South West Clinical Senate

Stage Two Clinical Review Report

Future Acute Services at Weston General Hospital

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Prepared by: Ellie Devine, South West Clinical Senate Manager

Signed off by: Dr Sally Pearson, South West Clinical Senate Chair

File path:

1 Executive Summary

1.1 Chair's Summary

This report has been produced by the South West Clinical Senate for Bristol, North Somerset and South Gloucestershire (BNSSG) Sustainability and Transformation Partnership (STP) and provides recommendations following a Clinical Review Panel (CRP) that convened on 20th November 2018 to review the BNSSG STP proposals for acute service reconfiguration at Weston Hospital, part of the wider Healthy Weston programme.

This was an independent clinical senate 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 early 2019. The Senate principally considers tests 3 and 5*; the evidence base for the clinical model and the 'bed test' to understand whether any significant bed closures will 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 BNSSG STP for their organisation and open discussion during the review.

The clinical advice within this report is given by clinicians with a shared common goal to the STP in developing the best services possible for the population, contributing through the value of peer experience 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 BNSSG STP with the offer of continued support.

Dr Sally Pearson, Clinical Chair, South West Clinical Senate

*For this review panel the focus was primarily on test 3 as it was initially agreed that the implications for beds were system wide and not possible to fully determine at this stage of service development. Following the draft publication of this report the Clinical Senate was asked by NHSE to review the bed test. The findings are included in an addendum in this final version of the report (section 9).

1.2 Executive Summary

The Clinical Review Panel (CRP) considered the Healthy Weston Team's proposal for three stages of change to services at Weston hospital over a 5-10 year period. This follows a long period of public engagement and a comprehensive process to develop a short list of options for change which has resulted in a preferred option that proposes the delivery of 3 options (9, 12 and 27b) delivered in 3 stages.

No changes have been proposed to paediatric provision (co-located short stay paediatric assessment unit)* or maternity services (24hr midwifery led unit) and the stages can be summarised as follows (changes to previous stage highlighted in bold);

Currently
A&E is open 14hrs a day and consultant led
Medical Assessment Unit with a registrar on site 24/7
Ambulatory Care Unit with direct GP referral pathways
Emergency Surgery rota/theatre availability 24/7** (very small volume of activity)
Level 3 critical care with 24/7 acute medicine or anaesthetic cover
Planned surgical activity up to ASA (American Society of Anesthesiologists) Physical Assessment Score 4

* Paediatric assessment unit opening hours to be extended from 8-7 5 days a week to 14/7 alongside the front door.
**Direct NOF admissions and emergency surgery are 24/7 however the only admissions overnight since ED closure are GP expected which are small in number.

Stage One - 2019
A&E is open 14hrs a day and staffed by medical consultants, physicians **and GPs**
Medical Assessment Unit with a registrar on site 24/7
Ambulatory Care Unit with direct GP referral pathways
Emergency Surgery theatre availability 4 hours a day
Level 2 critical care (becomes HDU) with 24/7 acute medicine or anaesthetic cover
Planned surgical activity up to ASA Physical Assessment **Score 3**

Stage Two – 2021-2024
A&E becomes a UTC, open 14hrs a day and staffed by GPs
Medical Assessment Unit with a registrar on site 24/7
Ambulatory Care Unit with direct GP referral pathways
Emergency Surgery theatre availability 4 hours a day
Level 1 critical care (becomes ward based care) with ability to step up to level 2 (acute medicine or anaesthetic cover TBC)
Planned surgical activity up to ASA Physical Assessment Score 3

Stage Three 2024-2028
UTC, open 14hrs a day and staffed by GPs
No Medical Assessment Unit
Ambulatory Care Unit with direct GP referral pathways **and 72hr short stay admission beds**
Daytime Consultant led surgical hot clinics but no emergency surgery theatre
No critical or anaesthetic care (provided in Bristol or Taunton)
Planned surgical activity up to (ASA) Physical Assessment Score 2

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Panel Recommendations

Stage One

- The CRP was unanimous that 'do nothing' as an option is not sustainable or safe for patients or Weston Hospital going forwards.

- The panel was in support of stage one of the proposed model for change, stating that there was a clear argument for this as evidenced by differences in patient outcomes and clinical quality. The panel encouraged progress to this effect as soon as possible as it considers the current model to be potentially unsafe.

- It would be helpful for the PCBC to more clearly describe the current caseloads for emergency surgery with some examples of outcome data, complication rates and the evidence around specific interventions as this clearly supports the case for immediate change in the public interest.

- The panel queried why the ambulatory care unit will run 5 days a week rather than 7.

- It has been stated that there will be no changes to the midwifery led maternity service but it was noted that midwives will be moving to an on call 24/7 rota. The impact of this should be referenced.

Stage Two

The CRP advised that stage two was more complicated and more unclear than the other proposed stages with concern that it would be unstable as a stand-alone model. The panel advised that stage two should be used to carefully develop the transition plan to go from stage one to stage three, rather than be a stage of service delivery in itself.

Key points of concern for clarification regarding stage two or transition to stage three were as follows;

- Managing workforce transition to a GP led UTC (including consideration of the role ENPs / ECPs could play).
- Concordance with national guidance on nomenclature to avoid risk that patients present at the wrong place. Once the original A&E becomes GP led, it should be clearly described as an UTC.
- What the medical admission pathway will be and medical staffing cover to safely manage acuity of different patients at each stage of transition.
- Risk assessment against processes for patient selection and triage to ensure patients end up in the right place for the right service at each stage of transition.
- Middle grade cover for medicine/surgery and consultant support, particularly for the hospital at night and out of hours.
- The definition of complex surgery and which pathways will and won't be delivered.
- Clarification of critical care pathways at each stage of transition; there was significant clinical concern regarding the downgrading of the higher dependency beds from the current position moving towards stage 3 and that the timings of the down grading should potentially lag behind the implementation of other changes to ensure critical care provision resilience (eg. Level 2 at stage 2 to reduce patient risk for the sickest patients.)
- The sustainability of the paediatric assessment unit once other services cease, noting that the current model is rather unusual.

- Clarity around what the frailty hub will look like and how it will be developed is required, particularly in relation to workforce and consultant geriatrician recruitment which has thus far been very difficult.

Stage Three

- The panel were supportive of stage three as a model of care to work towards at Weston hospital. The CRP encouraged the STP to consider whether this stage could be safely implemented sooner than the current proposal which gives a 5-10 year timeline. Crucial to this would be a focus on workforce planning and supporting the workforce to provide safe patient care during any transition period.

- The panel recognised that stage three needs to be considerably further worked up and that the future of the hospital in this model will be highly dependent on networking with other healthcare trusts in Bristol and Somerset. The panel encouraged ongoing conversations and relationship building with neighbouring service providers including the ambulance services as plans for service change are further developed.

- Whilst the panel were reviewing Weston Hospital service changes only, it was noted that BNSSG STP is already developing innovative community and primary care services in North Somerset and that there is a real opportunity to develop Weston as a vibrant hospital in the community; using the physical facility to maximise integrated community care with an MDT focus on frailty and active rehabilitation amongst other areas of population need.

- Some of the areas the CRP identify in this review that particularly need further focus and clarity in stage three in addition to workforce include;

    - pathways for the short stay beds in the ambulatory care unit
    - pathways for the surgical hot clinics (including arrangements to transfer patients elsewhere for emergency surgery)
    - the remaining surgical offering at Weston
    - the medical model including pathways for acutely unwell patients and critical care
    - the links to out of hospital service improvements, of which progression will be crucial to the success of the new model for acute services at Weston. This includes integrating with daytime primary care, 111, ambulance services and other community teams.

- As the model develops, the provision of patient stories to demonstrate how the new pathways will work compared to the current state would be helpful.

- Further clarity could be provided in the final PCBC to demonstrate the service model now and the differences between each stage of progress towards the final model.

Next Steps

The panel was assured of the case for change and that proposals are in line with other systems, national guidance and available evidence.

In summary the CRP recommends an initial move to Stage One with a very carefully planned transition to Stage Three as soon as is deemed possible through further work up of the proposal.

The major risk factor was felt to be the workforce. Clear planning and strategy around more innovative use of a well-supported multi-disciplinary workforce was advised.

Once stage three and proposals for transition have been further developed (decision making business case) this may need to come back to the clinical senate for review prior to implementation, subject to discussion with NHSE.

2 Background

The proposals for acute service reconfiguration that are the subject of this review, form part of the wider Healthy Weston Programme which focuses on healthcare across the Weston Locality in the southern part of North Somerset. This is being delivered under BNSSG STP's Healthier Together Programme.

The Pre-Consultation Business Case that has informed the clinical review focuses specifically on changes required to the model of acute care at Weston General Hospital, but places these in the context of being one critical element for a broader system-wide strategy to transform local services. North Somerset Council's Health Overview and Scrutiny Panel (HOSP) has confirmed that the out of hospital service improvements do not require public consultation.

Weston General Hospital is one of the smallest acute trusts in the country. The population living in Weston, Worle and the surrounding areas (including parts of Somerset who use Weston General Hospital) is just over 150,000. This population is predicted to grow faster than the national average over the next 30 years and is on average older than the population of England, with the number of frail elderly and people with long-term conditions expected to rise. The number of children under the age of 14 is also predicted to rise. There are pockets of high deprivation and health inequalities in the Weston area. All of these characteristics of the population have implications for the health and care services that will be needed in future.

Although health service outcomes are good on average across North Somerset, there are some very marked health inequalities, particularly in Weston. In particular, three groups emerge as main priorities as a result of population level data:

1. Frail and Older People.
2. Children, Young People and Pregnant Women (including complex needs and young people's mental health).
3. Vulnerable Groups, for example people with mental health needs, learning difficulties and those who struggle with drug and alcohol addiction.

At the moment WGH sees 50,000 to 55,000 A&E attendances per annum (~141 per day): 80% are minors, 29% arrive by ambulance, 58% walk-in, and the remainder are mainly GP referrals. Within the next 15-20 years, however, Weston-super-Mare's population will rise from approximately 81,000 to exceed 100,000.

The catchment population for Weston General Hospital's urgent and emergency care model is significantly lower than that which would be expected in the context of the standards for urgent and emergency care guidance summarised in the 2015 Keogh report. The hospital has a history of of clinical sustainability issues, with challenges in clinical recruitment and retention in specific specialities.

For safety reasons associated with the availability of staff, there has been a temporary overnight closure of the A&E (currently operating 14 hours a day, 7 days a week) in place since July 2018, following an inspection from the CQC. Since the temporary overnight closure, the Trust has been trying to substantively recruit a minimum 80% of the clinical staff required under national guidelines for A&E staffing. So far this has not been possible and, even if the required number was reached, turnover of staff would present the risk of further unplanned closures in the future if the existing model of care persists.

For a number of years Weston General Hospital has had a lack of substantive consultants to provide 24/7 care in acute specialties, with a 67% vacancy rate (excluding locums) in A&E Whole Time Equivalent staff numbers (WTE) and a 44% vacancy rate (excluding locums) in general medicine as at March 2018.

Because of the staffing challenges, junior doctors do not always get the level of supervision they need and report low levels of satisfaction in their jobs. Overall junior doctor satisfaction with training is 68% which is significantly lower than the national average of 79% and has caused the Deanery to question the role of the Trust in training junior doctors.

3 Senate Engagement to Date

BNSSG STP and prior to that North Somerset CCG have undertaken comprehensive public and patient engagement in relation to services at Weston Hospital in recent years. The STP has been engaging with the South West Clinical Senate since 2017. In March 2017 the clinical senate undertook an initial desktop review (Appendix 10.5) of North Somerset's developing plans. In October 2017 the STP published their 'Commissioning Context' document and the Clinical Senate undertook a desktop review of this documentation in January 2018 (Appendix 10.5).

In advance of the requirement for formal clinical review via panel, the Clinical Senate undertook a further desktop review of BNSSG STP's developing PCBC documentation in October 2018 (Appendix 10.5). This desktop review was undertaken by a sub-panel of the CRP.

The clinical senate advice had some core themes throughout;

- Clarity and support for case for change
- Workforce highlighted as key risk factor
- Acute pathways to be made more explicit
- Impact on other providers to be detailed

The Clinical Senate Chair and Clinical Senate Manager have also been present at some of the NHSE early assurance meetings.

4 The Review Process

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 for reconfiguration. Reviews are undertaken to inform the NHS England assurance process which signs off proposals for change prior to public consultation.

The Senate's CRP reviewed the final PCBC document plus appendices provided by the STP to detail their proposals ahead of the panel meeting (appendix 10.4) and also referred to the October 2018 desktop review as well as national guidance, specifically Rethinking Acute Medical Care in Smaller Hospital, Nuffield Trust, October 2018 (appendix 10.8). The panel also fed in comments, based on their pre-reading documentation, which contributed to the panel's key lines of enquiry (KLOES) used to guide discussion at the panel meeting. These supported the generic KLOES for clinical review processes developed from a national guidance document on conducting senate reviews (appendix 10.6).

The Clinical Chair held a preliminary meeting with the STP team in November 2018 before hearing its proposals for change presented formally at the clinical review panel meeting on 20th November. The review meeting provided opportunity for the STP's clinical team to present its proposals and for the clinical panel to discuss the proposals, ask questions and raise concerns. The agenda can be found in appendix 10.3.

At the review panel, the Clinical Chair emphasised to the STP that the Clinical Senate regards its independent role as being a supportive one, raising legitimate clinical concerns aimed at strengthening the clinical case for change, PBCB and preferred option for implementation; 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.

5 BNSSG STP's Healthy Weston Proposal for Acute Services at Weston General Hospital

During 2018 the Healthy Weston steering group have undertaken a comprehensive process to review options for change at Weston Hospital. This has resulted in a preferred model that proposes the delivery of 3 options (9, 12 and 27b) delivered in 3 stages over the next 10 years.

No changes have been proposed to paediatric provision (co-located short stay paediatric assessment unit open 14 hours a day)* or maternity services (24hr midwifery led unit).

*PAU hours to be extended to mirror that of the UTC.

The stages can be summarised as follows (changes to previous stage highlighted in bold);

Currently
A&E is open 14hrs a day and consultant led
Medical Assessment Unit with a registrar on site 24/7
Ambulatory Care Unit with direct GP referral pathways
Emergency Surgery rota/theatre availability 24/7** (very small volume of activity)
Level 3 critical care with 24/7 acute medicine or anaesthetic cover
Planned surgical activity up to ASA (American Society of Anesthesiologists) Physical Assessment Score 4

* Paediatric assessment unit opening hours to be extended from 8-7 5 days a week to 14/7 alongside the front door.
**Direct NOF admissions and emergency surgery are 24/7 however the only admissions overnight since ED closure are GP expected which are small in number.

Stage One – 2019

Weston General Hospital would manage most acuities of patients but all major surgical emergencies would be seen in larger centres with more volume. Clinically-led modelling suggests 70% of A&E "majors", 85% of acute medicine and 70% of emergency surgical activity would continue to be managed at Weston General Hospital based compared to the current commissioned model. Overall, 91% of the current episodes of care commissioned for delivery at Weston General Hospital are described as remaining under this model of care.

- A&E is open 14hrs a day and staffed by medical consultants, physicians **and GPs**
- Medical Assessment Unit with a registrar on site 24/7
- Ambulatory Care Unit with direct GP referral pathways
- **Emergency Surgery theatre availability 4 hours a day**
- **Level 2 critical care (becomes HDU)** with 24/7 acute medicine or anaesthetic cover
- Planned surgical activity up to ASA Physical Assessment **Score 3**

Stage Two – 2021-2024
Clinically-led modelling suggests 52% of A&E "majors", 80% of acute medicine and 65% of current emergency surgical activity would continue to be managed at Weston General Hospital. These figures are based on comparisons to the current commissioned model. Overall, 90% of the current episodes of care delivered at Weston General Hospital are described as remaining under this model of care.

- **A&E becomes a UTC, open 14hrs a day and staffed by GPs**
- Medical Assessment Unit with a registrar on site 24/7
- Ambulatory Care Unit with direct GP referral pathways
- Emergency Surgery theatre availability 4 hours a day
- **Level 1 critical care (becomes ward based care) with ability to step up to level 2 (acute medicine or anaesthetic cover TBC)**
- Planned surgical activity up to ASA Physical Assessment Score 3

Stage Three 2024-2028
52% of A&E "majors", 50% of acute medicine and 45% of emergency surgical activity currently would continue to be managed at Weston General Hospital. These figures are based on comparisons to the current commissioned model. Overall 88% of services currently commissioned are described as remaining at Weston General Hospital.

- UTC, open 14hrs a day and staffed by GPs
- **No Medical Assessment Unit**
- Ambulatory Care Unit with direct GP referral pathways **and 72hr short stay admission beds**
- **Daytime Consultant led surgical hot clinics but no emergency surgery theatre**
- **No critical or anaesthetic care (provided in Bristol or Taunton)**
- **Planned surgical activity up to (ASA) Physical Assessment Score 2**

The following services have been described as common to all stages;

- outpatient services
- diagnostic and therapy services including x-ray, MRI, ultrasound, pathology, physiotherapy, occupational therapy, dietetics and speech and language therapy
- an integrated frailty service
- non-complex elective surgery
- midwifery led maternity services
- services for acutely unwell children and children with complex needs*

*The existing short-stay paediatric assessment unit (SSPAU) requires an onsite consultant paediatrician during opening hours. It cares for children with acute illnesses and trauma and those requiring a short stay admission (up to 8 hours). It would not support children requiring over 8 hours of intervention or admission, or neonates requiring a Neonatal Intensive Care Unit (NICU).

The STP team's intention is to go out to public consultation between 16th January and 10th April 2019.

6 Panel Discussion and KLOES

6.1 Pre-Meet Discussion

The Clinical Review Panel met before the presenting STP clinical team arrives. It was discussed that the BNSSG STP team had only recently placed the specific proposals for changes to acute services at Weston Hospital in the broader context against the wider Healthy Weston case for change. It was noted that the proposals do not stand alone but that wider changes to community services across the patch do not require public consultation. It was acknowledged that at this point the bed test would not be assured as the impact and reprovision would largely be on beds in other hospitals and more information was required. Note addendum 9 for more information on the bed test.

Some of the issues the panel wanted to ensure were explored in addition to the wider Clinical Senate KLOEs were as follows;

1. Success of services will rely absolutely on relationship with community services and front door medically/GP led model.
2. Impact of proposals on other providers should be more clearly modelled to understand pressures elsewhere.
3. What will overall 24/7 consultant or equivalent staffing cover be in the hospital?
4. How will they recruit geriatrician input to develop as a centre of excellence for frailty?
5. How will developing proposals for dementia bed provision link in?
6. What active rehabilitation provision will there be at the hospital?
7. How will proposed links with UHB support the model of care and link in with BNSSG as an aspirant ICS?

8. Additional ambulance resources to match journey times and ensure availability should be clarified, particularly in relation to Musgrove Park hospital where more activity has been shown to go since the overnight closure of A&E.
9. Concern around clarity in nomenclature and that a UTC or A&E should be called that only if it meets national guidance.
10. Assurance regarding workforce strategy and recruitment of primary and community care workforce, particularly for the frailty hub.
11. How frailty pathways will work to ensure the right patients are identified, delays aren't added to pathways and interventions are made.

Further questions and issues were also explored by the CRP following the STP presentation.

6.2 STP Presentation

The STP Clinical and Managerial team delivered a comprehensive presentation (appendix 10.7) describing how the proposed model was developed with McKinsey using evidenced based practice from a long list of thousands of options. These were reduced to 37 models most relevant for a small acute trust such as Weston General Hospital and evaluated formally against 5 key criteria.

It was acknowledged that there have been previous attempts of redesign and emphasised that Weston Hospital cannot be considered in isolation to the rest of the health and social care system. However a resolution to current challenges must be achieved both for the patients and staff of Weston Hospital. There is a well-recognised and urgent case for change with the principle challenge behind this being workforce. Proposed changes to Weston hospital would be delivered within the wider context of the BNSSG STP Healthier Together Partnership.

The team described how stage one will make immediate changes to the emergency surgery offering as the small numbers of procedures undertaken make it increasingly difficult for surgeons to maintain their skillsets. This will include a move to a mixed skill set of staff running A&E at the front door. It is anticipated that this would immediately help to stabilise current provision.

Stage two will see A&E develop into a UTC with more changes to the wider acute provision as the integrated frailty hub is developed in line with developments in the out of hospital services.

Stage 3 would see Weston Hospital as part of a wider BNSSG STP acute care collaborative, as a hospital in the community, delivering enhanced community services. Theatres would be used for elective surgery and a fully integrated frailty model as a critical part of the model would see Weston develop as a centre of excellence for frailty. There would be diagnostics on site but high acuity patients would be seen elsewhere and there would be no emergency surgery, ICU or A&E.

The presenting team highlighted that Weston Hospital is too small to deliver all the services currently on offer and that patients going into Weston are not necessarily getting the high acuity care they need. Clinicians do not see the correct caseloads per procedure whilst the best practice frailty models are not being delivered to the ageing population either. In the proposed system solution model it is felt there is real potential to use Weston hospital as a true asset in the wider offering of healthcare across the STP. Paediatric and maternity services will remain as is although it was noted that the midwifery led unit will move to a 24/7 on call staffing as part of the wider BNSSG Local Maternity Plan.

The team described how services can be networked across the 3 neighbouring acute trusts and that this has already begun for maternity services across BNSSG as well as for integrated mental health services outside of the hospital environment via a developing business case for a town centre 'crisis café'. With the development of joined up GP practices, Pier Health will bring together 10 GP practices in one of the more deprived areas of Weston by April 2019, working at scale to share back office functions and the GP workload to improve access for patients. A supporting 'ask my GP' IT solution will go live in March. Significant engagement with the public in recent years has meant that proposals have been co-designed to ensure the hospital has a better fit in the system and for the community. Examples of other systems elsewhere in the country working to similar models were also provided.

The team described that they are working in close operational partnership with the other acute trusts in Bristol and that some of the city based estate challenges may be relieved by development of some services in Weston whilst the frailty hub should have a positive reduction on bed days. It was noted that a 6 month review of the overnight closure of A&E had been undertaken and that the system is already managing this with the sickest patients being transferred by SWAST to Taunton or Bristol.

On a financial level it was acknowledged that no models close the financial gap with stage 3 leaving a £3.7m challenge. Estate and bed modelling needs to be undertaken along with further workforce analysis however the STP were clear that the challenge of service delivery at Weston is being owned by the wider system.

The PCBC is being put forward for assurance and subsequent consultation to confirm that the case for change is robust, that no change is not an option and that stage one can be progressed. The STP is also seeking support that the proposed direction of travel is correct, albeit with significant further work required ahead of implementation.

6.3 Panel Q&A

Staffing

The CRP explored the issue of chronic understaffing in the emergency department with an establishment of 2 consultants against an establishment of 8 and 2 middle grades against an establishment of 9. The loss of middle grade trainees is a threat to attracting junior trainees and existing staff do not want to work in isolation. Uncertainty around the provision of service has also contributed to the high vacancies rates. There is currently no care of the elderly consultant although there is some stroke provision.

The CRP wanted clarification regarding acute physician staffing and provision of airway support as well as other protocols for deteriorating patients at each stage of the model.

It was noted that historical reputational damage to Weston hospital has also made staffing issues difficult to reverse. Paediatrics were not listed in the vacancies data in the PCBC and it was observed that this is because there is a rotational arrangement with the children's hospital however the day centre opening hours are limited due to staffing numbers. It was agreed that changes to services will

be heavily dependent on realistic workforce recruitment and retention modelling as well as innovation around new clinical roles.

Surgical Outcomes

The CRP discussed with the team that there are some stark variation outcomes for emergency surgery procedures at Weston Hospital, that the small numbers of procedures mean that staff cannot maintain their skills adequately and that it is unsafe, unethical and unfair on staff providing services not to address this. The SHMI (Standard Hospital Mortality Indicator) reported at 1.15 was felt to be unacceptable.

It was noted that vascular activity has already been transferred but that emergency colorectal activity will move in the proposed model and emergency laparotomies would stop immediately. This was based on the low numbers of these types of procedure being carried out per year. Staffing levels also have an impact with the acute bleed rota for example currently led by only 3 individuals.

Elective surgery would continue and the short stay ambulatory service and hot clinics would have consultant surgical team input. As transition to stage three is planned in further detail it will be key to understand the interdependencies and clinical cover within the hospital, particularly in surgery and out of hours as emergency surgery is rolled back. For example, will the removal of other services impact the direct access fractured neck of femur service; how will evening ward rounds for review and transfer work and what will daytime and weekend cover look like?

Community Integration and the Frailty Model

The panel asked for assurance that integration with NHS 111 and other out of hospital services will support appropriate pre-hospital assessment and decision making to ensure that for stages 2 and 3, patients with high acuity are not sent to Weston and that the care home population and patient pathways are considered in particular.

As the hospital changes its acute service provision other providers will need to be educated on changing pathways. The importance of building up capacity and capability in primary and community care was regarded as key.

The panel had some concerns around how the integrated frailty service would expand and attract workforce and noted that joint appointments, rotating roles and competency rather than solely medical based appointments would be key in developing a dynamic workforce strategy if the frailty model is to ultimately reduce attendances by 25% and admissions by 50% as described.

The panel discussed and acknowledged that removing uncertainty at Weston Hospital will be one of the biggest contributors to supporting recruitment but that the changes as some services are stopped and others expanded will need to be communicated clearly to retain staff during this period.

UTC

The panel noted that the PCBC was not clear regarding the nomenclature for the current A&E in future stages of the model. The advice from the CRP was that there should be clarity for patients and

in stages two and three the current A&E should be called a UTC. Whilst it may be described as medically led rather than GP led as it is the competency of staffing that is most important, there was concern that sick patients would turn up at an A&E that is actually a UTC if the name did not reflect the change in services. It is particularly important that consistency in national guidance is followed with the large tourist population that is seen accessing services in the summer and given that 58% of attendances are walk in patients.

The panel noted the GP workforce needs to be carefully considered in the workforce strategy as there could be a knock on effect for practice shortages if the UTC is relying on the GP workforce at its front door.

6.4 Panel Feedback

The panel noted that there was wide clinical representation and engagement from across healthcare providers in the Weston locality as well as the wider STP and that the thinking behind the proposals is very much at a whole system level, which the CRP encouraged. The panel was impressed by the shared commitment to the proposal that was demonstrated and by the process and methodology that had been used to develop the model to its current point. The case for immediate change to address clinical quality and risk in emergency surgery was compelling while the panel could see that supporting work is progressing concurrently for other services as part of the wider healthy Weston programme.

The overall direction of travel was understood and supported but timeframes were felt to be too long. Bearing in mind other system change that could take place over the next 5 to 10 years it was felt that if carefully planned, the move to stage 3 of the model should happen more quickly to help stabilise services at Weston Hospital, manage clinical risk and harness momentum for change.

It was noted that there are strong working relationships with UHB Trust but that perhaps more work needs to be done to link with NBT, Musgrove Park hospital, AWP and SWAST given that the future of the overall model will be highly dependent on networking and joined up services across Bristol and Somerset.

Stage two was regarded more as a transition phase rather than an end point and more work needs to be done to clarify clinical pathways in the final model as well as what will happen to acutely unwell patients and how the workforce at Weston Hospital will be structured and staffed going forward.

Stage two was felt to be less clearly described with concern about the clarity of general medical admission pathways in particular as well as medical cover and that there would be different clinical risks depending on the time of day. Critical co-dependencies need to be carefully thought through in relation to managing acuity, critical care, the medical model and the surgical offering during transition.

Workforce remained the area of key concern for the panel and it was felt that transition from stage one to stage three will need clear management in terms of patient care and workforce retention but should not last longer than necessary.

Whilst no changes to paediatric services and the existing paediatric assessment unit were proposed, the panel suggested that in planning for stage three, the rationale and sustainability of the service should be sense checked. The extended opening hours will cope better with peaks in demand but the last patients will still need to be seen at 8pm. Given that children cannot stay overnight the interdependencies with other services going forward should be checked to ensure the service remains safe and sustainable and that it can be recruited to. The panel felt that in the worked up stage 3 proposals, it would be helpful to include some examples of best practice so support the evidence base for this type of paediatric model.

In developing a comprehensive transition plan to stage three, the hospital bed base model (currently 270 and expected to go down to 126 in the draft PCBC) will need to be clarified. The CRP agreed that there would be opportunities to the wider system (in addition to undertaking elective surgery), to using a non-acute bed base at Weston in the longer term for active rehabilitation and step up and step down beds.

6.5 Conclusions

Overall, the panel could see the vision and potential for a new future for Weston as a hospital in the community as described and that proposals are supported by published evidence, national guidance and best practice for similar systems of healthcare.

The panel were unanimous that doing nothing is not a safe or sustainable option for Weston Hospital as is. There was no doubt that the current configuration of services at the hospital is not best for the population of Weston. The differences in patient outcome data demonstrate the stark reality of the risks and clinical quality that the current workforce is working hard every day to manage.

There was unanimous support for consultation on and progression with stage one of the proposed model as soon as possible. The panel were supportive of the direction of travel of stage 3 in the model but that this should be properly developed with a full transition plan to maximise opportunities for service delivery at Weston Hospital. Crucial to this will be a realistic and comprehensive workforce strategy and careful planning of patient pathways as acute care is stepped down to ensure patient safety during transition.

It was suggested that the full potential of this final stage and the links to existing innovations in primary and community care could be more strongly described to demonstrate the vision and possibility regarding the future of services at Weston Hospital. Once developed, this stage along with the workforce strategy would need further review.

7 Next Steps

The summary recommendations were shared verbally with the STP at the end of the panel meeting in order that they could start work immediately to further develop their PCBC for the stage two assurance meeting on 19th December. The STP need to agree with the assurance team which stages they will be consulting on, their response to the CRP advice (in particular in relation to stage 2), when information will be available in relation to the bed test and workforce strategy and modelling and confirm what needs to be brought back to the Clinical Senate in the future.

8 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 by 13th December. BNSSG 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. The STP requested the draft executive summary be shared with them for a HOSC meeting on 5th December.

9 Addendum 1 (18th December)

Since the CRP met on 20th November and fed back to the Weston team, NHSE have advised that changes have already been made to their PCBC to reflect the advice contained within this report. The model has been updated to include only two phases as recommended and nomenclature of the UTC has been clarified as well as feedback given that many of the recommendations for stage 2 are being taken into account.

Following sharing of the draft report on 4th December the NHSE assurance team subsequently asked the Clinical Senate and CRP to undertake the bed test for phase one of the model as a desktop exercise, with the provision of additional information from the STP to be shared by 13th December.

The information provided showed that in the intervening period, the proposals for changes to beds were amended considerably by the STP who have since reviewed their modelling for beds and capital funding as part of the model described in this report.

Subject to these changes, it was felt that the bed test was being met for phase one and did not need a further desktop review.

A summary of the original and updated proposals are as follows;

Previous Proposal in draft PCBC of 20/11/18

- Phase 1 – Reduction of 71 beds (24 no longer needed as a result of integrated frailty service and 29 reprovided at UHB, 9 reprovided at NBT and 9 reprovided at Musgrove)
- Phase 2 – Approx' 150 beds to close (22 no longer needed as a result of integrated frailty service and 80 reprovided at UHB, 24 reprovided at NBT and 24 reprovided at Musgrove)

Updated Proposal

- Demand expected to be reduced as a result of implementing the frailty unit in phase one. 24 beds may be repurposed or closed but only if reduction in demand materialises. Beds will not be closed until evidence has shown these are not required. There will be checkpoints within a set of criteria that will be finalised at the STP's decision making business case stage with input from the whole system to review the reduction in demand.

- 11 beds of activity will have to go elsewhere (roughly equates as UHB – 5; NBT – 3 and T&S 3). These 11 beds at Weston will not be closed and the expectation is that the repatriated elective surgical work over the next 18 months will utilise these beds.

- Phase 2 - Over the course of 5 years, 46 beds will be repurposed from Non Elective capacity to Elective Capacity at Weston Hospital.

Assurance given in relation to beds moving to other trusts in phase one was as follows;

- The repurposing of the 11 beds over the course of a year following DMBC (Decision Making Business Case) will be included in the 19/20 single STP plan that is already in development (and including T&S).
- The trusts' concerns about potentially having to take a far higher number in beds in phase 1 has been ameliorated.
- Following assurance sign off and prior to public consultation the updated PCBC goes to all 3 Trusts for sign off.

Following senate feedback and a subsequent STP clinical design group the STP has reported that there is now more detail in the phase 2 model which is included in the revised version of the PCBC. This work included revaluating the overall capital assumptions and the impact of phase 1. The expectation is that the changes to services in phase one will have a small impact in terms of activity (critical care goes from level 3 to 2 and some emergency surgery is removed). These changes in terms of volume are now not expected to require the bed closures initially described in phase one at Weston, which have been amended from 71 to a possible 24. These will not be closed unless demand is reduced by the frailty service. The non-elective activity from a further 11 will be absorbed by neighbouring acute trusts, subject to their agreement prior to consultation and implementation but with the beds remaining open for elective care at Weston.

The work to better define phase 2 (27b) means the STP are now proposing that only 46 beds will be impacted by a change in use from non-elective to elective care beds. In turn elective care beds elsewhere in the system may change in use to become non-elective care beds to absorb the impact of changes to acute services at Weston Hospital. No beds will be closed at Weston Hospital.

The Clinical Senate Chair will be present at the NHS England Stage 2 Assurance meeting on 19th December which takes the Clinical Review Panel Feedback into account when signing off the model of care to go to public consultation. Any further input to or review of their decision making business case by the Senate will be agreed at this point.

10 Addendum 2 (30th January 2019)

10.1 Consultation on Phase One only

Following the 19th December assurance meeting, there was some discussion between the assurance team and the Clinical Senate Team to confirm the advice given at the November Clinical Review Panel (and detailed in the report) indicated that the CRP supported phase one for implementation and consultation with what is now phase two (phase two and three combined) only as a direction of travel for further work up.

Subsequently to the November CRP meeting it was noted that the Healthy Weston team had worked up phase two to some extent but that this was likely not yet sufficiently developed for sign off at a subsequent clinical review panel should it take place. As such the Healthy Weston team agreed with the assurance team that they would only consult on phase one with some information about phase two included as a direction of travel for the future, with phase two likely to require further CRP input and consultation.

During January the Clinical Senate Chair reviewed the updated PCBC to confirm that the description of the proposals for change for consultation were consistent with model that was assured by the Clinical Senate.

10.2 Critical Care

The Healthy Weston team highlighted that a change had been proposed to critical care in phase one as part of their final PCBC (version 0.22a 11/01/19). The proposed change meant that following a step down from providing level 3 to level 2 critical care that deteriorating patients escalated to level 3 could be cared for at Weston hospital before being transferred for up to 48 hours instead of the 12 hours originally proposed.

The Clinical Senate team therefore shared the information on the change of approach for critical care services with 4 relevant members of the Clinical Review Panel. The Clinical Chair also spoke with Nick Kennedy, who is an intensivist and a Council member at the suggestion of the CRP*. The feedback provided was as follows:

Panel members understood the need for flexibility to avoid patients being inappropriately transferred to other critical care units after 12 hours potentially increasing the risk above that of continuing their treatment in Weston. However, to extend the normal operating model to retain patients for up to 48 hours was not significantly different from retaining a level 3 model and the safety and sustainability barriers to this were well articulated to the CRP in November. As a consequence the senate could not offer assurance on the 48 hour model without seeking further specialist independent advice, which is not achievable in the timescales required to allow BNNSG to maintain their consultation timetable.

The Clinical Senate subsequently suggested that the system revises its PCBC and Consultation Document to reflect the model of critical care previously presented to the Senate but includes the possibility that by exception patients requiring level 3 support will be able to be cared for in Weston beyond the 12 hour period, where in discussion with the potential receiving unit, it is agreed that the

risks of transfer would outweigh the risks of continuing to care for the patient in Weston. This would be consistent with the original assurance from the CRP and the subsequent comments from the panel.

*Conflict of Interests noted as NK is on the BNSSG Governing Body.

11 Appendices

11.1 The BNSSG STP Presenting Team

Name	Title, organisation
Jonathan Hayes	Clinical Chair, CCG
Robert Woolley	Chief Executive, UHB (representing the STP)
James Rimmer	Chief Executive, WAHT
Julia Ross	CEO BNSSG CCG
William Oldfield	Medical Director, UHB
Peter Collins	Medical Director, WAHT
Andrew Hollowood	Associate Medical Director, UHB
Colin Bradbury	Executive Lead, Healthy Weston Programme, BNSSG CCG
Penny Hynds	Healthy Weston Interim Programme Manager, BNSSG CCG
Glyn Howells	Chief Finance Officer, BNSSG CCG
Tim Whittlestone,	Clinical Director, Surgery, NBT
John Heather	GP Provider Lead, Weston & Worle
Kevin Haggerty	GP Commissioner Lead, Weston & Worle
Mary Lewis	Director of Nursing and Therapies, NSCP
Stuart Walker	Medical Director, TSFT
Katy Richards	SWASFT

Andrew Burnett	Director of Public Health, NSC
Rebecca Dunn	WAHT
Claire Weatherall	Acute Care Collaboration Projects Director
Eva Dietrich	AWP

11.2 The Review Panel

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

Panel Role	Name	Title
Chair	Sally Pearson	Clinical Chair, South West Clinical Senate
1. Psychiatrics	Martin Ansell	Consultant Old Age Psychiatrist
2. Psychiatrics	Paul Winterbottom	Consultant Learning Difficulties Psychiatrist
3. Emergency Care	Dave Partlow	Clinical Development Manager *COI noted
4. Emergency Care	Leilah Dare	ED Consultant and Specialty Lead, Southmead Hospital *COI noted
5. Emergency Care	Dominic Williamson	Consultant Emergency Medicine at RUH Bath NHS Trust
6. Surgery	Katie Cross	Consultant Colorectal Surgeon
7. Pharmacy	Bettina Kluettgens	Clinical Director and Q member
8. Geriatrics	Tara Fleming	Consultant Geriatrician
9. Paediatrics	Miles Wagstaff	Consultant Paediatrician
10. Nursing	Marion Andrews-Evans	Executive Nurse & Quality Lead, Gloucestershire STP
11. Maternity	Dawn Morrall	Clinical Improvement Lead and Better Births Midwife Lead for Gloucestershire
12. Patient/citizen representation	Nick Pennell	Chair, Healthwatch Plymouth

Review panel biographies are available upon request.

*COIs were declared and noted but did not exclude participants from the panel.

The following appendices are available by email upon request from rachel.perry12@nhs.net

11.3 Clinical Review Panel Agenda

11.4 Pre-Consultation Business Case

11.5 Desktop Review Reports March 2017, Jan 2018 and Oct 2018

11.6 KLOEs

11.7 STP Slides

11.8 Nuffield Trust Document

11.9 Terms of Reference for Clinical Review Panel