NHS
South West
Clinical Senate

Gloucestershire ICS Service Reconfiguration: Fit for The Future Programme Phase 2
Clinical Review Panel Report
10 August 2022

1. Chair's Introduction

This report has been produced by the South West Clinical Senate for Gloucestershire Integrated care board (ICB) and provides recommendations following a Clinical Review Panel that convened on 10 August 2022 to review Gloucestershire ICB's proposals for service reconfiguration across the Gloucestershire Royal Hospital (GRH) and Cheltenham General Hospital (CGH) sites.

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. The Clinical 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 3 conditions around alternative provision, treatment, and bed usage.

The advice within this report is given dispassionately by external clinicians from the perspective of developing the best services for the population given current resources and supporting the development of clinically sound service models. This report sets out the methodology and conclusions of the review and is presented to Gloucestershire ICB with the offer of continued support.

2. Background

Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT) currently operates from two main hospital sites, Cheltenham General Hospital (CGH) and Gloucestershire Royal Hospital (GRH), 8 miles apart. The 'Centres of Excellence' element of the wider Fit for the Future

Programme focuses on developing CGH as a centre for planned care and GRH as a centre for emergency care. The vision is for a single hospital on two sites, linked by the A40 corridor.

3. The Clinical 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.

Gloucestershire ICB (and previously Clinical Commissioning Group (CCG)) has been engaging with the South West Clinical Senate since 2020 regarding its Fit for the Future Programme. In 2020, the Clinical Senate undertook a Clinical Review of Gloucestershire CCG Fit For the Future Phase 1 which included centralisation of the acute medical take and centralisation of emergency general surgery to the GRH site, development of an image-guided interventional surgery hub, Trauma & Orthopaedics, Upper GI surgery, and Gastroenterology. The proposals included maintaining an Emergency Department at Cheltenham General Hospital with MIU provision overnight, i.e. no change. The panel concluded that it broadly supported the CCG's proposals for the split of services across the centres of excellence, subject to some observations and provisos and Gloucestershire are now implementing these proposals.

In November 2021, the Clinical Senate was asked to review Gloucestershire's Fit for the Future Phase 2. A timeline for Desktop and Clinical Reviews was finalised and agreed on 21 March 2022. A Clinical Review Panel was convened to consider Gloucestershire ICB's proposals for service reconfiguration as part of its Centres of Excellence work under the Fit for the Future Programme. This was undertaken to inform the NHS England assurance process against tests 3 and 5, before approval to go to public consultation.

The Senate's Clinical Review Panel reviewed the final Pre-Consultation Business Case (PCBC) and other materials (Appendix 8.2) provided by Gloucestershire ICB, ahead of the Panel meeting. The Panel gave feedback on the PCBC and other materials, in the form of comments and additional key lines of enquiry (KLOEs).

At the pre-Panel meeting, the Head of the Clinical Senate, and the Review Chair (Vice Chair of the South West Clinical Senate) met with the Programme Director, Gloucestershire ICB, to present the additional key lines of enquiry (KLOEs) that would be used to guide discussions at the Clinical Review Panel meeting. These were supported by the generic KLOEs (Appendix 8.4) for clinical review processes developed from a national guidance document on conducting Clinical Senate reviews.

The Clinical Review Panel meeting provided the opportunity for the ICS clinical team to present its proposals and for the panel to ask questions and raise concerns. The agenda can be found in (Appendix 8.1). The major key themes explored during the meeting are listed in Appendix 8.7

4. Gloucestershire ICB's Proposal

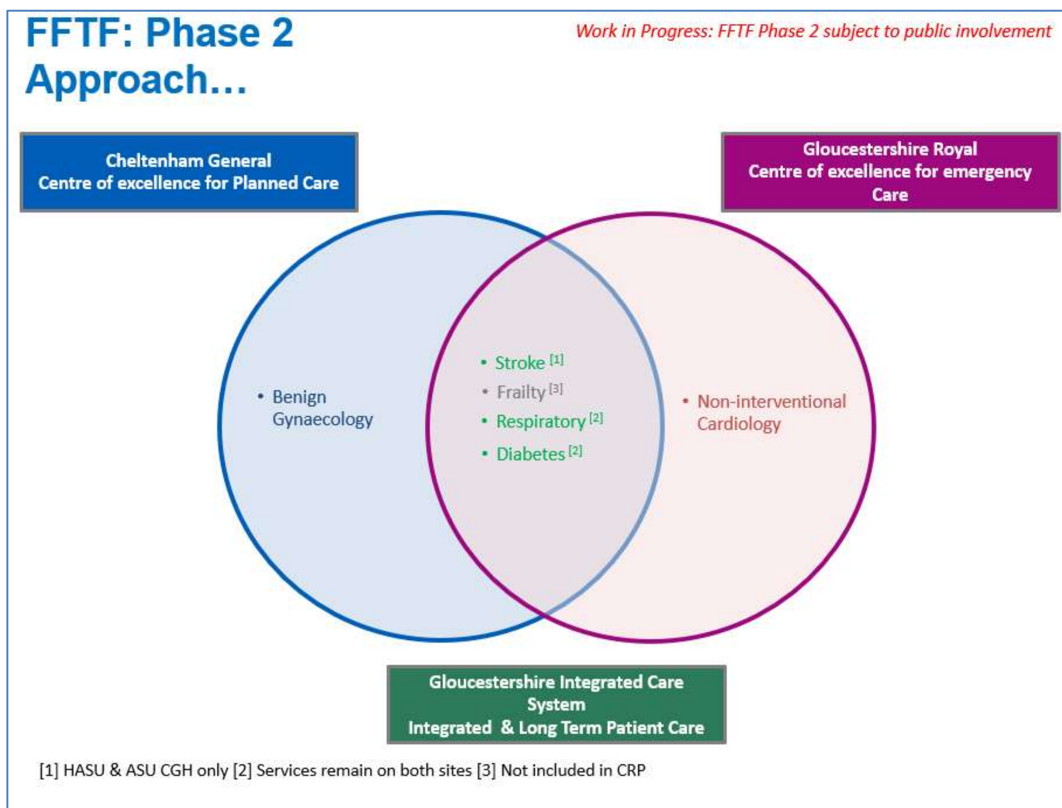
Gloucestershire FFTF Programme - Phase 2 seeks to improve the wider care pathways for patients, whether at home, at the GP surgery, or via support in the community.

The services under review in Phase 2 are predominantly inpatient:

- Diabetes
- Frailty/Care of The Elderly**
- Respiratory
- Stroke
- Non-interventional Cardiology
- Benign Gynaecology (Day Cases only)

**The initial proposals included Frailty/ Care of the Elderly pathway, however, following the Desktop Review process, a decision was made by the ICB to stand down the review of the proposals for Frailty/ Care of the Elderly at the Clinical Review Panel stage.

The Venn diagram below represents how the services listed above align with Gloucestershire's Centres of Excellence strategy, and in some cases, cover the wider journey of care



5. Clinical Review Panel Conclusions

The Panel assessed the proposals and concluded that there are no major concerns with any of the service changes proposed. The Clinical Review Panel (“The Panel”) concluded that it could offer assurance that the proposed clinical models presented are ready to proceed to public consultation, with the following provisos and observations:

General

- The Panel observed that the proposals would deliver some clear benefits for patients, had good clinical leadership, that they had been well thought through and appraised, and that there were clear plans for implementation.

- The Panel did not have any concerns about the proposals from an access, equality or diversity perspective.
- Some of the proposed service changes were introduced as temporary measures as part of the response to the COVID pandemic and the Trust has had the opportunity to learn from this.
- Some of the proposed service changes have impacts outside the services included in the scope and these have been considered alongside the specific proposals.
- The panel was reassured that the Trust has ensured that all specialities providing specialty medical consultation services at CGH have included this work in Consultant job planning. The panel believes that it is essential that this continues in the future.

Stroke

- Whilst most stroke services are co-located with the acute medical take, the Panel believed that the proposals would deliver clear benefits for stroke patients but that there are also some possible disbenefits including for those presenting to GRH who will need to be transferred to CGH for management and rehabilitation, and may experience delays in their early management.
- Integration of the ASU and HASU on the same site at CGH in purpose-built accommodation is advantageous for both patients and staff.
- "Direct to CT" pathways will save valuable time in assessing and managing people with a stroke brought to hospital by ambulance.
- It would be preferable for stroke mimic patients to be cared for at GRH under other acute medicine pathways, instead of in the Stroke Unit at CGH, but this may not always be possible, and bed and workforce planning must allow for the continuing management of stroke mimics at CGH.
- The Panel observed that the imaging support at CGH is currently unable to identify late presenting patients who may be suitable for thrombectomy using CT Perfusion Imaging in line with NICE Guidance NG128 and the national optimal stroke imaging pathway. The Panel recommended that this is addressed as soon as possible.

Respiratory

- The Panel believed that the proposals would deliver clear benefits for respiratory patients.
- The panel believed that the development of a Respiratory High Care Unit (RHCU) is an important advance that would have benefits for patients and is likely to have a positive impact on workforce recruitment and development. However, the panel did not think the development of this unit would have the proposed impact on future critical care bed requirement as many patients are currently receiving respiratory support on the respiratory wards.
- The Panel agreed that the proposals resulted in good training opportunities for respiratory registrars working at CGH during the daytime.

Diabetes & Endocrinology

- The panel agreed that the rationalisation of the diabetes and endocrine in-patient service to a unit at GRH was advantageous.
- The Panel agreed that the move would strengthen links with vascular surgery, renal medicine and maternity services and that this would be advantageous for people with diabetes.
- The Panel was reassured that there will be sufficient specialist input available at CGH for the management of in-patients there with diabetes or other endocrine conditions.

Non-interventional Cardiology

- The panel agreed that the move of non-interventional cardiology in-patient services to the same site as the interventional service (i.e. at GRH) was advantageous.
- The Panel noted that routine echocardiograms performed by physiologists are not available at weekends at either GRH or CGH. They were reassured that when clinically necessary, echocardiograms can be performed by an on-call consultant cardiologist; however, recognising that the provision of echocardiograms is essential to an acute cardiology service and to other service such as critical care and stroke, the Panel recommends that, if possible, steps are taken to address this issue.

Benign Gynaecology

- The Panel supported the proposals for benign gynaecology services.
- The Panel noted that in many Trusts Advanced Nurse Practitioners and Nurse Consultants now carry out much of the ambulatory care in gynaecology, including hysteroscopy, cystoscopy, and colposcopy and recommended that Gloucestershire explores these working practices to assist with capacity and workforce issues.

Impact of Proposed Service Changes on Other Services

Out of hours medical services and care of the deteriorating patient at CGH

- The panel considered the impact of the service changes on the out of hours care for medical patients at CGH. The out of hours medical staffing and the configuration of the Acute Care Response Team are not affected by the current proposals. Out of hours, the medical registrar will provide advice on medical issues arising at CGH and for respiratory, cardiology and diabetic problems can seek advice from an on-call consultant. The Panel recommended that the registrar must also have adequate access to senior specialist medical advice for stroke patients (not just about decisions about thrombolysis). The Panel also recommended that there must be robust arrangements for handover at the start and end of shifts. The Trust should ensure that all medical trainees, particularly the registrars, have regular supervision from a consultant regarding the out of hours work at CGH that allows and encourages them to highlight any issues or concerns regarding this work and training.

- The Panel was of the opinion that although the move of medical take to GRH will reduce the need for medical review of patients at CGH overnight, there will still need to be adequate expertise available on site 24/7 to review walk-in medical patients arriving at CGH Emergency Department (ED) as well as inpatients awaiting transfer to GRH (when there is a delay in transfer) or the Same Day Emergency Care (SDEC) pathways at CGH. The Panel recommended that current proposals should consider the impact of this workload on the out of hours medical staffing and the Acute Care Response Team workload as well as the impact on bed capacity at CGH.

- The Panel recommends that the Trust should undertake regular reviews to ensure that out of hours staffing levels are adequate.

- The Panel recommended that Trust should identify other Trusts where similar out of hours cover has been developed (e.g. University Hospitals Bristol and Weston NHS Foundation Trust) and learn from their experience.

Intensive Therapy Unit/ Critical Care/ High Dependency Unit

- The Panel noted that no changes to critical care services at CGH are contained in the current proposals and that critical care outreach remains adequate.

- The Panel considered the operating procedures for the transfer of patients requiring a medical escort from CGH to GRH or to Bristol and were satisfied that these were adequate.

Impact on Emergency Departments

- The commitment to maintain the current ED services provision at CGH was understood by the Panel; however, it is important to note that a previous Review Panel supported a reconfiguration of Emergency care pathways in Gloucestershire which included a single site Emergency Department. It is recommended that work is continued to develop the best possible health and care services, that deliver the optimal patient outcomes, whilst ensuring alignment with emerging clinical models and reducing health inequalities.

- The Panel noted that no changes to ED services at CGH or GRH are contained in the current proposals.

- The ICB must work urgently with South Western Ambulance Service NHS Foundation Trust (SWAST) to develop protocols to ensure patients are conveyed to the ED or direct access pathways at the most appropriate hospital.

- The proposals will have an impact on walk-in patients presenting to the ED at CGH with medical problems. Some of these patients will be managed by Same Day

Emergency Care (SDEC) services at CGH, but some will require transfer to GRH. From the evidence presented, the Panel was reassured that during the temporary changes to address the COVID pandemic there had not been any significant compromise of clinical care.

- The Panel noted that an increasing number of patients are opting to 'walk in' rather than wait for an ambulance, and some of these patients could choose to go to CGH. This could potentially result in a higher number of patient transfers to GRH than has been predicted, and if there are no available beds at GRH, this could adversely affect patient flow and could result in delays to treatment. The Trust should take this into account in their modelling of bed numbers and transfer requirements

- The Panel highlighted the importance of completing all patient transfers out of the Emergency Department at CGH each night before the Department closes, to avoid a back-up of patients in the Emergency Department and an adverse effect on patient management and flow. They recommended that the Trust develops contingency plans to address situations when it has not been possible to move all patients out of the ED.

- The Panel recommended that the Trust monitors the time taken and impact of transferring patients in both directions between sites when clinically necessary. The Panel recommended that the expected patient flows between the hospitals should be modelled and included in the proposals.

- The Panel recommended that there should be a programme in place to review all inpatient transfers so that learning is captured, to help minimise the number of avoidable transfers.

- The Panel recommended that the ICB should develop a communications strategy that informs patients about the location of specialist medical services such as cardiology and stroke and encourages patients to present to the most appropriate hospital (see below)

- The Panel noted that over time the proposals will have an impact on the training opportunities at Cheltenham ED and recommended that this, as well as the most appropriate use of clinical staff, was considered in a long-term strategy to ensure that Trust continues to offer services that deliver optimal patient outcomes, are aligned with emerging clinical models and reduce health inequalities.

Patient Transfers

- The Trust has commissioned a patient transfer service for patients needing transfer between hospitals. The Panel recommended that there should be central coordination of this service to ensure that journeys in both directions are used optimally and that empty return journeys are minimised.

Communication and Engagement

- The Panel recommended that the benefits that have been observed during temporary changes in response to the pandemic (e.g. direct and timely access to specialist care) should be communicated via simple and clear messaging to patients and the public.

- The Panel recommended that clear messaging should be developed to set out when and where services will be available, and the best ways to access the required services.

- The Panel recommended that communication channels should not be limited to digital channels or English language, so that these messages reach all patients and the public.

- The Panel recommended that ICB should identify other Trusts where similar communication has been necessary (e.g. University Hospitals Bristol and Weston NHS Foundation Trust) and learn from their experience.

- The panel recommended that the Trust publicise the availability of the inter-hospital bus service, which the Panel commended.

Workforce

- The Panel was impressed by the work undertaken to develop non-medical roles to support services, however, it observed that this seemed to focus mainly on the development of the nursing workforce.

- The Panel considered it likely that medical consultant shortages will continue for the foreseeable future and recommended that activity is undertaken to develop non-medical consultants, and advanced practitioners including therapy roles and apprenticeship roles at degree and master's levels, and this should be consolidated within a Workforce Development Plan across the Trust rather than for each of the individual services.

- The Panel considered it likely that medical consultant shortages in stroke would continue for the foreseeable future and recommend that the development of non-medical consultant(s) with responsibility for the rehabilitation part of the stroke inpatient bed base at CGH should be pursued as soon as practicable.

Training

- The Panel noted that the move of in-patient specialty medical services to GRH may have positive and potentially negative effects on the training opportunities for medical staff and recommended that this is discussed urgently with the Deanery to minimise any disruption to the medical staffing numbers.

Risk

- The Panel recommended that in addition to the broad clinical risk that is articulated in the documentation, the breakdown of specialty-specific risk analysis (including risk mitigation) should also be included. As part of this, consideration must be given to the risks associated with patients being at the ‘wrong’ hospital for their specialist care needs.

Governance

- The Panel was generally reassured about the proposed governance arrangements but recommended that there should be tracking of any problems or issues that arise from the changes, to ensure that minimum harm is done, and learning is captured,

The Bed Test

- The Panel noted that details of the bed numbers in the PCBC were split according to specialty needs and did not appear to take account of medical patients who did not need a bed in specific specialty ward.

- The Panel observed that the bed modelling for respiratory medicine and cardiology services appear to be based on an "uncontaminated" bed base. The Panel sought clarification as the bed modelling needs to include general medicine patients who will not be identified via specialty care pathways.

- The Panel noted that there was a reference in the documentation to a change in the number of beds at GRH and CGH for medically optimised for discharge (MOFD) patients. The Panel advised that if this was a proposed change, it would need to be formally reviewed so that it can be assured as part of the bed test. The panel was told that there were no current plans to change the location or number of beds for MOFD patients. The panel therefore recommended that the bed numbers should be removed from these current proposals

- The panel recommended that further details on the following issues should be included in the business case before the Panel could assess whether or not there were problems regarding the Bed test.

  - The impact of a 24/7 PCI service

  - The arrangements for general medicine patients, the impact on bed numbers for each specialty and the total number of medical beds required.

6. Next Steps

The provisional summary recommendations were shared verbally with the ICS management team on 10 August 2022. These recommendations will be shared with the Clinical Review Panel for comment and sign-off before going to the Senate Council to agree on a final report and be accountable for the advice contained therein. A draft version of the report was shared with the ICB for the sole purpose of fact-checking.

The final report was be shared with the ICB and NHS England Assurance Team.

Gloucestershire ICB 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.

7. Panel Membership

Clinical Review Panel members

Panel Role	Name	Title
Review Chair	David Halpin	Vice-Chair, South West Clinical Senate and Review Chair Consultant Respiratory Physician
Accident and Emergency representative	Leilah Dare	Emergency Medicine Consultant
Accident and Emergency representative	Emma Redfern	Assistant Director, NHS England
General Practice	Mary Backhouse	GP
Intensivist	Nick Kennedy	Consultant Anaesthetist and Intensivist
Stroke Physician	Martin James	Consultant Stroke Physician
Stroke Physician	Graham Venables	Clinical Networks Clinical Director, NHS England Yorkshire & the Humber
Cardiologist	Mark Sopher	Consultant Cardiologist , GIRFT Clinical Ambassador, SW region
Diabetes Consultant	Parag Singhal	Consultant Endocrinologist
Gynaecologist	David Richmond	SW GIRFT Ambassador and NCIP National Lead for Gynaecology

Secondary Care Specialist Nurse	Caroline Smith	Consultant Nurse for Stroke Yeovil District Hospital Programme Manager (CVD, Respiratory, Diabetes & Long COVID) Clinical Delivery and Networks NHS England – South West
Therapy (OT/ PT)	Michael McGibben	Clinical Lead Physiotherapist
Ambulance Services	Alex Sharp	Senior Clinical Lead - Dorset
Patient/ citizen representative	Peter Buttle	Vice Chair, Citizens' Assembly
Patient/ citizen representative	Nick Pennell	Chair, Citizens' Assembly
Managerial Lead	Ajike Alli-Ameh	Head of South West Clinical Senate

Gloucestershire ICS Team Contributors

Specialty	First Name	Surname	Job title
Cardiology	Rafe	Chamberlain-Webber	Consultant Cardiologist
Critical Care	Alex	D'Agapeyeff	Interim Director of Safety & Medical Director/ Consultant in Anaesthesia and Intensive Care
Critical Care	David	Windsor	Consultant in Intensive Care and Anaesthesia
Diabetes & Endocrinology	Tom	Millard	Specialty Director, Dermatology/ Endocrinology/ Diabetes/Rheumatology/ MDU
Executive Team	Mark	Pietroni	Interim CEO / Director for Safety & Medical Director
Executive Team	Simon	Lanceley	Director of Strategy & Transformation
Executive Team	Ellen	Rule	FFTF Programme Executive Lead and Deputy CEO/Director of Strategy & Transformation, NHS Gloucestershire

Gynaecology	Mark	James	Consultant Obstetrician & Gynaecologist
Nursing	Gavin	Hitchman	Divisional Director of Quality & Nursing, Medicine Division
Patient, Public Voice	Jenny	Hepworth	Patient representative
Respiratory	Charlie	Sharp	Consultant Respiratory Medicine
Stroke	Dipankar	Dutta	Consultant Stroke Physician
Managerial Lead	Micky	Griffith	Programme Director FFTF

8. **Appendices** (see comment)

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Prepared: Ajike Alli-Ameh, Head of South West Clinical Senate

Signed off: Professor David Halpin, Vice- Chair of South West Clinical Senate