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NHS Sheffield Clinical Commissioning Group

Commissioners Working Together Transformation Programme
Review of Children's Surgery and Anaesthesia

Governing Body meeting G

7 July 2016

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Sponsor	Tim Moorhead Clinical CCG lead Phil Mettam Chief Officer Lead

Is your report for Approval / Consideration / Noting

Approval

Due to the size of the supporting documentation, this is available for Governing Body members in the 7 July 2016 Governing Body papers at:
http://www.sheffieldccg.nhs.uk/about-us/GB-meetings.htm

Are there any Resource Implications (including Financial, Staffing etc)?

None identified at this stage

Audit Requirement

CCG Objectives

Strategic Objective - To ensure there is a sustainable, affordable healthcare system across South Yorkshire and the Working Together Programme footprint

Equality impact assessment

An equality Impact Assessment has been completed on the work to date.

PPE Activity

There is planned patient and public engagement within the next stage in this work programme

Recommendations

The Governing Body is asked to:
- Note the work to date
- Consider and approve the options appraisal and emerging model.
- Support the next phase of development of the full business case, and receive a full business case for approval

Commissioners Working Together Transformation Programme
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1. Purpose and Context

This paper provides an update on the progress following the report in November to CCGs across the *Working Together Programme.*

The purpose of this paper is to:

- Summarise the work undertaken to date, by the Working Together programme on behalf of our CCGs, in reviewing Children's Surgery and Anaesthesia across South Yorkshire, Bassetlaw and North Derbyshire.

- Seek support from Governing Bodies on the options appraisal work and the emerging model of care. Moving towards public consultation in the autumn on the preferred option outlined in the options appraisal document.

- To agree to consider a full business case with recommendation for change for Governing Body approval.

The paper is presented for approval.

2. Background

We know from the review and work undertaken to date that there is variation in provision, this can lead to a variation in the quality of provision available and potentially impact on clinical outcomes, as the care can vary dependant on where services are located.

Referral thresholds to services also vary; therefore the patient journey and provision available will vary dependant on where services are accessed, and at what time, and on what day.

There are problems with developing and sustaining workforce skills, as well as issues with the further development of the paediatric workforce for both anaesthesia and surgery.

Clinicians are identifying that the current configuration is not consistent or sustainable in the short, medium or long term.

The economic case for change is demonstrated in resource and cost pressure within the NHS overall and we know that.

A needs assessment has been undertaken, which outlines the trajectory of need for future provision as well as some of the challenges to the current administrative data, workforce planning and measures of clinical outcomes.

The solutions and size of change have been tested in an options appraisal around proposed future configuration of services across a tiered model of care.

There would need to be a change in the provision; this could include changes in local access and where care is provided.

A clinical task and finish group has been considering the specified standards of care and the options around organising services across a tiered model.

The project has been supported by the Yorkshire and Humber Strategic Clinical Network, which supported the service specification development through wider clinical engagement and supported the steering group overseeing the project.

The work to date has also been referred to the Yorkshire and the Humber Clinical Senate for consideration and their recommendations have been taken on board and informed the next steps of development of both the overall case for change and the service specification specifically.

The options for modelling the services have been appraised, and an emerging model is developing which requires change in provision from its current configuration.

3. Key Messages for Governing Body Members:

- The current configuration needs to change and the case for change was agreed by governing bodies in Autumn 2015.
- The specification for provision has been agreed clinically and a designation toolkit has been developed to designate providers as part of a network across CCGs
- A proposed model on future configuration has been drafted and considered by the clinical task and finish group, the basis of the model was clinically supported and now forms part of the options appraisal.
- An options appraisal around a model has been drafted and appraised and is being discussed more widely.
- A service model is emerging and needs considering as this will change pathways of care.
- A managed clinical network has been funded for 16/17, as part of the provider working together vanguard to enable the mobilisation and implementation of change in line with the proposed service model.
- Pre consultation is now complete and all CCGs and providers are engaged in the consultation and engagement plan for the next phases.
- A full business case for mobilising change is being drafted, which will include proposals for contracting and commissioning intentions for 17/18 for CCGs.

The outline of the approach to improve children's surgery services for all our local populations is taking place in 3 phases. Governing Bodies will be consulted at each stage and at key milestones for their support and approval. The programme is still working within phase 2 of the plan.

Phase 1 January 2015 – September 2015 - included

The development of the case for change including:

- Engaging with key stakeholders
- Undertaking a baseline assessment of current services
- Forming consensus of the issues
- Identifying best practice models
- Specifying the pathways that should be in place to meet standards
- Exploring strengths and benefits of potential models
- Considering our populations needs for the future
- Seeking external clinical scrutiny of the work to date (Senate)

Phase 2 October 2015 – September 2016 - current work plan

The development of specification, options on a model and full business case including:

- Implementation of communication and engagement strategy - Pre –engagement with patient and the public, key stakeholders (Health Overview and Scrutiny Committees) and staff
- Enacting procurement advice, including a provider engagement event
- Development of a service specification and gap analysis against existing provision
- Development of options on a service model and assessment of options
- Development of full business case including activity and financial impact
- Formal consultation starts (ends December 2016)
- Consideration of options to implement change

Phase 3 October 2016 – March 2017

Implementation planning and mobilisation of preferred Option

4. Work to date

4.1 What did we do (phase 1)

We talked with doctors, nurses and healthcare staff in hospitals, NHS staff who commission hospital and GP services, and data and clinical experts about what the future of Children's Surgical care should look like:

- We asked hospitals to look at the national core standards for providing children's surgery and assess how they were doing against these standards
- We gathered data on the numbers of people needing the service and assessed what the numbers might look like in the future
- We asked hospitals to gather information on their current workforce
- We met with hospitals to assess and agree all the information and their current challenges
- We held a series of workshops with staff and stakeholders to look at and agree the issues
- We worked with clinical experts to agree possible high level options to consider for the future.

4.2 What have we done so far and progressed in phase 2

We provided an update to CCG governing bodies and asked permission to progress the programme of work, including, the pre consultation phase and the development of options and a service specification for future provision. We continued our conversations with providers and clinicians in a task group.

- We have developed and agreed a service specification that provides the clinical care pathways needed, this has been approved by the Clinical Senate following work up regionally and within the local task and finish group.
- We have undertaken a Prior Information Notice of service changes and held a provider engagement event outlining our intentions to review and propose changes to sustain services.
- Providers have undertaken a self-assessment of their ability to meet the new proposed service specification.
- We held an expert assessment panel to review the work to date and advise on development of a new model and redesign, this included national experts as well as regional and local experts.
- We have developed a designation toolkit for commissioners to use to embed the proposed specified pathways of care.
- We have developed a proposed tiered model for providing surgery, which outlines the options for future configuration.
- We have appraised these options and are discussing them more widely and considering how change might be developed into a full business case.
- We have completed the pre consultation phase of work and gathered information on what is important to patients and the public when considering change to surgical provision.
- Funding has been secured through the Working Together Programme provider Vanguard to mobilise a Managed Clinical Network to support implementation of a new model.

5. Other factors to consider as part of this phase of work

From the work completed to date we know that there are a number of issues that need consideration when thinking about changes, some of these issues have been raised from the clinical senate others from the task and finish group or local CCG commissioners.

5.1 The interface with the management of acute medical paediatrics is a vital consideration and forms part of both the planned care pathway and is a significant consideration for patients with unplanned surgery needs, and those needing overnight planned recover from a surgical episodes of care.

5.2 The impact on transport services needs further assessment and quantification in the proposed new model as entry points would change from the current configuration.

5.3 Cross border clinical pathway issues need further consideration and assessment, we would need to manage any impact of changes in the proposed model on clinical pathways already agreed throughout Yorkshire and Humber and across to East Midlands.

5.4 Contractual and financial changes in the proposed model need further consideration and assessment as part of the full business case.

5.5 The development of the work plan for the Managed Clinical Network as part of the implementation plan, as this will be a vital part of mobilisation and the enabler of sustainability of pathways of care in the future.

5.6 The development of common commissioning and contracting intentions as part of the full business case development.

5. Next Steps/Timeframe

The project is now more widely discussing the options for a model, which is emerging following appraisal, and developing a business case for CCGs to consider as part of commissioning intentions for 17/18.

Such a programme of work will require commitment from all Working Together members to ensure that a collective approach is taken to continue delivery of this next phase of work.

6. Recommendation

Governing Body is asked to:

- Note the work to date
- Consider and approve the options appraisal and emerging model.
- Support the next phase of development of the full business case, and receive a full business case for approval

Paper prepared by: Kate Laurance, Head of Commissioning for Children Young and Maternity on behalf of the Working Together Programme and Will Cleary-Gray - Working Together Programme Director

June 2016

This paper is to be read in conjunction with the full Options Appraisal document.

Joint commissioners and provider Working Together Programmes

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

June 2016

June 2016

Title	Non- specialised Children's Surgery and Anaesthesia – Options Appraisal		
Author	Kate Laurance/ Children's Services Core Leaders Group		
Version	V10		
Created Date	27/4/2016		
Document Status	Final		
To be read in conjunction with	3 C Children's Surgery Options Appraisal		
Document history			
27/4/2016	1	KL	Worked up following discussion at task and finish group
28/4/16	2	KL	Options updated
29/4/16	3	KL	Data with analysis and split supported by activity data being modelled.
13/5/2016	4	KL	With feedback from Children's Core Leaders steering Group
18/5/2016	5	KL	Minor changes following Core Leaders Group
27/5/2016	6	KW	Re-formatted
30/5/2016	7	LD	Expansion of introduction, removal of cross reference from 1.1, reference to assumptions in 2.7
31/5/2016	8	JCS	Confirm Draft Status, Intro statement on paper purpose / content, minor amendments to new intro material, amendment to numbering in section 2 from 2.7 onwards, addition of reference to scoring tool and draft matrix, 2.8 extended caveat around

			assumptions, 2.8 note on status of following RAG rating for options. Changes to sections 3.2,3.3 re OA next steps
1/6/16	9	JCS	Update section 3 re process, next steps – consultation, OA, 'do-ability', Governing Body sign support. Consistent formatting. Data by options added
2/6/16	10	KL	With Updates to Section 2 on matrix for scoring
Governance Route:			
Group	Date	Version	Purpose
Working Together Programme Board	7th June 2016	1	For Sign off and support

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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.

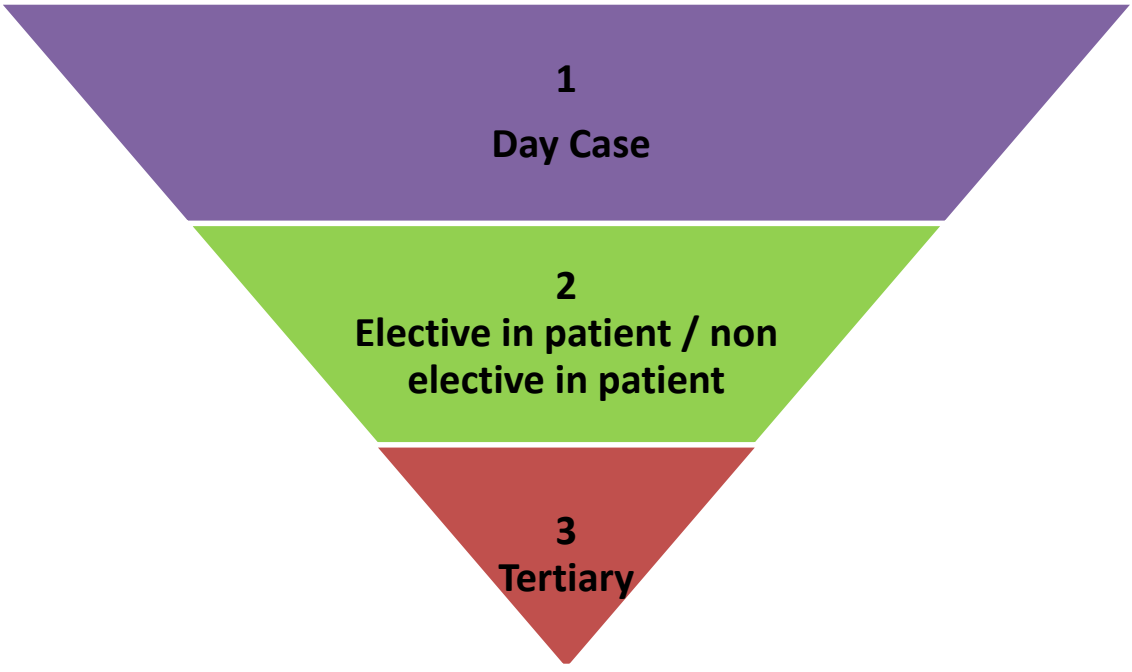
1. Proposed Model for Planned Surgery

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	2	4	3	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	1	0	0	0	109	70	**967**
Elective 0 LoS Total		**1752**	**267**	**299**	**1626**	**539**	**965**	**288**	**1034**	**644**	**112**	**834**	**264**	**8624**
Elective Non-DC	BHNFT	38	1	0	0	0	0	0	0	7	0	19	0	**65**
	CRH	130	1	0	0	0	3	0	0	6	0	23	0	**163**
	DBH	140	4	0	11	0	0	0	0	0	0	48	0	**203**
	MYH	29	4	0	2	0	0	0	0	0	0	46	1	**82**
	Other	36	1	0	0	1	24	3	22	13	7	35	0	**142**
	SCH	0	0	0	0	0	407	2	79	217	0	0	0	**705**
	STH	9	0	0	3	0	0	0	0	0	0	18	1	**31**
	TRFT	96	5	6	5	0	0	0	0	0	0	26	0	**138**
Elective Non-DC Total		**478**	**16**	**6**	**21**	**1**	**434**	**5**	**101**	**243**	**7**	**215**	**2**	**1529**
Emergency	BHNFT	42	262	0	0	0	0	0	0	0	0	197	0	**501**
	CRH	34	131	3	0	0	1	0	2	0	0	145	0	**316**
	DBH	175	195	8	12	0	0	0	0	0	0	407	20	**817**
	MYH	110	212	2	37	0	0	0	0	0	0	260	108	**729**
	Other	39	130	1	9	0	6	0	79	19	4	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**	**4**	**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