Question following FFTF KLOE doc review (Feb 2020)	PCBC v3.2 Section Reference	PCBC v3.2 Comments (Aug 2020)
1. It would be most useful for evaluating the proposals if the overall emergent preferred option was put forward and supported by details as to how this option was reached. If this is not possible then further detail modelling the clinical viability of each of the options and the impact they will have on interdependent clinical services should be provided.	Section 9.7	Section 9.7 includes further detail on all 'preferred' elements of the model as well as comparative data on the two remaining clinical configurations to be agreed (vascular surgery and elective colorectal). There is no intention to decide between these two before public consultation.
2. A plan to move the timeline for Acute Medical Take centralisation forward or clinical justification for delaying it for 2 years.	Section 9.8	Timeline provided in section 9.8. The final switch is enabled by the Trust capital programme which delivers capacity in 2023. However, clinical pathway changes can take place in the years leading up to this so that only undifferentiated presentations with no alternative established route into CGH will transfer - there is further detail in 8.3.1.
3. Justification of the decision to retain urgent and emergency care front door services (ED/MIIU) in CGH as currently configured.	Section 8.3.1.2 Section 8.3.2.7	See section 8.3.1.2 which states that a. we think the existing ED staffing model is sustainable and b. we will commence pathway development work in the run up to Phase 1 implementation to enhance our urgent and emergency care offer in CGH. Section 8.3.2.7 (EGS) provides further detail on the standard operating procedures for support to CGH ED and ward reviews, and these are also included as appendices.
4. Details of the Estate plan to describe the anticipated service moves.	Section 9.9	Section 9 provides the overall timeline, which is enabled by capital allocations as part of our estates strategy. These are referenced in Section 11 but detail is not provided at this stage due to separate assurance processes.
5. Proposals for neurology and their evaluation of options.		Neurology is no longer part of this PCBC
6. Details of the impact of the proposals on stroke services and the relationship with neurology services.		Neurology is no longer part of this PCBC
7. Details of numbers of beds for each service affected by the proposed changes.	Section 9.2.4	Section 9.2.4 details bed capacity mitigations and the specific requirements are details in Sections 9.3.5.2, 9.4.5.2, 9.5.5.2 & 9.6.5.2
8. How proposed changes are expected to affect workforce and recruitment and risk assessment and mitigation if this cannot be achieved.	Section 9.2.3	Generic workforce impact is detailed in section 9.2.3. and separaely for each model in Sections 9.3.4, 9.4.4., 9.5.4 & 9.6.4
9. The overall workforce proposals lack detail with no workforce strategy or modelling included. Given the workforce challenges are described as significant, this information is key to understanding the clinical viability of the models and in particular cross-site surgical cover resilience. Information around both the potential opportunities and challenges resulting from the changes for workforce would be helpful. It should also be evidenced that core services can be covered before pulling back more specialist work eg. interventional cardiology from Bristol.	Section 9.2.3	Generic workforce impact is detailed in section 9.2.3. and separately for each model in Sections 9.3.4, 9.4.4., 9.5.4 & 9.6.4
10. Details of out of hours medical cover on each site for each of the services.	Section 9.2.3.7 Appendix 31	Detailed in section 9.2.3. , separately for each model in Sections 9.3.4.2, 9.4.4.2, 9.5.4.2 & 9.6.4.2 and in a separate appendix
11. Contingency plans if nursing staff from CGH do not want to move.	Section 9.2.3	Our approach to staff enagagement is detailed in Section 9.2.3
12. Modelling of the potential impact of changes at CGH on junior doctor supervision, training & rotas, and the accreditation of these posts. Engagement with deanery regarding the full scope of the proposed changes would be helpful to demonstrate given the reference on p8 to concerns with surgical trainees.	Section 9.2.3.8 Appendix 31	Full details are provided in Section 9.2.3.8 and in a separate appendix
13. Details of the impact of service moves on provision of and requirement for therapy services (physio & OT).	Section 9.2.3.8	Generic impact is detailed in section 9.2.3.8 and separately for each model in Sections 9.3.5.5, 9.4.5.5, 9.5.5.5 & 9.6.5.5
14. Detail to demonstrate that the level of ITU staffing on both sites will be sustainable. Will the ITU consultant cover surgical and medical CT/TG with any sick patient at CGH?	Section 9.2.5	Generic impact is detailed in section 9.2.5 and separately for each model in Sections 9.3.5.3, 9.4.5.3, 9.5.5.3 & 9.6.5.3
15. Detail to demonstrate that the overnight/weekend staffing of the ED and ED /MIU is sustainable.	Appendix 31	There are no plans to change staffing in ED but details are included in Appendix 31
16. Training needs assessment for move to more minimally invasive procedures and timescale.	9.3.4.2 9.5.4.2	See section 9.3.4.2
17. Workforce plans for out of hours IGIS service and rota cross cover.		See answer to Q 16
18. Staffing of the deteriorating patient team at CGH and the availability of critical care staff at all levels to support.	Section 9.2.3.7 Appendix 31	Detailed in section 9.2.3. , separately for each model in Sections 9.3.4.2, 9.4.4.2, 9.5.4.2 & 9.6.4.2 and in a separate appendix
19. There is very little in regard to Nursing or AHPs. Being able to train and focus on specialism would not only improve outcomes and safety but also should have some positives HR affect such as improved retention and recruitment.	Section 9.2.3	Generic workforce Impact is detailed in Section 9.2.3 and separately for each model in Sections 9.3.4, 9.4.4, 9.5.4 7 & 9.6.4
20. Assurance that a Consultant surgeon from GRH travelling to CGH for an out of hours emergency with support staff needed for opening a theatre available is a viable option when necessary and that this can be staffed.	Section 8.3.2.7, 9.2.3.7	SOPs are provided in Appendices and section 9.2.3.7 details Medical Staffing –Out of Hours
21. Plans for weekend consultant ward reviews of surgical patients at CGH.	Section 8.3.2.7, 9.2.3.7	SOPs are provided in Appendices and section 9.2.3.7 details Medical Staffing –Out of Hours
22. A move of colorectal services is dependent on urgent endoscopy provision. How will the UGI bleed rota be managed? If gastroenterology is at CGH, is the UGI bleed rota/urgent endoscopy provision at CGH? What is the provision for an acute GI bleed when attending GRH on the acute medical take?	Section 8.3.2 8.3.5	See section 8.3.2 (EGS) and 8.3.5 (gastroenterology) - provision of county-wide oncall rota will remain unchanged with attendance to either hospital overnight as required. Emergency endoscopy capacity will continue to be available on both sites.

23. How will IBD acute patients at GRH be managed if colorectal and gastro consultants are at CGH?	Section 8.3.2 Section 8.3.5	See section 8.3.2.6 (EGS) and 8.3.5 (Gastro). Gastroenterologist of the Day in GRH provides 7 day a week cover. EGS cover will be based 24/7 in GRH but there will be arrangements in place for colorectal cover of ward patients in CGH.
24. For gallstones, is there an UGI cons on-call every day to assess the acute admission? What about day-case patients who end up staying in with difficult gallbladders?	Section 8.3.2	Details in EGS section.
25. How will colorectal and upper GI cover at be managed at weekends if EGS is at GRH and/or elective colorectal is at CGH? Is there consultant buy-in for increased elective weekend working?	Section 8.3.2, 9.2.3.7 Appendix 31	There remains variation in consultant opinion
26. Will there be vascular consultant on-call cover over weekends and how will acute vascular cases such as ruptured AAAs be managed, including any transfers?	Section 8.3.8, 9.2.3.7 Appendix 31	Section 8.3.8. There is and will be consultant on call covering all sites but if Vascular is in CGH all emergencies will need to be transferred there regardless of where they present. The only exception are where they cannot travel further due to instability.
27. Page 19 of the document shows vascular on both sites.		PCBC shows correct configurations.
28. Modelling the number, impact, management and risk of the patients presenting to CGH ED who need acute admission. This should include modelling ambulance transfers to GRH to include current numbers versus anticipated. Diagram 9.2 (future patient pathway) implies that all patients will be coming through the single front door in the ED.	Section 8.3.1.1	This is included in our activity and bed modelling numbers. SWASFT ambulance modelling delayed due to Covid-19 response.
29. More details around proposed repatriation of patients in future, what cases/from where.	Section 8.3.8, 9.2.2.1	Further information provided on type and volume of cases
30. More consideration of the potential negative impacts of solutions A3, B2 in Appendix 3, and actions to mitigate these.	Section 8.3.1 Section 8.3.8.6 Section 10.1.1 Section 10.3.4	This appendix reflected a status in February that is more up to date in the PCBC main narrative.
31. Assurance that SWAST have been involved in planning and can cope with inter-hospital transfers of sick patients. The work between Weston Hospital and SWAST may be useful.		SWAST have been and are involved, but pending their own modelling we have not yet defined the impact on them. Modelling delayed due to Covid-19 response.
32. Details on how services and beds will be accommodated on the 2 sites (e.g. Appx 3 p56 section 3.6 says "Some displacement of existing services will be required to establish a sufficient footprint for an IGIS hub at GRH (incl. associated daycase beds), relocation of the hybrid theatre and relocation of the vascular bed base to GRH. Further implementation planning required if this is a shortlisted solution" and Appx 3 p72 section 5.4 and p93 section 5.4 "Ward and theatre capacity would be required – plan for this not yet developed").	Section 9.2.4	Section 9.2.4 details bed capacity mitigations and the specific requirements are detailed in Sections 9.3.5.2, 9.4.5.2, 9.5.5.2 & 9.6.5.2
33. The travel impact assessment provided shows only the estimates of the impact at peak driving time. The additional impact assessments (off-peak, for staff and most importantly for patients using public transport) must be included in the PCBC.	Section 9.2.2	Section 9.2. gives generic information of travel, in peak and off peak for patients, carers and staff and the specific impact for each model are detailed in Sections 9.3.3, 9.4.3, 9.5.3 & 9.6.3
34. Clarification around phasing and what phase 3 looks like to understand the steps and order of changes towards delivering the overall vision. This will also help determine any other impacts on key stakeholders such as primary care, ambulance service, social care etc.	Section 9.8	