South West Clinical Senate

Stage Two Clinical Review Report

Gloucestershire STP 'One Place' Acute Transformation Proposals

27th September 2017

Final

Document Title: Stage Two Clinical Review Report: Gloucestershire STP One Place Acute Transformation Proposals

First published: in draft format 8th August 2017

Updated: Final Version 27th September 2017 updated following the mini panel for stroke on 26th September 2017 to include stroke mini-panel report as addendum 11

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Signed off by: Phil Yates, South West Clinical Senate Chair

1 Executive Summary

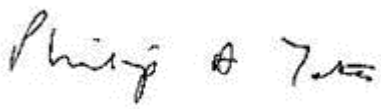
1.1 Chair's Summary

This report has been produced by the South West Clinical Senate for Gloucestershire Sustainability and Transformation Partnership (STP) and provides recommendations following a Clinical Review Panel (CRP) that was convened on 18th and 19th July 2017 to consider the STP's proposals for its Clinical Advice and Assessment Service (CAAS), Urgent Care Centres (UCCs), its Acute Assessment Unit (AAU) and split of urgent and elective care between Gloucester Royal Hospital (GRH) and Cheltenham General hospital (CGH) and its Community Rehabilitation Stroke model.

This was an independent review carried out to inform the NHS England stage 2 assurance checkpoint which considers whether proposals for large scale service change meet the Department of Health's 5 tests for service change prior to going ahead to public consultation, which in this case is planned for November 2017. The Senate principally considers test 3, the evidence base for the clinical model as an independent clinical advice giving body. The Senate also takes into account test 5, introduced in 2017 to show whether any significant bed closures can meet one of 3 conditions around alternative provision, treatment and bed usage.

I would like to thank the clinicians who have contributed to this review process, providing their commitment, time and advice freely. In addition I would like to thank the Gloucestershire STP for hosting the panel and for their organisation and open discussion during the review.

The clinical advice within this report is given in good faith and with the intention of supporting further developments of clinically sound service models. This report sets out the methodology and findings of the review and is presented to Gloucestershire STP with the offer of continued support.



Dr Phil Yates, Clinical Chair, South West Clinical Senate

1.2 Summary Recommendations

The Clinical Review Panel (CRP) concluded that it broadly supports the STP's proposals for its urgent and acute care model which are ambitious in their aim to improve patient care. This report draws attention to a number of recommendations to support the proposals and some concerns where further detail is needed to provide assurance around delivery and implementation of a clinically sound model.

The panel did not however support the model presented for stroke rehabilitation and a follow up sub-panel should be arranged to discuss the queries around this model and examine the evidence further (see addendum).

Overall the proposals which are extensive were considered broadly well thought through and well aligned with national guidance and best practice. Whilst full granularity of detail would not be expected at this point in time the panel felt that detail was too thin in some places and insufficient to fully assure that the anticipated reduction in demand will be delivered as expected through an improved streaming of urgent care patients and changes to estates at the Gloucester site.

The panel supports the preferred reconfiguration options presented for Emergency care pathways in Gloucestershire including a single site for ED and agrees that running parallel services across two sites is less easily sustained especially given workforce challenges . The vision for an integrated 'front door' is correct and with the right blend of services and careful implementation this could deliver real positive change for patients. However as with all very ambitious plans with challenging timescales the CRP noted that the model will stand or fall on the operational detail that has yet to be fully described.

The model was commended as having significant potential benefits and a much better chance of sustainably meeting the needs of patients than the current arrangements but there is considerable work to be done and its success will hinge on available suitably skilled workforce and detailed delivery planning. Panel members involved in previous reviews felt that the Gloucestershire plans demonstrated a good level of whole system engagement.

The STP team described how they will move from 'design' into the 'design for delivery' phase using improvement methodology to support the changes envisaged. Workforce was noted as a key limiting factor with a huge amount of detail still to be worked out, making it hard at this stage to be fully assured that the model will improve efficiency. The intention is predominantly to use the same workforce differently; however, complete workforce modelling and risk analysis of the whole programme is yet to be completed.

Areas of clinical risk pertaining to potential crowding of patients at the Gloucester Urgent Care Centre (UCC); failsafe tracking of patients through the new system; and workforce modelling must be addressed prior to implementation, particularly to ensure the new model will deliver the expected change in inpatient admissions.

Clinical and public engagement to date appeared to have very positive foundations to build upon. The panel noted the importance of communicating a clear summary of the model that highlights the key change points, as this can be difficult when enmeshed within the broad scope of the changes.

It was noted that significant investment and changes to estates and locations of services is required to deliver the reconfigured services and that the focus is on achieving a steady state through constraining activity as the ageing population grows. This also militates against the projected £226m financial gap by 2021. The business case depends on improved triage and signposting as a result of

Clinical Advice and Assessment (CAAS) usage; and both the central and peripheral UCCs providing competent ambulatory care which avoids the need for hospital admission.

The issues detailed in the recommendations below, other than that of stroke, do not need to be resolved prior to consultation but do need to have been explored in much more depth prior to implementation with assurance that this has been done provided to NHS England.

The panel concurred that the evidence for change is clear but would like to see evidence of further work to demonstrate that the anticipated benefits for patients through the new clinical model are deliverable and sustainable particularly with respect to workforce.

Principal Recommendation

The South West Clinical Senate Review panel supports the STP's proposals for CAAS, UCCs and the split between emergency services at Gloucestershire Royal Hospital (GRH) and elective care at Cheltenham General Hospital (CGH), developed as centres of excellent. The proposed urgent care model is in line with the policy direction set out by Five Year Forward View. The panel therefore recommends that, with respect to the clinical basis for the model for CAAS, UCCs and Centres of Excellence with emergency services at GRH and elective care at CGH, the consultation should proceed, taking into account the recommendations of the review panel as the plans are further developed for implementation.

Although the quality of stroke care is a pressing issue for the STP, the plan as presented may not measurably improve the quality of this in Gloucestershire. Furthermore the panel was not convinced that the 12 bed community stroke rehabilitation model would be sustainable. At this point in time the panel recommends that the proposal for community stroke rehabilitation beds needs further examination in the context of the broader plans for stroke prevention, acute care and rehabilitation. At this stage, therefore, the Senate does not assure this component of the plans prior to such a re-examination.

Recommendations to support development of the proposals*

CAAS

1. Information sharing protocols will need to be reviewed and CAAS clinicians need access to the electronic patient record, at times including that component held on GP systems.

2. The CAAS should be set up under a lead provider model to strengthen the clinical governance of a multi provider service. Robust clinical governance arrangements are essential to enhance patient safety, and protect against clinical and corporate risks.

3. The staffing model for the CAAS both in and out of hours needs to be confirmed, as do the links to and payment arrangements for specialist consultant advice.

4. The health community should be encouraged to move to a position where the CAAS is enabled to directly book appropriate GP appointments for a more integrated service.

UCCs

5. The risk of the UCC at GRH creating a bottle-neck of patients needs to be fully assessed to mitigate against unsafe or tardy patient flows. Entry and exit pathways particularly to the Acute Assessment Unit (AAU) should be clarified.

6. Gloucestershire STP should seek to comply with the recently published national guidance (appendix 10.7) on Urgent Treatment Centres (UTCs), using this nomenclature if compliant rather than Urgent Care Centre (UCC) in line with the use of consistent language nationally for the provision of urgent care. It is noted that the guidance may allow some exceptions for rural centres.

7. Delivery planning should ensure that equipment and staff are available to provide an imaging service to match opening hours across the proposed 5 UCC locations including arrangements for out of hours.

Centres of Excellence

8. The two site plan needs further consideration service by service to resolve issues particularly around cardiology and vascular services and the acute cover for these services.

9. Clarity around 24/7 diagnostics support and provision for each site is required.

10. Clarity around how therapies support will be split across each site is required to ensure emergency cover over 24 hours and that skills to manage deteriorating patients are available.

11. Clarity around the functioning and staffing of the frailty unit is needed. Geriatricians and specialty therapists would be required for it to function effectively and they are hard to recruit.

12. The internal pathways for admission or follow up from the Acute Assessment Unit (AAU) need to be clearly defined with frailty and ambulatory care well established to support a reduction in admissions, which include engagement with SWASFT.

13. Planning should ensure the Clinical Senate's Six Emergency General Surgery recommendations are met at GRH (appendix 10.11.5).

14. The staffing cohort and cross-utilisation of staff and senior clinical decision makers between the UCC at Gloucester and the AAU needs to be clarified to achieve the right balance.

15. The CRP were particularly concerned about medical cover arrangements for the 'deteriorating patient', particularly at the CGH site and the risks in using non-physician based solutions. The junior medical cover will not be based at CGH but elective patients that are deteriorating are most likely to have medical rather than surgical issues to address. The complex frail elderly particularly need senior medical cover for complex post-operative problems.

16. Medical cover at CGH needs clear 24/7 arrangements. Some middle grade cover will still need to be duplicated and expertise will need to be sustained at CGH for complex elective cases. Conducting patient 'walk-throughs' for some specific examples (elective hip replacement patient at Cheltenham with chest pain and possible acute MI) is suggested. It is

recommended that significant work on the staffing model for the acute site split is worked up as a priority with particular consideration given to cover for emergencies at the elective site.

17. It is recommended that significant work on the staffing model for the preferred acute site split proposal is worked up as a priority to confirm medical cover arrangements for the 'deteriorating patient', particularly at the CGH site and address the risks in using non-physician based solutions. The junior medical cover is not planned to be based at CGH but elective patients that are deteriorating are most likely to have medical rather than surgical issues to address. The complex frail elderly, particularly, need senior medical cover for complex post-operative problems. Some middle grade cover will still need to be duplicated and expertise will need to be sustained at CGH for complex elective cases.

18. If the option to become a true elective centre of excellence is confirmed following public consultation, it is recommended that the trust is ambitious in seeking to deliver gold standard services that target post-operative care and length of stay with early multidisciplinary and specialist geriatric peri-operative team input.

19. Clear plans need to be developed as to how freed up capacity will be used in the elective care centre to streamline pathways otherwise there is a risk that waits will not improve.

20. Clarity regarding the use of beds at CGH under the preferred option as a centre of excellence for elective care is needed. There is also a need to ensure that there is a mechanism to prevent large scale transfers from Gloucester to Cheltenham which may affect elective care in a similar way to the current situation.

21. Where access to the ED will be only via ambulance, the UCC and GP referral in the new model, and also into the proposed network of 5 UCCs, the impact on the ambulance service in terms of additional journey times and increased call cycles should be modelled. Overall admission avoidance in the agreed model must include engagement with the ambulance service to improve levels of appropriate conveyance and reduce the complexity of admission pathways through ED.

Stroke

22. The panel commended the commitment of the stroke team to improve services and noted the merits in the separation of longer term rehabilitation beds. However, the panel expressed concern that the whole picture for stroke needs to be considered to ensure improvements in the quality of the acute service are prioritised in light of poor performance data. GRH is one of the worst performers in the National Stroke Audit and an outlier in the Sentinel Stroke National Audit Programme (SSNAP) data and it was not felt at review that a 12 bed peripheral unit in the community is evidenced to address the performance issues and deliver the service improvements required. This model also does not appear to fit closely with the wider acute reconfiguration model. The panel was concerned that the GRH stroke unit has low levels of therapy, access, delays to CT scanning and were not made aware of the STP's proposals to address these significant issues in the pathway. The panel was not confident that the community rehabilitation bed model will achieve the improvements in therapist provision or significant changes that are required in stroke rehabilitation.

23. The CRP recommended that the stroke rehabilitation element of the model should be considered within the context of a wider improvement plan for the stroke service before it is put forward for consultation. It was agreed a sub panel to discuss community stroke rehabilitation beds and wider model for acute stroke would be set up between the STP and Clinical Senate.

General

24. There was concern that workforce modelling has not been completed yet. Further detail outlining the workforce that will deliver the new clinical model must be provided. This should include a breakdown of current staff and clarity on roles to avoid spreading the workforce too thinly. Health Education England (HEE) trajectories are required to confirm if the staff needed exist and will be there in the medium to long term as both the junior and middle grade and GP & community nurse workforce is already fully extended. The panel encouraged the proposal for the system to build out reliance on bank and agency staff.

25. The timescale for implementation and enabling works appears challenging and the detail needs to be made available. Caution is advised to take enough time to plan for successful implementation.

26. Overall further detail and clearer articulation of the model as developed so far would support both consultation and planning for delivery.

*Some further data and evidence has been requested by the Senate to support references made in the presentations.

2 Background

The Clinical Senate Review Process is used across England to provide independent clinical review of large-scale service change to ensure there is a clear clinical basis underpinning any proposals. Reviews are undertaken to inform the NHS England assurance process which signs off proposals for change prior to public consultation.

Gloucestershire STP led by Gloucestershire CCG started work in December 2015 to develop a more sustainable model for its acute services delivered primarily at Cheltenham General and Gloucester Royal Hospitals, as well as for it's out of hospital urgent care provision. There are long standing performance issues and A&E bottle necks with the current model of provision which is viewed as unsustainable. The Gloucestershire 'One place, one system, one budget' STP proposes emergent options, with the emerging preferred options summarised as follows. These options remain subject to full public consultation;

- Development of 'Centres of Excellence' with a hot and cold model for the two acute settings; GRH providing predominantly Urgent Care and CGH providing Elective Care as a centre of excellence (with an Urgent Care Centre providing 24/7 urgent care for people in Cheltenham) . An AAU will support the model for urgent care streaming at the Gloucester site.

- 24/7 UCCs on both acute sites with an additional 3 rural networked UCCs proposed in the Forest of Dean, Stroud and Cirencester. The intention is that 98% of Gloucestershire residents will have access within 30 minutes drive to a UCC. The development of a network of 5 UCCs in Gloucestershire will replace existing Minor Injury and Illness units (MIIUs) at their 7 community hospital sites. This means that the 5 MIIUs at Tewkesbury, Cinderford, Moreton in Marsh, Lydney and Vale will close.

- Development of a Clinical Advice and Assessment Service (CAAS) that is expected to have 50% of all NHS 111 calls forwarded to them. The CAAS will be staffed by clinicians and provide clinical telephone advice and signposting to reduce unnecessary A&E attendances and hospital admissions as well as booking UCC appointments and seeking specialist clinical advice through an agreed framework where required.

- A community bed based stroke rehabilitation stroke model which proposes that 12 inpatient rehabilitation beds are moved from the acute setting to one of the 7 community hospitals for specialist rehabilitation on the basis that the current setting in GRH does not present the most optimal environment for rehabilitation.

Interdependencies that impact upon the proposals under review and of which the panel were made aware include;

- **Wider STP Programme**
  This includes core workstreams such as the 'prevention and self-care strategy' and the 'Mental Health 5YFV'. There are links across the STP programmes for pathways such as respiratory to help the matrix of STP workstreams fit with one another.

- **Development of GP Clusters model**
  All 81 GP practices across Gloucestershire have been brought into a model of 16 groups of GP practices that work closely together supported by local health and social care teams.

- **Forest of Dean Community Hospital Facilities Business Case**
  Separate to the proposals taken into consideration for this review, the STP is also due to consult on proposals for the location of a new build Forest of Dean Community Hospital to replace facilities that are no longer fit for purpose at Cinderford and Lydney.

3 Senate Engagement to Date

In advance of the requirement for formal clinical review Gloucestershire STP shared its developing proposals for its urgent care model at the November 2016 Senate Council meeting. A slide deck was circulated, entitled 'One Gloucestershire' and the following improvements expected in the quality of care were discussed:

- Improved patient experience (fewer handoffs, more likely to present in correct setting, closer to home)

- Increased safety (earlier specialist assessment where required, resources and skills aligned to need)
- Reduced number of admissions (alternatives in the community and alternatives from acute assessment)
- Reduced length of stay (earlier identification of correct treatment plan)

Noted for consideration when developing the model was;

- Clarity around access to different types of urgent care services.
- Workforce early engagement and implications as the key to success. The need to set realistic timescales for change and use HEE support.
- Clinical Engagement to be described.
- The evidence base for the proposals and clarification around loss of services.

The Clinical Senate Chair and Manager were also present at the NHSE early assurance meeting on 4th April and the NHSE sense check meeting on 6th July 2017 which supported the planning of this review.

4 Local Context

Gloucestershire STP is a large area covering a population of 632,500 (2015 registered population) people in the West of England. This is expected to rise to 674,500 by 2030. People in the region as elsewhere in the country are living longer, with increasingly complex care needs that require more support from health and social care services. The STP reports that 47,500 people over 65 are currently living with a long term condition and this is projected to rise to 77,000 by 2030. The 75-84 age group is expected to increase by 20% by 2021 which is factored into the projected £226m financial gap by 2021 if savings are not made through changes to the way patient services are delivered. There are currently 81 GP practices, 7 community hospitals co-located with 7 MIIUs and one acute hospital trust, Gloucestershire Hospitals Foundation Trust (GHFT) that comprises GRH and CGH which are 6 miles apart. The GHFT has been in financial special measures since 2016.

The Gloucestershire STP Programme entitled 'Joining up your care' proposes greater emphasis on self-care and prevention, provision of more out of hospital care and joined up care around communities, reducing variation and using staff and their skills as effectively as possible.

The 'One Place, One Budget, One System' programme is part of the wider STP plan and includes the urgent care model and 7 day services as a key work-stream. Since 2008 all patients potentially requiring admission have been channelled through A&E. This model, which was adopted to address patients admitted directly onto wards facing delays in assessment and treatment, is no longer considered optimal as the two A&E departments struggle to respond to increases in demand for emergency care with patients now not consistently seen within the 4 hour standard.

5 The Review Process

The Senate's CRP reviewed the documentation provided by the STP to detail their proposals ahead of the panel meeting (appendix 10.12) and also referred to the outputs from the Clinical Senate Council and Citizens' Assembly on principles for acute reconfiguration which were based upon case study and evidential review as well as review of national guidance (appendix10.11). The panel also fed in

comments based on their pre-reading documentation to the Senate which were subsequently shared with the STP in preparation for the panel itself and which contributed to the generic list of review panel key lines of enquiry (KLOEs) (appendix 10.10) used to guide discussion at the panel meeting.

The Senate Manager and Clinical Chair held a preliminary meeting with the STP team on 6th July before hearing its proposals for change presented at the formal clinical review panel meeting on 18th and 19th July. The review meeting ran over two days to provide opportunity for the STP to present its proposals and for the panel to discuss the proposals, ask questions and raise concerns. The STP team and its clinicians presented individually on the STP programme and 4 service change areas. The agenda can be found in appendix 10.4.

At the review panel, the Clinical Chair emphasised to the STP that the Clinical Senate regards its role as being a supportive one, raising legitimate clinical concerns aimed at strengthening the clinical case for change, identifying potential gaps and ensuring that the model is as robust and well thought-out as possible through frank and open clinician to clinician discussion.

6 Gloucestershire STP's Proposal

To support the pre-reading provided to the panel the STP described their overall 'one place' rationale and joined up place based approach. The focus is on re-modelling urgent care services to ensure patients receive right care, in the right place, at the right time and to reduce the pressure on hospital based services, ensuring the system can make better use of resources from the front door through to urgent treatment, admissions and onwards care and rehabilitation.

The intention is to deliver a new streaming model of patients at the front door using a CAAS, to move from the existing MIIUs to a new model of urban UCCs networked with rural ones and a re-organised stroke rehabilitation model. The STP team have sought to align its models with national best practice and have also received support from the 'Getting it right first time' (GIRFT) team. Public engagement to date appears to have been positive and fed back into developing the model. Clinical engagement has included the 16 GP clusters, the GHFT's own Clinical Senate, the STP Urgent Care strategy group and the CCG Governing Body. The next step will be to take clinical engagement across the board to ensure all partners are involved and that the clinical leaders take the rest of the clinical body with them.

The STP team's intention is to go out to public consultation in January 2018.

6.1 Clinical Advice and Assessment Service

The CAAS is the clinical hub referred to in the business case documentation and is described as a 24/7 team of virtual and office based clinicians (expected to be Advanced Nurse Practitioners (ANPs), GPs and paramedics) who will receive calls from NHS 111 and provide clinical advice over the telephone, booking appointments at UCCs or seeking specialist advice and reporting back to the patient as appropriate. It is anticipated that the ability to book UCC appointments will help manage

surges in activity. In the future there is an aspiration that the CAAS would be able to book GP appointments as well. It is expected that the service will divert patients away from UCCs and the A&E at GRH as calls will allow for more clinical interrogation than 10 minute GP consultations.

Currently, local analysis suggests that the under 5s and complex elderly do not always receive best outcomes when utilising NHS 111 and are expected to be better managed by the CAAS which is expected to receive 30-50% of all of Gloucestershire's NHS 111 calls, which will then match national targets for enhanced clinical triage. Staff from NHS 111 and the Gloucestershire Single Point of Access (SPA) team are expected to move to the CAAS which will run from within Gloucestershire county using local staff. On the day urgent primary care calls will initially continue to go into GP practices. The possibility of using retiring consultants on their bank staff as an alternative to locums was discussed but caution was advised around clinical governance and ensuring that staff are able to keep up their medical registration.

Paediatrics was described as ahead of the curve in relation to CAAS with a consultant advice line for children (available to GPs) already in place. Currently there are different numbers that GPs can call to access advice (paediatrics line and CAMHS team) and in future access will be incorporated via a single number through the CAAS. CAAS will also handle calls in relation to dental emergencies as well as mental health in partnership with the 2gether trust.

It was noted that all IT systems need to operate in all locations to support the office based and virtual functioning of the CAAS team. This will be supported by a project due to be implemented in October called 'Joining up your data'. The intention is that in the future the CAAS will also link to the development of a digital 111 service.

CAAS Recommendations

As a nationally recognised model the clinical review panel felt that the CAAS service had the potential to improve patient streaming and therefore the quality of care in the right place at the right time. It was noted by the panel however that the functionality of the service needed to be very clearly defined, advising caution to avoid increasing the number of steps in a patient journey and clarifying how they will they ensure the right type of clinician speaks to the patient. If the CAAS is not working well there is a risk that patients will go straight to the Gloucester UCC creating unnecessary demand there.

Whilst all the clinicians don't need to work for the same organisation there must be excellent clinical governance in an integrated system like this with a responsible clinician at the point of patient decision making. It is recommended that the outputs of the similar service in the Midlands are closely followed. There is also a risk that there is an over reliance on GP staff for both the CAAS and UCCs for which GPs either won't be available for or which will weaken the GP cluster model. Consideration should be given to the use of specialist Physiotherapists in the CAAS as there is an increasing role for Physiotherapists as first contact practitioners.

Information sharing protocols will need to be reviewed and CAAS clinicians need access to the electronic patient record, at times including that component held on GP systems. (Recommendation 1)

The CRP recommended that the CAAS is set up under a lead provider model to strengthen the clinical governance of a multi provider service and emphasised how important robust clinical governance arrangements must be to enhance patient safety, and protect against clinical and corporate risks. (Recommendation 2)

The staffing model for the CAAS both in and out of hours needs to be confirmed, as do the links and payment arrangements for specialist consultant advice. (Recommendation 3)

The panel praised the facility to book UCC appointments and encourage the CAAS to develop functionality to book GP appointments in the future for a more integrated service. (Recommendation 4)

6.2 Urgent Care Centres (UCCs)

The current service provided across 7 MIIUs in Gloucestershire is described as fragmented with varying appointment types. The MIIUs are ANP led units that are small and struggle with any surges in activity. The STP team has reviewed their top 10 pathways and activity by hour. They have in the proposed model made a commitment to ensuring access for over 90% of residents to an UCC within a 30 minute drive. The proposal is that there will be 24/7 UCCs on both acute sites with a network of an additional 3 rural UCCs proposed in the Forest of Dean, Stroud and Cirencester. The proposed development of a network of 5 UCCs in Gloucestershire will replace existing Minor Injury and Illness units (MIIUs) at their 7 community hospital sites. This means that the 5 MIIUs at Tewkesbury, Cinderford, Moreton in Marsh, Lydney and Vale would close. The expectation is that rural UCCs will use existing MIIU staff and hospital UCCs will use ED staff and be supported by the GP workforce for front door patient streaming.

The intention is that the first UCC specification could be agreed by January 2018 to be up and running in the Spring.

The proposed UCCs will be subject to the 15 minutes to assessment standard, 2 hour treatment and overall 4 hour target. Extended access in primary care will link to UCC and may in the future be delivered from the UCCs.

The STP team confirmed that workforce was their biggest area of risk with similar issues to elsewhere in the country. The panel suggested reviewing post graduate training to support the new model and both cascade staff into the community and develop GP training.

UCC Recommendations

The panel supported the proposed concept of a consolidated UCC model that was networked to replace existing MIIUs and noted that the single front door and UCC model is in line with national direction and guidance.

The panel recognised that the maintenance of skills for nurses in small MIIUs is difficult and better integration with the Trusts and OOH services should support the workforce. The model describes a network of UCCs although no detail around what the networking would offer in practice was provided. The pathway flow charts provided to the CRP were considered simplistic and requiring more work with involvement from clinicians for each speciality area. Some assessment was also

recommended around access to the UCCs for hard to reach and vulnerable groups. More detail also needs to be provided around the link in of the community offer to UCCs and what the impact will be for the community hospitals that will have neither a MIIU nor a UCC. The role of the Occupational Therapists and Physios in the UCC and ED environment can also be helpful in facilitating discharge from ED and prevent admission as well as linking with the 'home first' objectives and should be considered in workforce planning.

The panel also advised caution around the possible use of radiographers to also provide a nursing function at UCCs when there is a shortage of radiographers themselves, and suspected that this aspiration would prove impossible to implement.

The increased travel time for some patients to access an UCC rather than an MIIU are felt to be outweighed by the clinical benefit of the new model. The STP team described co-location of GP OOH services with the UCCs as not being part of the model but that this may happen in the future. The panel have noted the recently published national guidance around Urgent Treatment Centres (UTCs) however there was some concern that if in the future GP OOHs services only run from the UCCs, rather than from the 7 MIIUs currently the impact may be to make GP OOH access more difficult for some patients.

There was some concern around the UCC at GRH potentially acting more like a 'minors department' of ED and that the model based on a demand-led system via walk ins and CAAS may create a bottle neck. This needs to be included in risk assessments with full mitigation plans against unsafe patient flow and links to assurance around the functionality of the AAU. (Recommendation 5)

The CRP also recommends that if possible, Gloucestershire STP seeks to comply with the recently published national guidance (appendix 10.7) on Urgent Treatment Centres (UTCs), using this nomenclature if compliant rather than Urgent Care Centre (UCC) in line with the use of consistent language nationally for the provision of urgent care. The information provided by the STP does suggest that the UCCs are expected to be largely compliant with the new UTC standards and that there would be a better experience for rural patients if full compliance was ultimately possible rather than downgrading to UCCs. The CRP note that the STP intend to review the use of UCC or UTC and that there are some exceptions in the national guidance in relation to rural centres. The key issue with compliance is expected to be around in hours GP clinical leadership for the rural centres. (Recommendation 6)

The STP plan describes using UCCs to improve out of hospital diagnostics and therefore ensuring that equipment and staff are available to provide an imaging service to match demand across the 5 locations is essential including OOH CT and also taking into account USS imaging provision. (Recommendation 7)

6.3 Centres of Excellence

Gloucestershire STP is proposing a preferred model for consultation where undifferentiated urgent and emergency services are provided at GRH and most elective care is provided at CGH, each developing as a centre of excellence. (The CGH site would offer a 2407 Urgent Treatment centre to ensure access to urgent care for people in Cheltenham.) Currently the two separate EDs on these

two sites are small and unable to independently cope with surges in activity with the alternatives for urgent care confusing to patients. The A&E at CGH has already been downgraded overnight and the 4 hour target is not being consistently met at either site. Elective pathways are subsequently impacted through cancellations consequent on acute admissions occupying elective designated beds. The proposed model is based on a completely integrated front door and built upon the premise of 'home first' and see, treat and discharge or see, assess and refer without admission. The GRH ED and on site UCC would be supported by an Acute Admissions Unit (AAU) that combines a Medical Admissions Unit (MAU), Surgical Admissions Unit (SAU), Frailty Unit and observation area.

The STP team described that there is broad consensus at an acute level around the principles of the preferred option for a hot/cold 'centres of excellence' acute site model and that they have been working as one trust with two acute sites since 2002. There is a long history of discussion around coalescing to improve services. Physicians are keen for a 'take' on one site but the detail of how and which services are run at each site in the new model still needs to be agreed with some key issues to be resolved.

Access to the ED at GRH will only be via ambulance, the UCC and GP referral in the new model. Patients will not be able to walk in directly to the ED (walk in will be provided through the UCC sited co-located with the ED). Through modelling the projected attendances are 17,000 a year. The early modelling projects that this will significantly reduce the footfall in the main ED, enabling the department to focus on the people who really need ED services. This will be achieved by minors being managed through the UCC and medical admissions being directed straight to the AAU. The CRP noted that there would currently be too many Consultants at GRH to support this and modelling needs to include UCC consultant staffing as the attendance to consultant ratio is considered too high currently for expected new volumes of activity. The panel assumed that the GRH ED consultants would also have a role in the Gloucester UCC and in supporting the extended AAU offer.

The key clinical risks described for the hot/cold centres of excellence model include insufficient bed capacity at GRH which should be mitigated by a reduction in length of stay and also the need for a further theatre which will be mitigated through extended hours and a capital build.

The STP team described a model for the management of the deteriorating patient on the CGH site which builds on the existing 24/7 acute care response team run by advanced nurse practitioners and technicians, supported by the Lead Consultant for Deteriorating Patients and Resuscitation.

No changes are expected for maternity, paediatrics or oncology services. In addition to the model of care proposed a 3-storey build for an acute oncology unit is taking place, funded charitably. Both sites will need ICU level 3 care and the continuation of some double running of services is inevitable.

All Children's services are already on the GRH site and children's outpatient services are not expected to change. Mental Health services were awarded an outstanding CQC for their 24/7 crisis team and have good liaison services set up. They have successfully reduced the adult mental health bed base by 50% over the last 11 years. The panel noted that potential implications of the proposals on these services must still be considered.

Decisions need to be made around cardiology, vascular and urology. Vascular was centralised in 2009 to the CGH site. Acute cardiology runs on both sites with one interventional cardiology service. This

is not 24/7 so some patients currently go to Bristol. The one site preferred urgent care model would support the prevention of this and needs to be developed with specialised commissioning. The expansion of the AAU will require some enabling works and moves within the geography of the Gloucester site including a new build.

It is expected that the overall number of acute beds in the system will not change but the preferred option would require that 60 elective beds at GRH will become 'acute' beds. Their escalation capacity will close but core capacity will remain. Opportunities for repatriation within wider clinical programmes such as orthopaedics, spinal, cancer and urology have been identified. Independent Sector Treatment Centre (ISTC) capacity is being used on a flexible basis but the CCG is not locked into any ISTC contracts. The model also anticipates a reduction in the use of agency staff. One of the key improvement measures being used are Standardised Admission Ratios (SARs) with a target of 90.

Recommendations – Centres of Excellence

The panel support a single site for ED as the preferred option for urgent care and agree that the current service configuration running parallel services across two sites is much less easily sustained. The vision for an integrated front door is correct and with the right blend of services and careful implementation this could deliver real positive change for patients.

There was concern that the UCC at Gloucester will be significantly different to the other UCCs with patients preferentially travelling there to access ED. There is a potential risk that patients will bottle neck in this UCC, with it acting as a 'minors' area of ED. There was some discussion that many national models of primary care streaming are based on minor illness only with minor injury continuing to go through ED where the expertise generally is higher. If resources are appropriately allocated this should mitigate the risk of creating similar delays to now but in a different environment. It was also noted that the acute trust should manage the front door of A&E in line with national guidance (appendix 10.8) How the emergency and elective centres will be developed as centres of excellence needs to be described more fully. Learning from the London models should be clearly laid out in the documentation as evidence of best practice.

Consideration of junior doctor rotations across two sites will need to be taken into account to ensure that both Trusts are attractive sites to work for juniors. It is vital that junior surgeons get access to 'simple' elective cases in order to build up their knowledge and experience. More thought should also be given to early diagnosis of cancer pathways and how the proposed model can help achieve cancer waiting times targets. As part of wider STP plans the model for community hospitals should link into the acute transformation proposals ensuring clear patient admissions criteria, and use of step-up / step-down beds.

The panel had concerns that the two site plan centres of excellence model has not been fully considered service by service with some difficult issues to resolve around cardiology and vascular services and the acute cover for these services. 24hr interventional radiology with on-call on both sites is not expected to be sustainable. Clinical engagement and modelling prior to implementation will be key in resolving these issues early on. (Recommendation 8)

Clarity around 24/7 diagnostics support and whether this will be on one site is required. (Recommendation 9)

Clarity around how therapies support will be split across each site is required to ensure emergency cover over 24 hours and that skills to manage deteriorating patients are available. (Recommendation 10)

Clarity around the functioning and staffing of the frailty unit is needed. Geriatricians and specialty therapists would be required for it to function effectively and they are hard to recruit. (Recommendation 11)

The internal pathways for admission or follow up from the AAU need to be clearly defined with frailty and ambulatory care well established to support a reduction in admissions. (Recommendation 12)

Planning should ensure the Clinical Senate's Six Emergency General Surgery recommendations are met at GRH. (Recommendation 13)

The staffing cohort and cross-utilisation of staff and senior clinical decision makers between the UCC at Gloucester and the AAU needs to be clarified to achieve the right balance. (Recommendation 14)

The CRP were particularly concerned about medical cover arrangements for the 'deteriorating patient', particularly at the CGH site and the risks in using non-physician based solutions. The junior medical cover will not be based at CGH but elective patients that are deteriorating are most likely to have medical rather than surgical issues to address. The complex frail elderly particularly need senior medical cover for complex post-operative problems. (Recommendation 15)

Medical cover at CGH needs clear 24/7 arrangements. Some middle grade cover will still need to be duplicated and expertise will need to be sustained at CGH for complex elective cases. Conducting patient 'walk-throughs' for some specific examples (elective hip replacement patient at Cheltenham with chest pain and possible acute MI) is suggested. It is recommended that significant work on the staffing model for the acute site split is worked up as a priority with particular consideration given to cover for emergencies at the elective site. (Recommendation 16)

To become a true elective centre of excellence it is recommended that the trust is ambitious in seeking to deliver gold standard services with early MDT and use of specialist geriatric peri-operative teams for post-operative support and to reduce Length of Stay. (Recommendation 17)

Clear plans need to be developed as to how freed up capacity will be used in the elective care centre to streamline pathways otherwise there is a risk that waits will not improve. (Recommendation 18)

Clarity regarding the use of beds at CGH is needed in the proposed elective centre of excellence model. There is also a need to ensure that there is a mechanism to prevent large scale transfers between the two sites. (Recommendation 19)

Where access to the ED will be only via ambulance, the UCC and GP referral in the new model, and also into the proposed network of 5 UCCs, the impact on the ambulance service in terms of additional journey times and increased call cycles should be modelled. Overall admission avoidance in the agreed model must include engagement with the ambulance service to improve

levels of appropriate conveyance and reduce the complexity of admission pathways through ED. (Recommendation 20)

6.4 Stroke Rehabilitation

The current acute stroke and stroke rehabilitation service is provided with 51 beds on one floor at GRH with a HASU at one end. The current ward is within the GRH 'tower block' and described as an unsuitable environment for longer term rehabilitation. The current level of therapy is described as very low compared to elsewhere. A rehabilitation review was carried out in 2014/15 by Attain which highlighted fragmented services with variable access.

The proposed model will provide two stroke rehabilitation pathways; the core rehab pathway will manage 80-90% of activity (the remainder via HASU) with 12 level 3A speciality beds in the community supported by a community team. The expectation is that length of stay would be 4-5 weeks and the preferred option for these beds is on a single site in one of the 7 existing community hospitals that each have around 20 beds. The preferred location for these specialist stroke beds was undecided at the time of the review. The intention would be to set up the community service by June 2018.

Currently GPs provide medical cover to community hospital beds through an MDT model, and carry ultimate clinical responsibility. The new stroke rehabilitation unit would be nurse or therapy led with a GRH stroke physician carrying ultimate clinical responsibility. The proposal is based on the assumption that by removing the long stay patients from the acute unit that it will be possible to deliver more therapy to other inpatients and increase therapy levels towards national standards so that patients are discharged more promptly. The Early Supported Discharge (ESD) team would also support the community beds by providing staffing backfill during periods of annual or sickness absence.

Recommendations – Stroke Rehabilitation

It was not felt that a small 12 bedded rehabilitation unit for patients who have already been in hospital for several weeks would be sustainable from a skilled workforce point of view, and that it would be too small to develop and sustain specialist skills and provide target levels of therapy. The use of the ESD team to backfill absences would inevitably deplete the resources available for earlier discharge and home-based rehabilitation, and may be geographically impracticable. If there is to be a community unit, it was suggested that consideration be given to increasing the number of beds in an external unit and that this proposal is arguably too modest for the substantial improvement required in acute performance for stroke services. It was noted that a central location would be needed for such a unit and suggested that a pilot of increased therapy staff on the acute site could be explored, taking into account best practice examples elsewhere.

The panel commended the commitment of the stroke team to improve services and noted the merits in the separation of longer term rehab patients/beds. However the panel expressed concern that the whole picture for stroke needs to be considered to ensure improvements in the quality of the acute service are prioritised in light of poor performance data. The panel was

concerned that the GRH stroke unit has low levels of access and issues with CT scan access and were not made aware of the STP's proposals to address these significant issues in the pathway. The panel was not confident that the community rehabilitation bed model will achieve the significant change that is required in stroke rehabilitation. GRH is one of the worst performers in the National Stroke Audit and outliers in SSNAP data and it was not felt at review that a 12 bed peripheral unit in the community is evidenced to address the performance issues and deliver the service improvements required. This model also does not appear to fit closely with the wider acute reconfiguration model. (Recommendation 21)

The panel recommended that the stroke rehabilitation element of the model not be put forward for consultation until the wider stroke model has been further examined. It was agreed a sub-panel would be set up for this without delaying progression on the rest of the model considered by the panel. It is expected that the sub-panel will gather information and consider the stroke pathway improvement plan across the STP and the different options available beyond a stand-alone community unit to ensure the most beneficial investment in stroke services is moved forward. (Recommendation 22)

7 Key Lines of Enquiry

A set of key questions for the panel to explore within the clinical review was shared in advance with both the panel and the STP. In addition to this the panel put forward their own questions following review of their pre-reading packs. This checklist of potential questions or lines of enquiry to help guide discussion was developed from a national guidance document on conducting senate reviews and is included in the appendices (9.8). As part of the panel's process to develop its recommendations it went through the checklist and confirmed the questions had been covered in the wider discussion. General commentary not already covered in the above recommendations is as follows in relation to the clinical evidence base for the model of care: -

The panel felt that the proposals do have the potential to deliver benefits to a wide number of people and improve the quality of care for patients in Gloucestershire but that more detail to support the proposals and ensure they are robust is required throughout, with particular reference to workforce planning. There is strong clinical leadership behind the proposals. However, both staff and the public need to be engaged on a very clearly articulated model with some more detail enunciated and the basics more clearly described. Many of the questions raised by members of the panel were considered similar to those likely to be raised by the public and the work up of further detail and clarity prior to consultation would be helpful.

The broader picture is well thought through and understood but a lot remains to be articulated and the detail is not yet robust enough. At this point it is hard to say for certain that the quality, safety and sustainability will improve without the operational detail. More examples of best practice elsewhere would be useful as supporting evidence.

There are no projected changes in bed numbers other than the removal of the temporary escalation capacity at GRH and therefore this model does not need assessment against the 5th test.

The links to the wider STP suggest that this acute transformation model is linked to whole system transformation but the links to primary care, self-care and social care are not fully referenced. The engagement with the primary care board and GP locality leads was reassuring when described. The iterative amalgamation through GP clusters is supporting a more consistent message about the wider STP and how to access urgent care services. The panel was reassured that the GP workstream is not developing in isolation to wider work.

Linked to GP practice clusters, the prevention strategy is being developed with the County Council. The STP has a £1.9m prevention fund and social prescribing model with £800k invested in 'community connect'. This links to their IPC work stream. Their integrated community teams are also aligned around the 16 GP clusters, with a focus on 'every contact counts'.

Gloucestershire confirmed that they are working with other CCGs to map flows in and out of the county and map the impact of the changes proposed, although evidence of this mapping wasn't seen.

8 Next Steps

- A date will be set for a sub panel meeting to review the wider programme for improvements in stroke care in Gloucestershire.

- The review panel advises that the recommendations laid out at the start of this report are reviewed as part of the design and delivery stage of developing the proposals more fully between now and implementation.

- A meeting with the NHS England Assurance team should be set up to review the response to the recommendations in advance of implementation and the timeline for this and the outcome of this meeting with NHS England should be fed back to the Clinical Senate.

9 Reporting Arrangements

The CRP team will report to the Clinical Senate Council which will agree this final report and be accountable for the advice contained therein. The report will be shared with the STP and NHS England Assurance Team. Gloucestershire STP will own the report and be expected to make it publicly available via its governing body or otherwise after which point it will also become available on the Clinical Senate website.

10 Appendices

10.1 The STP Presenting Team

CCG Team

Name	Title, organisation
Mary Hutton	STP Lead and CCG Accountable Officer
Andy Seymour	Chair, Gloucestershire CCG
Andrew Hughes	Locality Implementation Manager
Chris Roche	Information Manager
Shaun Clee	Chief Executive
Ellen Rule	Director of Transformation and Service Redesign, Gloucestershire CCG
Mark Walkingshaw	Deputy Accountable Officer
Sally Pearson	Director of Clinical Strategy
Candace Plouffe	Chief Operating Officer
Jeremy Welch	Governing Body GP
Maria Metheral	Senior Commissioning Manager – Urgent Care
Ian Quinell	Associate Director of Strategic Planning
Katie Norton	Chief Executive Officer

GHNHSFT Team

Andrew White	Clinical Lead
Simon Dwerryhouse	Speciality Director General Surgery
Daniel Engelke	Speciality Director Trauma and Orthopaedics

Chris Custard	Acute Physician
Matt Oram	Anaesthetist
Claire Fowler	Speciality Director Breast, Urology, Vascular
Ben King	Resuscitation Lead
Charlie Candish	Speciality Director Oncology and Haematology
Rob Gornall	Consultant Gynaecology
David Taylor	Physiotherapist
Sue Milloy	Divisional Nursing Director Medicine
Sean Elyan	Medical Director
Kate Helier	Consultant Physician in General and Old Age Medicine
Mike Roberts	Medical Director, GCS
Debbie Gray	Clinical Lead Therapist, CCG

10.2 The Review Panel

The review panel comprised members of the Clinical Senate Council, Assembly and clinicians brought in specifically for this panel.

Name	**Title, organisation**
Phil Yates	South West Clinical Senate Chair
Lance Allan	South West Citizens' Assembly member
Mary Baulch	Associate Director of Nursing, Women, Children and Sexual Health, Royal Cornwall Hospitals NHS Trust
Mark Cartmell	EGS Consultant, North Devon Trust & EGS Review Steering Group Lead
James Cawley	Associate Director Adult Social Services, Wiltshire
Aileen Fraser*	Clinical Nurse Director, Bristol Community Health
Martin James	Stroke Physician, Royal Devon and Exeter NHS Foundation Trust; Clinical Director, South West Cardiovascular Network

Kandaswamy Krishna	Consultant Colorectal Surgeon, Weston Area Health Trust
Amelia Randle	Clinical Lead SWAG Cancer Alliance and GP, Somerset CCG
Adam Reuben**	Urgent Care Consultant, Royal Devon and Exeter Trust
Genevieve Robson*	Geriatrics Consultant, Royal United Hospital, Bath
Emma Stapley	Head of Child Psychology, Consultant Clinical Psychologist, Somerset partnership NHS Trust
Debbie Stark	Public Health Consultant, Public Health England
Ros Wade	Head of Therapies, Royal Devon & Exeter NHS Foundation Trust
Jenny Winslade**	Chief Nursing Officer, SWAST
Joanna Kasznia-Brown	Consultant Radiologist, Musgrove Park Hospital, Taunton (commented on documentation but did not attend in person)

Review panel biographies are available upon request

* Declared a potential COI which was noted by the Chair but members were not excluded from discussions.

**In attendance for day one only

10.3 Timeline

Early discussion	October 2016	Senate SMT, STP
Sense Check	November 2016	Senate Council, STP
Initial Assurance Meeting	4th April 2017	NHSE Assurance and STP
Draft ToR	May 2017	Senate Management (ED/PY)
Establishment of clinical review team	May 2017	Senate Manager
NHSE Sense Check	6th July 2017	Senate SMT
Pre-meet with STP	6th July 2017	Senate SMT
Panel meeting	18th and 19th July 2017	SMT, review panel and STP
Report Writing	25th-27th July	Senate Manager/Senate Chair
Draft to Panel for Comment	27th July	Panel
Draft report to Senate council (via email)	8th August	Senate Council

Draft report to CCG for comment	10th August	STP
Sign off of final report	30th August	Senate Management Team
Sub-Panel Stroke Rehab	26th September	STP/SMT
Public Consultation	Nov/Dec	STP

The following appendices are available by email upon request from sarah.redka@nhs.net

10.4 Review Agenda

10.5 Terms of Reference

10.6 Clinical Review Meeting Notes

10.7 Guidance on UTCs

10.8 Principles for Clinical Streaming in the A&E Department

10.9 STP Presentation Slides

10.10 KLOEs and Senate Checklist

10.11 Pre-reading (Documentation from Clinical Senate)

10.11.1 IRP - Learning from Reviews (third edition)

10.11.2 5th test summary

10.11.3 Summary of outputs from 13th Senate Council (tabled on day two)

10.11.4 Citizens' Assembly Principles for Developing Reconfiguration Proposals

10.11.5 South West Emergency General Surgery Review - Key Recommendations

10.12 Pre-reading (Documentation from Gloucestershire STP)

10.12.1 Clinical Advice and Assessment Services – Service Delivery

10.12.2 Community Rehabilitation Business Case

10.12.3 Draft Consultation Documents and Approach

10.12.4 One Place, One Budget, One System – The Case for Change

10.12.5 Strategic Outline Business Case

10.12.6 Urgent & emergency Care Service Specifications v0.4

10.12.7 Urgent Care Centres Business Case

10.12.8 Modelling

10.12.9 **Service Reconfiguration**

10.12.10 **Further documentation requested from STP;**

- Deloitte UCC Staffing Methodology
- MIIU attendances Data 15/16
- GHFT A&E performance from April 2015 to June 2017.
- GHFT DToCs from April 2015 to June 2017
- GHFT monthly bed occupancy rates from April 2016 to July 2017.
- GHFT cancelled operations from November 2015 to November 2016
- Travel Time Assessments for UCCs

11. Addendum

Gloucestershire Acute Services Review: Stroke Rehabilitation Mini Panel

1. **Context**

Following the Clinical Review Panel held on 18th and 19th July to consider Gloucestershire STP's One Place Acute Transformation proposals, a subsequent mini panel (see appendix 1) to further consider stroke rehabilitation was convened on 26th September 2017.

The initial draft Clinical Review Panel report concluded the following in relation to the stroke business case:

"The panel commended the commitment of the stroke team to improve services and noted the merits in the separation of longer term rehabilitation beds. However, the panel expressed concern that the whole picture for stroke needs to be considered to ensure improvements in the quality of the acute service are prioritised in light of poor performance data. GRH is one of the worst performers in the National Stroke Audit and an outlier in the Sentinel Stroke National Audit Programme (SSNAP) data and it was not felt at review that a 12 bed peripheral unit in the community is evidenced to address the performance issues and deliver the service improvements required. This model also does not appear to fit closely with the wider acute reconfiguration model. The panel was concerned that the GRH stroke unit has low levels of therapy, access, delays to CT scanning and were not made aware of the STP's proposals to address these significant issues in the pathway. The panel was not confident that the community rehabilitation bed model will achieve the improvements in therapist provision or significant changes that are required in stroke rehabilitation.

The CRP recommended that the stroke rehabilitation element of the model should be considered within the context of a wider improvement plan for the stroke service before it is put forward for consultation. It was agreed a sub panel to discuss community stroke rehabilitation beds and wider model for acute stroke would be set up between the STP and Clinical Senate."

2. **Overview of the Stroke Improvement Programme**

Debbie Gray, Kate Hellier and Sue Field (appendix 2) presented an overview of the stroke improvement programme to allow the panel to consider the proposals in more detail than at the July review followed by a panel discussion which members of the wider STP team contributed to.

Background

Debbie Gray described rehabilitation as central to the STP's approach, with an intention to address the whole pathway. The 2014/15 Attain review was a key driver for change, identifying a lack of clear pathways, inconsistent referral routes and inequity of provision across localities. The model proposed develops two overarching pathways for core and specialist care. The aim is for rehabilitation to be home-based but some patients will need bed based care. Evidence shows that these specialist services are better delivered together on a single site with an MDT led service and Early Supported Discharge (ESD) Team. In July 2012 the two units in Gloucester and Cheltenham hospitals were combined on two wards at Gloucestershire Royal Hospital where there was a

thrombolysis service. To address admission inefficiencies with wards on separate floors this service was reconfigured with 51 beds on a single floor plus 8 on a neurology ward on the floor above in July 2015. The service runs 7 days with a HASU model and acute admissions at one end of the unit. However, some patients requiring longer term rehabilitation are not getting the best care that they could with only 3 therapy sessions per week within a limited environment on the hospital ward, against a national standard of 45 minutes per day over 5 days per week – it is this that the proposed model seeks to address.

Summary of Model

The model proposes development of a 14 bed stroke rehabilitation level 3A unit (up from 12 beds as proposed in July) located within one of Gloucestershire's existing community hospital sites. The location is yet to be decided however all community hospitals have a minimum of 20 beds. At 5 days in the acute unit, patients will be assessed for transfer to the rehabilitation unit which will be therapy led, with two stroke consultant ward rounds a week. Medical cover for the community hospitals is currently provided by local GPs. There are also currently some patients with stroke scattered across community beds in Gloucestershire and these are expected to use 6 of the 14 beds. It is also expected that the release of 8 beds in the hospital stroke unit will act to increase the amount of therapy delivered to those patients who remain, as the acute provider has undertaken not to alter the therapy staffing levels when the number of patients requiring rehabilitation reduces. Using these beds for other acute medical patients will also support acute flow which in turn will impact the capacity in the community beds, supporting the change in use of 14 beds from general medical beds to stroke rehabilitation beds.

The intention is that the stronger cross provider model will maximise the potential for patient recovery, independence and self-management via a bespoke environment and that the evidence for improved outcomes through the front loading of rehab supports this. Evidence references and a list of KPIs was provided.

Clinical Quality in the Acute Service

Kate Hellier presented recent work that has been carried out to improve clinical quality (as measured by the national stroke audit SSNAP) in the Trust, noting that it had previously been poor and not improving over a four-year period. They have recruited an additional 1.0wte stroke specialist nurses which has allowed the delivery of 7 day services from this team which has subsequently helped to drive change and deliver their SSNAP action plan since July, supported by weekly reports.

The panel saw that for the acute domains 1-4 of SSNAP that significant improvements had been made during August and September. Time to unit and swallow screens have improved and CT scan wait has come down to less than an hour from 2hrs. A good working relationship with the Emergency Department (ED) is being developed to get stroke patients out of ED as soon as possible with the whole stroke team is working to achieve this. The change in practice led by Dr Kate Hellier and catalysed by a focus on SSNAP, the recruitment of stroke specialist nurses and the challenge from the Senate to improve SSNAP results was felt by the hospital team to be sustainable.

Proposed Model

Therapy establishment in the acute provider is fully recruited, but the staffing model does not provide sufficient and balanced therapy between the sub-specialities across the week and further change is required. The STP Rehabilitation Steering Group set up in 2016 has modelled both local and national data and developed criteria against which options for developing a community stroke unit were scored (detailed in presentation slides in appendix 3). Against a context of limited estates options, the preferred option proposed was for a single community site with the support of the ESD team and a virtual network with the acute stroke unit. It is not currently anticipated that patients with complex medical needs will be moved to the community and patients for example that are NG fed or on IV fluids would not be transferred.

ESD Team

Gloucestershire has a well-established, stable and highly functional ESD team that works as a single team across the country but based across two sites to minimise travel. The ESD delivers a 7 day service with 16.8wte in the team, managing around 320 patients a year. The current scheme provides for a further 6 weeks of ESD input at home as required. The intention is to work towards rotational staffing and learning between the proposed unit and ESD team to support the recruitment and retention of staff, build on relations in the county and support sustainability. There is considered to be a lot of enthusiasm for the proposed model amongst therapy staff across the pathway.

General Discussion

There was some concern from the panel that the community hospital beds would quickly get blocked. The STP team were confident in their modelling of 170 patients per year with an average length of stay of 4 weeks and 90% occupancy. The expectation is that around 1874 excess bed days that cost the system £100 000 will be saved. It is anticipated that there will be the ability to flex capacity in the rehab unit through being based in a larger community hospital. Advanced care package and discharge planning will be prioritised for patients from the outset. As part of the local authority's commitment to DTOCs as part of the STP planning an extra £1.5m is being spent on domiciliary care.

In the community in Gloucester there are 7 community hospitals with 190 beds across a mixed estate with both wards and single rooms. The hospitals are all matron led with GP input and nursing and therapy staffing. The STP team is visiting the sites to complete the modelling around the best location to use for the unit, taking into account criteria on travel times, staffing, clinical criteria and refurbishment requirements.

The proposed staffing therapy cover over 7 days has used the national calculator system for stroke training and the staffing will run to that level. As well as rehab assistants, rehab nurses, SALT, social worker and psychologist input there will be band 5 and 6 Physiotherapy and Occupational Therapy roles and a band 7 therapy leadership role. Dietetics and pharmacy input will also be covered. Whilst

there will be consultant cover twice a week the intention is that the ESD team is enabled to control patient flow.

3. Panel Recommendations

- The system cohesion demonstrated by the CCG, GHFT and Gloucester Care Services as the community provider working together on this model as part of the STP was very encouraging.

- The work of the acute stroke team at Gloucestershire Royal Hospital to improve clinical quality and in turn improve outcomes for patients was commended. The panel encourage ongoing support from GHFT to the acute stroke team to continue this work. In particular, additional investment in therapy would still be required to address the significant deficit in delivery, even after the adjustment for the reduced number of stroke beds at the acute site.

The panel noted the potential advantages of a community based rehab unit and gave its support to the further development and implementation of the model, emphasising the importance and benefit of the proposals to rotate staff across the acute and community settings. The panel continued to have significant concerns regarding the size of the unit and make the following suggestions in relation to the overall stroke programme

i. **The size of the unit should be maximised from the outset with a review of the proposed criteria for admission to take on more complex patients, both in relation to their physical and medical needs (such as NG feeding) with a view to creating a minimum 15-18 bed unit.**

ii. **A Consultant Therapist/Nurse led model of clinical leadership should be adopted from the outset. This will provide not only the senior support but provide an attractive career pathway for the junior members of the team.**

iii. **In order to address the issue of therapy input for patients currently at the Gloucester site, additional therapists should be recruited to provide increased bedside therapy, ultimately rotating into the community unit model.**

iv. **Consideration should be given as to how to enhance the capability of the ESD team to take patients with greater levels of disability. This measure should also reduce the requirement for beds in the acute provider.**

v. **The panel recommended that the Gloucester team should visit non-medically led rehab facilities either at South Petherton, Somerset, or at Newton Abbot, Devon.** (Contact details for the clinical leads in these areas can be provided if required)

4. Next Steps

- The outcomes and recommendations from this mini-panel will be included in the final clinical review report on acute transformation proposals as an addendum.

- It is no longer expected that the model for stroke rehabilitation will be required to go out to public consultation. It is anticipated that the unit will be operational by Spring 2018.

- The review panel have asked to be updated on the selected site location.

- The review panel have asked for an update on implementation and progress in one year.

Appendix 1: Panel Members*

Name	**Title, organisation**
Phil Yates	South West Clinical Senate Chair
Martin James	Stroke Physician, Royal Devon and Exeter Trust
Jatt Khaira	Consultant Stroke/General Medicine, University Hospitals Birmingham NHS Foundation Trust
Jane Mitchell	Professional Lead for Physiotherapy, Royal Cornwall Hospital Trust
Genevieve Robson	Geriatrics Consultant, Royal United Hospital, Bath
Caroline Smith	Consultant Nurse, Yeovil District Hospital
Ros Wade	Head of Therapies, Royal Devon & Exeter NHS Foundation Trust
Ellie Devine	South West Clinical Senate Manager

*The panel included a core of members from the original review and some additional rehabilitation specific members.

File path:

Appendix 2: STP Members

Name	Title, organisation
Marion Andrews-Evans	Director of Nursing and Quality Lead, Gloucestershire CCG
Julie Clatworthy	Governing Body Nurse, Gloucestershire CCG
Debbie Gray	Clinical Lead Therapist, Gloucestershire CCG
Mary Hutton	Accountable Officer, Gloucestershire CCG
Ian Sprigmore	Programme Manager, Gloucestershire CCG
Sheena Yerburgh	GP Partner, Prices Mill Surgery, Gloucestershire CCG
Katie Norton	Chief Executive, Gloucestershire Care Services Team
Sue Field	Director of Nursing, Gloucestershire Care Services Team
Kate Hellier	Lead Consultant Stroke Physician, Gloucester Hospital Foundation Trust
Stuart Cannonier	General Manager, Gloucester Hospital Foundation Trust
Felicity Taylor Drew	Executive Team, Gloucester Hospital Foundation Trust

Appendix 3: Pre-Reading

1. Stroke Rehabilitation Presentation for Senate v7
2. Copy of Stroke SSNAP Recovery Action Plan Sept 2017
3. Gloucester Royal Exec Summary (SSNAP)
4. Gloucestershire CCG Rehabilitation Review 2014
5. Gloucestershire CCG Rehabilitation Review Summary 2014
6. Stroke Rehabilitation Business Case 2017

File path: