Gloucestershire Health and Care Overview and Scrutiny Committee (HCOSC)

13 November 2018

General Surgery Reconfiguration Pilot

Introduction

This paper provides a briefing on the proposal to pilot the reconfiguration of General Surgery[1] services across Gloucestershire Royal Hospital (GRH) and Cheltenham General Hospital (CGH).

The proposal is to centralise emergency and complex planned general surgery at GRH and short-stay and daycase planned surgery at CGH from autumn 2019.

Support for the pilot is being sought from HCOSC now to allow detailed implementation planning to begin that will ensure changes are in place to improve patient safety and outcomes as part of the system 2019 winter sustainability plan.

The proposed model of care has been designed by clinical teams to address a number of issues, including:

- Inability to sustainably deliver national standards for emergency general surgery
- Inability to provide emergency patients with consistent access to sub-specialist care (gastro-intestinal and colorectal)
- Unwarranted variation in patient experience across the two sites
- Inability to provide a suitable teaching environment for our Junior Doctors – this has been escalated to the General Medical Council (GMC) and Severn Deanery
- Recommendations from external reviews completed by South West Clinical Senate and national Getting It Right First Time (GIRFT) programme.

This proposal should be considered within the context of the One Gloucestershire Integrated Care System (ICS) and Sustainability and Transformation Plan (STP).

[1]General Surgery is an overarching term for upper gastrointestinal surgery and colorectal surgery. It covers the surgical management of disease of the gastrointestinal tract and associated organs from the rectum and everything in between, so includes stomach, small and large intestines (bowel), gall bladder, spleen and liver.

Context - One Gloucestershire ICS & STP

One Gloucestershire is the working name given to the partnership between the county's NHS and care organisations to help keep people healthy, support active communities and ensure high quality, joined up care.
http://www.onegloucestershire.net/

The five key priorities of One Gloucestershire are shown below. The proposed reconfiguration of general surgery will [in part] support the achievement of priorities three and four.

1. place greater emphasis on supporting people to keep healthy and look after themselves when they can;
2. provide truly joined up care and support in people's homes, GP surgeries and in the community, helping people to remain independent for as long as possible and reducing the need for hospital stays;
3. pursue excellence in hospital services – with an emphasis on quality, safety and the best health outcomes for local people;
4. develop a sustainable local health and care workforce – offering the best training, education, learning, professional supervision and environment to attract and keep the best staff; and
5. Make the most of new technology to improve and join up care.

In 2017 One Gloucestershire's STP set out a series of ambitions to be achieved by 2021 and we are making good progress towards these. The proposed reconfiguration of general surgery will [in part] support the achievement of the following three ambitions:

- Ensured that those people with more serious or life-threatening emergencies are treated in centres with the very best expertise and facilities in order to maximise their chances of survival and a good recovery.
- Ensured when an admission to hospital is needed, that we will start planning discharge home as soon as possible so people do not stay in hospital any longer than absolutely necessary, and so health and social care work together effectively to support safe discharges.
- Ensured that our main hospitals provide a range of services 7 days a week in order to meet the agreed national clinical standards.

An STP engagement programme was run in 2016/17 to ensure the views of local people informed the plan's ambitions. Feedback from this process that is relevant to the proposed reconfiguration of general surgery includes:

- 69% of respondents generally agreed we should bring some specialist hospital services together in one place.
- The most important thing if people needed urgent or emergency care services was: 35% Prompt assessment and decision making, 33% 7 day access to services, 14% Centres/services staffed by specialists, 10% Joined up services, 8% Distance to travel.

Context – previous service reconfigurations

To deliver safer care with better outcomes and experience for patients and their families, Gloucestershire Hospitals NHS Foundation Trust (GHFT) has a history of successfully centralising services at the two acute hospital sites within the county; either CGH or GRH. Recent examples include:

- **Centralised at CGH:** vascular surgery, urology, ophthalmology, orthopaedics[2] & gastroenterology[3]
- **Centralised at GRH:** obstetrics, acute paediatrics & neonatology, ear nose & throat, trauma.

Over the same period, for the same quality and safety reasons, specialties have been centralised at regional centres, for example Major Trauma at North Bristol NHS Foundation Trust.

Whilst service centralisations in Gloucestershire have been supported where there is a strong clinical case for change that will improve patient safety, experience and outcomes, these centralisations have recognised the importance of promoting local access, where quality can be assured. This has meant that outpatient and ambulatory care has typically been maintained at both acute hospital and in other community locations.

Drivers for Change

As national standards for care and training of medical staff have evolved, concerns about the sustainability of delivering emergency general surgical care at both hospital sites have grown amongst local clinicians. It is now clear that those standards cannot be met within the current county model. Junior doctors have expressed their concerns about the quality of their teaching experience to the General Medical Council (GMC), which increases the risk of the deanery removing the training status of the service.

Currently services for emergency and planned Upper Gastro Intestinal and Colorectal surgery are provided across both GRH and CGH. This model of care has proved difficult to staff sustainably and does not provide emergency patients with consistent access to sub-specialist care as is routinely available at other Trusts and set out in national standards (Gastro-Intestinal and Colorectal surgery are sub-specialisms of General Surgery). For example, patients presenting with gall stones, a high volume condition, will see a specialist at the point of presentation on less than 50% of occasions; similarly, patients with colorectal conditions will not see a specialist at least half of the time. The evidence for benefits, associated with specialist review, is considerable and is reflected in national standards, many of which the Trust is not able to meet.

Finally, external reviews of the service by the South West Clinical Senate and the national Getting It Right First Time (GIRFT[4]) programme, all of which endorse the

[2] Trauma & Orthopaedic reconfiguration is currently being run as a pilot with regular updates to HCOSC
[3] Gastroenterology reconfiguration goes live on 8th November 2018 with the first update to HCOSC due in March 2019

centralisation of emergency surgery onto a single site, concluded that a different model of care is essential if we are to provide the highest quality service for the people of Gloucestershire

Process used by GHFT to agree a preferred option

There is consensus among the clinical team for the centralisation of emergency general surgery at GRH. However, this centralisation requires a revision to the model of care for planned surgery and a number of options were developed by the clinical team to address the risks and issues of this part of the service.

In the absence of clinical consensus on the preferred model of care for planned surgery, the Trust established a process and independent panel to reach a conclusion on the most appropriate model. Under the Chairmanship of Mr John Abercrombie, General Surgeon, Queen's Medical Centre, Nottingham and national lead for the General Surgery Getting It Right First Time programme (GIRFT), alongside input from clinical subject matter experts, commissioners and patient representatives we undertook an appraisal to identify the preferred model through the evaluation of a number of options, against criteria agreed by the Panel Chair. All options assessed through this process were developed by the clinical teams and all included the centralisation of emergency general surgery at GRH.

Whilst all participants in the process agreed that services should centralise, not all senior clinicians were in unanimous agreement on the preferred site for planned care. However, there was majority support for the preferred option recommended by the Panel.

In line with previous reconfiguration and the Trust's prescribed governance, the Trust's Leadership Team (TLT) reviewed the recommendations from the independent Panel and, at its September 2018 meeting endorsed the recommendation outlined below, which was subsequently presented to the Trust Board on 13 September 2018 (2 days after HCOSC met in September 2018) and subsequently communicated internally to Trust staff. It is for this reason that, unlike Gastroenterology, which had already received the approval of the TLT, it was not presented to the September HCOSC.

The internal communication of key milestones such as the TLT decision is something done for all significant decisions. This communication was clear that this was a milestone towards possible reconfiguration and that public consultation would be required. With hindsight, it is evident that the language could have been less certain and more conditional and a wider briefing of external stakeholders regarding the communication would have been beneficial at the same time as the internal communication. This is a learning point for the Trust.

It is important to note that not all reconfiguration proposals garner support as they progress though our internal review processes and therefore never make it to the stage where a wider group of stakeholders become engaged.

[4] http://gettingitrightfirsttime.co.uk/

Proposed model of care

If the proposal for change was supported, then under the preferred option, day case patients would be treated in CGH in a dedicated Day Surgery Unit and outpatients continue to be provided on both sites. The location of this service at CGH would enable theatre lists to run without interruption from emergencies, leading to fewer cancellations and a better experience for patients.

At GRH there would be a dedicated Emergency General Surgery Unit providing patients with rapid access to assessment and clinical decision making by sub-specialist medical and nursing staff. The evidence indicates this will reduce the need for admission to hospital through early, senior specialist review as well as enable access to more timely surgical care, when warranted. A separate specialist unit would provide care for Upper Gastro Intestinal and Colorectal patients undergoing complex planned surgery.

On average, each day 140 patients attend CGH Emergency Department, of which 6 are admitted to General Surgery. Under the proposal, these 6 patients would be admitted to GRH rather than CGH. Improvements in the emergency pathway outlined above will reduce this to approximately 5 per day.

As part of its pilot mobilisation plan the Trust will consider travel and transport for those patients affected, and will pay particular attention to mitigating the potential impact of the changes on vulnerable groups.

Proposed timescales

- Approval for pilot requested at HCOSC - November 2018
- Implementation planning - November 2018 to March 2019
- Coproduction – February to April 2019
- Implementation approach approved by GHFT - Feb 2019
- System mobilisation - April to September 2019
- Go-live - September 2019 (to be confirmed through implementation planning)
- Progress reported to HCOSC - tba

Evaluation of the pilot

A number of Key Performance Indicators (KPI) have been identified to support the evaluation of the pilot and these are listed in appendix 1. The KPIs have been divided into three groups: Patient safety and experience, activity and workforce. If the proposal is supported, HCOSC will be updated on performance against these KPIs on a timescale to be agreed.

Next steps

As part of the One Place Programme, progress with which is regularly reported to HCOSC through the Integrated Care System (ICS) Update Report, a public consultation is envisaged for 2019/20. This will be informed by a period of coproduction to develop proposals for consultation. This consultation would include proposals to formalise the trauma and orthopaedic and gastroenterology pilots, and

the changes to General Surgery described here (subject to the pilots demonstrating anticipated benefits have been achieved).

Progress with the Trauma Pilot was reported to HCOSC in March 2018 indicating that it had delivered a 20% increase in elective activity and 50% reduction in trauma waiting.

As part of the planning for consultation, once the preferred General Surgery option has been coproduced in more detail, targeted engagement with a wider group of staff, Trust governors, commissioners, patient groups would be planned and reported and discussed with HCOSC as we have done for previous service reconfigurations.

In the meantime, the proposal is that the changes to General Surgery described here are considered as a pilot as part of this year's local system-wide sustainability plan (alongside the Trauma and Orthopaedic and Gastroenterology pilots already supported).

It is clear that our aim is to produce a vibrant future for both Trust acute sites and work such as that described above will continue to achieve this aim. HCOSC will be regularly updated on progress and, as timescales for consultation become firmer, these will be discussed with HCOSC to allow for proper scrutiny of our emerging plans.

The Gloucestershire STP/ICS partnerships are seeking HCOSC support to pilot the General Surgery reconfiguration change described above from September 2019, as we want to ensure changes are in place to improve patient safety and outcomes as part of the system 2019 winter sustainability plan.

We have listened to feedback from the public, stakeholders and our staff and want to ensure we offer a period of pre-consultation coproduction with a wider group of stakeholders, so we can incorporate ideas into the future design of urgent and emergency care across Gloucestershire. We will build on our experience of recent local engagement and consultation activities, for example learning from the recent engagement work using a Citizens' Jury in the Forest of Dean relating to location the new Community Hospital.

We would welcome the opportunity to share the outcome of the system pilots (T&O and Gastro) and test and learn work (UTC and Acute Floor) at an additional single item HCOSC meeting in spring 2019. At this session it would be our intention to share the implementation plan for the General Surgery pilot.

Appendix 1: Pilot Key Performance Indicators

1. Patient safety and experience

- All emergency admissions will be reviewed by a consultant within 12 hours of the decision to admit or within 14 hours of arrival in hospital
- All elective and emergency patients will have a daily senior review
- Number of emergency general surgery cases done on the day that the surgery was originally planned
- Best practice pathways are in place for patients with biliary colic, abscesses or appendicitis
- Length of stay reduction across all groups of patients
- 'High risk' patients have their operation carried out under the direct supervision of a consultant surgeon and consultant anaesthetist
- Deteriorating patients will be managed according to timed clinical protocol, e.g. patients with septic shock are operated on within three hours
- All patients with a predicted mortality (p-Possum) >5% should be admitted to DCC.
- Time to access a surgical opinion 24/7 from GI team by site and specialty
- Improvement in patients recommending the hospital to friends and family
- GP experience survey.

2. Activity

- Number of emergency patients assessed on Surgical Assessment Unit
- Number of emergency patients admitted – short and long stay
- Number of emergency patients 'Return To Home' for overnight stay and subsequent treatment
- Number of patients seen in ambulatory clinic
- Number of outliers on Emergency Surgical Unit
- Number of electives by site and type (e.g. day case, in-patient)
- Number of GI emergency patients presenting to Emergency Department by site and type, e.g. walk-ins, 999 ambulance
- Number of transfers between Gloucester (GRH) and Cheltenham (CGH)
- Emergency imaging reported real time and urgent imaging within 4 hours
- Number of critically ill patients having IR within 1 hour and within 12 hours if not critical
- Number of emergency theatre cases undertaken out of hours
- Number of cancellations for non-clinical reasons.

3. Workforce

- Consultant rota no more frequent that 1:7
- Specialty trainees available within 30 minutes to see and treat acutely unwell patients
- Trainee rotas are compliant with national trainee contract, EWTD and Deanery regulations for each tier
- Positive GMC survey returns
- Staff feel positive about working in the service – all professions and grades
- Reduction in agency and locum spend
- Internal stakeholders recognise the benefit for patients and staff.