South West Clinical Senate

Stage 2 Clinical Review Report

Bristol, North Somerset and South Gloucestershire Stroke Reconfiguration Proposal

04 March 2021

Final

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

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

Date	Version	Comment
11/02/2021	Final Draft	
04/03/2021	Final	Minor amendments . "STP" replaced with "ICS".

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) Integrated Care Systems (ICS) and provides recommendations following a Clinical Review Panel (CRP) that convened on 27 January 2021 to review the BNSSG Stroke Programme proposals for the reconfiguration of stroke services under the governance of the Healthier Together Acute Care Collaboration.

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 prior to going ahead to public consultation, which in this case is planned for June 2021. 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 ICS Team for their organisation and open discussion during the review.

The clinical advice within this report is given by clinicians with a shared commitment to the ICS in developing the best services 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 ICS 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 BNSSG Stroke Programme's proposals to reconfigure stroke services. These proposals will enable residents across the BNSSG geographical footprint to have access to the same high-quality services, thereby giving everyone the same opportunity of the best health outcome that they can achieve. These proposals were developed, following a period of public engagement and a comprehensive process, into a proposed model of care for consideration which was in line with the National Guidance and new draft National Stroke Service Specification.

1.2.1 Currently

In the BNSSG ICS geographical area, suspected strokes are taken to any one of the three acute hospitals as there is currently no designated Hyper Acute Stroke Unit (HASU).

Stroke services vary depending on where people live in BNSSG and are not organised in a way that is responsive to the needs of the population. The current service configuration restricts access to specialist treatments available for stroke at Southmead Hospital and provides inconsistent rehabilitation support across BNSSG.

In addition, outcomes for people that have a stroke in BNSSG vary depending on where they receive treatment. The Sentinel Stroke National Audit Programme (SSNAP) grades the care provided by hospitals and healthcare systems. The hospitals in BNSSG have overall SSNAP scores of between B (Southmead Hospital) and D (Weston Hospital). In other areas, best practice has been achieved by reconfiguring to a more centralised service provision.

1.2.2 The proposed model

The proposed model has been developed by a partnership of clinicians, people with lived experience and other health and social care staff from across BNSSG health system.

The clinically led process used evaluation criteria developed (as part of the BNSSG Healthy Weston Programme) and tailored these to the BNSSG Stroke Programme. These criteria were used to shortlist two options of models of care between December 2019 - February 2020. The two options centralise the hyper acute care for stroke patients at Southmead Hospital which will have a "hyper acute stroke unit" (HASU). (See Figure 1 below)

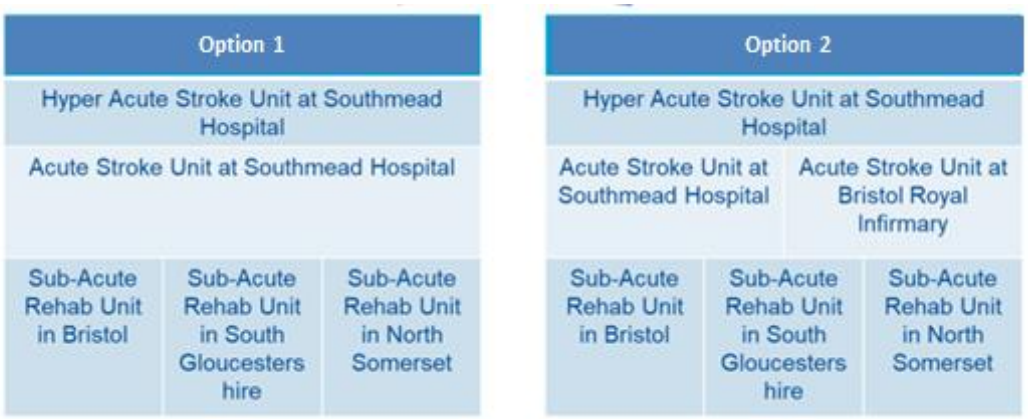


Figure 1. Initial options for reconfiguration of stroke care

Option 1
This model of care would have a centralised hyper acute stroke unit (HASU) and acute stroke unit (ASU) at Southmead Hospital. Stroke patients at Weston General Hospital and the BRI would be transferred to Southmead Hospital for either hyper acute or acute care. A specialist workforce will be provided onsite at Bristol Royal Infirmary (BRI) to support patients whose specialist needs mean, they are unable to transfer to Southmead HASU or ASU.

Option 2
This model of care would maintain the centralised HASU at Southmead Hospital with two ASUs, one at Southmead Hospital and the other at BRI. The BRI ASU would also support patients with specialist needs that can only be provided at the BRI site. Stroke patients from Weston General Hospital and the BRI would be transferred to Southmead Hospital for hyper acute care. Once the hyper acute care episode is completed, the patients from the BRI and Weston Hospital catchment areas would "step down" to the ASU at the BRI.

A transformational aspect of this model is the proposed Integrated Community Stroke Service (ICSS) which brings together community, elements of social care and the voluntary sector as one community-based system to support people after a stroke. It will enable patients to move swiftly through immediate and acute treatment, and to have all their rehabilitation needs (that don't require inpatient care) met at home or as close to home as possible in a sub-acute rehabilitation unit (SARU). To this end, a couple of variations were proposed to the models of care.

- Under Variation A, it is proposed that there are three SARUs. One in each local authority area: Weston Hospital, South Bristol Community Hospital and, an adapted Care Home in South Gloucestershire ahead of Frenchay Community Hospital development.

- Under Variation B, it is proposed that there will be two SARUs, the location of these to be determined considering existing/planned NHS estate and the greatest population need. (See Figure 2 below)

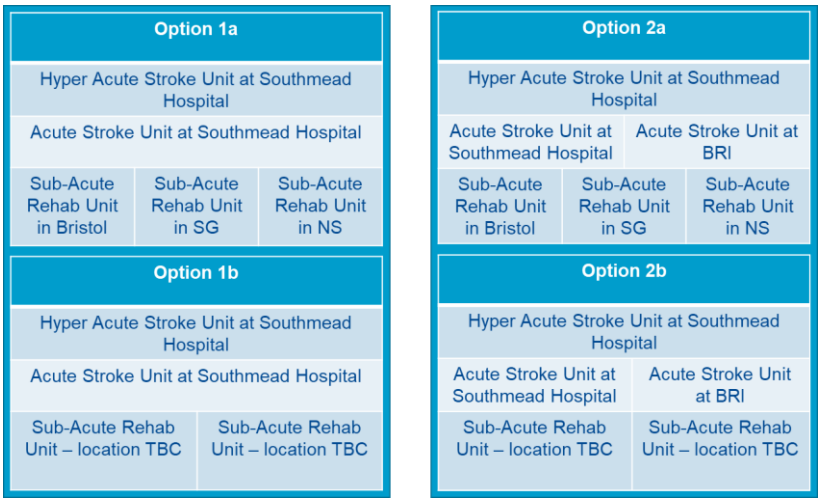


Figure 2: Options for reconfiguration of stroke care including variations

Under this proposed new model for stroke care in BNSSG, all patients could reach the Southmead Hospital HASU by ambulance within 45 minutes. Here they can access lifesaving and life changing specialist treatment for stroke. It should be noted that a small number of patients (estimated at less than one per week) from the south of the BNSSG area would be taken to Taunton as their nearest receiving A&E and stroke service.

1.2.3 Panel Recommendations

Overall, the BNSSG proposals for stroke care were considered broadly well thought through, well presented and motivated by a clearly articulated case for change. The Clinical Review Panel (CRP) concluded that it could offer assurance that the proposed clinical models presented are supported by a clinical evidence base and are ready to proceed to public consultation, with the following provisos and observations:

- The business case should confirm the preferred clinical option and the rationale for this. Based on the evidence presented to them and utilising the criteria of reducing the number of transfers in a pathway, the feasibility of staffing and cost effectiveness the panel concluded that the preferred clinical option would be 1b.

- The business case should include more details on the workforce models anticipated and how the risks in the models will be mitigated. In particular:

    - The level of organisational support for the single stroke workforce

    - The maintenance of competence in thrombolysis units away from the main stroke centre

- Inclusion of more information on the integrated community stroke service (current service and what is proposed for the future) would help develop confidence in the ability to shorten length of stay and reduce the demand for bed-based care

- There should be a clearer consideration of the impact of these proposals on the demand for imaging and the extent to which any increase in capacity required has been included in the workforce and financial plans

- Flow through the pathway relies on robust and timely repatriation arrangements which are not clearly articulated in the case at present

- The case would benefit from a strengthened section on staff engagement that not only describes how staff have been engaged but how the proposals have been modified to reflect what has been learnt and to be explicit about those elements of the proposals where there may be differing clinical perspectives.

- The system should consider building in at an early stage robust evaluation from a user perspective, working in partnership with others, as appropriate.

- The capacity and demand modelling included in the PCBC is sophisticated but is focused on the impact on flow through the stroke pathway in isolation. There should be more work done to:

- demonstrate that the impact on other pathways (particularly emergency presentations) have been adequately modelled

- test the impact of predictable risks in the pathway including increased presentations, lack of available beds, staff shortages and delayed repatriations

- demonstrate the impact of changes in demand arising from demographic changes or service developments (e.g. thrombectomy)

In respect of the bed test, the business case is informed by robust capacity and demand modelling. The model utilised has been peer reviewed and the panel have explored the clinical assumptions on which the model is based and can confirm that these are realistic. The bed numbers included in the case are based on this model. These assumptions however do not currently include any future proofing in terms of changes in demand to reflect demography or service developments

2 Background

The proposals for stroke service reconfiguration that are the subject of this review, form part of the BNSSG Stroke Programme which focuses on healthcare across the Bristol, North Somerset and South Gloucestershire geographical footprint. This is being delivered under the governance of the Healthier Together Acute Care Collaboration.

The Pre- Consultation Business Case that has informed the clinical review focuses specifically on changes required to the model of stroke services currently provided in the BNSSG ICS area across three acute trusts. It also highlights that:

- the provision of stroke services varies depending on where people live in BNSSG. Services are not organised in a way that is responsive to the needs of the population

- Outcomes for people that have a stroke in BNSSG vary depending on where they receive treatment. The Sentinel Stroke National Audit Programme (SSNAP) grades the care provided by all hospitals and healthcare systems. The hospitals in BNSSG have overall SSNAP scores of between B (Southmead Hospital) and D (Weston Hospital). BNSSG is an outlier in comparison to what many health systems achieve for their patients and in many areas this best practice has been achieved by reconfiguring to a more centralised model

The proposals are to agree hyper acute, acute and sub-acute provision for the region and develop an integrated stroke pathway for the whole of BNSSG. The preferred option provides a single centralised HASU based at Southmead Hospital. This is supported by either a single Acute Stroke Unit (ASU) also at the same location OR for two ASUs (where one is at Southmead Hospital and the other at Bristol Royal Infirmary).

These proposals also include the provision of sub-acute rehabilitation beds via either two or three Sub Acute Rehabilitation Units (SARUs). In the former, the location of the SARUs is yet to be determined and in the latter, there will be a SARU in each local authority area.

These proposals are made within the context that there currently is no designated Hyper Acute Stroke Unit (HASU) in BNSSG with suspected strokes taken to any one of three acute hospitals. North Bristol Trust is the regional thrombectomy centre and is also a major trauma centre and the vascular centre for the region. University Hospital Bristol is the cardiac and oncology centre for the region.

It should also be noted that Sirona Care and Health, a community provider, commenced delivering community services across the whole of BNSSG, from April 2020.

3 Senate Engagement to date

BNSSG ICS has been engaging with the South West Clinical Senate since 2017 in regard to the reconfiguration of these services.

In March 2020, the Clinical Senate undertook a desktop review of BNSSG's developing PCBC documentation for the reconfiguration of stroke services. This desktop review was undertaken by a sub-panel of the CRP. (See Appendix 8.5)

The Clinical Senate feedback can be summarised as:

- Robust case for change and model supported by evidence and best practice.
- Model for HASU and co-located ASU at NBT broadly supported at this point.
- Concerns that workforce and recruitment issues will not be easily addressed.
- A preferred option for ASU number and location should be articulated.
- Clarity around rehabilitation provision is required.

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

On the 14 January 2021, BNSSG ICS submitted a suite of documents to the South West Clinical Senate, to be reviewed by the Clinical Review Panel in preparation for the BNSSG Stroke Programme and Clinical Senate Review Panel meeting scheduled on 27 January 2021. These documents included: (i) Stroke Programme PCBC v2.2, (ii) Stroke Programme PCBC v2.2 Appendices, (iii) BNSSG Stroke Programme Summary Document, (iv) BNSSG Stroke Services -Senate Desktop Review Action Plan Checklist 11.0.

On 20 January 2021, 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 Clinical Review Panel). This meeting was held for the Panel to give comments and feedback on the BNSSG Stroke Services Reconfiguration Proposal and identify key areas of enquiry that would be further explored with BNSSG ICS, in addition to

the standard Clinical Senate Key Lines of Enquiry (KLOEs). Panel members who were unable to attend the meeting were invited to submit their comments by the end of the same day.

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 ICS Clinicians in the Clinical Review Panel meeting

1) Patient pathway from presentation to discharge with emphasis on:
    a) the impact that additional presentations of stroke patients to NBT will have on other emergency pathways, with emphasis on the pathways for mimics and strokes
    b) the transfers from HASU to ASU
    c) transfers from ASU to community rehabilitation and early supported discharge and acceptance criteria
2) Clinical Assumptions used in capacity and demand modelling;
    a) their evidence base
    b) the extent to which they have factored in changes in demand in the future including the impact of the proposed mechanical thrombectomy provision
3) The physical space to be allocated for the HASU
4) The clinical benefits and disadvantages of the 2 ASU options, with reference to access for vascular surgery in the 2 ASU model and support for other services at BRI in the one ASU model
5) Workforce
    a) what is meant by a shared workforce and how is it intended this is deployed across the pathway
    b) Impact of these proposals on training of the future workforce and clinical rotations
    c) the extent of clinical support for the proposals within the system
6) Inclusion of a map to show the relative locations of the services in the proposal and the distances between them

Following the meeting, the Clinical Review Panel Chair sent the draft agenda for the Clinical Review Panel meeting and the KLOEs that were identified by the Panel, to BNSSG to give them an opportunity to address these enquiries ahead of the meeting either in a presentation or in additional documentation.

On 26 January, BNSSG provided a Power Point presentation (with audio) and further information to address each of the KLOEs raised by members of the Clinical Review Panel.

BNSSG discussed its proposals for change formally at the CRP meeting held on 27 January 2021. The meeting provided 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 ICS's Stroke Services Reconfiguration Proposal

In BNSSG, a programme to consider the national evidence surrounding best practice and outcomes for stroke care has been running for over three years. In 2019, the BNSSG Stroke Programme under the governance of the Healthier Together Acute Care Collaboration undertook a comprehensive process to review options for change across BNSSG.

5.1.1 Currently

In the BNSSG ICS geographical area, suspected strokes are taken to any one of the three acute hospitals as there is currently no designated Hyper Acute Stroke Unit (HASU).

Stroke services vary depending on where people live in BNSSG as these are not organised in a way that is responsive to the needs of the population. The current service configuration restricts access to specialist treatments available for stroke at Southmead Hospital and provides inconsistent rehabilitation support across BNSSG.

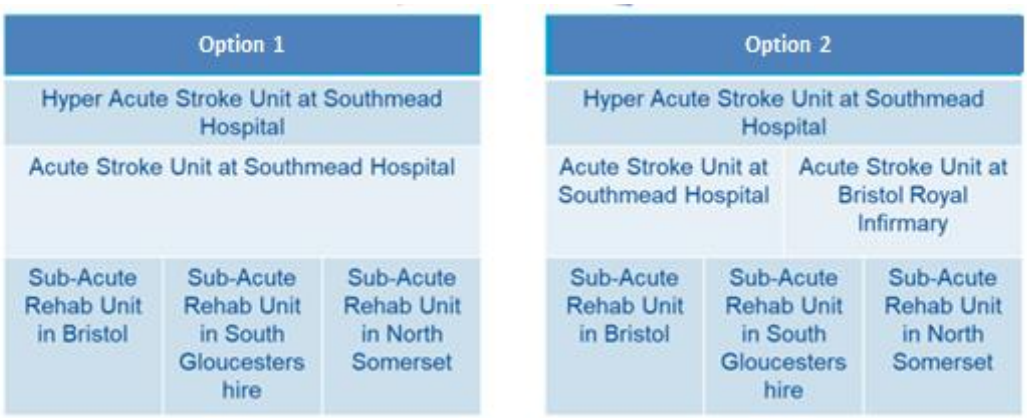
In addition, outcomes for people that have a stroke in BNSSG vary depending on where they receive treatment. The Sentinel Stroke National Audit Programme (SSNAP) grades the care provided by hospitals and healthcare systems. The hospitals in BNSSG have overall SSNAP scores of between B (Southmead Hospital) and D (Weston Hospital). In many areas, best practice has been achieved by reconfiguring to a more centralised service provision.

5.1.2 The proposed model

The proposed model has been developed by a partnership of clinicians, people with lived experience and other health and social care staff from across BNSSG health system.

The clinically led process used evaluation criteria developed (as part of the BNSSG Healthy Weston Programme) and tailored these to the BNSSG Stroke Programme. These criteria were used to shortlist two options of models of care between December 2019 - February 2020.

The two options centralise the hyper acute care for stroke patients at Southmead Hospital which will have a "hyper acute stroke unit" (HASU). (See Figure 1 below)



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A transformational aspect of this model is the proposed Integrated Community Stroke Service (ICSS) which brings together community, social services and the voluntary sector as one community-based system to support people after a stroke. It will enable patients move swiftly through immediate and acute treatment to have longer-term rehabilitation needs to be met at home or as close to home as possible in a sub-acute rehabilitation unit (SARU). To this end, a couple of variations were proposed to the models of care.

- Under Variation A, it is proposed that there are three SARUs. One in each local authority area.

- Under Variation B, it is proposed that there will be two SARUs, the location of these to be determined considering existing/planned NHS estate and the greatest population need. (See Figure 2 below)

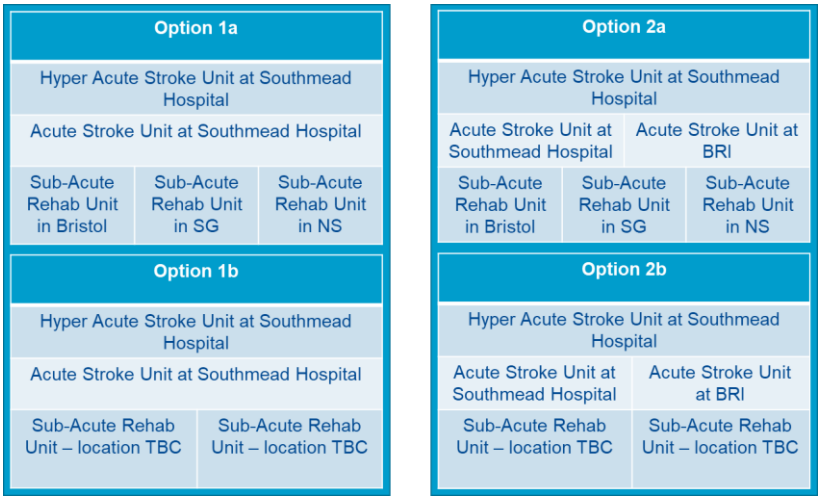

Figure 2: Options for reconfiguration of stroke care including variations

Under this proposed new model for stroke care in BNSSG, all patients could reach the Southmead Hospital HASU by ambulance within 45 minutes. Here they can access lifesaving and life changing specialist treatment for stroke. It should be noted that a small number of patients (estimated at less than one per week) from the south of the BNSSG area would be taken to Taunton as their nearest receiving A&E and stroke service.

6 Panel Discussion and KLOES

6.1 ICS Presentation

On 26 January 2021, in response to the key areas of enquiry received from the Clinical Review Panel and in preparation for the Panel meeting, BNSSG provided a PowerPoint presentation (with audio) and further information to address each of the key areas of enquiry.

The PowerPoint presentation was comprehensive and described how the proposed model sought to determine the preferred option for the local reconfiguration of stroke services that will support improvements in the current service.

6.2 Panel Q&A

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:

Patient pathways from presentation to discharge

The Panel explored with the team how the potential for unforeseen and adverse outcomes on urgent and emergency care would be managed given that emergency departments are currently operating at full / near full capacity: particularly in light of the impacts of potentially greater numbers of stroke and non-stroke patients arriving at NBT, additional patients coming from outside of the catchment area. The Panel also wanted to explore the management of pre-alert calls, how patients would be managed acutely if there wasn't an

immediate access to a high acuity and how would patients be vetted pre-hospital so that only the appropriate patients arrive at the Emergency Department (ED).

Impact on Radiology Services

The Panel explored with the team the impact of increased referrals, and number of patients coming to North Bristol Trust (NBT) on managing increased imaging demand on radiology. They sought clarification as to how this demand will be managed during the daytime and the details of the overnight service provision and, whether any of the additional staffing described in the PCBC will be associated with this aspect of the clinical pathway (such as interventional neuro-radiology posts).

Patient Repatriation

Locating the hyper acute stroke unit on a single site which will have the most developed Thrombectomy Unit in the region, will result in larger numbers of patients attending Southmead Hospital with stroke and non-stroke, from outside of the natural catchment area. This will require repatriation of patients which is often difficult and delayed by transport issues and the lack of available beds in the hospital that the patient is being repatriated to. The Panel sought clarification on how the BNSSG bespoke repatriation pathway would work.

Managing the interface with frail elderly pathway

Some of the people that will come through the system will be frail elderly which creates a potential for ongoing care requirements. The panel were keen to explore with the team how these patients would access the specialist frailty services.

Criteria for pathway acceptance

The Panel questioned the criteria that would be used for pathway acceptance and consistency with the SWAST criteria. In addition, the PCBC mentioned public education around non-FAST symptoms and the panel explored how this would impact on other services such as 111, 999 or GPs.

Use of Technology – Telemedicine

The Panel asked whether consideration had been given to the use of technology (particularly telemedicine) as in areas this had reduced the number of stroke mimics presenting in the pathway. Reference was made to "Implementation of a Prehospital Stroke Triage System using symptom severity and teleconsultation in Stockholm Stroke Triage Study[1]" (Mazya MV, Berglund A, Ahmed N, von Euler M, Holmin S, Laska AC, Mathé JM, Sjöstrand C, Eriksson EE. JAMA Neurol. 2020 Jun 1;77(6):691-699. doi: 10.1001/jamaneurol.2020.0319. PMID: 32250423; PMCID: PMC7136864.)

[1] https://pubmed.ncbi.nlm.nih.gov/32250423/

The clinical benefits and disadvantages of the 2 ASU options, with reference to access for vascular surgery in the 2 ASU model and support for other services at BRI in the one ASU model

The Panel sought to explore the interface between vascular surgery and stroke and TIA services in both options and the level of engagement of the vascular surgical teams across Bristol.

Exploring the interface with cardiology

The Panel explored the interface with other specialties such as cardiology including access to specialist stroke care for cardio- thoracic patients at the BRI and, what the effects of the new model on the cardiology emergency pathway. Finally, the Panel wanted to understand the level of engagement of the cardiology team in developing the options.

Stating the preferred option within the business case

The proposals include four different options for service configuration. The Panel asked whether there was a preferred option and suggested that if there was, the business case should assert which is the preferred option and the rationale for this. Based on the evidence presented to them and utilising the criteria of reducing the number of transfers in a pathway, the feasibility of staffing and cost effectiveness the panel concluded that the preferred clinical option would be 1b.

Workforce

The Panel probed to find out how the workforce would support the proposed models of care. In addition, some of what was presented on workforce during the Panel meeting was not adequately reflected in the PCBC and the Panel it felt would be helpful for the PCBC to be updated to support future discussions.

The Panel noted the ambition of the proposal to have a single agnostic workforce working across three large service provider organisations. This presents an opportunity to make job roles appear more attractive in the job market which is positive. However, this strategy is not without challenges. e.g. whilst it is possible to rotate certain bands, it becomes more difficult to maintain competencies. This could become an issue as more services are brought in. In addition, there will be staff in community-based teams that will not want to work in an acute setting and vice versa. The Panel suggest that this will require significant executive level commitment which is not detailed in the BNSSG Proposals.

The Panel explored the role that training would have to play in future proofing the workforce particularly, for the new roles. The Panel felt that the costings of including training posts should be included within the proposals as this will help with workforce development into the future.

Systematic Evaluation of Patient Views

The Panel noted that the proposal does not include any detail on activity around the evaluation of patient views. There is evidence that patient experience and patient report of outcomes can help improve the quality and safety of service. The Panel suggested that

BNSSG consider undertaking a systematic evaluation. This evaluation could be undertaken in partnership with an independent body such as The Stroke Association or Healthwatch, the latter being explicitly mandated to convey patient voices to Service Commissioners and Providers. The output from the Evaluation should be reflected within the proposals which will serve, to potentially increase public / patient buy-in during public consultation.

Modelling and testing assumptions

The business case is informed by robust capacity and demand modelling. The model utilised has been peer reviewed and the panel explored the clinical assumptions on which the model is based. The inclusion of flex capacity within the modelling was considered to be valuable. The Panel asked questions about how the model will work in circumstances of increased demand due to an aging population, growth in presentation of strokes and growth in thrombectomy activity. Whilst it is acknowledged that there may be a separate business case that is looking more specifically at the development of the thrombectomy service, it is important that these business cases are aligned.

The Panel suggested the proposals include robust forward planning to future proof the model particularly in the context of the Urgent Care pathways (i.e. including number of 999 calls, conveyances to hospital, admissions to acute beds, etc) which creates increased pressure on the system and so consideration will need to be given within the proposal as to how to maintain a separate service without being impacted by the increased activity or impacting on the care that is provided in the rest of the system.

The Panel questioned the team about the reduction in length of stay and whether this is due to system inefficiencies or whether it is due to more of the rehab being delivered at home. The Panel asked if this was the latter, how would the system ensure that patient anxiety is managed to reduce the risk of failed discharge and what are the interfaces with primary care, so that this doesn't result in readmission.

In respect of the bed test, the bed numbers included in the case are derived from the application of the model (See Table 1 below). The model utilised has been peer reviewed and the panel have explored the clinical assumptions on which the model is based and can confirm that these are realistic. These assumptions however do not currently include any future proofing in terms of changes in demand to reflect demography or service developments

Table 1: Stroke inpatient capacity – current state (2018/19) and future state

2018/19 Actual beds used					
	Weston	**NBT**	**UHBW (inc. SBCH)**	**Thornbury & BIRU**	**Total**
Acute	6	31	14		**51**
Rehab	6	27	12	4	**49**

Total	**12**	**58**	**26**	**4**	**100**
Future state beds predicted – Option 1a					
	Weston/ North Somerset	**NBT/South Glous**	**UHBW/ Bristol**		**Total**
Acute		**44**			**44**
Rehab	**12**	**12**	**18**		**42**
Total	**12**	**56**	**18**		**86**
Future state beds predicted – Option 1b					
	Weston/ North Somerset	**NBT/South Glous**	**UHBW/ Bristol**		**Total**
Acute		**44**			**44**
Rehab	**21***		**21***		**42**
Total	**21**	**44**	**21**		**86**
Future state beds predicted – Option 2a					
	Weston/ North Somerset	**NBT/South Glous**	**UHBW/ Bristol**		**Total**
Acute		**36**	**9**		**45**
Rehab	**12**	**12**	**18**		**42**
Total	**12**	**48**	**27**		**87**
Future state beds predicted – Option 2b					
	Weston/ North Somerset	**NBT/South Glous**	**UHBW/ Bristol**		**Total**
Acute		**36**	**9**		**45**
Rehab	**21***		**21***		**42**
Total	**21**	**36**	**30**		**87**

*location yet to be confirmed

(Ref. BNSSG Stroke Programme Pre- Consultation Business Case v2.2)

7 Conclusion

The CRP concluded that the proposed clinical models presented by BNSSG **are supported by clinical evidence and reasonable assumptions relating to the potential for the change in service model to reduce length of stay and reduce bed requirements and therefore are ready to proceed to public consultation.**

Next Steps

The summary recommendations were shared verbally with BNSSG ICS at the end of the panel meeting in order for them to start work immediately to address the recommendations of the Panel prior to consultation.

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 BNSSG ICS and NHS England Assurance Team. BNSSG ICS 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 ICS Presenting Team

Name	**Role**
Phil Clatworthy & Justin Pearson	Stroke Consultant NBT
Claire Holmes & Emma-Kate Reed	Stroke Consultant UHBW & Clinical Chair for Medicine, UHBW
Mike Haley	Stroke Clinical Lead WGH
Julie Packman & Chris Easton	Therapies Lead UHBW
Martin Robinson	Therapies Lead NBT
Phillipa Cozens & Emma Richards	Therapies Lead Sirona
Phil Simons	General Practice Lead
Marcus Bradley	Radiology Consultant, NBT
Joydeep Grover	Emergency Medicine Consultant, NBT
Richard Jeavons	Emergency Medicine Consultant, UHBW
Rhys Hancock	SWASFT

Sue Mallett	Nursing
Helen Southwell & Rebecca Sheehy	Voluntary Sector
Anthony Dorman & Liz Perry	Workforce
Chris Priestman, Claire Angell & Stephen Hill	Lived Experience
Rob Jones	Quality and Improvement
Chris Burton	Programme SRO & Medical Director, NBT
Rebecca Dunn,	Stroke Programme Director & 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**	**Title**
Chair	Sally Pearson	Clinical Chair, South West Clinical Senate
Stroke consultant	Martin James	Clinical Lead, Devon & Cornwall Integrated Stroke Delivery Network (ISDN)
Stroke consultant	Annie Chakrabarti	Norfolk & Norwich University Hospital NHS Foundation Trust
Stroke consultant	Louise Shaw	Stroke Consultant, Royal United Hospital, Bath & Clinical Lead for South West North Integrated Stroke Delivery Network (ISDN)
Stroke nurse consultant	Caroline Smith	Consultant Nurse Stroke & Clin AF lead South West Academic Health Science Network
Care of the Elderly	Mike Jeffreys	Consultant Geriatrician Royal Devon & Exeter NHS Trust & North Devon District Hospital
GP	Ed Ford	GP – Minehead & Somerset, Chair Somerset CCG
Cardiologist	Christopher Gibbs	Lead Cardiologist - Devon
Community Rehab lead	Fiona Robson	Senior PT, Wiltshire Health & Care
Radiology	Richard James	Radiology Consultant, Royal United Hospital, Bath
Patient Rep	Tessa Trappes-Lomax	Citizen Assembly Member/Healthwatch Devon
Patient Rep	Jon McLeavy	Citizen Assembly Member/Healthwatch Cornwall
Neurosurgery	Peter Whitfield	Consultant Neurosurgeon
Interventional neuroradiologist	William Mukonoweshuro	Lead Radiologist, University Hospitals Plymouth NHS Trust
Ambulance service	Alex Sharp	Senior Clinical Lead, SWASFT -Dorset
Vascular Surgery	Neil Hopper	Consultant Vascular Surgeon
Emergency Medicine	Dom Williamson	Emergency Medicine Consultant
Therapies	Ros Wade	Head of Therapy Services

Clinical Delivery & Networks	Michelle Roe	Head of Clinical Programme (CVD, Respiratory & Diabetes)
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 ICS Slides

8.8 Terms of Reference for Clinical Review Panel