Joint commissioners and provider Working Together Programmes

Non- specialised Children's Surgery and Anaesthesia – Options Appraisal

June 2016

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			assumptions, 2.8 note on status of following RAG rating for options. Changes to sections 3.2,3.3 re OA next steps
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Contents

Introduction and Overview

This paper has been worked up to give an overview of the potential options and impact for redesigning children's surgical services across South and Mid Yorkshire, Bassetlaw and North Derbyshire (the Working Together footprint). The paper proposes three main options, gives an early indicative assessment of those options using a 'traffic light' scoring, and suggests a systematic option scoring approach to run alongside this.

The enclosed gives an overview of the potential change in flows and impact of redesigning services to meet quality, safety and sustainability requirements.

The impact assessment also covers change in flows from a CCG population perspective which has been developed following the assessment panel and a subsequent meeting of the original task and finish group on the 14th of April 2016.

It is important that the **case for change** for Children's Surgery and Anaesthesia services within the Working Together footprint is considered to enable provision commissioned to be equitable, safe and sustainable for the future.

The case for change and subsequent Health Needs Assessment takes into consideration quality aspects of the service, draws on national and regional guidance and clinical best practice within services, and sets out the national standards for Children's surgical services.

In summary the challenges facing the future provision of children's surgery raised by stakeholders (surgeons, anaesthetists, Trust managers and commissioners) and identified as the key drivers for the Working Together Programmes (provider and commissioner) at meetings are as below.

- Providing a comprehensive range of effective and sustainable children's surgery and anaesthetic services.

  Changes in clinical practice have been influenced in recent years by guidance from the Royal College of Surgeons (RCS) and Royal College of Anaesthetists (RCoA) and an increased focus on clinical governance.
  One of the more significant changes has been to the training of general surgeons, with a reduction in the paediatric component of general surgical training. Individual general surgical trainees have been given free remit to choose any sub-specialty area, and unfortunately, the numbers training in any given sub-specialty do not always match the needs of the service. As a result, as surgeons retire, they are not being replaced by surgeons with the

same level of experience in paediatric surgery.

There is evidence, from the workforce profiling undertaken by providers, that concern about the ability to provide safe and effective surgery for children has caused some surgeons to limit the range of surgery that they offer, or limit the age range of children that they treat.

- Avoiding unplanned unmanageable changes to referral patterns for children's surgery.

  Within the region there is evidence that the issues identified above have resulted in unplanned changes to service provision and 'activity flows' away from smaller DGH's towards larger centres, leading to problems in capacity planning. There is recognition among clinicians that transformation of services may be required to make best use of clinical manpower, and that this needs to be addressed strategically.

- The need to consider clinical interdependencies

  The provision of children's surgical and anaesthetic services is dependent on the provision of other children's services and vice versa; in particular the provision of a number of children's services relies on the provision of paediatric anaesthetic services. There is also interdependency between medical paediatrics and maternity and neonatal services. Therefore, changes to individual services can have an impact on the overall 'portfolio' of services offered by individual Trusts. We are also taking into account the urgent and emergency care review and the work of the developing South Yorkshire and Bassetlaw Sustainability and Transformation Plan, and those of our neighbouring regions.

- Implementation of the Standards for Children's Surgery and Anaesthesia leads to challenges that are beyond the ability of individual organisations to solve.

  There is widespread recognition that meeting the standards in full may be a challenge for some Trusts. The view among clinicians is that there are options for addressing these (e.g. through the provision of in-reach and outreach services, joint training, education and audit), but that this would also require joint working. Alongside this, is the view that for the standards to be effective, they should be monitored by people who understand the services and who are able to make informed assessment against compliance; ideally peers. Also, that the standards will need to be reassessed in light of changes to national clinical guidance, in order to remain relevant.

In light of all the above, the overwhelming view from attendees at stakeholder meetings and engagement events was that:

- There is a need for change because 'continuing as we are is not sustainable'.
- Ensuring good quality and sustainable provision of services in future and implementation of standards would require cross-organisational working.
- There is lack of co-ordination across pathways and patient flows are not managed.
- The interdependencies of children's services are complex.
- There is a need for managerial leadership and clinical leadership across organisations.

Recently, regional CQC visits have highlighted the need to improve staffing levels which have led to the increased usage of locum/bank staff in various providers of children's surgery.

Between January and April 2016, Commissioners Working Together gathered the views of patients and the public during a pre-consultation phase. The following were the key themes identified as being important to people when accessing children's surgery and anaesthetic services:

- Safe, caring, quality care and treatment
- Access to specialist care – with a willingness to travel for specialist care
- Care close to home
- Communication – between children, parents, carers and their clinicians – and also between hospitals
- Being seen as soon as possible

Following the expert assessment panel held on 7 March 2016, which considered all aspects of the review and advised on a way forward, and the subsequent task and finish group discussion on the sustainable options for modelling services held on 14 April 2016, the options detailed in the main body of this paper emerged as requiring further consideration. This paper moves towards a formal assessment of those options, prior to them being circulated for public consultation.

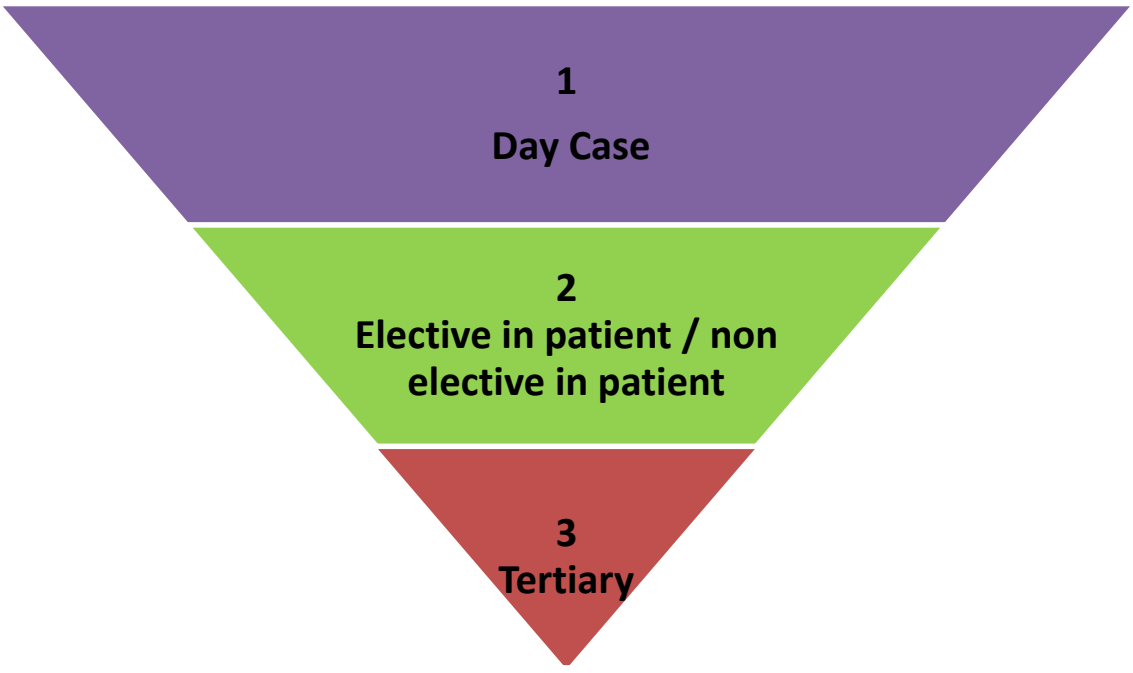
1. Proposed Model for Planned Surgery

1.1 The general principles around provision of safe and sustainable planned surgical care which providers are required to meet are outlined within the Service Specification. The intention of commissioners is to use a 'designation' approach, i.e. units meeting the specification will become designated surgical centres. This will mean designation within the tiers described within the service designation toolkit. There will also be a managed clinical network function in organising and sustaining provision across tiers within the designated centres.

Levels of care for surgery will be tiered as follows:

Tier 1 = Day Case Surgery
Tier 2 = Tier 1 + elective + out of hours non elective inpatient surgery
Tier 3 = Tier 2 + specialist (tertiary)

Surgery Tiers



1.2 This will be organised and planned at a sub specialty level, i.e. the service map for one specialty may differ from that for another specialty. The reason for this is acknowledgment of the accessibility of workforce skills in some sub specialties, which enables some aspects of surgery

to be undertaken more easily than others.

The use of outreach services to support tiers 1 and 2, as well as outpatient services will be a key function that will need to be further developed and supported from the centre hosting the expertise. Within the Managed Clinical Network (MCN) there should be a clear remit to distribute the workforce across the geography in response to need and to undertake improvement and planning activities to ensure compliant services in the designated units.

There are some common widely acknowledged procedures that have lower or higher thresholds or considerations when thinking of the models of care and specified requirements. There are some procedures, for example in general surgery where age thresholds vary, and in ENT airway management and wider support services are critical.

We also know that there are a number of time critical procedures and we must ensure we can respond and treat these effectively. The example of torsion of testes is a well-sighted example. Also the skills and expertise to respond to surgical and anaesthetic care needed within under 3 year olds is another area of great debate and one that consensus to transfer to an appropriately skilled unit has been reached across clinicians.

This means that the consideration of out of hours surgery needs a clearly defined pathway and protocols in place between centres and hospitals within the area.

2. Options and Scenario Appraisal

2.1 The proposed service model should be tested and considered alongside the current need for surgical care across the patch.

2.2 To enable a sustainable service to be established for the future, there will need to be less entry points, more critical mass of planned provision and clarity across pathways to enable out of hours, non-elective care to be directed to the most appropriate centre.

2.3 Providing the appropriately trained workforce through a managed and organised network will be critical to providing a sustainable model of care, therefore the workforce challenges, new models and skills in existence will need careful planning.

2.4 Following discussion at the assessment panel and subsequent service model discussions at the task and finish group, there was a conclusion to propose a model highlighting a range of options for the development of tier 2 hubs for surgical care, as the tier 1 and tier 3 provision are less debatable and easier to plan across the footprint.

2.5 The option needs to provide sustainability, with particular focus on sustaining care across the geography and safe management of the acutely ill child presenting non-electively out of hours.

2.6 There is also a significant interface with the acute care work stream on ensuring that paediatric 24/7 medical care is in place that may further impact on inpatient care levels in the future. As well as this, there is an acknowledged interface with acute maternity and neonatal care due to workforce interdependencies.

2.7 The criteria to assess options and impact of changes within proposals must consider as a minimum:

Criterion	Indicator	Questions
Access **Red** – High Impact negative Impact **Amber**- Some Impact and some changes minimal Impact **Green**- Changes in access but equitable timeframes	Patients would access the same standard of care; ensuring care is equitable across geography and sites. Patients would access the right care within similar timeframes. Therefore population location would not mean negative impact on access.	Will populations from across the WTP footprint access provision for urgent surgery care within critical times frames for treatment? Would populations particularly from areas of high deprivation have to travel longer distances for treatment and care? What will patients value more access to right care in a location further away, or access to substandard care but in a location need by with quicker access?

Activity and flow **Red**- Deliverability of changes in activity are challenging or workforce skill maintenance would be an issue **Amber**- Sustainability of workforce skills although challenging **Green** – Activity changes should be able to be maintained	Any changes in activity or flow can be sustained and managed between providers	Are there are sufficient activity levels to maintain workforce skills? Is there sufficient activity to be able to justify planning care for a group of patients? Will there be a mechanism in place to plan for changes between providers to meet the care needs for surgery provision across the WTP? Have the providers got the ability to deliver an increase in activity or will capacity be an issue?

Workforce sustainability, quality and best practice **Red-** Workforce sustainability still a major challenge **Amber –**possible to maintain but challenging. **Green –** Should be sustainable	That workforce skills and competencies are sustainable longer term and can be developed where needed within the proposed option.	Does the proposed option enable workforce development across a whole system? Can skills be further developed to enable future needs to be met? Will provision be able to meet specified standards? Can proposed models to develop workforce be implemented?

Cross boundary impact **Red –** Significant change, high impact on transport and care across boundaries **Amber –** Some change, some impact **Green –** Change will have minimum impact or could be managed effectively within proposal	That any changes across boundaries are managed with the least possible negative impact and the potential impact on transport is scoped, understood and assessed. Cross boundary provision is considered,	Does this change have a significant impact on transport? Will there be patients from one area travelling more to another area/site for care? If so out of the proposed options which have the most cross boundary changes? Do the proposals have an impact on provision or care across boundaries to neighboring CCG's? If so what might the negative impact of change be?

An indicative “Traffic Lighted” assessment of the models against the relevant criterion (using a “Red, Amber, Green” or “RAG” rating) is included below in sections 2.9 - 2.12. For the implementation of any recommendation it is acknowledged that further collegiate scoring methods should be undertaken in depth by a clinical sub group and by at specialty level in order to support operational delivery and change management requirements.

2.8 There has been some natural migration already within the services into a Tiered approach. This primary gap in service delivery is around paediatrics requiring overnight stay and out of hours services.

2.9 Tier 1 proposals indicate the continued delivery of day case surgery for hospitals that can do two things:-

- Firstly, meet the service specification and associated designation to provide day case surgery.
- Demonstrate enough critical mass to warrant planning and providing this level of activity given that some lists will be provided by an outreach model and at sub specialty may require specific surgical skills.

Tier 2 proposals have focused on appraising and assessing options over 2-4 centre model and will be the area that the largest level of change is needed.

For tier 3 provision this would be provided over only a few centres within the geographical boundaries of the programme.

The options appraisal is based upon current hospital sites, although we know from the needs assessment and the map of population growth rate that the need for provision falls across all areas over time.

Activity numbers associated with each of the options are based upon assumptions, i.e. taking historical patient activity levels in particular sites, and assessing, based upon the shape of each option, a) whether activity would stay at that site or leave and b) if it leaves that site, where it is likely to go to, based upon local geography, transport links, etc.

As this work proceeds, potentially to public consultation against a viable option following appraisal, it may be necessary and good practice to invite further scrutiny of those assumptions.

The following RAG rated / traffic lighted options assessments in sections 2.9-2.11 is based upon initial views of the core members of the programme team, with a focus on an option in light of its ability to meet the relevant standards and meet the intentions of the project. Section 3 will talk about the conclusions and recommendations following the RAG rating.

RAG Rating of Options:

Completed by the Working Together Programme and Project Management team and discussed and approved by members of the Children's Core Leaders Group.

Baseline Activity

The variances associated with each option should be applied to the base 2014-15 activity data which is shown here:

Base Activity 14-15	Trust	ENT	Gen Surg	Ophth	Oral Surg	Paed Dent	Paed ENT	Paed Ophth	Paed Surg	Paed T&O	Paed Urol	T&O	Urology	Grand Total
Elective 0 LoS	BHNFT	269	17	0	362	0	0	0	0	46	0	74	14	782
	CRH	258	59	53	0	0	<5	<5	<5	20	0	76	15	490
	DBH	454	57	58	182	0	0	0	0	0	0	225	26	1002
	MYH	380	45	67	448	0	0	0	0	0	0	218	98	1256
	Other	118	17	23	17	0	32	12	104	25	112	73	14	547
	SCH	0	0	0	0	0	931	271	927	553	0	0	0	2682
	STH	59	16	27	171	539	0	0	0	0	0	59	27	898
	TRFT	214	56	71	446	0	0	<5	0	0	0	109	70	967
Elective 0 LoS Total		1752	267	299	1626	539	<968	<293	<1036	644	112	834	264	8624
Elective Non-DC	BHNFT	38	<5	0	0	0	0	0	0	7	0	19	0	65
	CRH	130	<5	0	0	0	<5	0	0	6	0	23	0	163
	DBH	140	<5	0	11	0	0	0	0	0	0	48	0	203
	MYH	29	<5	0	<5	0	0	0	0	0	0	46	<5	82
	Other	36	<5	0	0	<5	24	<5	22	13	7	35	0	142
	SCH	0	0	0	0	0	407	<5	79	217	0	0	0	705
	STH	9	0	0	<5	0	0	0	0	0	0	18	<5	31
	TRFT	96	5	6	5	0	0	0	0	0	0	26	0	138
Elective Non-DC Total		478	16	6	21	<5	434	<5	101	243	7	215	<5	1529
Emergency	BHNFT	42	262	0	0	0	0	0	0	0	0	197	0	501
	CRH	34	131	<5	0	0	<5	0	<5	0	0	145	0	316
	DBH	175	195	8	12	0	0	0	0	0	0	407	20	817
	MYH	110	212	<5	37	0	0	0	0	0	0	260	108	729
	Other	39	130	<5	9	0	6	0	79	19	<5	146	14	447
	SCH	0	0	0	0	0	67	7	388	174	0	0	0	636
	STH	47	130	0	0	0	0	0	0	0	0	63	62	302
	TRFT	71	294	5	94	0	0	0	0	0	0	238	10	712
Emergency Total		518	1354	19	152	0	74	7	469	193	<5	1456	214	4460
Grand Total		2748	1637	324	1799	540	1473	300	1604	1080	123	2505	480	14613

2.10 **Option One** - **Development of 4 tier 2 hubs**:

Based upon the current providers and need across the patch, hubs would be located at Sheffield, Doncaster, Pinderfields and Chesterfield. This would site tier 2 provision over the geography evenly to meet need. There are existing arrangements between Nottingham and Chesterfield Royal these could be explored further and developed further.

Criterion	RAG	Initial Assessed Impact
Access		This would mean some cases would be transferred to the proposed Tier 2 units and not have a procedure at units providing Tier 1 care. They might be stabilised and transferred to the nearest tier 2 unit. This would mean continuation of the current configuration with most units and sites sustaining and developing full care pathways for all surgery needed. We know this is unlikely to be sustainable model of care, and from the review to date we know this will mean variation when patients access care, or pose a significant challenge in providing equitable access to care.
Activity levels and levels of change		This would mean trying to maintain the activity levels and flows with some activity in most sites, so almost status quo on activity assumptions. It is likely that there would be a level of transfer to ensure patients got the right care. This is not easy to quantify or predict.
Cross boundary impact and transport		This would mean little cross boundary impact. There would be a level of transfer needed which is not easy to quantify given the uncertainty around stabilising clinical appointments on some sites.
Adequate Workforce, safety and quality		There would not be the ability to provide the workforce to provide this cover consistently across all sites.
Impact on visitors/carers		For some care that was not planned this would mean travelling to another site.
Finance		We know the current position overall is not sustainable financially across all NHS provision and there are less resources available in the future.

Challenge in delivery	N/A	This would mean almost status quo
Total weighted score		The status quo is not an option

Option 1 : Indicative Activity Changes:

Four Hubs - Variance Impact by Selected Specialty

1. Emergency

	ENT	*Gen Surg*	*Ophth*	*Oral Surg*	*T&O*	*Urology*	*TOTAL*
Current Activity	518	1354	19	152	1456	214	**3713**
Variance by Provider							
BHNFT	-42	-262	0	0	-197	0	**-501**
CRH	-6	-26	-1	0	-35	0	**-68**
DBH	-12	75	-2	27	-27	-4	**57**
MYH	21	106	0	0	89	-2	**214**
Other	0	0	0	0	0	0	0
SCH	110	401	8	67	408	16	**1009**
STH	0	0	0	0	0	0	**0**
TRFT	-71	-294	-5	-94	-238	-10	**-712**

2. Elective with LOS >0

	ENT	*Gen Surg*	*Ophth*	*Oral Surg*	*T&O*	*Urology*	*TOTAL*
Current Activity	478	16	6	21	215	2	**738**
Variance by Provider							
BHNFT	-38	-1	0	0	-19	0	**-58**
CRH	-36	0	0	0	-5	0	**-40**
DBH	-23	0	1	-1	-1	0	**-24**
MYH	36	0	2	0	7	0	**45**
Other	0	0	0	0	0	0	0
SCH	157	6	3	6	43	0	**215**
STH	0	0	0	0	0	0	**0**
TRFT	-96	-5	-6	-5	-26	0	**-138**

2.11 **Option Two** - **Development of 3 tier 2 hubs**:

To meet need equitably across the geography these would be at Sheffield, Pinderfields and Doncaster. This would provide even distribution over the geography and stabilise the currently established outreach approach with North Lincolnshire and Goole (NLAG) provision. Chesterfield would need further consideration.

Criterion	RAG	Initial Assessed Impact
Access		This would mean some cases would be transferred to the proposed Tier 2 units and not present at units providing Tier 1 care, or be stabilised and transferred to the nearest tier 2 unit. This would mean all CCG populations would have equality of access to the same standards of surgical care, but mean further travel for procedures for some populations.
Activity levels change		This would change the activity and flow with some activity moving from existing sites to the designated Tier 2 units. Therefore a change in activity and flow from 2 existing sites.
Cross boundary impact and transport		This would mean populations from Rotherham, Bassetlaw and Barnsley travelling to Doncaster, Wakefield or Sheffield, if these sites were to be developed as the tier 2 sites. This would impact on transport services, this would need planning in, the number of new transfers overall would increase.
Adequate Workforce, safety and quality		There would need to be concentrated workforce planning throughout and across the 3 hub sites.
Impact on visitors/carers		For some care that was not planned this would mean travelling to the Tier 2 centre instead of a local hospital site.
Finance		Not known at this stage
Challenge in delivery		This option although challenging requires a substantial change could be delivered. It would need a level of additional planning for increased capacity in the proposed tier 2 centres.

Total weighted scores		This option would mean a radical change across inpatient provision and moving to a planned network across outpatient and day case surgery.

Option 2 : Indicative Activity Changes:

Three Hubs - Variance Impact by Selected Specialty

1. Emergency

	ENT	*Gen Surg*	*Ophth*	*Oral Surg*	*T&O*	*Urology*	*TOTAL*
Current Activity	518	1354	19	152	1456	214	**3713**
Variance by Provider							
BHNFT	-42	-262	0	0	-197	0	**-501**
CRH	-34	-131	-3	0	-145	0	**-313**
DBH	-12	76	-2	27	-27	-4	**58**
MYH	20	106	0	0	89	-2	**214**
Other	0	0	0	0	0	0	0
SCH	139	505	8	67	518	16	**1252**
STH	0	0	0	0	0	0	**0**
TRFT	-71	-294	-5	-94	-238	-10	**-712**

2. Elective with LOS >0

	ENT	*Gen Surg*	*Ophth*	*Oral Surg*	*T&O*	*Urology*	*TOTAL*
Current Activity	478	16	6	21	215	2	**738**
Variance by Provider							
BHNFT	-38	-1	0	0	-19	0	**-58**
CRH	-130	-1	0	0	-23	0	**-154**
DBH	-23	0	1	-1	-1	0	**-24**
MYH	36	0	2	0	7	0	**45**
Other	0	0	0	0	0	0	0
SCH	251	6	3	6	62	0	**329**
STH	0	0	0	0	0	0	**0**
TRFT	-96	-5	-6	-5	-26	0	**-138**

2.12 **Option Three** - **Development of 2 tier 2 hubs across the geography**:

These would be located at Sheffield and Pinderfields. This would provide a site for inpatient care within the geography based at a larger distance apart to the current configuration.

Criterion	RAG	Initial Assessed Impact
Access		This would mean some cases would be transferred to the proposed Tier 2 units and not present at units providing Tier 1 care, or be stabilised and transferred to the nearest tier 2 unit. This would mean all CCG populations would have equality of access to the same standards of surgical care, but mean further travel for procedures and may build in a time delay to treatment.
Activity levels – levels of change		This would change the activity and flow with some activity moving from Rotherham, Barnsley, Doncaster and Bassetlaw to the tier 2 units. The level of activity needed at the 2 sites would be challenging to provide.
Cross boundary impact and transport		This would mean populations from Rotherham, Barnsley, Bassetlaw and Chesterfield travelling and would impact on transport services as there would be a significant number of transfers.
Adequate workforce		There would be the ability to plan the workforce to provide this cover apart from the acute paediatric workforce in the future for this care
Impact on visitors/carers		For some care that was not planned this would mean travelling to the Tier 2 centre
Finance		Not known at this stage
Challenge in delivery		There would be bed capacity issues with this proposal as the shift of inpatient activity would be significant
Total weighted score		This could have a significant impact on patients access to care without a radical upgrade in transport and capacity at the 2 site proposed.

Option 3 : Indicative Activity Changes:

Two Hubs - Variance Impact by Selected Specialty

1. Emergency

	ENT	*Gen Surg*	*Ophth*	*Oral Surg*	*T&O*	*Urology*	*TOTAL*
Current Activity	518	1354	19	152	1456	214	**3713**
Variance by Provider							
BHNFT	-42	-262	0	0	-197	0	**-501**
CRH	-34	-131	-3	0	-145	0	**-313**
DBH	-175	-195	-8	-12	-407	-20	**-817**
MYH	48	163	1	1	108	3	**324**
Other	0	0	0	0	0	0	0
SCH	274	719	15	105	879	27	**2019**
STH	0	0	0	0	0	0	**0**
TRFT	-71	-294	-5	-94	-238	-10	**-712**

2. Elective with LOS >0

	ENT	*Gen Surg*	*Ophth*	*Oral Surg*	*T&O*	*Urology*	*TOTAL*
Current Activity	478	16	6	21	215	2	**738**
Variance by Provider							
BHNFT	-38	-1	0	0	-19	0	**-58**
CRH	-130	-1	0	0	-23	0	**-154**
DBH	-140	-4	0	-11	-48	0	**-203**
MYH	47	1	2	2	16	0	**67**
Other	0	0	0	0	0	0	0
SCH	357	10	4	14	100	0	**486**
STH	0	0	0	0	0	0	**0**
TRFT	-96	-5	-6	-5	-26	0	**-138**

3. Conclusions and Recommendations

3.1 Governing Bodies are asked to support the designation of Tier 1 and Tier 3 surgical care, enabling the implementation of this through the Managed Clinical Network and through commissioning and contracting teams within CCGs.

3.2 Governing Bodies are also asked to support further consideration of the options. Building upon the initial, indicative RAG scores above, and noting that (at this stage) the three-hub model appears to offer the greatest benefit and scope for feasibility, and should be appraised further.

3.3 This is likely to lead to the formal classification a “Preferred Option”, with subsequent development of a business case to examine detailed implementation aspects.

3.4 It is acknowledged from the outset and from the RAG scoring and supporting data that there will be potential capacity issues, to a greater or lesser degree, with all options, as well as potential sustainability impacts upon other services at sites not designated as Tier 2. The ‘do-ability’ of options should be a substantial factor in their appraisal.

3.5 Following the first phase of work on the Acute Care pathway in May and the STP initial modelling to be completed in June 2016, further consideration of the potential impacts of these upon surgical models will need to be undertaken. There is an acknowledged interdependency between the assessment and management of acute care within paediatric assessment and the pathway to surgical care for procedure and intervention.

3.6 At this stage, whilst the three-hub model presents the most promising initial findings, the Working Together Programmes recognise that, in addition to option scoring, all proposals will and should be subject to adequate public consultation, and that this should take place in a transparent way. It is anticipated that this consultation will start in September 2016.

Kate Laurance on behalf of Commissioners Working Together and *the Working Together Programme*
1 June 2016