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Rebecca Dunn
Healthy Weston Programme Director

Via Email

Dear Rebecca

We had a conversation last week where you asked me to provide feedback on the Healthy Weston Alternative model. I enclose an annotation of Slide 5 with comments. I have made a narrative below of my views on this model. I have kept my comments relating to the A & E aspect of this model. I have not commented on the other areas. These are not my area of expertise. I make these comments in my role as Regional advisor for Emergency Medicine and as a Consultant in Emergency Medicine. I have previously been involved in review of the Healthy Weston proposals as a part of the Southwest Clinical Senate.

My role as Regional advisor is advisory. I work within the Southwest under the National Team led by Dr Cliff Mann. My role is to advise on Emergency Medicine and to promote the national initiatives such as implementation of the Long Term Plan 1. I do this using the GIRFT data, in conjunction with the 6 weekly Sitrep data. With this I can combine my knowledge as an ED Consultant. It is important to detail what I am not. I am not a regulator, nor am I part of ECIST.

I advise Weston General Hospital; the issues facing Weston are compounded by uncertainty about its long term future. More specifically what is going to be the exact nature of the ED? My aim is to contribute to the process to help create clarity over which is the best model for Weston going forward. By doing so Weston will then be in a position to work with that model to make it the best it can be for patients and staff. Until there is certainty it is difficult for Weston ED to address its challenges.

The Temporary overnight Closure (TOC) was put in place as a result of safety concerns and issues relating to the fragility of its staffing model. The alternative model here does not show in what way the approach to staffing is any different from before the TOC. The current staffing at Weston has a 34% vacancy rate at Registrar grade and a 25% vacancy rate at consultant level. This is staffing 16 hours per day. I remain sceptical about how the workforce can be expanded to cover 24 hours a day. This staffing issue is fundamental to the whole proposal.

The staffing model is not explicit about the need for ED trained staff (ED ST4+, Consultant or Experience Specialty Dr) I welcome the use of a hybrid model in general. This fits in with the Nuffield Document on the provision for smaller hospitals [2] . However in this alternative model, to be an Emergency Department it must have appropriately trained Emergency Staff. Substituting ED Staff with other staffing groups is acceptable as long as there is an ED trained clinician present. This is the cornerstone of Emergency Medicine. The public have an expectation that when they present to their ED they will be seen by a clinician who is able to manage their

undifferentiated emergency presentation. Should there not be an Emergency Medicine trained clinician present then the service should be designated a UTC.

The model is confused over whether or not there will be 247 access for Walk ins. It talks about 247 MIU/UTC but simultaneously about 147 walk ins. Any possibility of walk ins 247 is of concern particularly relating to children. Weston does not have 247 paediatric cover, any service providing walk in access must be able to safely manage unwell children. Without paediatric backup this service should be designated a Paediatric minor injuries unit and an Adult only ED. There is still huge risk of an unwell child being bought in when the ED trained staffing is so fragile. This is exacerbated with the high numbers of seasonal holiday makers visiting Weston. They will not have knowledge of what services are provided locally and any branding as an ED misleads them as to the level of paediatric provision present.

The TOC data shows that 4-8 ambulances are redirected per night that would have previously attended Weston. I would question whether the demand capacity model is viable for such few attendances. The staffing vacancy rate is such that to expand it for small numbers is questionable.

The long term plan is explicit about the need to improve and increase the use of SDEC and to provide expanded front door frailty services. Weston is ahead of the game in terms of its provision for frailty. It also already has SDEC services in place. A cornerstone of the 9a proposal is limited hours ED opening with improved access to SDEC and frailty. This seems a much more sensible, pragmatic and workable option to meet the need of the local community in a sustainable way. I feel that this model, should it go ahead would enable Weston to be at the forefront of how to deliver Emergency care in a smaller hospital in a safe and sustainable way.

I would be happy to discuss my comments at any stage.

Yours Sincerely

Leilah Dare

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**The Regional Clinical Advisor role is a joint role across NHS England and NHS Improvement and provides advice to acute providers in the Southwest area**
**www.england.nhs.uk**
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## References

[1]https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/

[2] Rethinking acute medical care in smaller hospitals. Nuffield trust  Vaughan et al..