Surgery Reconfiguration at Heart of England Foundation Trust

Building a Sustainable Future

The Case for Change

Vision

To have emergency and planned surgical services in our hospitals which are sustainable and enable the provision of high quality, safe care to our patients.

Version Control

Revision	Date	Originator	Checkers	Approver	Description
V 1	8th September 2014	Ruth Paulin	Matthew Cooke Richard Steyn Lisa Thomson Lorna Grinnell-Moore	Matthew Cooke and Lisa Thomson	First draft
V2	21s September 2014		Richard Steyn Lorna Grinnell-Moore	Matthew Cooke	Comments from above incorporated

Contents

Appendix B – Stakeholder Reference Group, Terms of Reference

1. Executive Summary

Reconfiguration of services across and within trusts is considered inevitable by many leading voices in the UK healthcare system. Consolidation of services into fewer sites has shown benefits in other specialties and is a concept supported by the Royal College of Surgeons.

Reconfiguring surgery across Heart of England NHS Foundation Trust (the Trust) sites is a key element of the Trust's strategic plan. It has been given extensive consideration over recent years in order to seek to devise a robust, workable plan to deliver high quality, sustainable surgical services to our patients in the future.

This case for change document describes the comprehensive process that has been undertaken to reach the conclusions drawn and outlines the next steps as these proposals are taken to public consultation and formal external scrutiny.

There is a compelling clinical case for change and internal stakeholders believe that doing nothing is not an option in order to protect and develop services and build a sustainable model for delivery of surgery across the Trust.

External engagement through a diverse Stakeholder Reference Group has contributed to the co-design of the proposals and will continue to be a vital part of our implementation planning to ensure the needs of patients and other service users are properly considered and incorporated into the Trust's plans.

Transforming surgical provision, as described in this document, is focused on delivering the following benefits:

- The ability to meet current and future clinical standards for surgery;
- Better outcomes and experiences for patients;
- Shorter waiting times and more certainty with dates for planned surgery;
- Faster access to emergency surgery and reduction in bed days waiting for such surgery;
- The ability to create of centres of excellence in a number of surgical specialties;
- The capacity to deliver all NHS activity internally without the need for premium rate waiting list or private sector work;
- The opportunity to meet increasing demand in those specialties experiencing growth; and
- Gains in efficiency from consolidation and best practice benchmarking eg reduction in Length of Stay and increased theatre utilisation.

Most of the Trust's patients will not be affected by the proposed changes as it is only the operating theatre component of a patient's surgical pathway that may move. The Trust sees approximately 1.2 million patients a year across three hospital sites and carries out about 45,000 surgical operations in its 25 operating theatres. Of these, less than 10,000 would be undertaken in a different location within the Trust if services reconfigure as described in the summary tables following.

Current Configuration:

Heartlands	Good Hope	Solihull
Emergency Surgery All specialties including Orthopaedic trauma **Planned surgery** Obstetrics Gynaecology Thoracic Vascular Colorectal Upper Gastrointestinal (UGI) Bariatrics General Surgery Urology Ears Nose and Throat (ENT) Paediatric surgery	**Emergency Surgery** General surgery Orthopaedic trauma **Planned Surgery** Orthopaedics Obstetrics Gynaecology Vascular (minor) Colorectal Urology General Surgery Ophthalmology	**Emergency Surgery** No emergency surgery **Planned Surgery** Orthopaedics Gynaecology General Surgery Urology Ophthalmology

Proposed Configuration:

Heartlands	Good Hope	Solihull
Emergency Surgery Most specialties (excluding Urology and Upper Gastrointestinal) Orthopaedic trauma **Planned surgery** Obstetrics Gynaecology Thoracic Vascular Colorectal ENT Paediatric surgery Some General Surgery	**Emergency Surgery** General surgery assessment Urology Upper Gastrointestinal **Planned Surgery** Obstetrics Gynaecology Urology Upper Gastrointestinal Some General Surgery	**Emergency Surgery** No emergency surgery **Planned Surgery** Orthopaedics Ophthalmology Some General Surgery Possibly some ENT
No change **All outpatient attendances as now e.g consultations, imaging, physiotherapy** **Non theatre diagnostic investigation as now e.g endoscopies**		

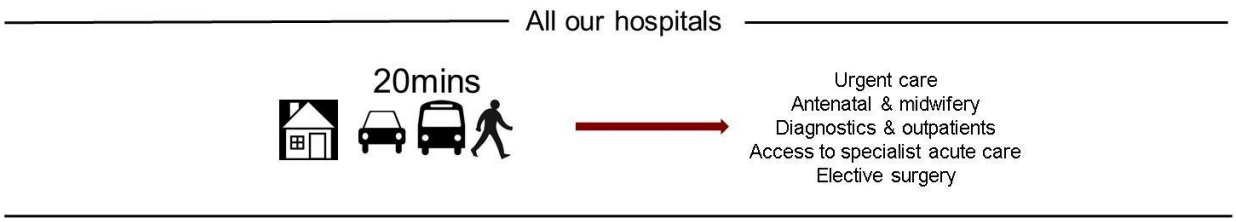
The challenges, key success factors and interdependencies of this complex programme are significant and the next phase will be iterative with modifications to the above configuration possible as additional issues are identified and addressed.

The Trust appreciates that the solution proposed may not be universally welcomed by all consultants, other staff or the public but the rationale for change is overwhelming and the senior clinical leaders believe the proposal is the best way to configure surgery within the existing Trust infrastructure to create sustainable surgical services across all specialties.

2. Background

2.1 Strategic Context

The Trust's strategy is to develop a more distinct identity for each of its hospitals as is illustrated by the following:



Birmingham Heartlands Hospital
A&E services
Centre for complex and emergency care
Inpatient paediatrics
Obstetric care
Academic centre

Good Hope Hospital
A&E services
Acute medicine
Home to surgical specialties
Obstetric care
Hollier Simulation Centre

Solihull Hospital & Community
Urgent care
Care for the elderly
Home to large elective care centre
Community services hub
Midwifery led labour unit

2.2 Case for Change.

There are a number of drivers behind the need to reconfigure surgical services:

a) **Clinical case for change**

- National trends and evidence of best practice create a compelling case for change as described in detail in section 3.

b) **Quality**

- A desire to improve the patient experience and satisfaction eg faster access to emergency surgery and certainty for elective surgery dates.
- Wanting to deliver improved outcomes and lower mortality in the future with higher levels of safe and harm free care.
- The opportunity to create centres of excellence with space to develop services.

c) **National trends (outside of our control)**

- Greater sub specialisation in surgical specialties is making it impossible to deliver each sub specialty at each site.
- Fewer surgeons are being trained which challenges the sustainability of safe surgery across multiple sites.
- Royal College requirements are more demanding in respect of both emergency and planned surgery standards.
- There is evidence that consolidating services can achieve better outcomes.

d) **Financial Challenge**

- The financial challenges facing the Trust, and the NHS as a whole, are significant and reconfiguration may release greater opportunities to meet them.

e) **Operational Performance**

- Significant difficulties can be experienced at times with aspects of current operational practices.
- Key internal stakeholders express a desire to not only improve operational efficiency e.g. in theatres, scheduling and patient flow, but also to rationalise the configuration of services with teams working at one (or possibly two sites) instead of three.

f) **Belief**

- The Trust's clinical leaders believe things need to change to protect and develop the services provided to our patients and that now is the time to consider how to best do so.

2.3 Previous proposals

Over the last few years there have been several proposals for surgery reconfiguration developed which have not progressed for various reasons including difficulties in the enormity of the challenge, the impact of individual areas vs the "big picture" view and a lack of clarity around the evidence base for change.

There is now a widely held view that things need to change and most clinical and operational stakeholders are keen to progress to detailed implementation planning so that the benefits can be realised.

A number of factors have therefore combined to create a "burning platform" and hence the right timing for changes which will be clinically led, improve outcomes and the experience for patients, create a sustainable model of service delivery and deliver cost efficiencies for the Trust.

3. Clinical Case for Change

To supplement the initial research undertaken and the assessment against emergency surgery standards carried out by the surgical Clinical Directors, an independent review of the national guidelines and best practice evidence was commissioned. It describes a compelling clinical case for change and provides many useful references and case studies for us to consider as we plan the implementation of surgical reconfiguration within the Trust. This is attached as appendix A.

Some of the key findings are summarised as:

- Reconfiguration of hospital services across trusts is considered inevitable by many leading voices in the UK healthcare system;
- The future state and delivery of emergency surgery are a major focus for the NHS and the Royal Colleges;
- Successful reconfiguration of services requires strong clinical and managerial leadership as well as public engagement from the start;
- As demand for surgery services continues to increase, separating some elective and emergency resources has benefits for patients and staff; and
- Consolidation of services into fewer sites has shown benefits in other specialties and is a concept supported by the Royal College of Surgeons.

4. Stakeholder Engagement

Extensive stakeholder engagement and management are vital to the success of the surgery reconfiguration programme. It is important that a wide range of internal and external groups and individuals understand the rationale and proposals fully. The feedback so far, when the "story" is properly and fully presented has been very positive.

4.1 Engagement so far

A summary of the stakeholder engagement activity and feedback undertaken to date is shown in the table following and expanded on in the subsequent sections.

External

- Patient/carer groups – Solihull and Good Hope
- Consultative Health Council
- Stakeholder Reference Group
- CCG Locality Ops Boards
- JCCG meetings
- Sutton MP/councillor engagement

Feedback

- Understand the rationale for change

Internal

- Surgery Advisory Group meetings
- Directorate meetings
- Intranet site
- Staff information leaflets
- Heartbeat on line
- Specialty design meetings for T&O and urology
- Programme Board

Feedback

- Some resistance to change
- Some buy in
- Desire for decision to be made

4.1.1 External

Since December 2013 presentations at all the Trust's patient groups have been made. The groups understand the rationale for change and see potential benefits of consolidation into surgical centres of excellence. The concerns raised by all groups are mainly around factors such as transport, drive times, parking and ease of visiting.

A Stakeholder Reference Group has been recruited to help co-design solutions to the challenges faced by the need to consider reconfiguring surgery. Chaired by an independent chair, it met four times during March and April and then monthly from June onwards and is comprised of members from the following groups which represent the diverse nature of our external stakeholders:

- Patient/carer group for Solihull Hospital
- Patient/carer group for Good Hope Hospital
- Consultative Health Council
- Health Watch Birmingham
- Health Watch Solihull
- Experts by experience from the three catchments
- GP representatives
- Our Associate Medical Director for Surgery and a staff member from each site
- The Programme Lead and Project Manager to provide clarification on the proposals if necessary

The input and challenge from this group has been very useful and their conclusion after three meetings was unanimously supportive of the case for change. They will be a powerful and influential voice in the formal consultation and scrutiny process.

Presentations have been made at multiple CCG forums in the last year including the JCCS, CCG Local Operational Boards (Sirius, Solis and South East Staffordshire) and the Cross City CCG LCN Chairs Committee. Initial patient access assessments have been undertaken and are summarised in section 6.

4.1.2 Internal Engagement

Internal engagement has been undertaken with a wide range of staff as shown in the table above and it will remain of critical importance to continue extensive staff engagement as the programme progresses, using a variety of communication channels and approaches.

It is recognised that the proposals are not universally welcomed by all of the Trust's consultants and staff – all agree that change and reconfiguration of some nature is required but personal site or specialty perspectives are not always aligned.

4.2 Engagement and communication planned

A comprehensive communications plan for the next year has been drafted by our communications team, focusing on the internal stakeholders, patients, the public, external stakeholder groups, MPs and GPs.

4.3 Key messages

There are a number of key messages we will aim to communicate through this process:

a) The clear and compelling clinical case for change;
b) The clinically led process from design through implementation planning;
c) A strong articulation of the benefits;
d) An understanding of any potential impact on patients and our desire to work with stakeholders to minimise these and support patients;
e) That this will underpin the future sustainability of all three hospitals – it will secure their future through a clear identity; and
f) A commitment for services to remain locally based whenever possible eg. outpatients, diagnostics, pre-operative assessment, physiotherapy etc.

5. Operational Design

5.1 Option Design

The proposed configuration has been developed through a number of phases and an iterative process since December 2012.

- An initial piece of work by a strategic planning consultancy (Provex) considered the feasibility of a day case/short stay elective surgery centre on the Solihull site which was assessed as possible but did not look at where the long stay activity from the Solihull site would relocate to, so concluded that surgery (day case and in patient, elective and non-elective) needed to be considered as a whole.

- A Clinical Reference Group (CRG) comprising of all the surgical Clinical Directors and speciality leads was set up which profiled the specialties, current and future requirements and decided which specialties needed to stay at particular sites and which could potentially move to achieve the objectives outlined in the case for change.

- A Surgical Advisory Group, SAG, (CRG plus representatives from the directorate and operations teams) then further considered the facilities on each site in light of each specialty's requirements, the support services required and the interdependencies between specialties. Two further strategic options were developed with the fundamental design principles being:

    - Intent to retain three busy surgical hospitals so where one service moves out to consolidate another will move in to consolidate; and

    - Intent to retain local access points for local people through our three hospitals with most aspects of the patient's pathway being delivered locally as now.

- The Executive Management Board reviewed the three options at their meeting in September and in light of scores from the option appraisal process undertaken by core members of the SAG decided that two should be worked up in more detail. The day case/short stay centre at

Solihull was discarded as a suitable option at this stage as it did not address bed availability issues on the other sites, meant that surgeons for all specialties would need to operate on at least two sites making creation of centres of excellence more difficult and all patients requiring a day case or short stay procedure would need to travel to Solihull. Greater consideration of the remaining two options then took place with input from internal multidisciplinary teams and external engagement through an independently chaired Stakeholder Reference Group (see appendix B for Terms of Reference).

As operational work up progressed, a hybrid, preferred option evolved which it is felt is most likely to be deliverable within the existing Trust infrastructure and meet the challenges posed by the drivers of change – this is shown in the table following:

Heartlands	Good Hope	Solihull
Emergency Surgery Most specialties (excluding Urology and Upper Gastrointestinal) Orthopaedic trauma **Planned surgery** Obstetrics Gynaecology Thoracic Vascular Colorectal ENT Paediatric surgery Some General Surgery	**Emergency Surgery** General surgery assessment Urology Upper Gastrointestinal **Planned Surgery** Obstetrics Gynaecology Urology Upper Gastrointestinal Some General Surgery	**Emergency Surgery** No emergency surgery **Planned Surgery** Orthopaedics Ophthalmology Some General Surgery Possibly some ENT
No change **All outpatient attendances as now e.g consultations, imaging, physiotherapy** **Non theatre diagnostic investigation as now e.g endoscopies**		

A number of assumptions relating to capacity have been made during this process including:

- Solihull theatres operate six days a week, at least 10 hours a day, increasing capacity by 50%;
- Good Hope and Heartlands theatres operate 5 days a week, 8 hours a day apart from where extended lists are already in place and preferred; and
- The staff work patterns required can be delivered.

5.2 Implementation planning

Clearly the implementation of this proposal will need to be carefully managed in a phased way to ensure service continuity throughout.

The detail for this will be planned in parallel with the public consultation phase as the operational design is finalised.

Current and proposed patient pathways have been mapped for most of the likely first four moves i.e.

- Elective orthopaedics (and ophthalmology) to Solihull;
- Urology to Good Hope;
- Trauma to Heartlands; and
- UGI/Bariatrics to Good Hope.

Followed by:

- Consolidate colorectal surgery at Heartlands; and
- Create a dedicated paediatric theatre for all paediatric surgery at Heartlands.

5.3 Critical Paths

High level critical paths have also been prepared for the four of the phase 1 moves and potential "show stoppers" for each have been identified. The ease with which these can be solved or mitigated will help determine the final implementation plan. The risk registers capture these and the other risks identified so far. The key risks are highlighted in section 5.6.

5.4 Work streams

Programme wide work streams were defined at the start of this phase of the programme. These have now evolved to be more specialty based for those specialties likely to move, in addition to those applicable to the whole programme. All have a clinical and operational lead and additional resources will be added as things progress to the implementation planning phase.

Work streams making up the programme are:

- Orthopaedics;
- Trauma;
- Urology;
- Upper Gastroenterology;
- Colorectal;
- Environment/support services;
- Workforce;
- Engagement/Communication;
- Business Case Development; and
- Transport (patient, staff and visitor).

5.5 Interdependencies and impact on implementation planning

The current surgical provision is a grid locked jigsaw so one piece needs to move to create space for another and most of the individual moves cannot be considered in isolation due to constraints in theatre and bed space and the relative size of each specialty.

For example, both urology and UGI/bariatrics cannot move into Good Hope until both elective orthopaedics *and* trauma have moved out, but trauma cannot move into Heartlands until urology has moved out and a second trauma theatre has been created.

It is therefore key that detailed workable implementation plan is developed which considers all the interdependencies and ensures service continuity.

5.6 Current status

The work streams above are progressing with the detailed operational design and implementation planning at different rates dependent on availability of resource and other pressures. An intensive period of design is planned for November when all necessary individuals will be back filled from their day jobs to be released to finalise the operational detail and undertake the financial appraisal. The timing of this phase is deliberate to allow input from the consultation process to be properly considered and incorporated before the plans are finalised.

5.7 Risk Management

A risk register has been developed for each proposed specialty move and for the programme as a whole. These will be owned and updated by the directorates and the project team through phase 4 of the programme.

Some of the most highly scoring risks include:

Risk	Score	Mitigation
Ability to provide interventional radiology at both GHH and BHH		Radiology directorate are considering innovative solutions
Commitment to, and availability of, clinical leadership and accountability		Work with Medical Director to facilitate release of required clinicians
Time and accountability from directorates not available		Management direction from EMB and support from project team.
Retaining and recruiting suitably trained staff in wards and theatres		Robust workforce plan, early engagement, training needs assessments and recruitment. Possible incentives
Consultant job planning – resistance and objections to change		Direction from Medical Director

6. Patient Impact

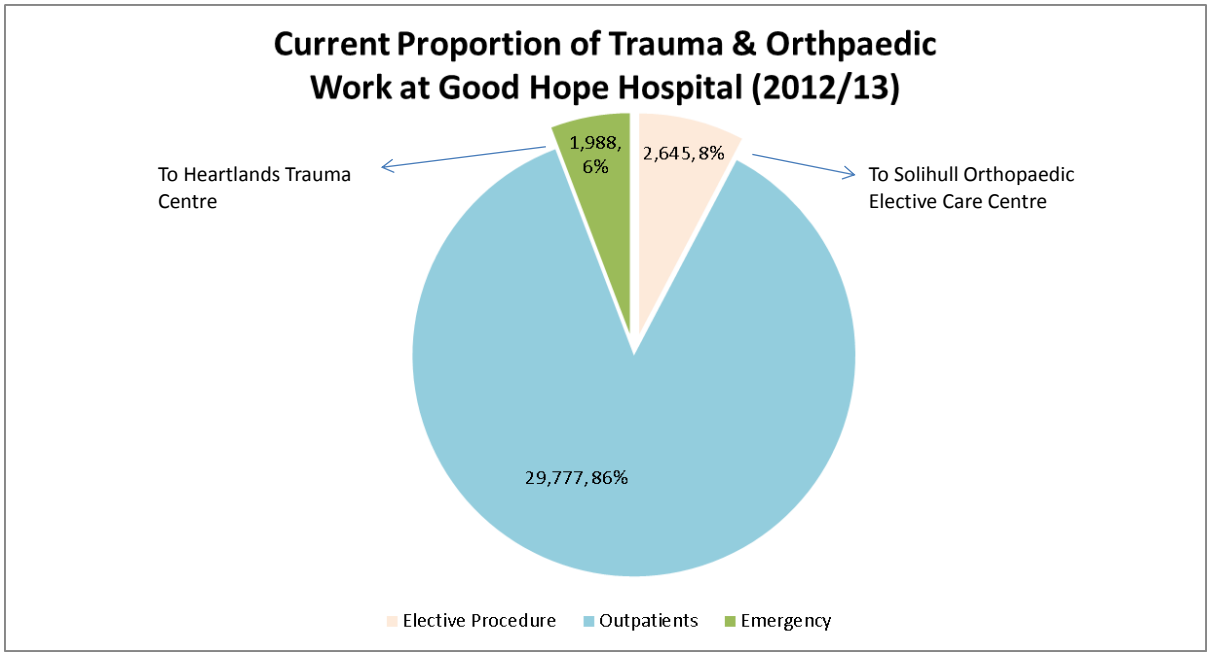
The overarching rationale for reconfiguring surgery services with the Trust is to ensure that emergency and elective surgical services are sustainable and enable the provision of high quality, safe care to patients.

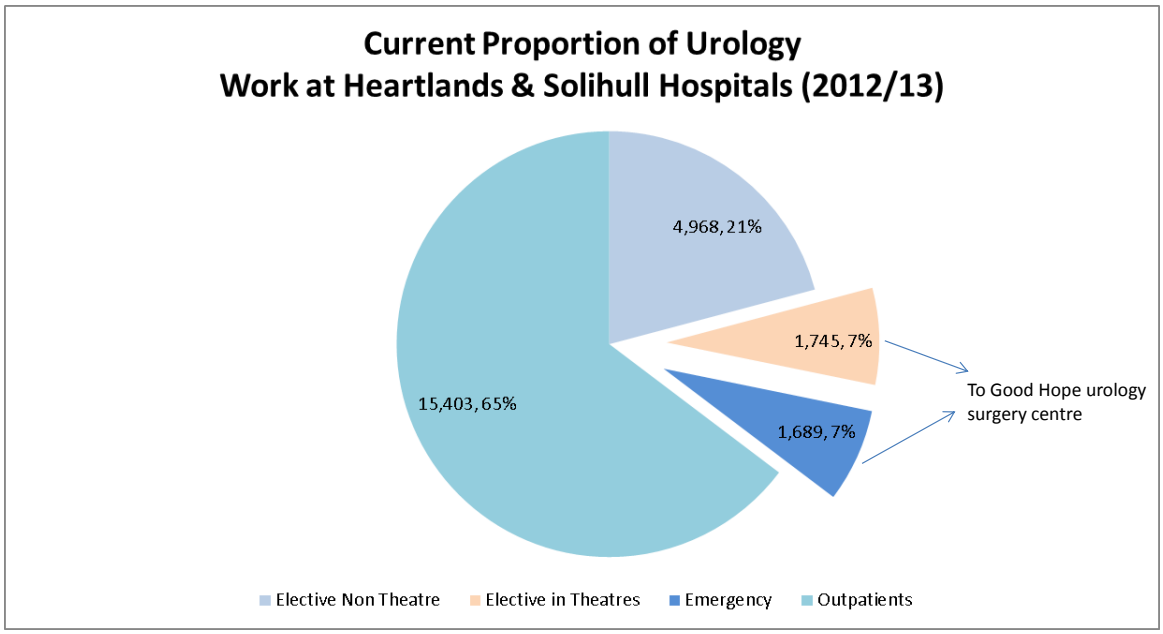
Whilst the clinical case for change is compelling and will deliver a number of benefits to patients as described in section 2, the Trust has undertaken a range of assessments to identify and mitigate any potential adverse impact on service users. In addition, an equality impact assessment is being commissioned.

6.1 Proportion of patients affected

Compared to competitor providers, as a three site organisation, the Trust is committed to offering local access to local patients. Therefore all options for reconfiguration have retained the outpatient pre- and post-operative activity and non-theatre diagnostics, as now, at patients' local hospitals.

The charts following, illustrate how a relatively small proportion of total patient attendances are for the actual surgical procedure. Stakeholder groups have been reassured by this information and the fact that consideration will be given to patient and visitor transport between sites.





6.2 Travel time analysis

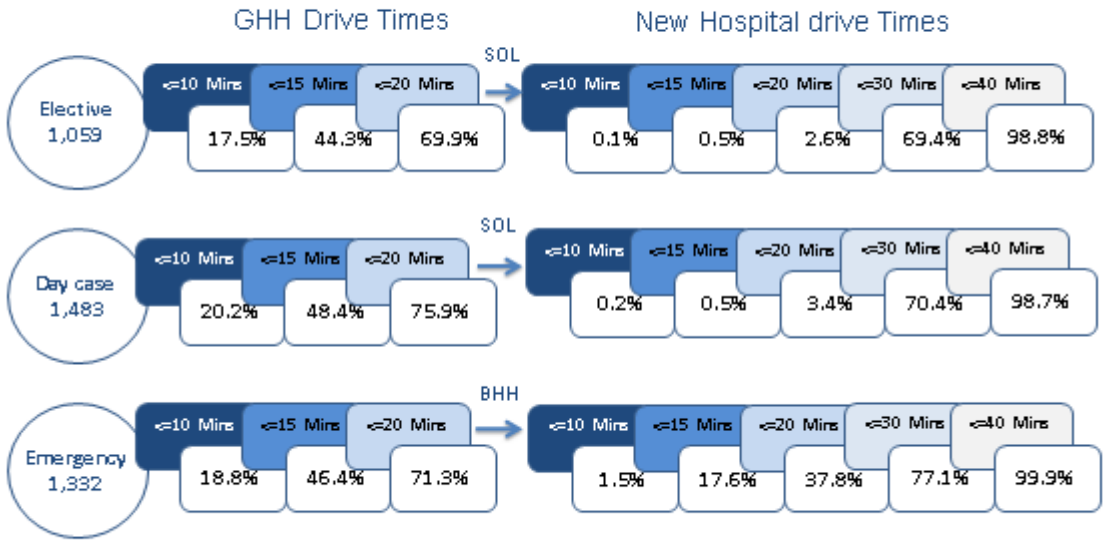
Travel times from patient home post codes to the current and proposed locations for surgery have been mapped and the findings illustrate slightly increased drive times for some patients. This shows that most patients will not have significantly increased journey times as in most cases over 70% of patients have a journey of less than 30 minutes compared with less than 20 minutes now.

The analysis undertaken also compared travel times for patients to reach potential alternative providers at University Hospital Birmingham (UHB), Walsall, University Hospital Coventry & Warwick and City and Sandwell. In most cases there is a lower or comparable drive time when compared to the proposed Trust site. If patients choose to be referred to competitor providers then they would travel for every attendance (pre and post operation) not just the surgical episode.

When patients have reviewed this data they understand that the benefits of having very local access for most of their hospital attendances offsets any slight inconvenience of having to travel slightly further for their surgical procedure to what will be a centre of excellence.

The fact that their surgery will be undertaken in the consolidated surgical centres created for each specialty through the proposed reconfiguration together with the expected improvements in waiting times and certainty around dates for elective surgery, gave the stakeholder reference group reassurance and they all supported this approach.

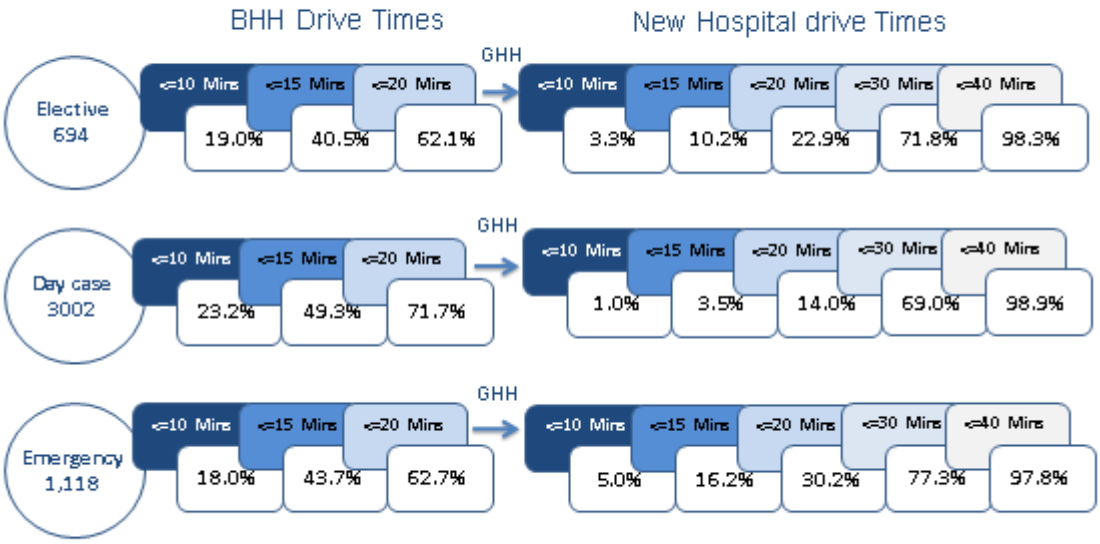
Spells with a T&O Procedureat GHH (Patientsaged 17+)
January – December 2013



	Drive Time (Mins)					
Hospital	**10**	**15**	**20**	**30**	**40**	**Total**
Walsall	8	96	804	2,737	3,762	3,874
	0.2%	**2.5%**	**20.8%**	**70.7%**	**97.1%**	**100.0%**
UHB	6	17	56	1,982	3,205	3,874
	0.2%	**0.4%**	**1.4%**	**51.2%**	**82.7%**	**100.0%**
S&WB	8	15	1,030	2,614	3,605	3,874
	0.2%	**0.4%**	**26.6%**	**67.5%**	**93.1%**	**100.0%**

*This is for all patient classes i.e.. Inlec, nonelec and daycase

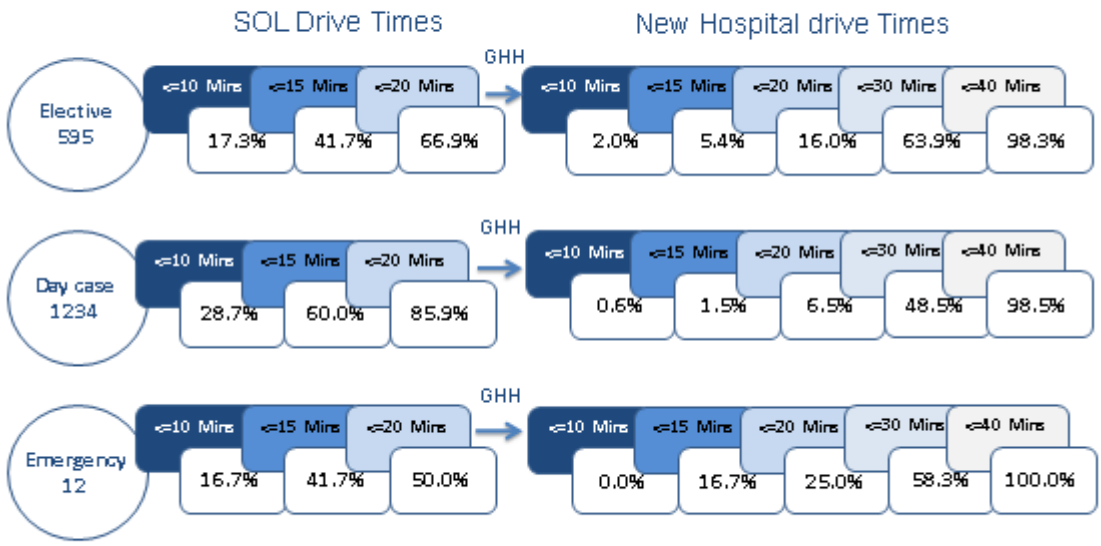
Spells with a Urology Procedure at BHH (Patients aged 17+)
January – December 2013



	Drive Time (Mins)					
Hospital	10	15	20	30	40	Total
UHB	4	85	543	3,538	4,633	4,814
	0.1%	1.8%	11.3%	73.5%	96.2%	100.0%
S&WB	5	46	294	2,553	4,743	4,814
	0.1%	1.0%	6.1%	53.0%	98.5%	100.0%

*This is for all patient classes i.e.. Inlec, nonelec and daycase

Spells with a Urology Procedure at SOL (Patients aged 17+)
January – December 2013



	Drive Time (Mins)					
Hospital	10	15	20	30	40	Total
Cov & Warwick	0	1	3	481	1,767	1,841
	0.0%	**0.1%**	**0.2%**	**26.1%**	**96.0%**	**100.0%**
UHB	6	27	159	1,338	1,802	1,841
	0.3%	**1.5%**	**8.6%**	**72.7%**	**97.9%**	**100.0%**

*This is for all patient classes i.e.. Inlec, nonelec and daycase

6.3 Self assessment against the Secretary of State for Health 'four tests

As the option design has progressed the programme team has undertaken a self-assessment to demonstrate compliance with the Department of Health 'four tests', used to assess major service reconfiguration. This will be re-assessed towards the end of the consultation period. The activities against each test is shown below

Test	Requirement	The Trust Activity
Support from GP commissioners	Commissioners will need to consider the engagement / involvement that may need to take place with practices whose patients will be significantly affected by the case for change, inviting views and facilitating a full dialogue where necessary. Local commissioners will need to demonstrate the nature of the discussion with consortia or with other appropriate bodies as a proxy. For example, the commissioner could obtain written sign off from relevant local consortia representative.	The Trust has engaged with GPs and the Clinical Commissioning Groups (CCG) through their Operational Boards and the Joint CCG meetings. A GP has been involved in the stakeholder reference group and it is anticipated more will be as the co-design continues.
Strengthened public and patient engagement	The National Health Service Act 2006 requires local health organisations to make arrangements in respect of health services, to ensure that users of those services such as the public, patients and staff are involved in the planning, development, consultation and decision-making in respect of the proposals. Local commissioners should engage Healthwatch and Health Overview and Scrutiny Committees to seek their views.	The Trust has set up a Stakeholder Reference Group to be involved in the co-design of solutions. This is chaired independently and has representatives from various patient groups, experts by experience, Healthwatch and the CCGs. The next phase of the programme will involve broader public and patient engagement through a formal consultation and scrutiny process.
Clarity on the clinical evidence base	It is recommended that clinicians should lead in gathering this evidence, considering current services and how they fit with the latest developments in clinical practice, and current and future needs of patients.	The design of potential options for reconfiguration has been clinically led by the surgery advisory group, comprised of all the surgical clinical directors within the Trust. A review of the literature, national trends and best practice guidelines has been undertaken to inform the design process.

Consistency with current and prospective patient choice	Local commissioners will need to consider how the proposed service reconfiguration affects choice of provider, setting and intervention; and the choice this presents the patient compared with the current model of provision. Commissioners will need to ensure this consideration is part of any dialogue with local clinicians, Healthwatch and Scrutiny Committees. In meeting the choice test, commissioners will want to make a strong case for the quality of proposed services and improvements in the patient experience.	The Trust will commission an external assessment of the impact on choice in addition to an equality impact assessment. In the designing of options the intention has always been to maintain local access and hence choice for most of a patient's interaction with the Trust.

7. Workforce Plan

The high level impact on staffing numbers at the Programmed Activity (doctors clinical sessions) and whole time equivalents (WTE) level has been considered for each of the proposed moves and built into the financial appraisal where available. Where work streams are not as advanced, assumptions have been made on the basis that the same activity will be delivered in a different configuration so the worst case scenario is that the same numbers of staff will be required. The expected operational efficiencies may deliver savings in staff number but once identified these will be met by natural wastage or by not filling vacancies. There are no plans to make any staff redundant as part of these proposed changes.

A cross site, cross functional framework for a work force plan has been developed.

The key messaging is that no redundancies are anticipated, the Trust wants to keep all staff and that where possible staff will have choices about whether to align to their specialty or site.

It will be important to reassure throughout the next phase of this programme so that staff turnover is not increased as a result of the planning.

Training needs assessments will be undertaken and support for re-training will be provided if needed.

A 90 day consultation period will be required given the numbers of staff potentially involved.

8. Financial Appraisal

It was agreed by the Executive Management Board that when appraising the potential benefits of surgery reconfiguration the cost of surgical provision as a whole across the Trust should be the metric used and that usual directorate boundaries for budgets should not be seen as constraining factors. Savings might be possible in one specialty whilst another needs additional resource to facilitate reconfiguration for the good of the whole.

A preliminary costing exercise has commenced to determine the total cost and savings to be made across the surgical directorates following implementation of the recommended option. At this stage a number of work streams are being progressed operationally by the Programme Team, working in close conjunction with the surgical directorates, to determine the final configuration of staffing and equipment required.

Assumptions are however being made about changes to the operating efficiencies expected, the impact on medical staffing, the potential for reconfiguration to unlock capacity blocks to additional income streams such as the growth in bariatric surgery and the opportunities to avoid future spend on waiting list initiatives. The granular detail in regard to these can only be reconciled once a final blueprint had been agreed by the operational teams.

8.1 Potential impact of reconfiguration and working assumptions.

The work streams below are currently working up cost assumptions as the design progresses:

8.1.1 Trauma and Orthopaedic (T&O) Nursing

A T&O elective care unit and day case and admissions lounge will be re-configured on the Solihull site using the existing T&O nursing establishment from across Solihull and Good Hope Hospitals. Proposed rosters have been drawn up and costed with respect to this. A new post anaesthetic care unit (PACU) within T&O is also proposed to be created at new additional cost. Further staffing and length of spell savings will need to identified across the existing critical care pathway to offset this new proposed expenditure.

8.1.2 Physiotherapy

In order to support the revised T&O pathway and to enable length of spell savings additional physiotherapy input will be required post re-configuration. Therapy staffing of 1wte Band 5 Physiotherapist and 3wte Band 4 Therapy Support Workers have been identified as being necessary.

8.1.2 Private Sector conversion to internal capacity savings

The current working assumption is that there is potential to remove the need to use the private sector and bring this outsourced activity back in to the Trust.

8.1.3 Interventional Radiologist – additional staffing

A further interventional radiologist will be required as a result of reconfiguration to provide on-call support to the Urology activity moving to Good Hope Hospital. Radiographer and nursing operational staffing models are currently being devised.

8.1.4 Waiting Lists Savings

The current working assumption is that 50% of this could be accommodated through the reconfiguration. There is scope to increase this however a prudent approach has been taken at this stage.

8.1.5 Theatre Staffing

Extended theatre sessions are proposed to be provided. A revised staffing model has been proposed by the Theatres directorate to deliver this. In addition, the new model will attract premiums associated with unsocial hours working.

8.1.6 Anaesthetics

The current working assumption is that 5.2wte additional consultants will be required.

8.1.7 Length of Stay Savings

A reduction in the existing T&O bed base is envisaged following re-configuration. Further work is currently being undertaken by the Project Team to quantify the likely impact.

8.1.8 Medical Staffing

The T&O, Urology and General Surgery directorates are currently assessing the impact on their medical staffing establishment by completing pre and post reconfiguration job planning exercises. An initial assessment by the Clinical Director of Urology is that five additional programmed activities for ward referrals will be required. However, at this stage this assessment is only indicative.

8.1.9 Urology Nursing

The operational impact on the Urology nursing has yet to be determined.

8.2 Capital Investment

Additional capital investment will be required to support the delivery of the project. This includes the installation of two additional laminar flows and associated theatre equipment.

9. Implementation Plan

9.1 Specialty Moves

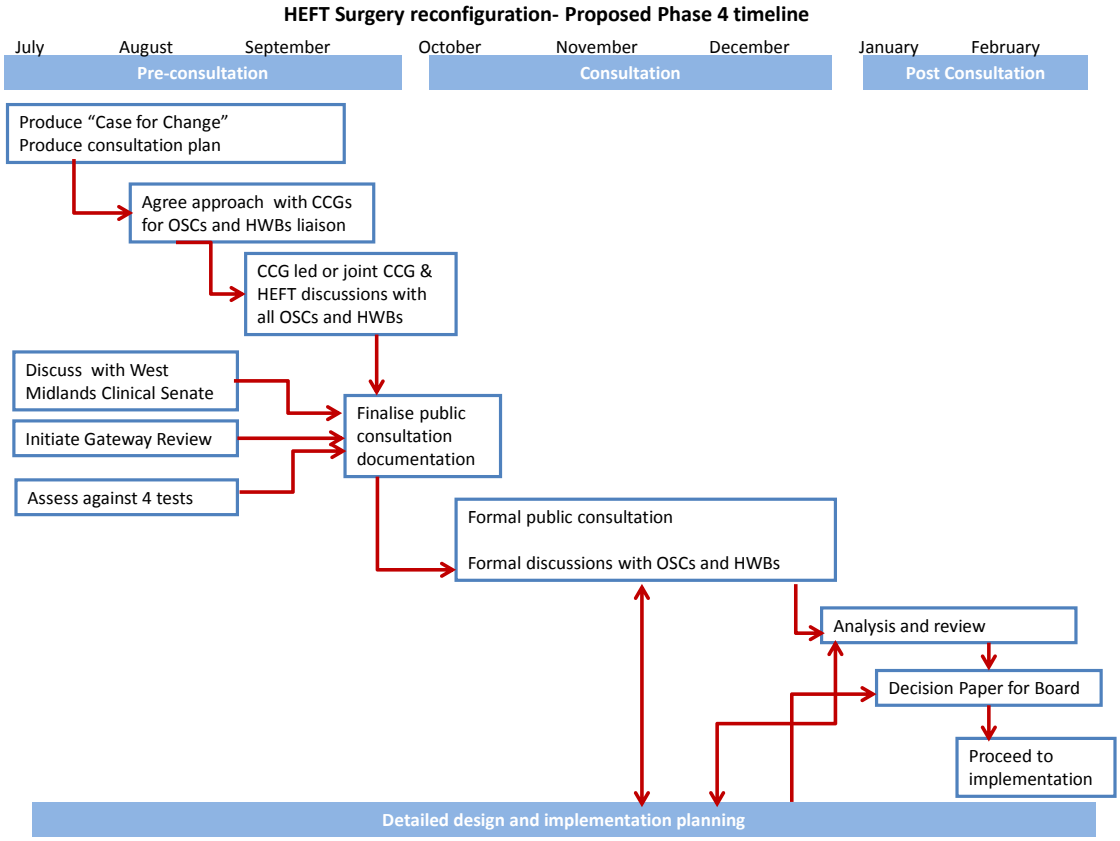
The high level critical paths show key milestones and dependencies. Gantt charts are also being utilised for each work stream, with timeframes and responsibilities allocated.

In order to further populate these, create and successfully deliver a detailed implementation plan for each specialty, requires significant input from the directorates as well as the project team.

The discussions and work up to date have focused on the four main specialties. However, there will be a knock on effect for other specialties at all sites as theatre lists are moved around to best achieve the benefits of consolidation. This will be built into the implementation plan.

9.2 Formal Consultation

One of the main limiting steps with this complex programme will be the pubic consultation and external scrutiny and decision making phase. Pre-consultation engagement is well underway and it is anticipated that the formal public consultation will commence on the 13th October, as per the time frame below:



9.3 Implementation Resources

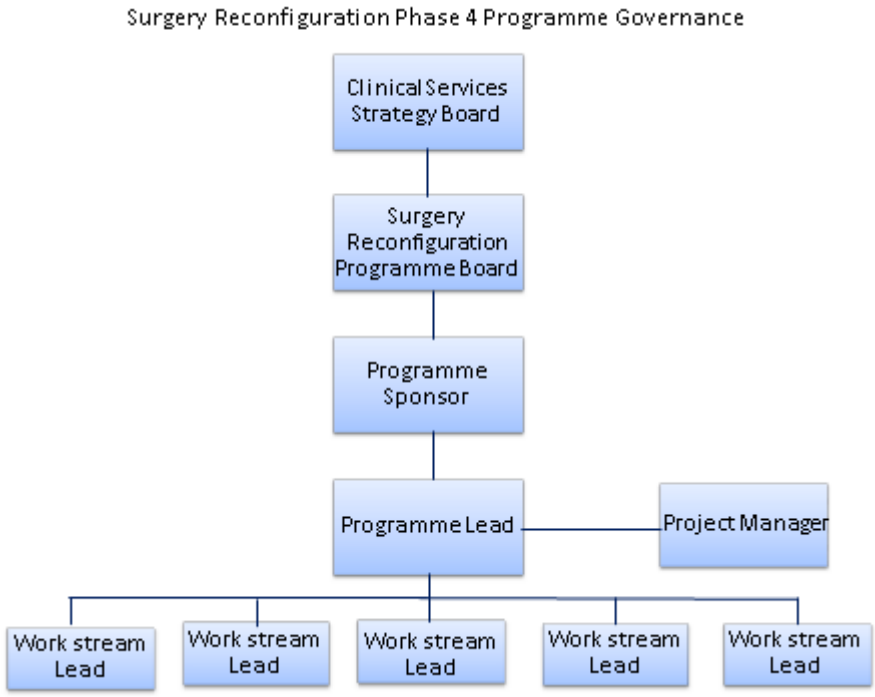
Allocating appropriate resources to deliver this complex transformation project is crucial to the success of the programme.

Input, challenge, ownership and decision making by the directorates will be key. They will be held accountable for delivery in conjunction with a project/ implementation team which will manage the project, undertake programme wide activities and facilitate/support the operational teams in providing the input required.

As identified in the clinical case for change, strong clinical and managerial leadership is vital to the successful reconfiguration of services. A budget has been allocated to cover the costs involved in successfully delivering the programme which is managed by the Programme Lead and Sponsor.

9.5 Programme Management Arrangements

Phase 4 of the surgery reconfiguration is being managed through a programme management approach under the leadership of a programme lead, supported by the Programme Management Office through a dedicated project manager and accountable to the surgery reconfiguration programme board.



The programme board is chaired the Deputy Medical Director for Strategy and Transformation/Associate Medical Director for Surgery and its membership will be reviewed as things progress to ensure the proper governance is in place for each stage of the programme. Representation will be as follows:

- Programme Lead;
- Associate Medical Director for Surgery;
- Clinical Directors of general surgery, urology and orthopaedics with others co-opted as required;
- Head of Operations Clinical Services;
- Theatre, anaesthetics and Critical Care General Manager;
- Operations Manager T&O;
- General Manager Surgery;
- Senior Site Operations or Clinical representatives from all three Hospital sites – Solihull, Heartlands and Good Hope;
- Associate Head Nurse – from Solihull, Heartlands and Good Hope Hospitals;
- Deputy Chief Nurse;
- Senior HR business consultant;
- Head of Communications/Senior Communications Manager;
- Emergency Department representative – from Heartlands and Good Hope Hospitals;
- General Manager ENT and Ophthalmology;
- Other General Managers co-opted as required;
- Project Manager; and
- Operational Lead – Programme Management Office.

10. Key Success Factors

The following key success factors have been identified for this programme and it is important that they are given due consideration as planning, then implementation, progresses:

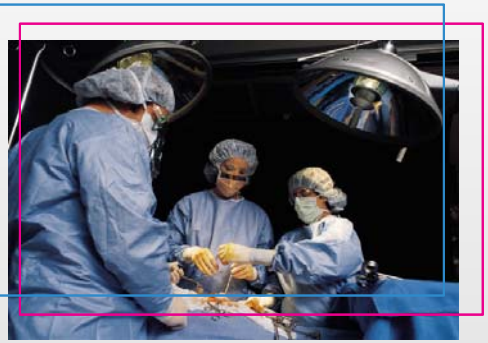
- Visible leadership and direction from the top of the organisation;
- Clinical and operational leadership with the mandate and authority to implement change across the directorates;
- The need to create belief across the organisation that surgery reconfiguration will actually happen and will deliver benefits to patients, staff and the Trust;
- Proactive and a multi-pronged approach to staff engagement to inform, reassure and excite;
- An external engagement process that wins the hearts and minds of the public and other stakeholders;
- Adequate programme resourcing;
- Mandated release of key personnel from their day jobs to design and implement solutions to create ownership and minimise the potential for feeling “done to”;
- Recognition of the need for cultural change and the breakdown of specialty/site silos for the good of the “whole” and commitment to the change management/cultural change facilitation to achieve this; and
- Aligned accountability and safety and quality measures.

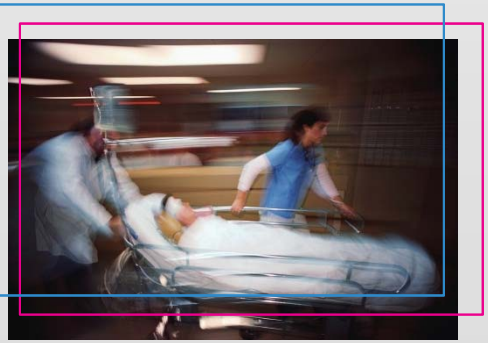
11. Next steps

As described in section 9.2, a formal public consultation will be run in parallel with the continued detailed operational and implementation planning so that feedback from the public, staff and external advisory and scrutiny bodies can be incorporated in the final solution.

This process is now scheduled to run for 14 weeks commencing in mid-October 2014 at which point a business case with recommendations will be presented to the Trust Board for a decision to be made as to how to proceed. Implementation can then commence and it is expected that this will be phased over several months.

Appendix A





Clinical case for reconfiguration of surgical services

Heart of England Foundation Trust

National Guidelines and Best Practice Evidence
March 2014

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Reconfiguration of hospital services across trusts is considered inevitable by many leading voices in the UK healthcare system

" … reconfiguration of services across hospital sites is likely to be the only way that some trusts can achieve financial balance… and (should) focus on achieving best practice outcomes and patient experience …"

– Keith Palmer for Kings Fund "Reconfiguring hospital services" 2011

" … there is increasing recognition that services such as emergency surgery may be unsafe out of hours and the provision of these services needs to be concentrated in fewer centers that are better able to provide senior medical cover …"

– Kings Fund "Transforming the delivery of health and social care" 2012

" … it is increasingly clear that we must radically review the organization of hospital care if the health service is to meet the needs of patients. We must act now and we must act collaboratively …"

– RCP "Hospitals on the edge: The time for action" 2012

" … the truth is that if we don't change the urgent and emergency care pathway from start to finish, we will simple repeat the mistakes of the past; timid, limited or disjointed initiatives will be insufficient …"

– Bruce Keogh "Transforming urgent and emergency care services in England" 2013

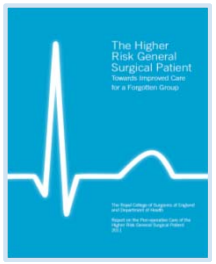
The future state and delivery of emergency surgery are a major focus for the NHS and the Royal Colleges this year

- Growing appreciation from patients, staff and politicians that service needs to change
- Centralisation of specialist surgery services will improve outcomes
- Commonest concerns regarding patient transport must be addressed
- Any reshaping of service must be based on patient and staff benefit

- Sub-optimal delivery of care due to lack of understanding and investment in this high risk work load
- Significant changes to commissioning of emergency surgery services is required
- Consultant led services with dedicated leadership and MDT focus needed to drive improvements

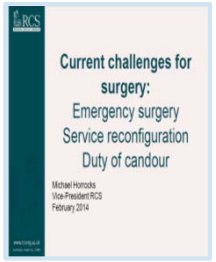
5 pillars of future service:

- Better support for patients to self-care
- Enhance NHS 111 service to get right advice first time
- Provide urgent care outside hospital
- Introduce Emergency Centres and Major Emergency Centres for the seriously ill
- Connect providers into networks to break silos



- EGS is high risk and high cost to the NHS
- Lack of consistency of care leads to large variations in patient outcomes
- Currently major surgery difficult to audit due to range of disease and pathways used to treat
- Adhering to defined standards of care for these patients will reduce morbidity, mortality and cost

- Emergency surgery deserves same dedicated resources as elective surgery
- Requirement for clear separation of workload to deliver quality emergency and elective surgery
- Dedicated leadership and management of EGS required



- Emergency surgery challenged by limited workforce skill and availability despite increasing workload
- Emergency surgery mortality rates highly variable within UK and compare poorly to USA
- NHS England to implement A&E reconfiguration in next 3-5 years

With surgical services failing to provide best outcomes nationally, things are likely to deteriorate under heavy intrinsic and external pressures

Patients

- Increasing emergency surgical admissions
- 60% increase in elective surgery workload 1995-2013 (NHS data)
- Increased frail elderly: 2001-2011 saw the population of over 85 year olds increase at rate 3.5 X higher than rest of population (NAO, 2013.) Within 25 years, it is estimated that the population of over 65's will increase by 65% (Office of National Statistics.)

Politics

- Increasing patient, public and political expectations
- 7 day working
- Duty of candour

Work force

- Significant decrease in number of surgical trainees planned by LETB's: required to shift to GP and Psychiatry
- Increased level of sub-specialisation much earlier in career
- Decreased flexibility and availability of staff due to EWTD impact: College analysis shows a loss of 400,000 surgical hours owing to regulation

Finances

- Public spending constraints set to remain
- Tight eligibility criteria for social care limiting service developments to funding from existing budgets
- Many trusts remain tied to heavy PFI debts
- £3.8 billion Better Care Fund to be pooled by taking savings from acute Trusts and allocating to integration of social care

Current performance:

- UK mortality rate (MR) for major surgery is 4 X higher (i.e.,worse) than USA for similar case profiles[1]
- Weekend MR for all emergency patients is 10% higher than for weekday admissions
- 55% of acute units have inadequate timely access to emergency theatres[2]
- < 20% of acute hospitals have a comprehensive interventional radiology service to support emergency work safely[2]
- Huge variation of practices and outcomes between Trusts performing emergency laparotomies[3]:
  - MR 15% (range 4%-42%)
  - Consultant surgeon presence in theatre ranged from 40%-100%
  - Post-op ITU admission ranged from 10%-88%
- ALOS of acute cholecystectomy in UK is 1 week vs 36 hours in other countries[4]

1 Comparison of P-POSSUM risk-adjusted mortality rates after surgery between patients in the USA and the UK; 2 ASGBI Issues in professional practice 2012; 3 Variations in mortality after emergency laparotomy: the first report of the UK ELN, British Journal of Anaesthesia June 2012; 4 The Future of Emergency Services, Iain Anderson, RCS Regional meeting Southampton

Following a recent seminar, the RCS and NHS England are due to produce a report outlining changes required to improve emergency surgery

Outcomes of round table seminar with Prof. Keith Willet, Nov 2013, will be summarised later this year and include:

- The RCS and NHS England will be supporting and leading on proposals for reshaping emergency surgery delivery
- The separation of emergency and elective work at trust level will be advised where appropriate
- Trusts will be urged to consider the “hybrid” surgeon model, e.g., 1 week of elective operating followed by 3-4 days EGS
- Compulsory A&E training will be re-instated for all trainee surgeons to address workforce and skill challenges
- Commissioning guidance for clinical standards will be developed to reward high quality services and best outcomes

Successful reconfiguration of services requires strong clinical and managerial leadership as well as public engagement from the outset

"…We recognise the critical need for dedicated clinical leadership of EGS…To be effective, such leaders require the support of management, and the devolution of sufficient executive power as well as responsibility."

– ASGBI "Emergency General Surgery: The Future" 2007

" … . Decisions about service redesign must be clinically led and clinicians must be prepared to challenge the way services – including their own service – are organised…"

– RCP "Hospitals on the edge: The time for action" 2012

" … The answer lies in part in finding more effective ways of engaging staff at all levels in developing new ways of delivering care and empowering them to make changes. Leadership of the highest order is required to make this happen both locally and nationally…"

– Kings Fund "Transforming the delivery of health and social care" 2012

"…Patients must be fully informed and involved in changes to their local services. Patients want to be active partners in their care. It is only right that they should want to be involved in the decisions around the provision of that care and treatment, in a process that is not tokenistic…"

– RCS "Reshaping Surgical Services: principles for change" 2013

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As demand for surgery services continues to increase, separating elective and emergency resources has benefits for patients and staff

Demand

- All emergency admissions have increased by 47% growing over the last 15 years[1]
- A&E attendances increased by 5.3% between 2009-2013[2], with 20% on average requiring surgical review or admission (RCEM)
- Demand for elective surgery operations has increased by 60% between 1995-2013 (NHS data)
- An increasing ageing population will continue to impact the need for both emergency and elective surgery as this group of patients is more likely to suffer from disease requiring operations

Benefits of dedicated emergency and elective beds, theatres and staff include:

- Reduce cancellations
- Achieve predictable workflow
- Increase quality training opportunities
- Increase supervision of complex emergency cases
- Reduce hospital acquired infection rates
- Enhance patient safety and experience
- Reduce unnecessary admissions
- Facilitate discharge
- Allow senior input for emergencies

1 http://www.nao.org.uk/wp-content/uploads/2013/10/10288-001-Emergency-admissions.pdf
2 http://www.kingsfund.org.uk/blog/2013/04/are-accident-and-emergency-attendances-increasing

Consolidation of services into fewer sites has shown benefits in other specialties and is a concept supported by the RCS and ASGBI

" … It is envisaged that where possible, major emergencies are centralised but patient assessment and lower risk surgery is delivered closer to patients' homes…"

– RCS / ASGBI Report: "Emergency General Surgery" 2013

" … Where there is clinical evidence supporting it, surgical reshaping will make optimum use of scarce staff and resources and provide high-quality training to enhance patient safety. With specialist resources and equipment in fewer locations, and a higher volume of patients with the same surgical conditions, staff will have more experience and expertise to ensure the highest patient safety levels…"

– RCS Report: "Reshaping Surgical Services" 2013

Examples of consolidated services

- Stroke – London reduced number of hospitals treating acute CVA from 32 to 8
- Cancer services- The Cancer Plan, 2000
- Major trauma – designation of status to only 25 UK centers
- Acute MI – only 1/3 of NHS hospitals offer 24/7 PCA service for acute MI
- Pediatric cardiac surgery- concentrate care in 7 national centres

Patient benefits

- Senior specialists readily accessible 7 days a week
- Narrowing of outcome quality gap through accelerated adoption of best practice models pathways
- Improved survival rates (as seen in case of stroke, MI, and trauma reconfiguration) despite further travel
- Improved patient experience

Staff benefits

- More readily able to staff a 24-hour 7 days service rota
- Training and education improved for junior staff through critical mass
- Efficient consolidated services on 1 site more readily attract funding for expansion into more specialist centre
- Increased long term sustainability of service

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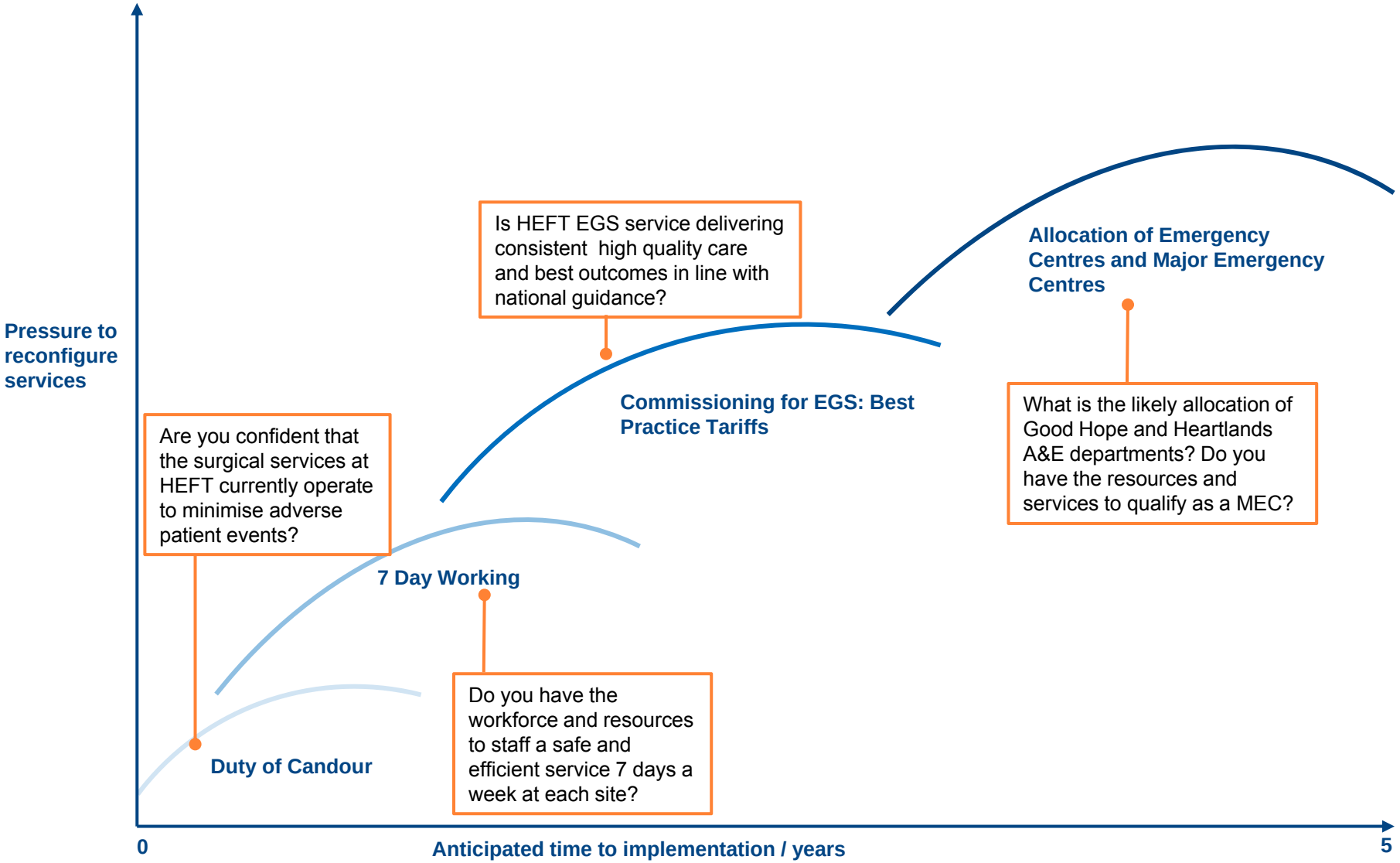
In coming years we will see increasing pressure on trusts to conform to national standards of care as well as new policies; is HEFT prepared?



The RCS has developed generic standards for future models of delivery for emergency general surgery

Standard

- Delivering an effective emergency general surgical service requires the entire team to be free of all other commitments, except in a few hospitals with low emergency workloads.
- The location of emergency patients within a single area greatly facilitates an effective service and enhances patient safety.
- Adequate consultant numbers required for a modern service, with junior or specialist nurse support.
- Immediate emergency theatre access required and in preference to elective work whenever necessary
- Adequate critical care support as needed (levels 1, 2 and 3)
- Be supported by a consultant based 24/7 diagnostic CT scanning service with GI specialist leadership
- Have access to a Trust wide or network interventional GI radiology service 24/7 on a published rota.
- Resuscitation should not delay surgery in patients in class 1 or 2. Resuscitation should be conducted in the anaesthetic room or similar.
- A consultant surgeon and consultant anaesthetist are present for all cases with predicted mortality ≥10% and for cases with predicted mortality >5% except in specific circumstances where adequate experience and manpower is otherwise assured.
- A consultant surgeon (CCT holder) should be present for all unscheduled returns to theatre.

Best Practice Patient Grading

- In order to minimise avoidable harm, patients require definitive treatment by surgery or similar intervention (most commonly interventional radiology) with an urgency which is graded and escalated according to the degree of illness.
  - On-going haemorrhage requires immediate surgery.
  - Septic shock patients who require immediate surgery are operated on within 3 hours of the decision to operate as delay increases mortality significantly.
  - Severe sepsis (with organ dysfunction) which require surgery, to be operated on within 6 hours to minimise deterioration into septic shock.
  - Patients with sepsis (but no organ dysfunction) who require surgery should have this within 18 hours.
  - Patients with no features to indicate systemic sepsis can be managed with less urgency but in the absence of modern and structured systems of care, delay will result in unnecessary hospital stay, discomfort, illness and cost.

SOURCE: Emergency Surgery: Standards for unscheduled surgical care, RCS, 2011

RCS generic standards for emergency urology services

- 24/7 consultant availability for immediate advice and can be on site within 30 minutes
- All emergency cases, especially those where operative intervention is planned, must be discussed with the consultant on call.
- A modern, effective emergency urology service requires adequate theatre access, senior radiological support (including interventional radiology), senior anaesthetic support and critical care facilities.
- Immediate 24/7 availability of:
  - CT scanning and ultrasound scanning with capacity for intervention in suspected urosepsis.
  - CT scanning for patients with suspected urinary tract trauma.
  - Senior trainee (ST3 or above) or consultant urologists to manage the obstructed bladder, which cannot be managed by urethral catheterisation alone.
  - Senior trainee or consultant urologist to operatively intervene for suspected torsion.
- Where an operation is required, a theatre team with adequate experience of urological surgery must be available.
- Outcomes of emergency treatment should be regularly audited.
- Patients with septic shock and evidence of obstructive uropathy require immediate intervention within three hours of the decision to operate as delay increases mortality significantly.
- The on-going care of inpatients/post-operative patients is managed by senior trainees and consultants, on appropriate urology wards with specialist-trained nursing care.
- Daily ward rounds carried out by senior trainees and/or consultants, including weekends.

SOURCE: Emergency Surgery: Standards for unscheduled surgical care, RCS, 2011

RCS generic Trauma and Orthopaedic Standards and Best Practice Metrics

- 7 day access to routine trauma lists which are independent of general emergency theatres. **Best practice**: An additional theatre is immediately available for urgent and complex orthopaedic problems, such as open fractures and those with neurovascular compromise.
- Trauma patients managed within regional trauma network. Complex injuries treated in centres with appropriate volumes within the region –this does not have to be the regional centre. **Best practice**: Appropriate triage by the ambulance service to minimise secondary transfers.
- Consultant led the trauma team 24/7 in all units receiving seriously injured patients.
- If CT scanning is to be performed in patients with multiple injuries, routine use of 'top to toe' scanning is recommended in the adult trauma patient if no indication for immediate intervention exists. **Best practice**: Within 30 minutes.
- Standardised transfer documentation of the patients' details, injuries, results of investigations and management with records kept at the dispatching and receiving hospitals. Include documentation for acute transfer and standardised documents for repatriation to the base hospital for continued therapy and rehabilitation.
- Hip fracture care is in accordance with the British Orthopaedic Association Standards for Trauma (BOAST 1) and data is submitted to the National Hip Fracture Database. **Best practice**: Compliance with the best practice tariff for fragility hip fracture care:
  1. Time to surgery within 36 hours from arrival in an emergency department, or time of diagnosis if an inpatient, to the start of anaesthesia.
  2. Admitted under the joint care of a consultant geriatrician and a consultant orthopaedic surgeon.
  3. Admitted using an assessment protocol agreed by geriatric medicine, orthopaedic surgery and anaesthesia.
  4. Assessed by a geriatrician in the preoperative period: within 72 hours of admission. Postoperative geriatrician-directed multi-professional rehabilitation team.
  5. Fracture prevention assessments (falls and bone health).
- Pelvic and acetabular fracture care in accordance with BOAST. **Best practice:** Regional protocols for initial emergency management.
- On identification of patients with a fracture of the pelvis or acetabulum in a non-specialist centre, referral is made within 24 hours. **Best practice**: Within an established trauma network, patients suspected of having sustained these injuries will be transported direct to the regional centre.
- Severe open lower limb fractures care is in accordance with BOAST aiming to achieve timely, specialist surgery rather than emergency surgery by less experienced teams. **Best practice:** Specialist orthoplastic care within a trauma network.
- Centres that cannot provide combined plastic and orthopaedic care for severe open tibial fractures have protocols in place for early transfer to an appropriate specialist centre.

SOURCE: Emergency Surgery: Standards for unscheduled surgical care, RCS, 2011

RCS generic emergency ENT standards and best practice care

- There is a dedicated ENT unit with immediate transfer to operating theatres.
- Emergency beds are available in the ENT unit for acute admission of either sex.
- Endoscopic cautery, suction and irrigation are available 24/7.
- Training in emergency ENT incorporated into nurse training modules
- Adequate facilities on paediatric ward or ED.
- Departmental protocols are in place detailing whether patients requiring resuscitation attend the ward or ED, with a clinically competent individual to be awaiting their arrival.
- There is a local, time- framed protocol detailing procedures from first contact to theatre, with or without flexible endoscopy referral. 90% of oesophageal foreign bodies are removed within 24 hours.
- 90% of sharp foreign bodies are removed within six hours.
- There is a written hospital protocol for initial management of ED or inpatient epistaxis prior to contacting ENT.
- At admission or next morning endoscopic examination is performed by ST3 or above/equivalent doctor, patients are treated and discharged if possible. Daily consultant management decision is recorded.
- Department has agreed written pathway for referral for angiography and embolisation including out of hours.
- Written guidelines of shared care between ENT and paediatrics are in place detailing provision of IV access, phlebotomy, daily review etc.
- Antibiotic treatment starts without delay once decision is made.
- Patients with orbital cellulitis require urgent ophthalmology opinion and CT scan with or without general anaesthesia available to manage complications
- Ability to carry out CT scan under general anaesthetic and transfer to theatre for drainage of parapharyngeal or retropharyngeal abscess.

SOURCE: Emergency Surgery: Standards for unscheduled surgical care, RCS, 2011

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East and North Hertfordshire has seen a reduction in mortality rates following reconfiguration of its general and orthopaedic surgery services

Background and changes

- The Trust **moved to consolidate general surgery to address concerns over high mortality rates and unavailability of consultant staff when on-call**
- In 2011, an ISTC 'surgicentre' took on the vast majority of the Trusts elective surgery workload resulting in **very small volumes of elective activity being managed across two sites** with **orthopaedics particularly affected**

Case for change

- Patient safety risks - above average hospital standardised mortality ratio (HSMR) for general surgery
- Staffing challenges - emergency surgery on–call across two sites provided by consultants with elective commitments
- Inefficient use of staff and resources e.g nurses, theatres, equipment

Reconfigured model

- **Centralisation of emergency general and orthopaedic trauma surgery** at Lister
- **Centralisation of fractured neck of femur services (FNOF) at a single site** (QEII) with;
  - dedicated laminar flow theatre
  - proximity to a physio gym and x-ray facilities
  - dedicated ortho-geriatrician pathway
- **Consolidation of all remaining elective services (not at ISTC) on one site**
- Use of more modern estate for day surgery services
- New critical care unit at the Lister
- New theatres blocks (to be completed by the end of 2014)

Benefits

- **Reduced mortality**
  - **HSMR has improved** following centralisation (73.8 in 2012/13 compared to 110.6 in 2010/11)
- **Improved clinical outcomes**
  - Timeliness of FNOF surgery
  - Better alignment with national guidelines
  - Reduced LOS for emergency surgery and FNOF patients
- **Staffing improvements**
  - Improved consultant availability
  - improved theatre staffing
  - Better nurse/patient ratio (1:3) in ASCU
- **Improved facilities and better capacity**
  - New Acute Surgical Care Unit (ASCU)
  - New critical care unit at the Lister
  - New theatres blocks (to be completed by the end of 2014)

SOURCE: ENHT Board document, 09/2011 http://www.enhertstr.nhs.uk/files/2011/09/surgical_service_reconfiguration_09_2011.pdf; East and North Hertfordshire NHS trust senior clinical fellow (SpR level) in general surgery recruitment material

East Kent Hospitals University FT is considering centralising emergency general surgery following a review by the Royal College of Surgeons

Background

The Royal College of Surgeons were invited to review surgical services at East Kent Hospitals University Foundation Trust (EKHUFT) in 2012. The review was aimed at considering current service delivery against best practice and future models of care.

- Emergency general surgery **(EGS) services provided at 3 sites** across the trust – Ashford (WHH), Canterbury (KCH) and Margate (QEQMH) with unselected surgical take
- **One of largest teaching hospitals** nationally – formed by merger of 3 acute Trusts
  - >0.7m catchment population
  - >6000 staff

Review findings

Case for change

The review identified **major challenges and significant variation in quality and resources** across sites

- **Quality concerns and issues with patient safety**
  - Lack of timely access to senior clinical input at some sites
  - Occurrence and sustained risk of major adverse events
  - Variable access to service adjacencies e.g. ICU, interventional radiology, vascular, urology, gynae, obstetric and paeds
  - Variable access to equipment
  - Lack of theatre capacity
- **Inability to meet adequate staffing levels**
  - Immediate challenges around provision of 24/7 consultant cover
  - Lack of middle grade doctors at some sites
- **Financial pressures**
  - Increasing cost of running surgical and other departments across 3 relatively small sites

Recommendations and expected benefits

Key medium to long-term recommendation

- Review recommended centralisation of services and reconfiguration using 'hub and spoke' model
- Key rationale for change is risk to patient safety and lack of sustainability
  - Preferred option – **single hub for EGS and major elective GI surgery and 2 spokes** (see other options below)

Options for change

- EKHUFT put forward 4 different options for review
  - No change
  - Single hub for high risk surgery and 2 other spokes
  - Single hub and 2 other spokes
  - 2 hubs and a spoke

Benefits

Centralising EGS at EKHUFT expected to yield **better patient outcomes, patient experience and system sustainability**

- **Improved patient outcomes**
  - Ability to provide adequate consultant cover
  - Enhanced surgeon expertise
  - Better availability of middle grade doctors
  - Better access to service adjacencies e.g. ICU
    - Potential for development of integrated pelvic team (urology/colorectal/gynaecology)
- **Efficient use of resources**
  - More equitable access to equipment
  - Improved theatre capacity

SOURCE: Bristol Council website; Bristol CCG website; Monitor, Co-operation and competition panel -Merger of parts of University Hospitals Bristol NHS Foundation Trust and North Bristol NHS Trust; Press search

Hospitals serving South and West Birmingham consolidated vascular surgery services to deliver improved clinical outcomes for their patients

Background

University Hospitals Birmingham FT (UHB) and Sandwell and West Birmingham Hospitals (SWBH) developed **a single clinical team for vascular surgery and consolidated major vascular surgery on a single site**

- SWBH previously ran a cross site vascular surgery service with emergency consultant cover provided jointly with UHB

Rationale for reconfiguration

Case for change

Improvement opportunities from reconfiguration identified include;

- **Clinical outcomes**
  - need to reduce morbidity and mortality rates
  - Inability to meet critical patient mass required to;
    - build and maintain expertise in more complex procedures
    - gain maximum patient benefit patients needing interventional radiology procedures
  - varied vascular surgery expertise
  - need to establish a recognised centre of excellence and support/undertake appropriate clinical trials.
- **Staffing and training challenges**
  - Inability to provide 24/7 rapid access to diagnostics, IR and emergency surgery
  - difficulty in attracting talent to small units
  - need to develop suitable training environment for vascular surgery
- **Sustainability**
  - inability to provide safe services meeting required national standards in an increasingly challenging financial climate

New service model and expected benefits

Across South and West Birmingham all inpatient elective and emergency **vascular surgery now consolidated at new 'centre of excellence' at** UHB's new Queen Elizabeth Hospital

- Vascular Surgery day case, 23 hour surgery and outpatient activity continues to be provided locally a 2 SWBH sites
- on call consultant rota for vascular surgery continues to cover both Trusts

Expected benefits include;

Improved clinical outcomes

- Alignment with national recommendations
  - 24/7 access to a specialist vascular surgery clinical team
  - 24/7 interventional radiology service
- critical mass of patients (i.e. 0.8m population) enabling clinical team to develop greater specialisation and undertake more complex procedures

A new centre of excellence allowing;

- Undertake clinical trials and research
- Support specialist training
- Provide access to cutting edge facilities and technology
- Attract high calibre specialist staff.

SOURCE: Sandwell and West Birmingham Hospital Trust papers, Health Service Journal, 'Birmingham hospitals identify surgery reconfiguration benefits',16 December, 2011; University Hospital Birmingham website

Bristol consolidated urological surgery onto a single site to improve clinical outcomes, patient experience and efficiency

Background and changes

As part of a larger reconfiguration exercise, a single centre of excellence in urology in Bristol was created early in 2013 to deliver improved clinical outcomes for patients and provide better patient experience

- Services formerly provided at both University Hospitals Bristol (UHB) and North Bristol Trusts (NBT) into single 'hub' at North Bristol
  - In 2011/12, services was worth ~£17m with ~£12m at North Bristol Trust

Case for change

- Consolidation was necessary to address;
  - Service variation
    - variability in patient experience
  - Inefficiency
    - inefficient use of consultant time from supporting a multi-site inpatient and surgical service
    - use of locum consultants due to difficulties with recruitment
    - difficulties making best use of clinical resources i.e. junior doctors; specialist nurses
    - duplication of staffing and equipment
  - Inequity in resources
    - patients access to clinical expertise and equipment determined by the organisation to which they were referred rather than clinical need
  - Capacity issues
    - preferred clinical option to release required theatre capacity and consistent with Trust's strategic plans

Delivery model

- Hub and spoke delivery model with spokes providing routine outpatient appointments and some diagnostic services at various locations
- Consolidation of all surgical inpatient and day case urology services into hub at NBT
  - transfer of 18 staff from UH Bristol to NBT.
- New single point of referral for urology patients
- One stop outpatient clinics at Southmead Hospital and new South Bristol Community Hospital
- Consolidated research at Southmead Hospital as part of Bristol Urological Institute (BUI)

Expected Impact

Improved clinical outcomes

- Concentrated surgical and clinical expertise
- Shared/Standardised best practice methods across clinical teams
- Reduced complications and improved survival rates from strengthened research capability encouraging research and innovation in surgical techniques and treatment regimes
- Enhanced ability to attract national and international talent
- dedicated urology ward
  - Improved access to specialist urology consultant-led ward rounds
  - Access to specialist nurses

Better patient experience and equity

- Single point of referral
- Improved communications – no barriers and lapses across multiple organisations
- Single waiting list management - Better and timely access to the right specialist and the right equipment

Improved efficiency

- Minimisation of duplication and waste
  - Efficient use of consultant time
  - Efficient use of equipment
  - Reduced cancellations
  - Increased buying power

SOURCE: Bristol Council website; Bristol CCG website; Monitor, Co-operation and competition panel -Merger of parts of University Hospitals Bristol NHS Foundation Trust and North Bristol NHS Trust; Press search

APPENDIX B

SURGICAL RECONFIGURATION WITHIN HEFT

Terms of Reference

Stakeholder Reference Group

Accountable to:
HEFT Surgery Reconfiguration Programme Board

Purpose:
The purpose of the Stakeholder Reference Group is to ensure that the views of patients and other stakeholders are heard and taken into account in any proposals for the reconfiguration of the provision of surgical services across the Solihull, Heartlands and Good Hope Hospital sites.

There is a Surgery Advisory Group/Board that has been set up to design and review options from a clinical viability perspective.

The overall remit of this group is:

- to understand and inform the process of the option design and evaluation
- to receive and scrutinise information from the Surgery Reconfiguration Programme Board (SRPB)
- to feed views and experiences from a patient/resident/referrer perspective back to the SRPB
- to participate with HEFT in agreeing options for change

Facilitation
Ruth Paulin - Surgery Reconfiguration Programme Lead and member of the Surgery Advisory Group (SAG) and/or Lorna Grinnell-Moore (Surgical Matron) will be present at the meetings as advisory support, to answer questions etc

Membership
A representative cross section of HEFT service users and other stakeholders including:

- Independent chair (non-clinician) Sharon Woodcock
- Up to 3 representatives from each hospital patient groups
- Up to 3 local people/patients (representative to area demographics as far as practicable)
- Up to 3 GP's from each hospital catchment area
- Mr Richard Steyn (Associate Medical Director for Surgery)
- 1 HEFT Local Patient Governor
- 2 Healthwatch representatives Birmingham & Solihull
- Front line staff group member TBC

Membership will be made to vacant seats through an open, independent and transparent process, needing to balance the HEFT geographic and demographic population profile where possible.

Frequency of meetings:
It is likely that the group will meet three or four times over the spring, summer 2014 however it is envisaged that the group may continue to need to meet until any consultation is completed, this is not compulsory but welcomed by HEFT.

Decisions:
The remit of this group is to understand and review the process undertaken by the SAG and SRPB to date and to contribute to the development of deliverable options for reconfiguration of surgical services. Opportunities may arise to support professionals in presenting options e.g. to the HEFT Trust Board/ Other key boards.

Any decisions to implement will be made by the HEFT Trust Board.

Any decision relating to Public Consultation will be subject to national policy and scrutinised locally by The Trust Board.

This group can raise any concerns about the fairness and transparency of the process with the programme team or programme board at any time.

Agendas and papers:
An appropriate set of papers for each meeting will be sent out at least 3 days before each meeting.

Minutes:
A set of formal minutes will not be produced for these sessions however a summary of discussions will be provided following each meeting. These notes may be used for press release and stakeholder briefing purposes.

Conflict of Interest:
Any actual or potential conflicts of interest must be declared.

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