Briefing paper on Fit for the Future
Update to Health Overview and Scrutiny Committee

Document Control

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1. Purpose of the Document

This paper for the Gloucestershire Health Overview and Scrutiny Committee (HOSC) provides:

- an update on the progress towards implementation of the Fit for the Future (FFTF) Programme
- a summary of issues previously raised by HOSC
- proposals for the next stage of the programme (FFTF Phase 2).

The approach set out in this paper (and the associated paper *Briefing paper on COVID-19 Temporary Service changes - update to HOSC (July 2021)* describes our plans for the continued development of our health services to improve quality and ensure sustainability.

2. Fit for the Future - Phase 1

Fit for the Future (FFTF) is part of the One Gloucestershire ICS vision focussing on the medium and long-term future of specialist hospital services at Cheltenham General Hospital and Gloucestershire Royal Hospital. The aim is to:

- Improve health outcomes for the people of Gloucestershire
- Reduce waiting times and ensure fewer cancelled operations
- Ensure patients receive the right care at the right time in the right place
- Ensure there are always safe staffing levels, including senior doctors available 24/7
- Support joint working between services to reduce the number of visits patients make to hospital
- Attract and keep the best staff in Gloucestershire.

Since the publication of the NHS Long Term Plan in January 2019 HOSC Members have received more than 10 reports and presentations relevant to the development of specialist hospital services in Gloucestershire:

- Dedicated FFTF Agenda Items; and
- Regular updates in the NHS Gloucestershire CCG Clinical Chair and Accountable Officer's Report and the STP/ICS Lead Report.

This paper provides an update on the progress made to date towards implementation of the FFTF proposals approved by the Gloucestershire ICS in March 2021.

2.1 FFTF Phase 1 Service Changes

The following service changes were approved by the CCG Governing Body at their meeting on 18 March 2021.

1. Formalise 'Pilot' Configuration for Gastroenterology inpatient services at CGH
2. Formalise 'Pilot' Configuration for Trauma at GRH and Orthopaedics at CGH
3. Centralise Emergency General Surgery at GRH
4. An Image Guided Interventional Surgery 'Hub' at GRH and 'Spoke' at CGH
5. Centralise Vascular Surgery at GRH
6. Centralise Acute Medicine (Acute Medical Take) at GRH
7. Planned General Surgery. The recommendation is that further work should begin to define a new option to deliver:
    a. Planned High Risk Upper Gastrointestinal (GI) and Lower Gastrointestinal (Colorectal) surgery at Gloucestershire Royal Hospital
    b. Planned complex and routine inpatient and day case surgery in both Upper and Lower GI (Colorectal) at Cheltenham General Hospital

2.2 HOSC Issues

FFTF proposals have been presented and discussed at HOSC on several occasions and members identified a number of areas where further information was requested, that were discussed at meetings in October 2020, January 2021 and March 2021. A summary of these is presented below, with a recap / signposting to the relevant document where the detail is provided, recognising that the membership of the committee has recently changed following the May local elections.

FFTF Pre-Consultation (PCBC) and Decision-Making business cases (DMBC), with appendices can be found at: https://www.onegloucestershire.net/yoursay/fit-for-the-future-developing-specialist-hospital-services-in-gloucestershire/

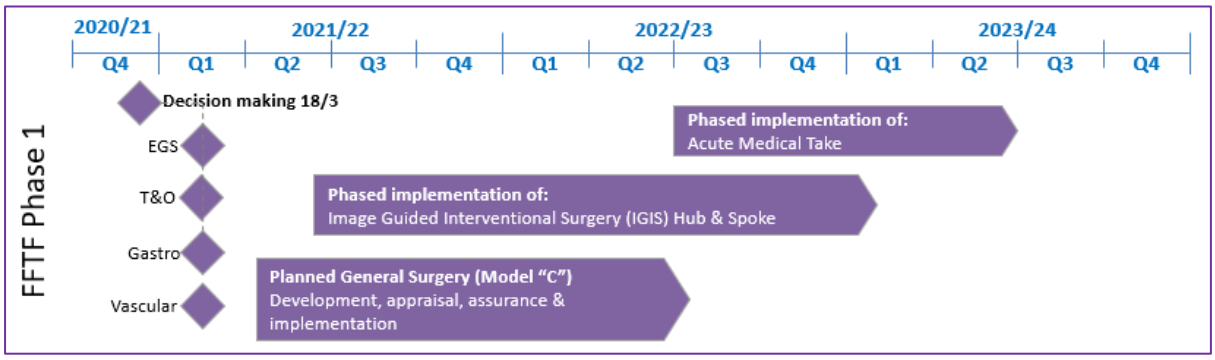
HOSC Issue	Update	Documents
Timing of the consultation in relation to the challenges and pressures presented by the COVID-19 pandemic	Paper to HOSC in Oct 2020 – HOSC confirmed that the Gloucestershire ICS could proceed with the proposed consultation timeline. Discussed in detail at meetings in Oct 2020, Jan and March 2021 (Issue closed)	HOSC Paper (Oct 2020) DMBC: Impact of Coronavirus (COVID-19) on the consultation (p8) Addressing themes applicable to all consultation proposals (p54)
Overlap of some FFTF consultation items and some Covid 19 Temporary changes.	Paper to HOSC in Oct 2020 – HOSC advised of what FFTF consultation was/was not about. Both FFTF and Covid 19 temporary changes discussed at meetings in Jan and March 2021. FFTF public material clearly set out what FFTF was/was not about. (Issue closed)	HOSC Paper (Oct 2020) DMBC: Learning from Coronavirus (COVID-19) Temporary Changes (p14) Citizens' Jury (p23) Addressing themes applicable to all consultation proposals (p56)

HOSC Issue	Update	Documents
HOSC opportunities to discuss FFTF	Over last 3 years, >15 updates and opportunities to discuss including specific workshops provided outside of the main meetings. Updates to HOSC since consultation launch, October 2020, January 2021 (output of consultation report), 2nd March (questions from HOSC Members re FFTF requested in advance of March meeting – Decision-making business case having been published. No questions received from Members for 22nd March meeting (dedicated additional meeting set up to discuss FFTF in case of any additional questions being received from members that needed to be addressed). (Issue closed)	HOSC Paper (Oct 2020) HOSC Paper (Jan 2021) HOSC Paper (Mar 2021) DMBC: Review and deliberation of consultation findings (p10) Process for decision-making (p111)
GRH Bed Capacity	Reference in HOSC meeting in the Autumn to South West Clinical Senate having a 'concern' about 'bed capacity' incorrect as per required information provided in Decision-making business case. This was confirmed at meetings in January and March 2021, South West Clinical Senate assured and NHSE&I confirmation that they were content that the bed test was met provided in writing to HOSC members. (Issue closed)	DMBC: Intended audiences and their decision-making roles (p3) Beds (p121-123) Appendix 9: NHSEI Stage 2 assurance
Travel Impact	Members directed to Independent Integrated Impact Assessment provided in October 2020 as part of Pre-Consultation Business Case and updated in March 2021 as part of Decision-making Business case. (Issue closed)	PCBC: Integrated Impact Assessment (p175) Appendix 14: IIA pre-consultation DMBC: Integrated Impact Assessment (p89) Appendix 2: IIA post-consultation
One New Acute Hospital	Discussed at meeting in March 2021. Explanation that FFTF is a 5-10-year programme designed to ensure our hospitals can be most effective now. A single new acute hospital would be a far longer-term programme requiring very significant national capital funding (which we do not have). (Issue closed)	DMBC: Addressing themes applicable to all consultation proposals (p61)

HOSC Issue	Update	Documents
Planned General Surgery	Discussed at meeting in March 2021. Decision-making business case included resolution to include Upper Gastrointestinal surgery within scope of clinical model which should result in additional operations being undertaken at CGH. (Issue closed)	DMBC: Continued public and stakeholder engagement (p52) Addressing themes applicable to all consultation proposals (p71 - 72, p80) IIA New evidence (p85) Consultation feedback and new evidence (p102) Recommendations (p115)
Consultation Process	Discussed at meetings in October 20, Jan and March 21. Consultation accredited by The Consultation Institute as "Good Practice" (Issue closed)	DMBC: Consultation (p8) Feedback from Public Consultation (p17) Appendix 1: Final Output of Consultation Report

2.3 FFTF Phase 1 Implementation

The high-level implementation timeline and a brief summary for each service is presented below:



Formalise 'Pilot' Configuration for Gastroenterology inpatient services at CGH

As this service was already operational as a 'pilot', following the approval of the Decision-Making Business Case and its resolutions in March 2021, it was formally implemented in April 2021.

Formalise 'Pilot' Configuration for Trauma at GRH and Orthopaedics at CGH

As this service was already operational as a 'pilot', following the approval of the Decision-Making Business Case and its resolutions in March 2021, it was formally implemented in April 2021.

Centralise Emergency General Surgery at GRH

As this service was already operational as a COVID-19 Temporary Service Change (see separate C19 HOSC paper), following the approval of the Decision-Making Business Case and its resolutions in March 2021, it was formally implemented in April 2021.

Centralise Vascular Surgery at GRH

The timing of this change was originally to be determined by infrastructure changes implemented at GRH: improved ward environment, access to the 24/7 Image Guided Interventional Surgery (IGIS) hub, provision of a new vascular hybrid theatre and the transfer of planned care theatre sessions from GRH to CGH. It was anticipated these infrastructure changes would be in place from November 2022.

However, as Vascular Surgery at GRH was one of the COVID-19 Temporary Service Changes, an internal GHNHSFT review has been undertaken to determine the best option for vascular surgery in the interim, either to remain at GRH or return to CGH. This review has recommended that vascular surgery should not return to CGH for an interim 18 months but be retained at GRH as a permanent change. The recommendation included 4 actions that will be explored to support this earlier implementation:

- Explore whether the IR Hybrid Theatre estate work on GRH site can be prioritised in 2021.
- Prioritise the community sub-acute pathway programme to mitigate any bed pressures due to the co-location on Ward 2A of Vascular and T&O.
- Complete a check and challenge of office space provision and to prioritise the placement of the vascular team, acknowledging that the in-extremis move did not provide enough office space.
- Ensure there is a robust pathway and appropriate use of the IR Hybrid Theatre in CGH for cases that can be completed safely in that facility in the interim.

An Image Guided Interventional Surgery 'Hub' at GRH and 'Spoke' at CGH

The 'IGIS hub' is enabled by capital investment as part of the phased implementation of the Trust Estates Strategy. Full implementation of the IGIS model requires us to locate the cardiac catheter labs, establish an additional Interventional Radiology (IR) labs and the vascular hybrid theatre facility at the main hub in GRH. Our implementation plan includes:

- Catheter-Lab Pre-enabling
- Catheter-Lab relocation (IGIS Stage 1)
- Additional IR Lab (IGIS Stage 2)
- Hybrid theatre at GRH (IGIS Stage 3)
- IGIS 24/7 Hub enabling works and displacements

Centralise Acute Medicine (Acute Medical Take) at GRH

The acute medical take will be centralised at GRH and this change will be phased in over the next 2 years. In this interim period, the acute medical take has reverted to a two-site model with the Acute Care Unit (ACU C) at CGH restored to manage a range of dedicated medical admission pathways.

Operating a centralised acute medical take over the past 12 months (as a COVID-19 Temporary Service Change), has confirmed the quality, safety, patient and staff benefits this model will provide in the long term, for example extended senior decision making through the co-location of acute physician, registrar and nursing teams and improved support for doctors in training. The temporary change also highlighted the strong clinical linkage between the management of acute medical take admissions and high care respiratory.

Planned General Surgery.

The Decision-Making Business Case recommended that further work should be undertaken to define a new option to deliver:

- Planned High Risk Upper Gastrointestinal (GI) and Lower Gastrointestinal (Colorectal) surgery at Gloucestershire Royal Hospital
- Planned complex and routine inpatient and day case surgery in both Upper and Lower GI (Colorectal) at Cheltenham General Hospital

The development of the new option includes a bariatric centre, pelvic floor centre and biliary centre. Staffing and rotas have been agreed and the stratification of procedures of procedures has been initiated. We are liaising with the South West Clinical Senate to ensure external clinical assessment of the proposals prior to NHSE&I assurance and have begun to engage with current patients.

3. Fit for the Future - Phase 2

3.1 Introduction

Through phase 1 of FFFT we described our centres of excellence vision for the future configuration of specialist hospital services with GRH focussing more (but not exclusively) on emergency care, paediatrics and obstetrics and CGH focussing more (but not exclusively) on planned care and oncology.

With these Phase 1 changes agreed and the principle of a greater separation of emergency and planned care established, the programme is starting to explore the next phases of reconfigurations that fit with this model.

3.2 FFTF Programme Approach

The FFTF programme is designed to meet the NHSE&I[1] guidance on *Planning, assuring and delivering service change for patients* and is quality assured by The Consultation Institute[2]. It is also continuously improved to take account of learning and feedback from our stakeholders, the public, patients and partners.

A high-level summary of the process stages is included in Annex 2 and a list is presented below including the points where proposals are shared and discussed with HOSC.

FFTF Stage	HOSC
1 - Case for change	Initial proposals shared with HOSC and discussions regarding 'substantial' nature of a proposed service variation
2 - Clinical model development	
3 – Integrated Impact Assessment	
4 - Public and staff engagement phase	Output of engagement report shared and discussed with HOSC
5 - Solutions Development	Pre-Consultation Business Case shared and discussed with HOSC and discussions regarding "Substantial nature" and requirements for consultation
6 - PCBC	
7 - Clinical Senate	
8 - NHSE / I Stage 2	
9 – Internal Governance	
10 - Consultation[3]	Output of Consultation report shared and discussed with HOSC
11 - Consultation review period	
11.1 -Citizens Jury	Decision-making Business Case shared and discussed with HOSC
12 - DMBC	
13 - Decision making	
14 - Implementation	Ongoing updates shared with HOSC as required

[1] NHS England and NHS Improvement came together on 1 April 2019 as a new, single organisation

[2] A UK based not-for-profit organisation specialising in best practice public consultation & stakeholder engagement.

[3] When required for service changes of a "Substantial nature".

3.3 FFTF Phase 2 Services

3.3.1 Long-List of Potential FFTF Phase 2 Services

The FFTF Programme is working with clinical and operational colleagues at GHNHSFT, ICS Clinical Programme Groups and patient groups to identify services that would be able to deliver improved patient experience and outcomes. These will follow the standard FFTF programme approach (presented above) and be shared and discussed with HOSC.

In accordance with our desire to engage with HOSC at an early stage in the development of our proposals, a long list of initial services is presented below on the basis that any proposals related to the future configuration of these services will be subject to continued patient, public, staff, stakeholder and regulator involvement.

GHNHSFT Service	Considerations
Frailty/ Care of the Elderly (COTE)	Development of services in line with the new ICS frailty strategy, with possibility of additional services at CGH.
Spinal, hand, wrists & ankles	Legacy services excluded from initial pilot split of trauma (GRH) and orthopaedic (CGH) – pilot formalised in FFTF Phase 1. Currently all at GRH, so assessing which, if any, procedures could be moved to CGH
Medical Cardiology	Linked to IGIS centralisation at GRH (FFTF Phase 1). When Catheter Labs located at GRH service will need to move activity from CGH to GRH
Renal/ Haemodialysis	New provider contract (2022/23) and consideration of relocation of second GRH Haemodialysis unit to improve patient travel access/ times. **NB:** No change to Forest of Dean facility.
Benign Gynaecology	As a result of learning from the Planned General Surgery service changes (FFTF Phase 1) investigating options for routine elective gynaecology procedures at CGH (risk-based). **NB:** No changes to Gynae-oncology.
Diabetes and endocrinology	Service review linking with community and primary care

3.3.2 FFTF Implementation Enabling Move

Distinct from the longlist Phase 2 services, detailed work on our implementation plans has indicated a requirement for the creation of a hub & spoke model for Lung Function and Sleep Services to support the phase 1 implementation plan. This is detailed below.

Lung Function and Sleep Services *Hub* at CGH and *Spoke* at GRH.

The Lung Function and Sleep department is a multi-faceted service providing diagnostic and monitoring testing for respiratory diseases; non-invasive and invasive ventilation provision and support; as well as diagnosis and treatment for sleep disordered breathing conditions. In addition to this, the service delivers diagnostic testing and assessment of the digestive tract in the G.I. department.

The Fit for the Future (FFTF) phase 1 programme proposals include the establishment of a hub for Image Guided Interventional Surgery (IGIS) at Gloucestershire Royal Hospital. Capital works to establish the IGIS Hub are expected to begin in August 2021, impacting on

Lung Function and Sleep in November 2021. Therefore, the relocation of the Lung Function and Sleep service from its current footprint will enable the preferred implementation option for the IGIS Hub, by allowing for the establishment of an IGIS day-case recovery area.

The proposed solution to manage the move and mitigate any impacts associated with it is to implement a 'hub and spoke' model for Lung Function and Sleep Services. This would mean that Lung Function and Sleep would have a main hub, where most of its activity would take place, at CGH. However, it would also operate a smaller 'spoke' service on GRH which would be responsible for providing support to inpatients as well as supporting outpatients on the Lung Cancer pathway.

Whilst the initial driver for change arises from the requirement to vacate their current footprint, the service has considered many innovative ways in which the impact of relocation can be mitigated, and additional patient benefits delivered including:

- Enable the service to become a one-stop shop for patients, by introducing multidisciplinary clinics. This will negate the need for patients to visit the site multiple times, or to visit multiple departments in one visit. On the whole, it is estimated that these multidisciplinary clinics would benefit around 164 Lung Function and Sleep patients each year, many of whom may visit up to every 3-4 months.
- Increase the accessibility of the service for impromptu / telephone patient queries.
- Create capacity to support a responsive inpatient service at GRH.
- Ensure staff resilience for the future of the service through centralisation and by cross training a number of clinical members of staff in G.I. Physiology.
- Optimise the stocking of equipment, therefore alleviating the need for outpatients to visit the service multiple times to access the equipment they need for treatment

The *MOU Pro- forma - Consideration of 'substantial' nature of a proposed service variation* is provided in Annex 1.

Proposal - Based on the need for the 'enabling move' to the wider FFTF programme and the identified benefits for patients of the Lung Function and Sleep Services Hub & Spoke model the ICS we intend to initiate the process for formal service change via a targeted engagement process. We will provide details of our plans to progress this at the next scheduled meeting of HOSC.

3.3.3 Learning from Temporary Changes

As detailed in the *Briefing paper on COVID-19 Temporary Service changes - update to HOSC (July 2021)*, we have requested an extension for the following temporary service changes:

Service	Proposal
High Care Respiratory at GRH	Our proposal is that High Care Respiratory remains at GRH as a Temporary Service Change until March 2022 to support our continued responsiveness to future waves of COVID-19. We will provide a further update on respiratory services at the next HOSC meeting.
Acute Stroke and Rehabilitation at CGH	Acute Stroke & Rehabilitation will remain at CGH as a Temporary Service Change until March 2022 (with an associated designation of the additional six Vale stroke rehabilitation beds) while we work through the detail on our longer term proposals for Stroke services in Gloucestershire. We will provide an update on this work at the next scheduled HOSC meeting.
Medical Day Unit at CGH	Based on the benefits of the MDU at CGH the ICS would like to initiate and undertake the process for formal service change and in order to do so with the minimum disruption to patients and staff, our intention is that the Medical Day Unit remains at CGH as a Temporary Service Change until March 2022.

The HOSC Temporary Service changes briefing paper included MOUs for each of the services listed above. As stated, an update for each of these services will be presented at the next scheduled meeting of HOSC.

We intend to progress with moving the MDU through the process towards permanent change without delay as we believe the case is clear for this move to be progressed as a permanent change. There is further work to do on High Care Respiratory and Acute Stroke, and this work will enable us to consider whether either of these temporary changes should be considered as potential future service configuration proposals within the FFTF Phase 2 programme. As indicated in the temporary service change paper, we will share our progress on this work at the next HOSC meeting.

4. Conclusion

This paper sets out a summary of the FFTF Phase 1 services, addresses issues raised by HOSC at previous meetings and presents a brief overview of progress to date on Phase 1 implementation. We have provided a high-level outline of the FFTF programme approach (and a reflective overview of the issues raised in previous HOSC sessions with our responses).

Finally, we present information on our FFTF Phase 2 programme grouped as follows:

- A longlist of potential FFTF phase 2 services (#6 services)
- A single FFTF implementation enabling move (#1 service)
- The potential for learning to emerge from the Temporary Changes we wish to retain, which may become future areas for FFTF Phase 2 inclusion

Annex 1: Pro- forma - Consideration of 'substantial' nature of a proposed service variation: Lung Function & Sleep Services

Name of NHS Trust/ Name of NHS Commissioning Organisation
Gloucestershire Clinical Commissioning Group **Gloucestershire Hospitals NHS Foundation Trust**
Lead Manager and contact details
Tom Hewish: Strategy and Transformation Programme Manager tom.hewish@nhs.net **Beverley Gray: Principal Clinical Physiologist and Service Manager** beverley.gray6@nhs.net
Details of the current service
The Lung Function and Sleep department is a multi-faceted service providing diagnostic and monitoring testing for respiratory diseases; non-invasive and invasive ventilation provision and support; as well as diagnosis and treatment for sleep disordered breathing conditions. In addition to this, the service delivers diagnostic testing and assessment of the digestive tract in the Gastrointestinal department. The majority of activity undertaken by the Lung Function and Sleep service is for outpatients. Approximately 1.7% of the service's recorded activity between April 2019 and March 2020 were inpatient attendances; however, this figure does not capture all inpatient activity. Inpatient testing is not booked into the TRAK care system and therefore would not show up in a BI report. In addition to this, there is an element of unscheduled support for inpatients for example where a lung function test may be requested to confirm if an inpatient requires any further procedures, or to issue them with treatment equipment prior to their discharge. For the latest pre-COVID-19 12 month period (Feb 2019 - Jan 2020), the Lung Function and Sleep service saw 7,389 patients, which reflects that the service were responsible for around 3% of the Trust's total outpatient activity (223,682 patients) In addition there are approximately 600 G.I. patients per year (8% of patients) seen by the service which are coded under a different clinical code to Lung Function and Sleep patients. Currently, the Lung Function and Sleep Service operate at both Gloucestershire Royal Hospital (GRH) and Cheltenham General Hospital (CGH), meaning that patients will visit either site for their appointment. However, the G.I. service is only available at CGH.
Details of the proposed change to service
The proposed solution to manage the move and mitigate any impacts associated with it is to implement a 'hub and spoke' model for Lung Function and Sleep Services. This would mean that Lung Function and Sleep would have a main hub, where most of its activity would take place, at CGH. However, it would also operate a smaller 'spoke' service on GRH which would be responsible for providing support to inpatients as well as supporting outpatients on the Lung Cancer pathway. This hub and spoke model will facilitate the best use of limited resources to deliver the best patient outcomes through the co-location of key staff and equipment.

Timescales involved

Based on the need for the 'enabling move' to the wider Fit for the Future (FFTF) programme and the identified benefits for patients of the Lung Function and Sleep Services Hub & Spoke model the Integrated Care System (ICS) we intend to initiate the process for formal service change via a targeted engagement process. We will provide details of our plans to progress this at the next scheduled meeting of HOSC.

Following approval of the FFTF proposals by CCG Governing Body in March 2021, the programme is now into implementation stage and to enable the IGIS hub to be established at GRH these proposed changes to the Lung Function and Sleep Service need to have been implemented by November 2021.

What is the reason for the proposed service change?

Whilst the initial driver for change arises from the requirement to vacate their current footprint, the service has considered many innovative ways in which the impact of relocation can be mitigated, and additional patient benefits delivered including:

- Enable the service to become a one-stop shop for patients, by introducing multidisciplinary clinics. This will negate the need for patients to visit the site multiple times, or to visit multiple departments in one visit. On the whole, it is estimated that these multidisciplinary clinics would benefit around 164 Lung Function and Sleep patients each year, many of whom may visit up to every 3-4 months.
- Increase the accessibility of the service for impromptu / telephone patient queries.
- Create capacity to support a responsive inpatient service at GRH.
- Ensure staff resilience for the future of the service through centralisation and by cross training a number of clinical members of staff in Gastrointestinal. Physiology.
- Optimise the stocking of equipment, therefore alleviating the need for outpatients to visit the service multiple times to access the equipment they need for treatment

Has any consultation or engagement/ involvement taken place to date?

Patient Engagement:

With the aim of providing an insight into patient views around the proposal to implement a hub and spoke model with a centralised hub at CGH, patients were asked to complete a series of questions when they attended the service for their appointment. The surveys were completed in April 2021 and 84 patients provided their feedback on the proposal.

Firstly, patients were asked about whether they had previously visited either site for an appointment. Out of the 84 patients who completed the questionnaire, 26 patients reported that they had visited CGH before for an appointment and 33 patients reported that they had visited GRH before for an appointment. Furthermore, when asked about their site preference, 27 patients (32%) reported that they had no preference over where they visited for their appointment, 33 patients (39%) reported that they would prefer to visit GRH and 24 patients (29%) reported that they would prefer to visit CGH for their appointment.

In order to understand more about patient's site preferences, the questionnaire asked patients about their reasons behind their preferred site. 51 patients had selected their preferred site based on ease of travel, 15 patients had selected their preferred site based on it being easier to find their way around, 14 patients had selected their preferred site based on it being easier to park at, 7 patients selected their preferred site based on it having better facilities and 6 patients selected their preferred site for another reason not specified. For both sites, the most common reason for patients selecting it at their preferred site was

because it was easier for them to travel to.

In addition to their preferred site, patients were asked whether any of the reasons behind their site preference would prevent them from visiting their least preferred site for an appointment. Excluding patients who did not have a preferred site, 36 patients reported that they would still be able to visit their least preferred site for their appointment, 14 reported that they would not be able to attend their least preferred site for their appointment and 7 patients did not answer this question.

When patients were asked about their thoughts on the proposal, 33 patients (39%) reported that they had no thoughts on the proposal, 39 (46%) patients reported that they liked the proposal, 6 patients (7%) reported that they did not like the proposal but weren't sure how it could be improved, 1 patient (1%) reported that they did not like the proposal and thought it could be improved by having the spoke site based at the location closest to the patient and 5 patients (6%) did not answer this question.

Finally, patients were asked about what the most important factor was to them when visiting the Lung Function and Sleep department. The results showed that the most important factors to patients where how close the department was to where they lived (35 patients), that the department had the latest possible medical equipment (30 patients) and the waiting time between referral and appointment (21 patients).

Health Overview and Scrutiny Committee (HOSC) Engagement:

This document provides the first engagement with HOSC for this proposed service change.

Staff Engagement:

Members of staff were involved in an engagement session to discuss the opportunities and potential risks that should be considered when redesigning the service. Initial feedback received suggested that the service could be reconfigured to either CGH; predominately for the GI service; on both sites, or on either location but single sited.

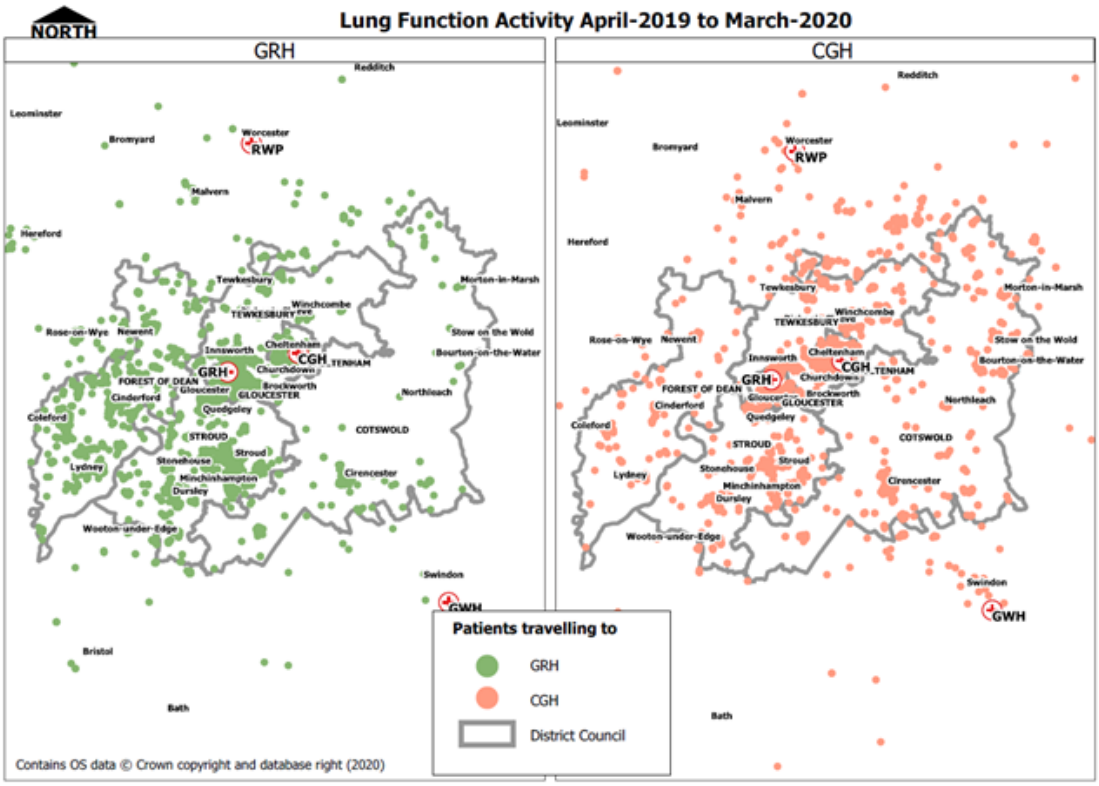
As a result of three viable options suggested by staff, more in-depth analysis took place which was centred on the feedback from the initial engagement session. The key themes that were discovered through the engagement session were that increased space for patients and equipment, better communication between staff and more flexibility for cover and a fit for purpose department for Lung Function were the most important factors to be prioritised when reconfiguring the service. In addition, careful consideration for clinical adjacencies, how patients and staff would travel to the site and support for staff working at spoke site would need to be made, it was recognised that these risks could be reduced through mitigations. When discussing the 'best fit' site, it appeared that CGH was preferable in terms of there being more available space, clinical adjacencies with Endoscopy and Cancer Services and more estates scope to increase the space available to patients and staff. The amount of space available was considered to be the most important factor to the service. Although it was also apparent that GRH had benefits in terms of accessing the small number of cardiology inpatients, transport links for staff and patients.

The engagement session proved that the Lung Function service were aligned with their preference of implementing a 'hub and spoke' model, as this would allow for benefits associated with the majority of the service having a presence on one site but with the flexibility to continue seeing inpatients.

Expected impact of change and what is being done to address this	
Changes in accessibility	Establishing a hub and spoke model for Lung Function and Sleep services will require all outpatients who are receiving lung function testing to visit CGH for their appointment. Whilst there is a neutral

(i.e. transport issues/ opening hours etc)	travel impact for the majority of patients for an estimated 34% of lung function patients and 26% for sleep patients, there will be a negative impact upon their travel time. Between April 2019 and March 2020, approximately 9,195 outpatient procedures were undertaken at GRH (approximately 4,418 patients); however, of these appointments 2,280 (25%) were sleep follow ups which are now primarily conducted by telephone. Under the proposed hub and spoke model 12,103 procedures which were carried out at GRH would now take place at CGH. GRH inpatients are unaffected. In order to assess the travel impact upon Lung Function and sleep services patients in more depth, patient postcode data has been utilised further to determine the type and extent of impact upon patient travel. For 66% of patients it will have a neutral impact, however, for 34% of patients the Hub and Spoke model will have a negative impact upon their travel time. Please note that the above figures exclude sleep patients. In addition to introducing telephone clinics that reduce the need for patients to travel to site, there are further opportunities the team are keen to implement in future to further reduce the requirement for travel such as: • the introduction of community sleep diagnostic hubs • the utilisation of PCNs to provide equipment to patients • and the introduction of 'Attend Anywhere' to introduce remote consultations. As a result of Covid-19, the Lung Function and Sleep Service have increased the utilisation of 'apps' and modems for sleep apnoea patients. Patients are now able to send their data from their sleep study device, directly to the service data base which allows for staff to monitor and alter a patient's prescription remotely. Through telephone clinics, the service has been able to assess patient usage of their equipment, whether a patient's requirements have changed and arrange for equipment parts to be posted to patients. Since May 2020, the service has utilised telephone clinics to speak to over 2,000 patients; patients eligible for this clinic are the largest cohort of patients seen by the service. Furthermore, the service will continue to use these clinics permanently as a result of their success which will negate the need for these patients to travel to either site. In addition, implementing the proposal contained in this paper will allow the service to implement multidisciplinary clinics which have the potential to benefit around 164 Lung Function and Sleep patients, many of whom may visit up to every 3-4 months. Patients who currently attend these clinics are often on long term home ventilation and are therefore the most unwell in terms of disease prognosis and physical condition. By moving to a hub and spoke model it would allow for these patients to be seen by all healthcare professionals involved in their care in the same appointment. Therefore, this would enable more appropriate and responsive

	care for these patients and their carers.
Patients/ carers affected (demographic assumptions that have been made)	Service level data has been utilised to understand the impact of a hub at CGH could have on patients with protected characteristics. There is no evidence to suggest that patients would be disproportionately positively or negatively impacted by our proposals on the basis of a protected characteristic. It is estimated that 23.6% of the total Gloucestershire population are obese, which is a risk factor for Obstructive Sleep Apnoea. As a result of this we would expect this group to be more impacted by the proposed changes. However, it must be noted that establishing a hub and spoke model for this service, alongside the movement of other services as defined in FFTF, will benefit these patients through providing specialist services in one place, as such meaning better care for patients with comorbidities. Approximately 7.7% of the Gloucestershire population live within the most deprived IMD quintile, at a district level Gloucester city has the highest proportion of its population living in the most deprived areas (25%). This data would suggest that patients who utilise the service and live in Gloucester city district would be most impacted by a hub at CGH in respect of to travel costs and time. However, there are mitigations in place such as the Pulham's 99 Bus which runs between the two hospital sites.
Changes in methods of delivery (venue / practitioner)	Currently patients from across the county are seen at CGH (see maps below) whilst GRH has patients predominantly from the central and west localities.



Patient Postcode Map 1: Please note that each 'dot' represents 1 patient.

Impact upon other service delivery	We have engaged with the service and given it is predominately an outpatient service, the residual need for clinical adjacency to support some inpatient care will be met by the spoke There are no other known impacts upon other service delivery
Wider implications (consider effects on community safety/ local economy etc)	There are no known wider implications of implementing a hub and spoke model for Lung Function and Sleep.
Equality/ Inequality issues *(how will it help achieve health improvement goals and reduce inequalities?)*	As previously mentioned, from our Equality and Inequality impact assessment; On the basis that there is a higher proportion of the population in the Gloucester district who are living in deprivation (25%) and who suffer from adulthood obesity (29%), there is a potential that patients who access the service from Gloucester may be the most impacted by a centralisation to CGH. However, it must be noted that the hub & spoke model will benefit these patients through providing multiple Lung Function and Sleep services in one place, as such meaning better care for patients with comorbidities especially through the provision of multidisciplinary clinics.
Name of person completing this pro-forma	Hannah Reed Project Manager Strategy and Transformation Team Gloucestershire Hospitals Foundation Trust
Date proforma completed	30/06/21
Outcome **(HOSC Comments)**	

Annex 2: FFTF Process Stages (Optimised)