South West Clinical Senate

Stage 2 Clinical Review Report

Bristol, North Somerset, and South Gloucestershire

Healthy Weston Phase 2 Proposal

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1.1 Chair's Summary

This report has been produced by the South West Clinical Senate for Bristol, North Somerset, and South Gloucestershire (BNSSG) CCG and provides recommendations following a Clinical Review Panel (CRP) that convened on 31 March 2022 to review the BNSSG Healthy Weston Phase 2 proposals for the reconfiguration of urgent and emergency services at Weston General Hospital.

This was an independent clinical 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 before going ahead to public consultation, which in this case is planned for June 2022. 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 can meet one of three 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 CCG Team for their organisation and open discussion during the review.

The clinical advice within this report is given by clinicians who share the commitment of colleagues from BNSSG, to develop the best services for the population. They have freely shared their knowledge and experience to ensure the proposals are based on clinically sound service models. This report sets out the methodology and findings of the review and is presented to BNSSG CCG with the offer of continued support.

Dr Sally Pearson, Clinical Chair, South West Clinical Senate

1.2 Executive Summary

The Clinical Review Panel (CRP) considered the Bristol, North Somerset, and South Gloucestershire (BNSSG) Healthy Weston Phase 2 proposals to reconfigure urgent (non-elective) and emergency services at Weston General Hospital. Notably, the baseline CQC rating for Weston Emergency Department (ED) in 2019 was “inadequate”, and the Get It Right First Time (GIRFT) standards for emergency surgery provision and paediatric staffing standards were not achieved. The Healthy Weston Phase 2 proposals are designed to increase compliance with national guidelines and create a sustainable future for Weston General Hospital.

1.2.1 Currently

There have been improvements made at Weston General Hospital since Healthy Weston Phase 1 with the implementation of the proposals around the paediatric service which provides care closer to home for those with younger families. The changes to the emergency surgery model have led to improved compliance with national clinical safety standards, as has the development of critical care services following integration with University Hospital Bristol.

Nevertheless, the current model of care remains unsustainable with the specialist medical inpatient at Weston General Hospital, unable to consistently meet national and local clinical quality standards because of low activity volumes and challenges in recruiting specialist staff (which has created a lack of resilience in the hospital).

Bristol, North Somerset, and South Gloucestershire (BNSSG) CCG has developed Healthy Weston Phase 2 proposals which seek to address these challenges and proposes a strengthened model for urgent (non-elective) and a surgical centre of excellence.

1.2.2 The proposed model

The aim of Healthy Weston Phase 2 is to establish a dynamic and sustainable future for Weston General Hospital.

The scope of Healthy Weston Phase 2 includes a single strengthened model for urgent (non-elective) care and a surgical centre of excellence. The following bullet points set out a series of fixed points the BNSSG Clinical Design Delivery Group agreed would run through the clinical model:

- A 7-day Emergency Department to continue to be provided 8 am-10 pm.
- Same Day Emergency Care (SDEC) provision (sometimes referred to as "Ambulatory Care") will be enhanced, Monday-Friday 9 am-9 pm.
- Community Ageing Well provision for older people, delivering reactive and anticipatory care interventions to be developed as a 24-hour, 7-day service.
- Paediatric services to continue to be developed through the integration with UHBW, open 8 am-10 pm 7 days a week.

- Inpatient general medicine would be centralised to larger neighbouring hospitals to ensure that people receive high-quality medical care.
- Routine emergency surgery –the most common emergency surgery procedures should continue to be provided during the day.
- Critical care –is to be provided at the hospital and this would be developed in line with the requirements of the new clinical model.

The Healthy Weston programme has been underpinned by a clinically led design process that started with the Stage Three model that was supported by the Clinical Senate in 2018.

Three options were considered for people that need an ambulance response, these included:

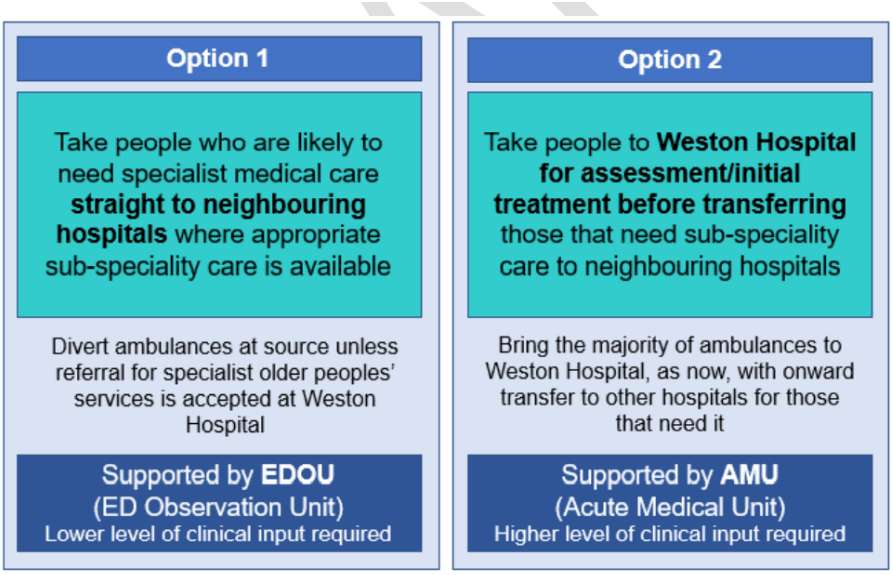

Figure 1: Non-Elective Model of Care

1. Option 1 – Take people who are likely to need specialist inpatient medical care straight to neighbouring hospitals where appropriate sub-speciality inpatient care is available
2. Option 2 – Take people to Weston General Hospital for assessment/initial treatment before transferring those that need sub-speciality care to neighbouring hospitals

The option that was removed as part of the clinical design process allowed undifferentiated ambulances conveying frail / older people to arrive at Weston General Hospital without referral but did not allow this for other patient groups. This option was removed because it placed a complex decision around differentiating unwell frail patients from unwell non-frail patients with the ambulance paramedic

Options 1 and 2 remain for consideration, and the Key Lines of Enquiry document as developed through the draft Pre-Consultation Business Case (PCBC) sets out the overview of the clinical model, workforce requirements, ambulance requirements, travel times, etc.

1.2.3 Panel Recommendations

The Panel recognised that the services currently delivered from the Weston site are significantly different from those reviewed by the panel in 2019. The panel were presented with evidence that the innovation and integration with the emergency, surgical, intensive care, paediatric and old age services at Bristol Royal Infirmary, has reduced clinical risk, improved compliance with standards and enhanced recruitment. The major risks are now associated with the ability to deliver safe resilient specialist medical inpatient care.

The business case articulated two options for consideration. The Panel assessed both options and concluded that it could offer assurance for Option Two, with a number of provisos (see listed below).

1. Assurance is conditional on the workforce model that has been described to the Panel and articulated within the business case. This means that BNSSG will need to be able to both fund and recruit to this model. There should be greater visibility in the business case of the comparison between the current and proposed workforce. This would make the scale of the recruitment challenge and its affordability more explicit.

2. The sustainability of the model is dependent on the continued integration of clinical models and staffing across the trust. Such integration maintains the quality and oversight of the patient pathways delivered on the Weston site, enhances the likelihood of recruitment to the posts required in the model and increases resilience and flexibility.

3. Assurance is based on the following assumptions in relation to the resident cover described in the Hospital at Night model:
    a. That the medical registrar holds Membership of the Royal College of Physicians (MRCP) and a level of competence equivalent to that required for a registrar occupying a specialist training number.
    b. That the senior house officer (SHO) is as a minimum a foundation year 2 (FY2) doctor
4. Whilst the Panel recognised the commitment expressed by providers in the wider system and beyond for option 2, creation of the additional capacity required to accommodate the activity displaced from Weston in this model is essential. This does not necessarily need to be additional inpatient capacity in the hospitals but could be capacity in the system that reduces pressure on the inpatient facilities.

5. Robust transfer protocols and logistics are essential to the safety of the model to ensure that individuals assessed in Weston and determined to need specialist in patient care can rapidly be transferred without detriment.

6. The proposals describe an aspiration to develop Weston as a centre for elective surgery and to increase the scale and scope of elective surgery on the Weston site.

The assurance of option 2 is based on the current scope and case mix of elective surgical activity. Any change in complexity or volume would need to lead to a review of the adequacy of provision of overnight medical cover.

The Panel recognised that the model described in option 2, including the integration with the services at University Hospitals Bristol, was innovative and if implemented successfully could provide a template for smaller hospitals across the country.

The Panel were not able to provide assurance for option 1. This was based on the following:

- The workforce requirements for option 1 were not significantly different from option 2 but the complexity and range of conditions presenting to Weston in option 1 is diminished. This will inevitably lead to a diminution of skills and experience and a resulting challenge to recruiting the necessary calibre of staff to maintain the model.

- This would impact on the competencies available to be deployed in the Emergency Department as well as the hospital at night model, compromising the quality of the care offered to older people and surgical inpatients.

- The other providers in the system were not able to support option 1 due to the impact on them of the displaced activity from Weston

The Panel suggested several areas within the business case that could be strengthened. This will be particularly relevant during the implementation phase:

- Diagnostics: there is an opportunity to do more around the diagnostic pathway and explain the linkages to the diagnostic hub. This is not directly linked to the proposals, but the Panel felt that it would make a powerful message to the local population about the range of services that will be available to them at Weston General Hospital.

- The Panel acknowledged that specialist support for patients on the wards is dependent on In-reach from specialists. The business case describes support from specialists when they are physically present on site for outpatient clinics, but more could be done to describe the potential for remote support exploiting technology and the benefits of shared information systems.

- Cancer pathways: There is an opportunity to make more of the fact that local access to cancer pathways can be maintained and arguably enhanced in the proposed model.

- Maternity pathways: The Panel observed that Weston General Hospital provides antenatal care and although this is not changing in the proposals, given the current national policy context, it would be useful to comment on the extent to which the proposals impact the maternity pathway.

In respect of the bed test, the panel has explored the clinical assumptions on which the model is based and has accepted these as reasonable with the caveats that, due to the impact of COVID, these are based on 2019 data with no trajectory showing likely future trends beyond 2019. The assumption around the proposed reduction of length of stay via disposition into care and community services, whilst based on shifts elsewhere, may be challenging to achieve due to the increased pressure on these services. Consequently, the assumptions may underestimate the impact on other providers in the model.

2 Background

Bristol, North Somerset, and South Gloucestershire (BNSSG) CCG set out a case for change for health services in Weston and the surrounding area in 2017. This identified the population needs and challenges facing health services for the area in the future. It recognised the challenges to the delivery of effective and sustainable local healthcare which were most visible regarding Weston Hospital with the temporary overnight closure of ED in 2017.

The Healthy Weston Programme was established in 2018 to look at the needs of the population and the health economy, including changes required to the hospital model of care. A Pre-Consultation Business Case (PCBC) was considered by the SW Clinical Senate and assured through the NHS England Stage Two Assurance process before public consultation and a final Decision-Making Business Case was approved in October 2019. The decision to approve the Healthy Weston Phase 1 proposals enabled the merger of the Weston Area Health Trust (WAHT) integrating Weston General Hospital with University Hospitals Bristol NHS FT from April 2020.

The case for change document in 2018 set out the issues relating to population growth and the need for more complex healthcare interventions, issues with health inequalities and differing access to healthcare, staffing shortages across primary and secondary care (20+ % consultant and nursing vacancies, particularly ED and General Medicine), and the increasing overspend against budget.

The proposals confirmed in 2019 included:

- Making the overnight ED closure permanent, with a department staffed from 0800 – 2200 but allowing 24-hour direct admissions via GPs and paramedics
- Providing critical care support up to level 3 (single organ support), with patients transferred to UHB for more complex support
- Daytime only emergency surgery with theatres closed overnight, with a more responsive daytime ambulatory service
- A daytime acute paediatric service

These changes were designed to increase compliance with national guidelines and were assessed against the case for change. The baseline CQC rating for Weston Emergency Department (ED) in 2019 was "inadequate", and the Get It Right First Time (GIRFT) standards for emergency surgery provision and paediatric staffing standards were not achieved.

Full details of these proposals and the outcome of the clinical review are set out in Stage Two: Clinical Review Report: Future Acute Services at Weston General Hospital (February 2019)[1].

Healthy Weston 1 responded to the immediate changes needed to ensure safe services for the local population and laid the foundations for further improvements at Weston General Hospital. It was recognised at that time that further phases would be required to fully respond to the case for change. A further phase of work commenced in 2021 and has brought forward proposals under Healthy Weston Phase 2.

3 Senate Engagement to date

BNSSG CCG has been engaging with the South West Clinical Senate since 2019 regarding the reconfiguration of urgent (non-elective) and emergency services via the Healthy Weston Programme.

In January 2022, the Clinical Senate undertook a desktop review of BNSSG's developing PCBC documentation for the Healthy Weston Phase 2 proposals. This desktop review was undertaken by the Clinical Review Panel (See Appendix 8.5)

The Clinical Senate feedback can be summarised as:

- The ongoing issue of whether the proposals include an A&E service or instead describe an Urgent Treatment Centre (UTC). This issue was raised at the Phase 1 Review and needs to be addressed. The models do not provide the standard of care required in an A&E and it is confusing for the public about what service they can expect to receive.
- Concerns that the workforce issues will not be resolved simply by changing the service model. There must be robust modelling of staffing particularly if rotating posts between UHB and WGH are being proposed and evidence that such posts are more staff-able than the current WGH only posts. The modelling should also include other healthcare professionals.
- Questions were raised by the modelling around patient escalation and transfers. Protocols need to be in place around transfers, and timely repatriation. Clarification is needed as to who will provide this service as it will be out of scope for SWAST.

[1] South West Clinical Senate. Stage Two Clinical Review: Bristol, North Somerset and South Gloucestershire (BNSSG) STP: Future Acute Services at Weston General Hospital (March 2019) - South West Senate (swsenate.nhs.uk)

- There must be assurances provided of the agreement and support of neighbouring Acute Trust, for these proposals to work. There needs to be capacity planning for the other hospitals involved, in terms of acute care and potentially planned care to understand how the impact of the changes to services at Weston General Hospital.

- A discussion was held as to whether Option 3 (previously discounted by Healthy Weston) with some modification might work effectively and this could be explored. In this case, there would be direct admission to ward rather than going via A&E.

The Clinical Senate Chair and the Head of Senate have attended some of the NHSE assurance meetings.

4 The Review Process

The Clinical Senate Review Process is used across England to provide an 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 before public consultation.

On 17 March 2022, BNSSG CCG submitted a suite of documents and a PowerPoint presentation (with audio) to the South West Clinical Senate, to be reviewed by the Clinical Review Panel in preparation for the BNSSG Healthy Weston Phase 2 Clinical Senate Review Panel meeting scheduled on 31 March 2022.

These documents include (i) Healthy Weston Phase 2 PCBC v2.0, (ii) Healthy Weston Phase 2 Appendices, (iii) Key Line of Enquiry Log from Desktop Review, (iv) SW Clinical Senate submission requirement, and (v) Map of the BNSSG area.

On 23 March 2022, a pre-Panel discussion and planning meeting was held with members of the Clinical Review Panel, chaired by the South West Clinical Senate Chair (who is also the Chair for the BNSSG Healthy Weston Phase 2 Clinical Review Panel). This meeting was held for the Panel to give comments and feedback on the BNSSG Healthy Weston Phase 2 Proposal and identify key areas of enquiry that would be further explored with BNSSG CCG, in addition to the standard Clinical Senate Key Lines of Enquiry (KLOEs). Panel members who were unable to attend the meeting had been invited to submit their comments the day prior.

At the meeting, the Clinical Review Panel identified the following KLOEs from the review of the PCBC that they wanted to explore further with the BNSSG CCG Clinicians in the Clinical Review Panel meeting:

- Patient pathways from presentation to discharge with emphasis on:
    - Fractured Neck of Femur (for Option 1 and Option 2) and what happens during inpatient stay for these patients.

- Acute Abdomen
- Overdoses: to understand the plans for substance misusers.
- Mental Health: to understand how cases of delirium and dementia are managed, and what the links are to local mental health services
- Patients on inpatient wards: to understand what happens if patients deteriorate overnight
- Paediatric services (under 16 years)
- Dealing with undifferentiated patients who don't neatly fit into a particular pathway

- A deeper dive into some clinical areas
  - Geriatric Emergency Medicine Service (GEMS): the staffing grades, specialty, providing overnight care for this patient cohort
  - Intensive Care: what this looks like in the new model and the rationale in option 1 and option 2
  - Accident and Emergency: how will the quality criteria be met for both options, and what is the staffing model for both options
  - Emergency General Surgery: the rationale for emergency general surgery
  - Diagnostics: how will these services be delivered?
- Clinical assumptions used in your capacity and demand modelling:
  - The assumptions at each stage of the model
  - The assumptions behind bed reduction on the Weston site and additional bed requirements on other sites
  - The assumptions in the 'Discharge to Assess[2]' model
- Ambulance Services
  - The training that will be in place to support ambulance staff decision-making processes

[2] Discharge to Assess model is where patients who are medically fit for discharge and do not require an acute hospital bed but may still require care services are provided with short-term, funded support to be discharged to their own home (where appropriate) or another community setting. Assessment for longer-term care and support needs is then undertaken in the most appropriate setting and at the right time for the person. Quick Guide: Discharge to Assess (www.nhs.uk)

    - The effectiveness of the inhouse transfer team to deliver a credible service that is available at the times that it is needed

- Workforce
    - The staffing model at the Front Door and the implication for other hospital processes such as out-of-hours, dealing with deteriorating complex patients, support for surgical, and care of elderly patients on hospital wards
    - The breakdown of staff grades and specialties
    - The implications for surgical trainees
    - The requirements for other non-medical clinical staff i.e. advanced nurse practitioners, emergency nurse practitioners, nurse consultants
    - The plans to address workforce recruitment challenges
    - The funding for the proposed new posts (Bristol Business case referenced)
- The overall patient travel times (peak and off-peak)
- The preferred option

On 23 March 2022, the Clinical Review Panel Chair and the Head of the Clinical Senate met with representatives from BNSSG in a 'pre-Panel' meeting, to share the additional KLOEs that were identified by the Panel. The aim was to allow BNSSG to prepare to address these enquiries ahead of and at the Clinical Review Panel meeting.

On 28 March 2022, the Clinical Senate sent BNSSG the additional KLOES and the agenda for the Clinical Review Panel meeting.

On 29 March 2022, BNSSG provided further information to address the KLOEs raised by members of the Clinical Review Panel. This included (i) Responses to recommendations set out in the Desktop Review Report which is updated to indicate where the information requested is located. (ii) Modelling Assumptions including Non-Elective calculator, Discharge to Assess Business Case, Secondary Transfers, Ambulance diverts at source (iii) Clinical Staffing Model – all medical staff associated within the new model of care (iv) Patient Pathway examples including those requested at the pre-Panel meeting.

BNSSG discussed its proposals for change formally at the CRP meeting held on 31 March 2022. The meeting provided the opportunity for the CRP to discuss the proposals and ask further questions, raise concerns, and for BNSSG to respond. The meeting agenda can be found in Appendix 8.3.

At the review panel, the Clinical Chair emphasised to the ICS Team 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.

5 BNSSG CCG Healthy Weston Phase 2 Proposal

In BNSSG, the Healthy Weston Programme designed to address the challenges to the delivery of effective and sustainable healthcare in Weston which gained visibility with the temporary overnight closure of ED in 2017. The programme considers the reconfiguration of urgent (non-elective) and emergency services and to increase compliance with national guidelines.

5.1.1 Currently

There have been improvements made at Weston General Hospital since Healthy Weston Phase 1 with the implementation of the proposals around the paediatric service which provides care closer to home for those with younger families. The changes to the emergency surgery model have led to improved compliance with national clinical safety standards, as has the development of critical care services following integration with University Hospital Bristol.

Nevertheless, the current model of care remains unsustainable with the specialist medical inpatient services at Weston General Hospital, unable to consistently meet national and local clinical quality standards because of low activity volumes and challenges in recruiting specialist staff (which has created a lack of resilience in the hospital).

Bristol, North Somerset, and South Gloucestershire (BNSSG) CCG has developed Healthy Weston Phase 2 proposals which seek to address these challenges and proposes a strengthened model for urgent (non-elective) and a surgical centre of excellence.

5.1.2 The proposed model

The aim of Healthy Weston Phase 2 is to establish a dynamic and sustainable future for Weston General Hospital.

The scope of Healthy Weston Phase 2 includes a single strengthened model for urgent (non-elective) care and a surgical centre of excellence. The following bullet points set out a series of fixed points the BNSSG Clinical Design Delivery Group agreed would run through the clinical model:

- A 7-day Emergency Department to continue to be provided 8 am-10 pm.
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- General medicine would be centralised to larger neighbouring hospitals to ensure that people receive high-quality medical care.
- Routine emergency surgery –the most common emergency surgery procedures should continue to be provided during the day.
- Critical care –is to be provided at the hospital and this would be developed in line with the requirements of the new clinical model.

The Healthy Weston programme has been underpinned by a clinically led design process that started with the Stage Three model that was supported by the Clinical Senate in 2018.

Three options were considered for people that need an ambulance response, these included:

3. Option 1 – Take people who are likely to need specialist inpatient medical care straight to neighbouring hospitals where appropriate sub-speciality care is available
4. Option 2 – Take people to Weston General Hospital for assessment/initial treatment before transferring those that need sub-speciality inpatient care to neighbouring hospitals

The option that was removed as part of the clinical design process allowed undifferentiated ambulances conveying frail / older people to arrive at Weston General Hospital without referral but did not allow this for other patient groups. This option was removed because it placed a complex decision around differentiating unwell frail patients from unwell non-frail patients with the ambulance paramedic

Options 1 and 2 remain for consideration, and the Key Lines of Enquiry document as developed through the draft Pre-Consultation Business Case (PCBC) sets out the overview of the clinical model, workforce requirements, ambulance requirements, travel times, etc.

6 Panel Discussion and KLOES

6.1 Information in response to the KLOEs

On 29 March 2022, in response to the key areas of enquiry received from the Clinical Review Panel and in preparation for the Panel meeting, BNSSG provided further information to address the key areas of enquiry.

The information included detailed responses to the areas of enquiry raised by the Panel within the Desktop Review Report and the 'pre-Panel' meeting, modelling assumptions, clinical staffing model, and patient pathway assumptions.

6.2 Panel Q&A

As part of this process, the Panel reviewed elements of the current model at Weston General Hospital, that would remain in the new model, to form a clinical view of those elements. This allowed the Panel to have a holistic view of areas of risk within the proposals.

The Panel asked several follow-up exploratory questions based on the key lines of enquiry previously shared with the BNSSG team. These can be grouped under the following headings:

6.2.1 Staffing model/ Medical Staffing model

The Panel sought to clarify whether the medical staffing information provided in the supplementary information by the BNSSG is aspirational and not the current position. If it is aspirational, the Panel suggested that BNSSG include a summary within the business case of the progress that has been made towards achieving this.

The Panel sought clarity on the following:

- the breakdown of the medical staff (including roles, grades) to the Front Door for Option1 and Option 2; and what this would look like during the night time hours and overnight.
- The on-call provision and the expectation as to how far away from Weston General Hospital, the on-call consultants could be, given that the expectation is that clinicians would be on rotation from the Bristol site. There is a standard requirement for an on-call clinician to be within 30 minutes of the hospital where they are providing this cover.
- The middle grades – the numbers and whether these are accounted for, in the numbers for training members at Weston.
- The staff is physically present in the hospital and the surgical cover, at night and overnight (beyond midnight until 06:00hrs).

6.2.2 Patient pathways from presentation to discharge

Fractured Neck of Femur (NOF) pathway

The Panel explored with the team, the information on this pathway that had been included in the slide deck. The panel noted that the figures (see below) included in the slide deck show a good level of performance against national averages. These figures are taken from the National Hip Fracture Database[3] and are confirmed as correct as of January 2022.

- KPI Orthogeriatric review: 92% performance against the national average of 88%
- KPI Surgery at WGH within 36hrs of presentation to ED: 84% performance against the national average of 65%
- KPI prompt mobilisation: 90% performance against the national average of 81%

[3] The National Hip Fracture Database (nhfd.co.uk)

- KPI return to original residence: 67% performance against the national average of 71%

The Panel noted that contemporaneously, Weston General Hospital had not undertaken elective work and questioned whether a similar level of performance would be achieved when undertaking elective surgical work, in relation to, access to operating theatre lists and therapy time, which may be more available, whilst elective work is not undertaken. The Panel questioned whether trauma lists were in place for seven days a week or whether these lists were shared with other surgical teams at the weekend.

The Panel observed that the proposed closing time for ED is 22:00hrs and explored with the team, the out-of-hours pathway for incoming patients who arrive close to the closing time, to understand how these patients would be managed and whether this would be via the daytime pathway or direct admission pathway.

The Panel explored with the team, the staffing model for the overnight Fractured Neck of Femur pathway and details of the medical staff grades and roles that would be involved in delivering care. They also sought the reassurance of patient safety.

Acute abdomen pathway

The Panel probed for detail on the staffing model for the pathway including the staff/ patient on-call ratio, and the current number of WTE consultant surgeons, and questioned the situation with regards to the trainees being pulled from working at Weston General Hospital following a Care Quality Commission Report. The team confirmed that this was about the internal medical F1 trainees who had challenges with clinical supervision however, the surgical trainees (F1 and surgical registrars) remain onsite.

The panel probed for detail on the experience of the pathway moving through the hospital at night, starting with the availability of CT scans (and whether this is 24/7), the mix of staffing grades – specifically the role of the juniors (F2s/ Trust grades), and the escalation process. Having learned from the team, that the juniors have been working the night shifts with on-call support by a consultant surgeon, the panel probed for further detail: how long had this been running, how often the consultant surgeon had been called up to attend to patients, the patient outcome and whether there had been any critical incidents that the Panel should be made aware of. The BNSSG team shared that there was available audit data which included the time of key activities in the pathway. Having learned from the BNSSG team that there had been pressure in the system relating to delays-in-transfer of patients through to Bristol, the Panel sought to clarify whether these would be addressed by the new in-house transfer team.

The Panel sought to clarify the resilience within the system for undertaking procedures such as Hartmann's procedure. E.g. number of beds with ventilators, etc. This is an important consideration, given the desire to increase the complexity of general surgery at Weston General Hospital.

The Panel questioned how the transfers would be managed in situations where the patient arrives at the hospital and by the time the decision is made that the patient requires surgery, it is after (or close to) 20:00hrs which is when the operating theatres close.

In these situations, if the in-house transport team is not available to undertake the patient transfer, and unless the patient is in a life-threatening situation that requires immediate surgery, the transfer would fall outside of the SWAST contract for inter-facility transfer (IFT). The Panel was also interested to understand what would happen if a patient was so unwell that they required surgery before being transferred, and in this context, what would be the impact of a delay in transfer. The Panel felt that these are important points that should be articulated within the business case.

The Panel sought clarification on how complex general surgery, gastrointestinal (GI) bleed rotas and hot upper gastrointestinal fit into the pathway (given that internal medicine is moving away from Weston General Hospital) and the clinical staff that would work in these areas.

Self-poisoning pathway / Mental Health pathway

The Panel observed that mental health pathway is not articulated within the business case. Given the government's push for the parity of esteem with physical health, the panel requested that the team clarify the mental health provision and the source of the mental health input i.e. consultant psychiatrist or a nursing-led team.

The Panel sought to clarify whether Weston General Hospital is used as a health-based place of safety[4] (Section 136) for young people under 18 or whether there is a different place of safety in Weston. The Panel questioned whether the hospital had ever detained patients under the Mental Health Act. For example, a patient who had taken an overdose would be detained under Section 2.

The Panel asked whether there will be a clinician in ED in the role of a mental health responsible clinician[5]. Under Section 12 of the Mental Health Act, a patient with mental health needs coming into ED should be provided with a mental health responsible clinician who oversees their care.

The Panel questioned the team to find out what the response to the national ambition set out in "The Five Year Forward View for Mental Health"[6] which states that by 2020/2021, 50% of acute hospitals should meet the 'core 24' standard. The Core 24 service standard requires

[4] PS02_2016.pdf (rcpsych.ac.uk)
[5] https://www.datadictionary.nhs.uk/nhs_business_definitions/mental_health_responsible_clinician.html

[6] https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

A&Es to have an on-site liaison psychiatry service commissioned to provide a 1-hour response to emergency referrals and a 24-hour response to urgent inpatient ward referrals.[7]

Given BNSSG's ambition to develop Weston General Hospital into a centre of geriatric care, there is likely to be an increase in the number of dementia and delirium cases coming into the hospital, the Panel sought clarification on what plans were in place to increase mental health input into GEMS or onto the wards, and whether this would be led by an old age psychiatrist or specialist mental health nurses.

The Panel noted that it is important that patients with mental health needs are identified at the Front Door, and there are community structures in place, to discharge these patients. The Panel probed for detail on the community structures to support patient discharge.

Patient on inpatient wards pathway

The Panel sought to clarify the number and types of wards that will be in the new clinical model and whether this would include an acute surgical ward, an Emergency Surgical Ambulatory Clinic (ESAC), and a Surgical Admissions Unit (SAU).

The Panel probed the staffing model: the number of junior doctors that would be working outside ED and within the Care of the Elderly Unit, and the numbers and staffing grades working the overnight staffing rota. The Panel sought to clarify patient management out of hours specifically, the on-call arrangements after midnight, and whether this is handled by a T&O (Trauma & Orthopaedic) Registrar, Surgical Resident, or Consultant. There are differences between what is described in the business case and what was presented by the BNSSG team at the Clinical Review.

The Panel questioned the rationale for the Medical Registrar providing the out-of-hour cross cover of predominantly surgical patients, recognising that the Medical Registrar would have management responsibilities as well. The Panel acknowledged that this would be a huge task for an individual.

The Panel sought to clarify whether specialist opinions (such as cardiology, respiratory, etc) would be accessible for inpatients on a day-to-day basis, and how this would be provided.

The Panel probed for details on the process for how a cardiac arrest patient would be managed, who would be responsible for arranging patient transfer and transport to Bristol Royal Infirmary, and for providing airway management at Western General Hospital.

The Panel probed how physicians providing In-Reach Services would provide these services: whether these would be job planned sessions or whether the physician would go to see the patients on the ward at the end of a clinic.

[7] https://www.healthylondon.org/specialist-ae-mental-health-support-around-clock-24-7/

Paediatrics pathway

The Panel noted that the existing paediatrics pathway seemed to be established and asked how long it had been running.

The Panel noted that the business case states that there would be paediatric nurses available in ED between 10:00hrs – 22:00hrs, however since the ED opens at 08:00hrs, the Panel questioned how the nursing cover would be provided between 08:00 -10:00hrs.

The Panel questioned how paediatric arrivals would be managed at the weekends and bank holidays, given that the Seashore Centre (which is a unit at Weston General Hospital for children aged between 0- 16 years) opens Monday – Friday and is closed on Bank Holidays.

The Panel sought to clarify the stabilisation and transfer policy for critically ill paediatric patients and questioned whether the skill sets and specialist equipment required to provide this care, would present a challenge, especially in a hospital that is unlikely to do any paediatric surgery.

The Panel sought clarification on how overdosing paediatric patient who does not require medical treatment would be dealt with. The Panel questioned whether paediatric patients with mental health needs would have access to liaison psychiatry services and if yes, what the age range for paediatric patients.

6.2.3 Patient Transfers

The Panel explored the in-house transfer team and the transfer model with the BNSSG team and questioned the 80% efficiency target set out in the business case, which the Panel felt is ambitious. To this end, the Panel suggested testing the tolerance of the efficiency against the redundancy in the existing model.

The Panel questioned the drop-off point for transferred patients and whether they would be admitted direct onto a ward or whether via A&E.

The Panel noted that the business case states that there will be between 5 -8 Intra- Facility Transfers (IFTs) per day however, it is not clear which of these will be undertaken by the in-house transfer team vis-à-vis South Western Ambulance Service NHS Foundation Trust (SWAST). In addition, the business case needs to clarify the acuity of calls that will be dealt with by each service – whether urgent, blue light, or non-blue light.

The Panel commented that it would be helpful to include within the business case the trajectory for future growth in demand, the financial modelling of the impact of the service, to future proof the service.

6.2.4 The Emergency Department

The Panel observed that there has been a fundamental shift in terms of the proposed model for the provision of emergency medicine since the Healthy Weston Phase 1 proposals. The

business case describes the Emergency Department (ED) as being appropriately staffed with Emergency Medicine (EM) Consultants or a team supported by senior decision-makers, with arrangements for out-of-hours on-call. The Panel felt that these plans are aspirational. The caveat in this model and critical to its success is the ability to recruit to these vacant posts and to provide the required overnight cover.

The Panel asked the team to confirm that during the ED opening hours, there will be clinical staff with the appropriate scope of practice to adequately manage presentations and specifically, the undifferentiated presentations. (This applies to Option 2 in the proposals).

The Panel noted that a key decision is whether the patient is likely to require admission. In this option, fewer clinical staff are required in Acute Monitoring Unit, but the same number of practitioners are being described in the Front Door. The Panel questioned whether this model would be attractive enough for staff to want to work there and whether this would be a risk. (This applies to Option 1 in the proposals).

The Panel noted there is a national drive for paramedics to take patients to Same Day Emergency Care (SDEC) instead of ED and questioned whether this potentially significant reduction in patients arriving at Weston General Hospital ED, would make this a less attractive offer in terms of recruitment.

6.2.5 Hospital at Night

The Panel sought clarification about "Hospital at Night" and asked the team to describe the service, the staffing model, and highlight any differences between the current and proposed model.

Healthy Weston Phase 2: Clinical Staffing Model: Hospital at Night

(Supplementary information associated with draft PCBC Chapter 6)

Overview of medical cover (all grades)

- A consultant from the acute medicine or Care of the Elderly team is on call 1:16 for medical inpatients **ON CALL non-resident** (acute physician on site until 2100)
- A consultant from the ED is on call 1:12 for ED/ observation unit **ON CALL non-resident** (on site until midnight)
- Consultant general surgeon on 24hour on call to cover surgical emergencies 1:8 **ON CALL non-resident** (on site until 8pm)
- Consultant orthopaedic surgeon on 24hr on call to cover orthopaedic emergencies 1:8 **ON CALL non-resident** (on site until 8pm)
- ITU consultant on call **ON CALL non-resident** (on site until 2200 weekday/ 2000 weekend)
- An ED middle grade is **on site overnight** to cover the front door, observation/ acute monitoring unit and referred overnight patients (with support from the HAN team)
- A medical middle grade from the COTE team is **on site overnight** as part of Hospital at Night response (can support ED/ surgery for acute medical problems if required)

- A surgical registrar is **on site until midnight** and from midnight surgical consultant covers from home
- An orthopaedic registrar is **on site 24/7** (overnight on call from residences on the campus)
- 2 SHO level doctors are **on site overnight** as part of Hospital at Night for the ward cover from medicine (and can support front door as required)
- An SHO for surgery and an SHO for orthopaedics are also **on site overnight** working as part of the hospital at night team
- On site team is based out of ED, the ED MG must remain in ED, other team members to flex as needed
- Airway trained Dr working out of ITU **24/7 on site**

The Panel noted that the business case states that the ED Middle Grade is covering the Acute Monitoring Unit but is expected to remain in ED and questioned whether these are co-located.

The Panel observed that the proposals appear to have used 'acute monitoring unit' and 'acute medical unit' interchangeably to refer to "AMU" and sought clarification from the BNSSG team, suggesting for clarity, there should be consistency within the PCBC, as to the terminology, and that it is set out what the acronym refers to and what this means.

6.2.6 Staffing Model – Medical

The Panel probed the team to find out more about the 4- 6 acute roles in the model, as these roles could be critical to the pathways that the hospital can sustain. The Panel sought to understand what the thinking has been around this. The panel questioned whether these roles are peripatetic or dedicated to Weston General Hospital, recognising that there are merits in either option, in terms of skills retention, and flexibility e.g. the Panel acknowledged the positive feedback about the community elements of the Geriatric Emergency Medicine Service (GEMS) model, however it recognised that this pathway is dependent on the strength of relationships, questioned how these relationships could be maintained if staff working within this Service are peripatetic or whether a mixed economy of both types of staff would be utilised.

The Panel questioned the team to find out the implications for the development of the Phase 2 working, where staff on existing contracts are not obliged to work across the sites, and whether this is envisaged to be a short-term or long-term issue.

The Panel sought clarification about the Medical Registrar post, in terms of the number of staff that would work in this post, their specialty, and whether they would have accreditation and membership with MRCP. The Panel was interested in understanding how many would contribute to the rota, to fulfil both daytime and night-time working.

The Panel asked the BNSSG team to reflect on whether there was a risk in other areas regarding the staffing models.

6.2.7 Complex Surgery

There is a move to expand services in general surgery at Weston General Hospital and the Panel probed to find out the types and complexity of operations that will be undertaken in the new model.

Having a clear understanding of what is 'complex surgery' is important however, the Panel acknowledge that there isn't a narrow definition as a surgical procedure can be deemed complex for several reasons. This includes the length of operation, the competence of the surgeon, and the available support for the operation. The Panel suggested that the focus should be on risk assessment and risk stratification, to identify and mitigate risks.

The Panel probed into the out-of-hours overnight care and questioned the level of resilience within the Intensive Therapy Unit (ITU) and the High Dependency Unit (HDU) and whether it is sufficient, to allow the further development of the service. This is significant because the business case sets out an aspiration to utilise capacity at Weston General Hospital and if this results in significant complexity changes, it will require certain aspects within the proposal, to be revisited.

6.2.8 Diagnostics

The business case sets out the 24/7 provision of computerised tomography (CT) scanning. The Panel sought further detail on this Service and enquired about the number of CT scanners available, the average number of CT scans overnight, resilience built-in so that CT scans will continue to be produced even if one of the scanners breaks down, and the on-call arrangements (whether the CT radiographers are resident or travel into the Hospital when on-call). The Panel also asked whether the out-of-hours CT reporting is outsourced.

The Panel sought detail on the availability of ultrasound scanning and magnetic resonance imaging (MRI) scanning.

The Panel enquired whether there is a shared picture archiving and communication system (PACS) within the Trust that would allow the images to be moved around the hospital and accessed easily.

The Panel questioned to what extent the service is currently integrated with the service in Bristol and how this might change in the future.

The Panel questioned how a patient presenting out of hours with suspected Cauda Equina Syndrome, would be managed on the pathway.

The Panel questioned whether there are formal arrangements in place, for situations where a patient needs to be transferred to another hospital. This would avoid delays caused by ad-hoc negotiations that would be required if there wasn't an arrangement in place.

The Panel noted the desire to increase breast services and probed the level of resilience within the radiology service. In addition, the Panel questioned if there was anything within the proposed model for Healthy Weston Phase 2, that was of concern more generally, for the radiology service.

The Panel questioned the impact of the proposals on the future requirement for the diagnostic pathway and whether plans had been developed to address this.

6.2.9 Cancer Services

The Panel observed that the proposals do not articulate activities around cancer care which could be a missed opportunity and questioned how the proposals aim to deliver the cancer diagnosis pathways and whether support is extended to the whole Trust to achieve compliance with the cancer standards. There is the potential to develop a green[8] ringfenced elective surgical unit supported with capital investment. This could be a way to support the System to meet the cancer waiting times standards[9].

The Panel highlighted that if chemotherapy will be delivered on-site, the proposals will need to describe acute oncology and what happens to neutropenic patients.

6.2.10 Stating the preferred option

The proposals include two different options for service configuration. The Panel asked whether there was a preferred option. The BNSSG team responded that whilst there had not yet been a formal evaluation process, Option 2 was emerging as the preferred option. They cited a few reasons:

- It will better serve the needs of the local population as it provides greater access for patients of Weston being treated at Weston
- It does not impact health inequality as compared to other options that have been described in terms of patient travel
- The ability to recruit to a model that will support the Front Door offer.
- Support from Medical Directors, and colleagues across the System from primary care and secondary care.

6.2.11 Modelling and Testing assumptions

The Panel has had full visibility of how the clinical assumptions were derived. The panel accepted these as reasonable with the caveats that these are based on 2019 data with no trajectory, and there is an assumption around the reduction of length of stay via disposition

[8] COVID-free areas of the hospital
[9] Guide to NHS waiting times in England - NHS (www.nhs.uk)

into care and community services which may be challenging due to the pressure in these services.

The Panel noted that if the modelling describes "bed displacement" rather than bed closure, this presents a challenge in that there will need to be an argument made for what the beds will be used for. If the plan is to use this for elective surgery, this could result in a case mix that will need a change to the workforce on site.

The Panel questioned to what extent the clinical assumptions had been shared and accepted by other Systems and Commissioners. The Panel went on further to probe the timescale by which System Partners would be able to accept the volume of patients as described in the business case. Where this was dependent on capital projects, the Panel asked the Systems for an indication of the timescale for delivery.

The Panel noted that the business case stated that the Same Day Emergency Care capacity is 5 days a week however, the staffing modelling is 7 days a week and questioned whether the modelling is based on the Same Day Emergency Care capacity going forward, as the benchmarking data is different.

7 Conclusion

The Panel acknowledged that there has been a significant amount of work undertaken by BNSSG to develop the proposals for Health Weston Phase 2 to articulate the case for change and as part of the Clinical Review process. This enabled the Panel to get a better understanding of the current and proposed clinical models.

The proposals provided two options – Option 1 and Option 2. The Panel assessed both options and concluded that it can give NHS England assurance on **Option 2**, subject to several provisos and observations which are presented in this report.

The Panel questions why Option 1 was considered a viable option, given that it would ultimately lead to diminishing skills in the workforce as a result of not seeing presentations, and this would make Weston General Hospital less attractive to the prospective workforce, and the challenges that this option would create for System Partners.

Finally, the Panel suggested that the team could reflect on what worked in terms of how they communicated their proposals to the Panel during this review process. The lessons learned could help to shape future communication with the public.

7.1 Next Steps

The summary recommendations were shared verbally with BNSSG CCG at the end of the panel meeting for them to start work immediately to address the recommendations of the Panel before public consultation.

7.2 Reporting Arrangements

The Clinical Review Panel team will report to the Clinical Senate Council which will sign off the final report and be accountable for the advice contained therein. The report will be shared with BNSSG CCG and NHS England Assurance Team. BNSSG CCG 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.

8 Appendices

8.1 The BNSSG CCG Presenting Team

Name	Role
Teresa Allain	Consultant for Care of the Elderly
Emily Bowen	Consultant for Care of the Elderly
Naomi Chalk	Physiotherapist Lead for the Weston Site
David Crossley	Consultant in Anaesthetics
Dermot Dowds	Consultant in Emergency Medicine
Anne Frampton	Consultant in Emergency Medicine and Deputy MD
Mark Gonion	Deputy Chief Nurse
Kevin Haggerty	General Practitioner, Weston Area
John Heather	General Practitioner
Will Hicks	Consultant Radiologist
Andrew Hollowood	Medical Director, Weston Hospital Site
Tracy Jolly	SWASFT Clinical Lead – BNSSG
Daniel Meron	MD Somerset FT
Rachael Morris	Associate Specialist in Emergency Medicine and Clinical Lead for the GEMS service
Koye Odutola	Consultant Trauma and Orthopaedic Surgeon and Clinical Director
Holly Paris	General Practitioner
Annabel Plaister	Public Representative and UHBW Governor
Paul Reavley	Consultant in Emergency Medicine
Ian Shaw	Clinical Lead for Gastroenterology, Gloucestershire Hospitals FT (invited contributor)
Paul Sylvester	Consultant Colorectal and General Surgeon and Clinical Director
Matthew Thomas	Consultant in Intensive Care and Clinical Lead
Stuart Walker	MD UHBW

Tim Whittlestone	MD NBT
Rebecca Dunn,	Deputy Director of Transformation, BNSSG CCG

8.2 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	Job Title & Organisation
Chair	Sally Pearson	Clinical Chair, South West Clinical Senate
General surgery	Mr Mukhtar Ahmad	Consultant Colorectal Surgeon, University Hospitals Dorset NHS FT
Community Nursing	Dr Marion Andrews-Evans	Executive Nurse, Gloucestershire CCG
Psychiatry	Dr Martin Ansell	Consultant Old Age Psychiatrist & Deputy Medical Director - Operations, 2gether NHS FT
Nursing	Sandra Burns	NHS CHC Nurse Assessor, NHS Glos CCG
General surgery	Mrs Katie Cross	Consultant Colorectal Surgeon, Northern Devon Healthcare Trust
Accident and Emergency	Dr Leilah Dare	EM Consultant, Southmead Hospital, Bristol, NHSE Regional Clinical Advisor EM (East)
Frailty services	Dr Sara Evans	Consultant Geriatrician, Lead for Medical Education, Research & Development, and medical workforce, Royal United Hospitals Bath NHS Foundation Trust
General medicine	Professor David Halpin	Consultant Physician & Honorary Professor of Respiratory Medicine, Royal Devon and Exeter Hospital
Critical Care	Dr Shondipon Laha	Consultant in Critical Care Medicine and Anaesthesia, Lancashire Teaching Hospitals NHS Foundation Trust & Honorary Clinical Professor, Faculty of Health and Care and Lancashire Applied Research Collaboration Hub, University of Central Lancashire
Trauma and orthopaedics	Mr Benedict (Ben) Lankester	Consultant Trauma and Orthopaedic Surgeon, Yeovil District Hospital
Bio-medical science	Anthea Patterson	Consultant Clinical Scientist, Royal Cornwall Hospitals NHS Trust
Patient Representative	Nick Pennell	Chair, South West Clinical Senate Citizens' Assembly
Radiology	Dr Giles Maskell	Consultant Radiologist, Royal Cornwall Hospitals NHS Trust
Cancer services	Mr John Renninson	Clinical Director – Pennisula Cancer Alliance
Ambulance Services	Mr Alex Sharp	Senior Clinical Lead – Dorset, South Western Ambulance Service NHS Foundation Trust

General practice	Dr Alison Tavare	GP, Clinical Lead, NHS@Home South West
Critical Care	Dr Sam Waddy	Consultant in Intensive Care Medicine, University Hospitals Plymouth NHS Trust
Management Support	Fiona Baldwin	Assistant Director, Clinical Programmes/ Networks
Management Support	Ajike Alli-Ameh	Head of Senate, South West Clinical Senate

Review panel biographies are available upon request. COIs were declared.

The following appendices are available by email upon request from ajike.alliameh@nhs.net

8.3 Clinical Review Panel Agenda

8.4 Pre-Consultation Business Case

8.5 Desktop Review Report

8.6 KLOEs

8.7 CCG Slides

8.8 Terms of Reference for Clinical Review Panel