STP's urgent and acute care model which included community urgent care settings as well as a proposed split of planned and urgent care services between its two acute hospitals, including a proposed reduction to one ED at GRH. At the time the panel concluded that it broadly supported the STP's proposals for its urgent and acute care model, noting they were ambitious in their aim to improve patient care and drawing attention in the panel report to a number of recommendations to support the proposals and some concerns where further detail was felt to be required to provide assurance around the delivery and implementation of a clinically sound model. This desktop review and the subsequent review planning is considering the further development of these plans.

## Summary of Core Proposals;

Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT) currently operates from two main hospital sites, (Cheltenham General Hospital (CGH) and Gloucester Royal Hospital (GRH)), 8 miles apart. Since merging to form a single Trust in 2002 many services have been centralised to one of the two sites, including paediatrics, stroke and trauma to Gloucestershire Royal Hospital and ophthalmology, oncology and urology to Cheltenham General Hospital. However, many adult medical and surgical specialties have continued to be delivered on both sites. As demand grows,

technology improves and staff availability and specialisation changes, these arrangements are leading to clinical quality, workforce and financial challenges.

The 'Centres of Excellence' element of the wider Fit for the Future Programme (previously called "One Place") focuses on developing Cheltenham General as a centre for planned care and Gloucester Royal hospital as a centre for emergency care respectively. The ICS vision is for a single hospital on two sites, linked by the A40 corridor. The proposed clinical models retain a 24/7 front door (ED/ED+MIIU) and ITU on both sites.

The first phase of the centres of excellence programme proposes centralisation of general surgery services (emergency and elective gastrointestinal including day surgery), image-guided interventional surgery (IGIS), interventional radiology, vascular and cardiology procedures, the acute medical 'take' and clinical support for the deteriorating patient.

Outpatient appointments, maternity and children's services and oncology appointments (chemo/radiotherapy) are out of scope.

The second phase of centres of excellence will review critical dependencies and enablers associated with the preferred option(s) for centralising the phase one specialties. This is likely to include clinical support services, care of the elderly, medical cardiology, respiratory, neurology and other elective services such as gynaecology, ENT etc.

The preferred configuration identified through a thorough options appraisal process includes the centralisation of acute medicine, an IGIS hub and Emergency General Surgery to GRH, with Gastro-intestinal day-cases moving to CGH. It has been noted that the centralisation of emergency general surgery to GRH is contingent on the centralisation of neurology to CGH. The location of centralised elective colorectal services and vascular services is yet to be determined through the variant options to be consulted on. The long-term configuration of Trauma & Orthopaedics and Gastroenterology, which have been centralised to date under pilot schemes to GRH, will also be confirmed as part of this process.

**Desktop Review**

Members of the Clinical Senate Council were convened to undertake a desktop review and to consider the case for change and early documentation. They had two weeks from February 14th 2020 to feedback on the following documents:

1. 'FFtF Senate KLOEs' Document (in lieu of Draft PCBC)
2. Appendices 1-10
3. FFtF Senate KLOEs v2 (received 20/02/20)

Panel members were specifically required to consider and provide feedback against the following key lines of enquiry;

1. **What are the proposals and are they clear?**
2. **Is the clinical case for change robust and in line with national best practice and evidence?**
3. **Will the outlined or preferred model improve the quality of care?**
4. **Do the proposed changes address the issues identified in the case for change?**
5. **What might need to be incorporated in future iterations of the model of care, when developing detailed options and where is further information needed?**

**Clinical Senate Desktop Review Feedback**

**Key Comments**

1. There is a general consensus in favour of and support for the direction of travel which is well understood from a clinical perspective. The proposals are needed to improve clinical care and should progress as soon as possible. However significantly more detail needs to be provided on the clinical models, their potential impact and the evidence base for them to support and document the decision making and assurance process.

2. The phasing of proposals and links to interdependencies are unclear. Outlining a preferred model for neurology (including the links to stroke), vascular and colorectal as has been done for other specialities would help to clarify the relevant clinical co-dependencies overall and provide a vision of how the system could be working in the next 5 years.

3. There is concern that the timeline proposes not moving the medical take for several years which is at odds with the clinical case for change.

4. There is concern that maintaining a full ED at CGH is not sustainable without other co-dependent clinical services.

5. It has been noted that the centralisation of emergency general surgery to GRH is contingent on the proposed centralisation of neurology to CGH, however no information about the clinical model for neurology is provided.

6. No information on the existing model for T&O and Gastroenterology has been provided although there is an intention to make this change permanent through consultation.

7. No workforce model or strategy has been included to demonstrate how workforce shifts will be managed and the workforce challenges highlighted in the case for change, addressed.

8. Information on activity figures, transfers and bed numbers should be included, particularly given the significant level of service moves proposed. Even if bed numbers are static there is a requirement to demonstrate the bed test is met for each component where there is movement.

9. The estates plan is key to understanding how the proposed service moves will be managed. It is referred to several times but no detail is provided.

10. An overview of the plans for phase two support services, which are described as critical but not detailed, as well as context around the wider FFtF programme and community urgent care offer should be provided.

**Feedback against key questions:**

1. **What are the proposals and are they clear?**

The Gloucestershire Integrated Care System are reviewing the services that their two main acute hospital sites provide. The vision and overall proposal is clear in its ambition which proposes that the two acute sites are developed as two centres of excellence with planned care being delivered at Cheltenham General Hospital and urgent care being delivered at Gloucestershire Royal Hospital.

There are currently four potential service models which have been narrowed down from a much larger number of options.

The proposals are far reaching and form a major part of the broader Fit for the Future programme. This leads to the challenge of presenting only part of a broader programme which is too big to be described in a single PCBC, whilst giving sufficient detail of the future model of care to allow a detailed assessment. The proposals are clearly stated but it was difficult to understand the interdependencies between each of the departments and therefore the impact of the options.

The broad concept underlying the proposals is clear. However, although preferred options for the 3 main components of the proposal are clear, a number of options for Image-guided interventional surgery (IGIS) (i.e. interventional radiology, vascular and cardiology), colorectal surgery, gastrointestinal day surgery, and neurology are described in varying detail in the documents. The merits of the various more detailed subcategories of options are not clearly articulated, and any emergent preferred options for these services are not clear. This makes it difficult to assess how the case for change will be addressed overall. There is no detail in these documents of the proposals for neurology services.

"Phase 2" enablers are included from 2020/21 on the implementation timeline chart on page 41 yet no details are given about phase 2 proposals. Reference is made at several points to the proposals being dependent on changes in estate and reference is made to the "Estates Plan". No information is provided about this.

2. **Is the clinical case for change robust and in line with national best practice and evidence?**

The clinical case for change is strong and many aspects of the changes proposed are in line with best practice and evidence. The broad direction of travel for the whole Centres of Excellence programme makes sense and given the case for change, components of the proposal, particularly the centralisation of the acute medical take, should be brought forward rather than waiting until 2022/23.

The documents state that the Trust has made a commitment to retaining urgent and emergency care front door services (ED/MIIU) in CGH as currently configured – the clinical justification for, and sustainability of, this commitment is not clear.

The case for change outlines three areas of challenge; namely clinical, workforce and financial. The items under each area are significant and best practice is referred to. There are also references to the Transforming Urgent and Emergency Care Services in England 2015 & The Royal College of Surgeons recommendations about separating emergency admissions from elective surgical admissions.

There are also predicted population changes within the next 5 years with an increase of 23,000 population, an increase of the 75-84 population of 25% and a corresponding increase in the number of people over 65 with a long-term illness. These factors need to be taken into consideration when addressing the case for change.

Neither the contingency plans for tacking medical admissions pressures, nor how interdependencies between surgery and medicine for some conditions will be managed, which may increase pressure on certain services, are clear.

The proposals list four key areas for change which include general surgery, IGIS, the acute medical 'take' and clinical support for the deteriorating patient. However, the headline clinical case for change hardly mentions IGIS and does not mention deteriorating patients support at all. The acute medical take which should be a priority is not discussed in detail.

Neither is the case for change regarding repatriating out of area patients well made. The piloted changes to T&O and gastroenterology mentioned are confusing and the impact of these not articulated properly.

It is also not clear which of the proposed changes, in particular IGIS, require building work or developments costs which will impact the pace of progression and interdependencies.

3. **Will the outlined or preferred model improve the quality of care?**

In broad terms the main components of the model will improve the quality of care, although the panel has some concerns about out of hours and weekend cover for all specialities at CGH once the changes have been implemented, both in terms of the number of clinicians available, their skills, the degree of senior supervision and the ability to recruit and train sufficient band 8a Advanced Clinical Practitioners. There is insufficient information in the proposals to determine the actual quality of care that the changes will provide as the preferred model is not specified.

The model does not contain enough information to assess whether risks associated with implementation, such as failure to recruit and management of the workforce across both sites, will have more or less of an impact on the quality of care in the future model than they do at present.

The highlighted clinical challenges suggest there is a focus on general surgical input to the proposals, where other specialities also need to be clearly involved. How the priority clinical challenges will be addressed by the proposals also needs to be more clearly laid out; for example; "At times, senior surgical decision makers are in theatre and unavailable to review patients waiting for specialist surgical assessment leading to delays in treatment." as well as the aspiration to offer more image guided procedures within county, or how shared access leads to sub-optimal EGS care. Compliance with national guidance on EGS, which the Senate reviewed in the South West in 2017 is well supported.

4. **Do the proposed changes address the issues identified in the case for change?**

The proposed changes fit with the aim for delivery of specialist care in a timely fashion by the most appropriately trained people. The case for change highlights problems with the current model of care and the broad direction of change proposed addresses some of these concerns; however, more detail is required on the preferred option to be able to assess how effectively and sustainably the changes will be able to address the concerns and improve care.

The proposed changes move staff so that for each discipline they are based on a single site rather than stretched across two. This will help address many of the clinical challenges. While these changes may help with some of the workforce challenges it is not demonstrated that they will overcome them. Many of the workforce issues are national rather than just local. Addressing local challenges may help with recruitment and training of surgeons but there is concern that acute medicine consultant recruitment issues will persist and this risk needs to be mitigated.

There is concern for those patients presenting to CGH ED who require inpatient medical or surgical admission and whom are potentially disadvantaged under the proposed model. Further detail and consideration of whether maintaining CGH as a limited opening hours ED fits with the clinical case for change should be provided with some modelling of the number of patients and pathways affected under the new model to understand the scope. It would be misleading to imply that patients will have the same same parity and experience presenting at ED at both sites. The non elective care supporting the ED will be minimal and the medical back up is not well articulated in the model. Further information and assurance around the resuscitation arm left at CGH overnight alongside the MIIU model should also be provided with clarification as to whether there will be resuscitation at CGH in the MIIU from 8pm onwards and who it would be delivered by. The clinical reasons for maintaining a limited hours ED rather than a 24/7 UTC front door model within the context of proposed reconfiguration need to be clearly detailed.

The Clinical Senate supported a 'one ED' model in 2017 based on the clinical case for change. The differences between a UTC and an ED are critical and acute medicine and surgery are considered crucial interdependencies for an ED (http://www.secsenate.nhs.uk/clinical-senate-advice/published-advice-and-recommendations/clinical-co-dependencies-acute-hospital-services-clinical-senate-review/). The management of the proposed model and its risk assessment therefore needs much more detail provided.

It would be good overall to ascertain as to how outcomes will be measured. NICE guidance and quality standards can help shape the development of outcome indicators.

5. **What might need to be incorporated in future iterations of the model of care, when developing detailed options and where is further information needed?**

**Key Areas**

1. It would be most useful for evaluating the proposals if the overall emergent preferred option was put forward and supported by details as to how this option was reached. If this is not possible then further detail modelling the clinical viability of each of the options and the impact they will have on interdependent clinical services should be provided.
2. A plan to move the timeline for Acute Medical Take centralisation forward or clinical justification for delaying it for 2 years.
3. Justification of the decision to retain urgent and emergency care front door services (ED/MIIU) in CGH as currently configured.
4. Details of the Estate plan to describe the anticipated service moves.
5. Proposals for neurology and their evaluation of options.
6. Details of the impact of the proposals on stroke services and the relationship with neurology services.

7. Details of numbers of beds for each service affected by the proposed changes.
8. How proposed changes are expected to affect workforce and recruitment and risk assessment and mitigation if this cannot be achieved.

**Workforce**

9. The overall workforce proposals lack detail with no workforce strategy or modelling included. Given the workforce challenges are described as significant, this information is key to understanding the clinical viability of the models and in particular cross-site surgical cover resilience. Information around both the potential opportunities and challenges resulting from the changes for workforce would be helpful. It should also be evidenced that core services can be covered before pulling back more specialist work eg. interventional cardiology from Bristol.
10. Details of out of hours medical cover on each site for each of the services.
11. Contingency plans if nursing staff from CGH do not want to move.
12. Modelling of the potential impact of changes at CGH on junior doctor supervision, training & rotas, and the accreditation of these posts. Engagement with deanery regarding the full scope of the proposed changes would be helpful to demonstrate given the reference on p8 to concerns with surgical trainees.
13. Details of the impact of service moves on provision of and requirement for therapy services (physio & OT).
14. Detail to demonstrate that the level of ITU staffing on both sites will be sustainable. Will the ITU consultant cover surgical and medical CT/TG with any sick patient at CGH?
15. Detail to demonstrate that the overnight/weekend staffing of the ED and ED /MIU is sustainable.
16. Training needs assessment for move to more minimally invasive procedures and timescale.
17. Workforce plans for out of hours IGIS service and rota cross cover.
18. Staffing of the deteriorating patient team at CGH and the availability of critical care staff at all levels to support.
19. There is very little in regard to Nursing or AHPs. Being able to train and focus on specialism would not only improve outcomes and safety but also should have some positives HR affect such as improved retention and recruitment.

**Emergency General Surgery (and potential impact on colorectal and vascular):**

20. Assurance that a Consultant surgeon from GRH travelling to CGH for an out of hours emergency with support staff needed for opening a theatre available is a viable option when necessary and that this can be staffed.
21. Plans for weekend consultant ward reviews of surgical patients at CGH.
22. A move of colorectal services is dependent on urgent endoscopy provision. How will the UGI bleed rota be managed? If gastroenterology is at CGH, is the UGI bleed rota/urgent endoscopy provision at CGH? What is the provision for an acute GI bleed when attending GRH on the acute medical take?

23. How will IBD acute patients at GRH be managed if colorectal and gastro consultants are at CGH?
24. For gallstones, is there an UGI cons on-call every day to assess the acute admission? What about day-case patients who end up staying in with difficult gallbladders?
25. How will colorectal and upper GI cover at be managed at weekends if EGS is at GRH and/or elective colorectal is at CGH? Is there consultant buy-in for increased elective weekend working?
26. Will there be vascular consultant on-call cover over weekends and how will acute vascular cases such as ruptured AAAs be managed, including any transfers?
27. Page 19 of the document shows vascular on both sites.

**Acute Admissions**

28. Modelling the number, impact, management and risk of the patients presenting to CGH ED who need acute admission. This should include modelling ambulance transfers to GRH to include current numbers versus anticipated. Diagram 9.2 (future patient pathway) implies that all patients will be coming through the single front door in the ED.
29. More details around proposed repatriation of patients in future, what cases/from where.

**Other**

30. More consideration of the potential negative impacts of solutions A3, B2 in Appendix 3, and actions to mitigate these.
31. Assurance that SWAST have been involved in planning and can cope with inter-hospital transfers of sick patients. The work between Weston Hospital and SWAST may be useful.
32. Details on how services and beds will be accommodated on the 2 sites (e.g. Appx 3 p56 section 3.6 says “Some displacement of existing services will be required to establish a sufficient footprint for an IGIS hub at GRH (incl. associated daycase beds), relocation of the hybrid theatre and relocation of the vascular bed base to GRH. Further implementation planning required if this is a shortlisted solution” and Appx 3 p72 section 5.4 and p93 section 5.4 “Ward and theatre capacity would be required – plan for this not yet developed”).
33. The travel impact assessment provided shows only the estimates of the impact at peak driving time. The additional impact assessments (off-peak, for staff and most importantly for patients using public transport) must be included in the PCBC.
34. Clarification around phasing and what phase 3 looks like to understand the steps and order of changes towards delivering the overall vision. This will also help determine any other impacts on key stakeholders such as primary care, ambulance service, social care etc.

**Additional Comments**

There is reference to national standards and undertaking a review of best practice in the document. It would be good to ascertain if NICE was included in this review and for this to be reflected. Referencing NICE would help to document that their proposals are underpinned by robust evidence in order to deliver the best possible care within the resources available and thus improve outcomes for people.

There is a wealth of guidance, quality standards and advice available pertaining to acute medical and surgical care which can inform their proposals. For example:

- Emergency and acute medical care in over 16s: service delivery and organisation - which includes Emergency and acute medical care in over 16s: service delivery and organisation (NG94) which aims to promote good-quality care in hospital and joint working between health and social services (includes recommendations pertaining to 1.2 Emergency and acute medical care in hospital (managing hospital admissions, timing and frequency of consultant reviews) and Quality standard - Emergency and acute medical care in over 16s which describes high-quality care in priority areas for improvement (includes Statement 2 Adults who are admitted with undifferentiated medical emergencies are assessed and initially treated in an acute medical unit and Statement 3 Adults admitted with a medical emergency have a timely consultant assessment and review);
- Acutely ill patients in hospital - encompassing Acutely ill adults in hospital: recognising and responding to deterioration (CG50) which aims to reduce the risk of patients needing to stay longer in hospital, not recovering fully or dying. Includes recommendations on using physiological track and trigger systems to identify at risk patients and response strategies for patients who are deteriorating;
- Gastrointestinal conditions
- Acute upper gastrointestinal bleeding
- Neurological conditions

NICE also has a selection of resources to help make effective decisions for local services, including:

- Emergency and acute medical care in over 16s: service delivery and organisation (NG94) Baseline assessment tool
- Acutely ill adults in hospital: recognising and responding to deterioration (CG50) Baseline assessment tool

**Next Steps**

This desktop report is signed off by the desktop review panel and shared with Gloucestershire ICS and the NHSEI assurance team to inform development of the final PCBC (by 13th March 2020).

31st March has been set as the date for Clinical Review and a panel is being convened for this in. Gloucestershire ICS have committed to share their final PCBC with the Clinical Senate by 17th March in order that this can be shared with the review panel members in advance of the panel date for pre-reading and to highlight any concerns or key lines of enquiry for the review.

Given the short time frame between desktop feedback report and sharing of the final PCBC, it is requested that a desktop commentary with responses to our points specifically addressed in either a covering note or highlighting where the information can be found in the PCBC is provided.

**Desktop Review Panel Members**

Dr David Halpin – Deputy Chair, Clinical Senate (Chest Physician)
Dr Mary Backhouse – GP
Barbara Yesson-Smith – Consultant Nurse
Dr Nick Kennedy – Consultant Intensivist
Dr Leilah Dare – ED Consultant
Katie Cross – Consultant General Surgeon
Jane Jacobi – NICE field team