Healthy Weston Pre-Consultation Business Case

Appendix 1:

Healthy Weston Programme Governance

TERMS OF REFERENCE FOR STEERING GROUP AND WORKING GROUPS

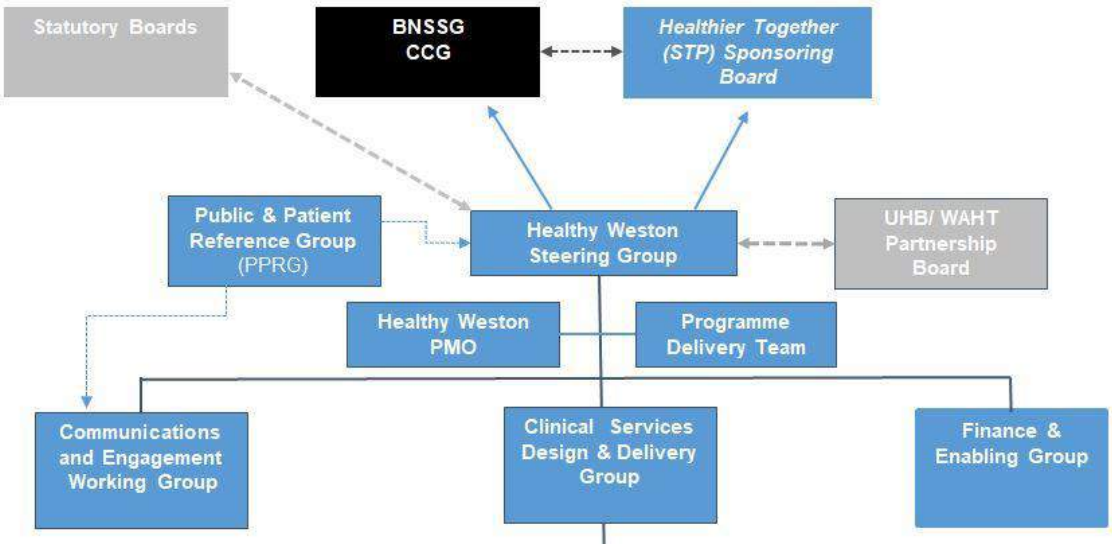
HEALTHY WESTON PROGRAMME

HEALTHY WESTON STEERING GROUP

Terms of Reference

The Healthy Weston Programme

The Healthy Weston Programme has been established to address the longstanding challenges associated with the provision of clinically and financially sustainable health services that can best meet the needs of people living in the Weston and Worle Locality.



1. Role and Responsibilities of the Steering Group

The **Healthy Weston Steering Group** will be responsible for setting the direction of the Healthy Weston Programme. It will ensure the Programme Delivery arrangements are progressing the priorities, plans and programme delivery in line with the overarching plan agreed by the Steering Group.

The Steering Group will have a direct relationship with the BNSSG Clinical Commissioning Group; which is the statutory body with decision making responsibility for the pre-consultation business case. It will also have a direct relationship with the Healthier Together Sponsoring Board, which provides STP assurance to the Health Weston Programme to assure delivery and alignment with other STP programmes, and with North Somerset Council through the North Somerset Partnership Board. It will also ensure effective links are maintained with Somerset CCG and other relevant stakeholders e.g. Healthwatch North Somerset. The Steering Group will also manage the relationship with regulators, specifically NHS England and NHS Improvement and take a lead role through the assurance process.

While recognising the individual statutory responsibilities of the organisations represented, the Steering Group will work collectively to ensure that the working groups are progressing agreed areas of work and that there is effective alignment across the scope of the Programme and in the context of the wider STP.

The Steering Group will oversee the detailed analysis and documentation for the production of the Pre-Consultation Business Case.

Specifically the Steering Group will:

1) Provide a mechanism to hold partners to account for progress against the Programme plan and priorities;

2) Provide advice and recommendations to the CCG Governing Body and STP Sponsoring Board to ensure system ownership of the PCBC and effective decision.

3) Ensure that regulators are effectively informed and engaged to support necessary assurance and oversight.

4) Maintain oversight of the Programme Risk Register to ensure that risks and issues are being effectively managed;

5) Ensure effective interfaces are established and maintained to ensure the Healthy Weston Programme is fully aligned with other key STP and BNSSG Programmes, including the UHB/WAHT Partnership Board.

6) Ensure strong stakeholder engagement in the Programme such that there can be confidence in the ability to progress service changes identified;

a) Membership

The Healthy Weston Steering Group will comprise a core membership as follows:

Bristol, North Somerset and South Gloucestershire CCG (BNSSG CCG)	Chief Executive (Chair)
Weston Area Health Trust (WAHT)	Chief Executive
North Somerset Community Partnership (NSCP)	Chief Executive
University Hospitals Bristol NHS Foundation Trust (UHB)	Chief Executive
North Bristol NHS Trust (NBT)	Chief Executive
Weston & Worle GP Provider Locality	Lead GP
South Western Ambulance Services NHS Trust.**	Chief Executive (or representative)
Somerset Clinical Commissioning Group **	Chief Executive (or representative)
Avon and Wiltshire Partnership NHS Trust **	Chief Executive
Taunton and Somerset NHS Trust **	Chief Executive (represented by CCG)
Healthy Weston Programme	Programme Director CSDDG Chair CSDDG Deputy Chair
In attendance	
North Somerset Council	Local Authority Chief Executive
Healthy Weston Programme	Finance and Enabling Chair and Comms Lead

*Where it is not possible to personally attend a steering group meeting, a sufficiently senior level may deputise.

Other system partners, and representatives from NHS England and Somerset will be invited as required, and will be appropriately represented in the Programme Sub Structure. (** formally invited as full members September 2018)

b) Quoracy

The Steering Group will be quorate if representatives of sufficient seniority from of the CCG, UHB, WAHT and two other organisations.

c) Frequency of meetings

The Steering Group shall meet each month, with the potential for the Chair to call additional meetings by agreement with the membership.

d) Reporting

Formal reporting, minutes and an action log will be produced and submitted to the STP Sponsorship Board and circulated to constituent organisations.

e) Secretariat

The secretariat to the Board will be provided by the Healthy Weston Programme Management Team.

HEALTHY WESTON PROGRAMME

HEALTHY WESTON CLINICAL SERVICES DESIGN AND DELIVERY GROUP

Terms of Reference

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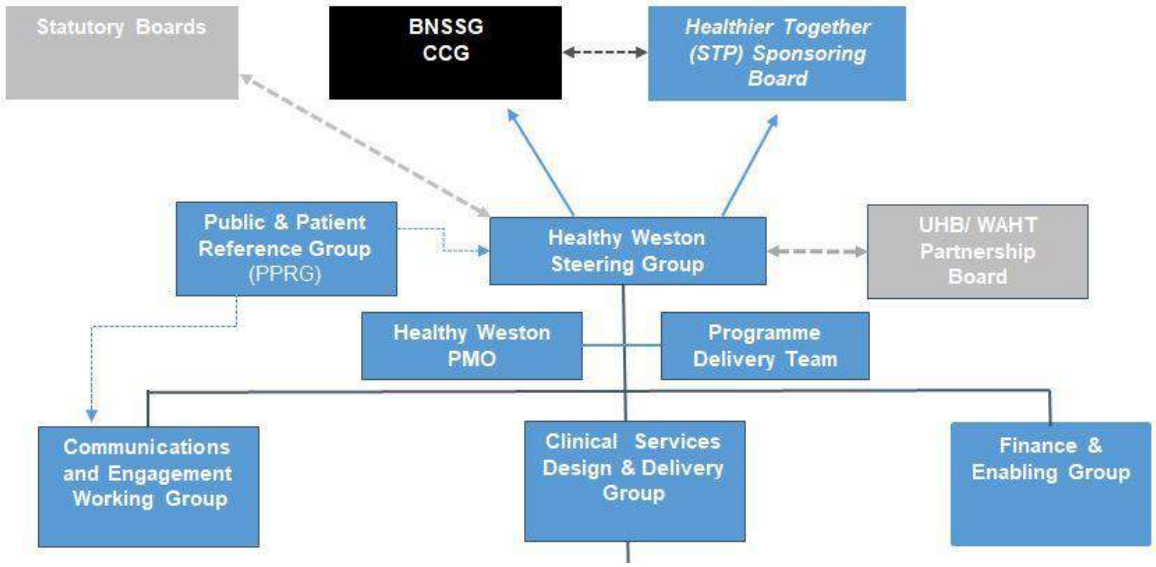

1. Role and Responsibilities of the Clinical Services Design and Delivery Group

The **Clinical Services Design and Delivery Group** will provide strong clinical leadership to support the design, development and delivery of sustainable clinical services best able to meet the needs of the population of Weston and Worle. The CSD&DG will lead the development of options for service change that will be set out within a pre-consultation business case and provide oversight of agreed service developments being progressed as part of the Healthy Weston programme.

Specifically, the Clinical Services Design and Delivery Group will:

1. Work to develop the options for clinically and financially sustainable services that will support the development of the pre-consultation business case for sustainable services at Weston General Hospital.

2. Oversee the design, development and implementation of new service models that support the aims and ambitions of Healthy Weston ensuring consistency across any clinical working groups, maintaining a whole system perspective;

2. Membership

The Healthy Weston Clinical Design and Delivery Group will comprise a core membership as follows:

	Representative *
BNSSG CCG	Medical Director (Chair) Locality Commissioning GP Lead
Weston Area Health Trust	Medical Director (Vice Chair)
UHB NHSFT	Medical Director (or representative)
NBT NHST	Medical Director (or representative)
AWP NHST	Medical Director (or representative)
T&S NHS Trust	Medical Director (or representative)
SWAST	TBC
North Somerset Community Partnership	Director of Nursing and Therapies
North Somerset Council	Head of Adult Social Care
Weston & Worle Locality Lead Woodspring Locality Lead	Lead GP Lead GP
Healthy Weston Programme	Programme Director Chair of Finance and Enabling Group
Clinical Leads	Vulnerable Groups Children Frailty Urgent Care
Management Leads	Vulnerable Groups Children Frailty Urgent Care

*Organisations will be represented at a sufficiently senior level to enable the Clinical Design and Delivery Group to discharge its functions.

The Group will also have the ability to secure the independent clinical input as required.

3. Frequency of meetings

The Clinical Group shall meet each month, with the potential for the Chair or Vice-Chair to call additional meetings by agreement with the membership.

4. Reporting

Formal report, minutes and an action log will be produced and submitted to the Healthy Weston Steering Group through the Chair.

5. Secretariat

The secretariat to the Group will be provided by the Healthy Weston Programme Management Team.

HEALTHY WESTON PROGRAMME

HEALTHY WESTON FINANCE AND ENABLING GROUP

Terms of Reference

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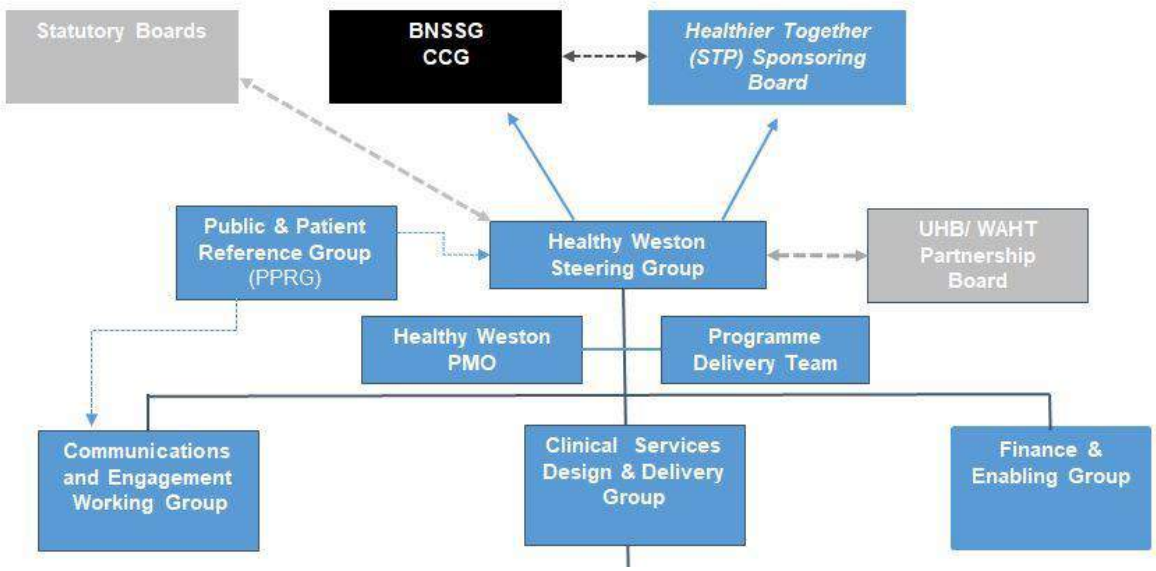

1. Role and Responsibilities of the Finance and Enabling Group

The Finance and Enabling Group will provide expert oversight of the modelling (financial, activity and workforce) to drive the development of business plans and commissioning frameworks. The Group will also maintain oversight of key enabling workstreams such as estates and IT required to support the clinical models developed through the programme.

Specifically, the Finance and Enabling Group will:

1) Provide expert financial and technical advice to clinical project groups to support the development of business cases and plans, ensuring common assumptions are being made.
2) Ensure that activity information informs clinical pathway design and underpins all financial assumptions.
3) Maintain oversight of the information technology requirements to support new models of care;
4) Maintain oversight of the estates implications relating to supporting the new models of care
5) Have responsibility for oversight of any capital requirements to support the Programme

2. Membership

The responsibilities of the Healthy Weston Finance and Enabling Group will be discharged through the Healthier Together STP Directors of Finance Group with short life groups being convened with the relevant resourcing to deliver each piece of work.

	Representative *
Healthy Weston Programme	Healthy Weston Finance Lead
BNSSG CCG	Director of Finance
Weston Area Health Trust	Director of Finance
North Somerset Community Partnership	Director of Finance
University Hospitals Bristol NHSFT	Director of Finance
North Bristol NHS Trust	Director of Finance

*Organisations will be represented at a sufficiently senior level to enable the Group to discharge its functions.

Links with Somerset CCG and Taunton and Devon NHS Foundation Trust will be maintained by the Healthy Weston Finance Lead.

3. Frequency of meetings

The STP DoFs meet fortnightly and it is expected that Healthy Weston will be a standing item at each meeting.

4. Reporting

Formal reports and an action log will be produced and submitted to the Healthy Weston Steering Group through the Chair

HEALTHY WESTON PROGRAMME

HEALTHY WESTON COMMUNICATIONS AND ENGAGEMENT GROUP

Terms of Reference

The Healthy Weston Programme

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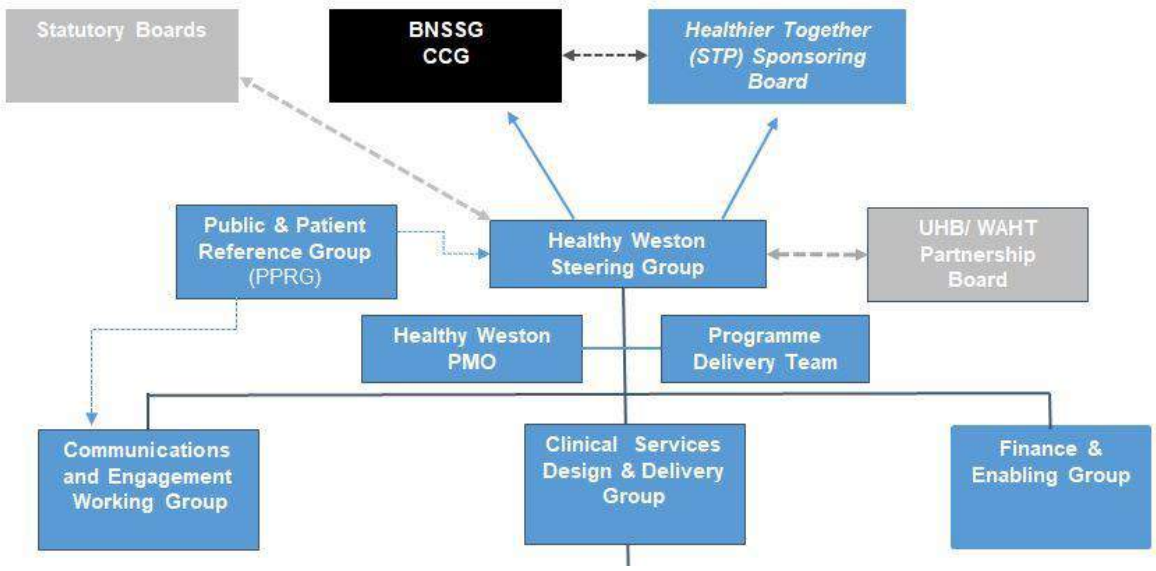

1. Role and Responsibilities of the Communications and Engagement Group

The Communications and Engagement Group will provide expert oversight of the communications and engagement activity required to support the Healthy Weston Programme, recognising the commitment to co-design and community engagement. Specifically, the Communications and Engagement Group will:

1) Developing and maintaining a comprehensive communications and engagement plan;

2) Ensuring mechanisms are in place for two-way engagement and communication with stakeholders, including clinical colleagues, service users and carers and the public;

3) Provide expert support to clinical project teams to ensure effective engagement and communication to support co-design as needed, including support for equality impact assessment;

4) Provide advice and support in relation to any formal engagement and consultation activity required to across the Programme;

5) Liaise with the Public and Patient Reference Group in terms of ensuring alignment of work programs.

2. Membership

The Communications and Engagement Group will comprise a core membership as follows:

	Representative *
BNSSG CCG	Healthy Weston Programme Director (Chair) Head of Communications North Somerset Locality PPI Lead
Weston Area Health Trust	Communications Lead
North Somerset Community Partnership	Communications Lead
University Hospitals Bristol NHSFT	Communications Lead
North Somerset Council	Communications Lead
Healthwatch North Somerset	Communications Lead
Voluntary Action North Somerset (VANS)	Communications Lead
Healthier Together STP	Communications Lead

*Organisations will be represented at a sufficiently senior level to enable the Group to discharge its functions.

3. Frequency of meetings

The Group shall meet each month, with the potential for the Chair to call additional meetings by agreement with the membership.

4. Reporting

Formal report, minutes and an action log will be produced and submitted to the Healthy Weston Steering Group through the Chair.

5. Secretariat

The secretariat to the Board will be provided by the Healthy Weston Programme Management Team.

HEALTHY WESTON PROGRAMME

HEALTHY WESTON PROGRAMME DELIVERY TEAM

Terms of Reference

The Healthy Weston Programme

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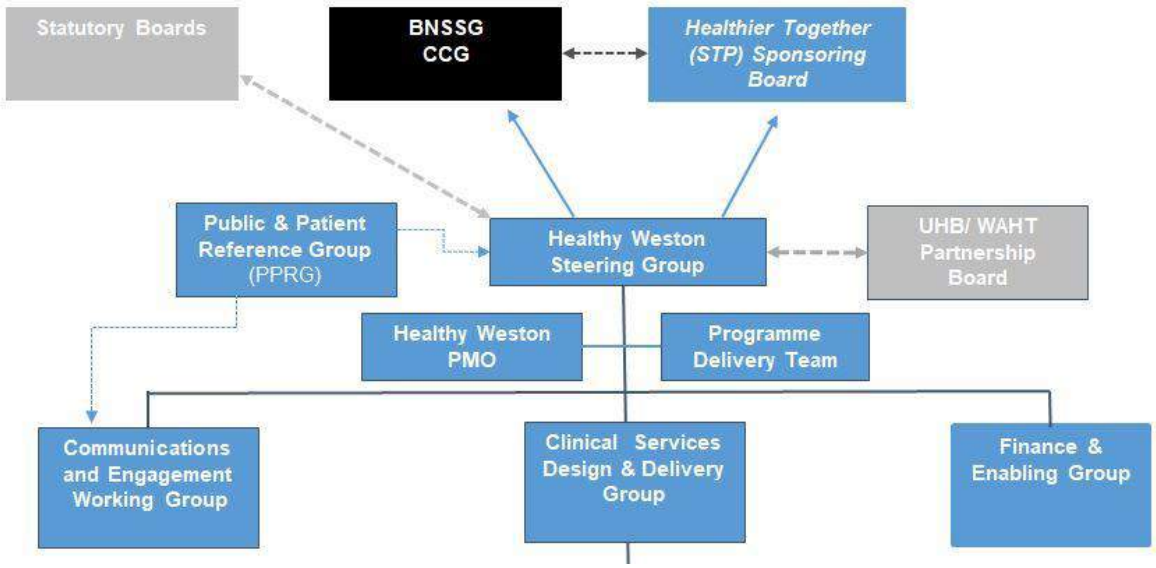

1. Role and Responsibilities of the Programme Delivery Team

The **Healthy Weston Programme Delivery Team** will be the Executive group responsible for the delivery of the Healthy Weston Programme. It will ensure the Programme Delivery arrangements are working and will report on this to the Steering Group.

The Programme Delivery Team will have authority to direct the Healthy Weston Programme Team and will own the responsibility for co-ordinating required actions in partner organisation to ensure delivery of the programme.

The Programme Delivery Team will work closely with system partners to deliver their respective elements of the Programme and as such the meetings will not be minuted in detail but will simply capture agreements and actions.

The Programme Delivery Team will manage risks on behalf of the Steering Group and will escalate issues to the Steering group where they are not able to resolve them through their roles in the Healthy Weston Program or their substantive roles.

2. Membership

The Healthy Weston Programme Delivery Team will comprise a core membership as follows:

Core Membership	Representative*
Healthy Weston Programme	Programme Director (Chair) CSDDG Chair CSDDG Deputy Chair FEG Chair
BNSSG CCG	Locality Director
Weston Area Health Trust (WAHT)	Deputy Director of Planning and Performance
University Hospital Bristol (UHB)	Acute Care Collaboration Project Director
North Somerset Community Partnership (NSCP)	Director of Nursing
STP Programme	Senior Project Manager

Other system partners, and representatives from BNSSG system or Somerset will be invited as required.

3. Quoracy

The Programme Delivery Group will be quorate if there are representatives of sufficient seniority from of the Healthy Weston Team and WAHT.

4. Frequency of meetings

The Programme Delivery Group shall meet fortnightly, with the potential for the Chair to call additional meetings by agreement with the membership.

5. Reporting

Brief minutes of agreements and an action log will be produced.

6. Secretariat

The secretariat to the Board will be provided by the Healthy Weston Programme Management Team.

MEETINGS OF STEERING GROUP AND WORKING GROUPS 2018

Steering Group	Finance and Enabling Group	CSDDG	Communications and Engagement
17th July	3rd August	26th June	26th June
23rd August	17th August	26th July	30th August
7th September	31st August	9th August	27th September
20th September	14th September	29th August	25th October
1st October	28th September	6th September	
18th October	12th October	26th September	
1st November	26th October	9th October	
29th November		24th October	
19th December		29th November	

Healthy Weston Pre-Consultation Business Case

Appendix 2: SWASFT Protocols

South Western Ambulance Service NHS Foundation Trust

Local Clinical Update

Notice ID	02-18
Title	Bypass criteria for Weston General Hospital
Issued by	Katy Richards, Clinical Development Officer
Approved by	David Partlow, Consultant Paramedic
Date Issued	12/07/2018
Review Date	24/10/2018
Clinical Publication Category	**Guidance (Green) - Deviation permissible; Apply clinical judgement**

Emergency department

Opening hours: 08:00-22:00

Inclusion criteria: All patients who are not outlined in exclusion criteria of specific patient groups noted below.

Between the hours of 22:00 and 08:00, WEGH will still accept GP admissions to the Medical Assessment Unit (MAU) following a face to face assessment and by prior arrangement with the out of hours coordinator.

Overnight fractured neck of femur (#NOF) direct admission pathway

Overnight, between the hours of 22:00 and 08:00, WEGH will now accept ?#NOF patients in order to improve treatment pathways for this vulnerable patient group and prevent unnecessary re-patriations.

Patients will come under the care of the orthopaedics team, but be admitted via Medical Assessment Unit (MAU) or ED if no beds are available, as this clinical area is set up for admitting GP referral medical patients overnight and is therefore the safest and most appropriate place for the initial assessment.

Process

1. Patient assessed by SWAST- assessment reveals likely #NOF
2. SWAST call WEGH switchboard on 01934 636363 and request to speak with the site manager on ‘bleep 4600’ to inform team that patient is en route
3. Crew will be directed to either ED or MAU, depending on bed availability
4. MAU to inform orthopaedic F2/clinical fellow of expected arrival
5. On arrival, nurse takes handover and observations.

Inclusion criteria:

- Patient has history of low energy fall AND pain in the hip/ groin
- No evidence of acute major head, chest or spine injury
- No evidence of immediate need for resuscitation / haemodynamic stabilisation
- No evidence of high energy trauma / polytrauma

Trauma

Weston General hospital does not offer Trauma services.

In all cases where major trauma is suspected, the ambulance clinician must complete the Major Trauma Triage Tool (MTTT) checklist (found in CG24) in order to determine the most appropriate receiving hospital. General guidance is that if the trauma is sufficient to make the clinician consider using the MTTT, then it will sit outside of Weston's capabilities and the patient should be taken to the nearest Trauma Unit or Major Trauma Centre.

Specific exclusion criteria include:

- Extensive chest wall injury
- Sustained systolic blood pressures of less than 90mmHg or absent radial pulses
- GCS motor score of 4 or less (flexing to painful stimulus)
- Neck or back injury with paralysis
- Suspected open, depressed or basal skull fracture
- Amputated limb
- Open long bone, midfoot or hind foot fracture
- Crushed, degloved or mangled limb
- More than 1 proximal long bone fracture
- Sustained respiratory rate <10 or >29

The nearest alternative hospitals offering Trauma services are outlined below:

Type	Location	Description
Major Trauma Centre (MTC)	• Southmead Hospital (>16 years only) • Bristol Royal Hospital for Children (<16years)	Provides the highest level of trauma care, through the provision of specialist services available 24/7
Trauma Unit (TU)	• Royal United Hospital, Bath • Musgrove Park, Taunton • Bristol Royal Infirmary	Provides a level of trauma care suitable to stabilise a patient suffering major trauma, prior to transfer to an MTC Ability to manage non-major trauma on-site.

If either the airway and/or catastrophic haemorrhage (if present) cannot be safely managed, the patient must be transported to the nearest designated unit which may be an MTC/TU/ED; whichever is the closest.

If cardiac arrest is imminent, consideration should be given to utilising Weston General Emergency

department during opening hours, where this is the closest hospital. This is a clinical judgement by the lead ambulance clinician caring for the patient, taking into consideration the additional travelling time to a TU or MTC, against the advantage of the trauma care available at these destinations.

For further information, please refer to Clinical Guideline 24- Trauma Care: Accessing Trauma Services.

Stroke

Opening hours: 08:30-16:30 Monday- Friday

Straight to CT is available at Weston General hospital. Outside of these hours and at weekends, FAST positive patients should be diverted to the following hospitals:

Hospital	Opening hours	Time window	Contact number
Musgrove Park	24/7	6 hours	01823 344920
Southmead	24/7	6 hours	01179 506862
Bristol Royal Infirmary	08:00-23:00, 7 days a week	6 hours	01173 422928

Obstetrics

Patients in normal labour must be taken to the unit where they have been booked.

Patients with a gestation of ≥20 weeks may still be conveyed to Weston Emergency Department during opening hours where **all** of the following criteria are met:

- The primary diagnosis is unrelated to the pregnancy
- The patient and the lead ambulance clinician have no current pregnancy related concerns
- The condition is not likely to need admission

Pregnant patients over 20 weeks gestation presenting with abdominal pain, PV bleeding or fits should be taken directly to the Maternity Unit at St Michael's Hospital or Musgrove Park Hospital- wherever they have been booked.

Overnight, the midwife on call and will not physically be present in the ward, unless managing a patient. Operational crews should continue to call Ashcombe Unit as normal on 01934 647082 when attending a maternity patient who is planned for the unit and requires admission. Please note that overnight the ward number will divert to switchboard. Please request to speak with the on call midwife.

PV bleeds

Patients presenting with **minor** and **stable** PV bleeds are accepted at Weston ED.

Patients presenting with severe or unstable PV bleeds must be transported to the next nearest ED with gynae specialist cover (Musgrove Park, Bristol Royal Infirmary or Southmead).

Severe or unstable PV bleeds can be defined as an estimated blood loss of >500ml or where there are signs of hypovolaemic shock or deteriorating physiological observations, including collapse.

In line with CG24 (Accessing Trauma Services), if cardiac arrest is imminent due to catastrophic haemorrhage, consideration should be given to utilising Weston ED where this is the closest hospital.

Examples of estimated blood loss:

Small, 10- ×10-cm 32 ply swab (maximum saturated capacity)	60 ml
Medium, 30- × 30-cm 12 ply swab (maximum saturated capacity)	140 ml
Large, 45- × 45-cm 12 ply swab (maximum saturated capacity)	350 ml
1-kg soaked swabs	1000 ml
50-cm diameter floor spill	500 ml
75-cm diameter floor spill	1000 ml
100-cm diameter floor spill	1500 ml

Burns

All adults who have sustained burns, with the exception of minor extremity or torso burns and those <5% coverage, should be conveyed to Southmead Hospital or Musgrove Park Hospital as appropriate.

All children (<16 years) with burns should be transported to the Bristol Royal Hospital for Children.

Neonates (≤ 28 days old)

Neonatal patients are not accepted at Weston General Hospital unless in cardiac arrest or peri-arrest.

Paediatrics (>28 days and <16 years old)

Opening Hours: 09:00-19:00 Monday- Friday (patient must be booked in prior to 19:00)

During these opening times paediatric patients should be conveyed to the Emergency Department where a Consultant from Seashore Ward will attend to review within ED.

Ambulances conveying paediatric patients are only accepted through the Emergency Department and there is no need to call Seashore

Outside of these hours, and during weekends and statutory bank holidays, all paediatric patients should be conveyed to Bristol Royal Hospital for Children or Musgrove Park Hospital, with the exception of children in peri-arrest who should always be conveyed to the nearest ED.

Children who are likely to require specialist paediatric input such as surgical intervention or paediatric anaesthetics are inappropriate for conveyance to WGH at any time.

South Western Ambulance Service NHS Foundation Trust

Ambulatory Emergency Care

Opening hours:
Monday- Friday 09:00 – 19:00 (last referral at 17:00)
Weekends and Bank Holidays 10:00 – 17:00 (last referral at 15:30)

AEC is for suitable patients who are independently mobile; require urgent assessment or treatment, and who are predicted to be suitable for discharge during the opening times of the unit. Examples of patients that an AEC unit can manage are:

- Cellulitis (lower limb)
- Hypertension,
- Atrial Fibrillation
- Palpitations <120 bpm
- Pulmonary Embolism
- Lower limb DVT
- Pleuritic chest pain/ Pleural effusion
- Painless obstructive jaundice
- Asthma exacerbation (PEFR >50% predicted best)/COPD
- Urinary tract infections
- Lower respiratory tract infections

Please note, this is not an exhaustive list. If no exclusions apply, please call 01934 881273 to discuss.

Exclusion criteria:

- HR >120
- RR >25
- Systolic BP <100
- SpO2 less than 95% (or less than 88% for known COPD patients),
- Potential cardiac chest pain,
- Severe sudden headache/?subarachnoid haemorrhage
- CVE/TIA
- Asthma exacerbation with PEFR Less than 50% of best/predicted PEFR
- Abnormal ECG changes
- Deliberate self-harm/acute psychiatric conditions/overdose
- Paediatrics
- Infection control issues
- Non-ambulant

Cardiac chest pain

Weston General hospital does not offer primary Percutaneous Coronary Intervention (pPCI).

Where a patient's ECG has ST segment elevation in two or more anatomically contiguous leads (1mm raised in limb leads or 2mm in chest leads), or LBBB with history and symptoms of acute myocardial infarction, they must be conveyed to Bristol Heart Institute or Musgrove Park Hospital with an ATMIST call (both 24/7).

All other patients with chest pain not fitting the PPCI bypass criteria should be conveyed to Weston General Hospital (between 08:00-22:00), or the nearest alternative emergency department outside of Weston's opening hours.

Further details can be found within CG01- Acute Coronary Syndromes and Stable Angina.

Vascular

Patients within the catchment area of Weston General who have a clinical diagnosis of ruptured aortic aneurysm or acute limb ischaemia, according to the bypass criteria in CG25- Vascular Emergencies, should be transported to Southmead (a main arterial centre- MAC) for specialist vascular intervention.

Actions

Please remember to use the airwaves handset or the SWASFT recorded line (01202 894003) for any clinical discussions.

If you are unsure about whether your patient is suitable for Weston General Hospital, discuss with the Emergency Department prior to conveyance. If the patient is declined, the rationale should be recorded as part of the clinical record and concerns feedback to rightcare@swast.nhs.uk.

All discussions regarding trauma patients should be had with the trauma team leader at the major trauma centre.

NHS
South Western Ambulance Service
NHS Foundation Trust

Weston General Acceptance Criteria (June 2018)				
Service/Specialty	**Contact number**	**Hours of operation**	**Inclusion**	**Exclusion**
Emergency Department	**Nurses station:** Via switchboard on 01934 636363 and extension 3519/ 3514 **Red phone/ATMIST:** 01934 881001	08:00-22:00	All patients not otherwise specified within this document	See below
Trauma	All discussions regarding trauma patients should be had with the trauma team leader at the major trauma centre using the SWASFT recorded line. Refer to CG24- Accessing Trauma Services for contact details of alternative hospitals		For major trauma patients, only those in peri-arrest or with airway or catastrophic haemorrhage that cannot be safely managed for the journey to an MTC/TU may be transported to WEGH during ED opening hours This remains the clinical judgement of the lead ambulance clinician.	WEGH cannot accept the following conditions (specified within the Major Trauma Triage Tool) • Extensive chest wall injury • Sustained systolic blood pressures of < 90mmHg or absent radial pulses • GCS motor score of 4 or less (flexing to painful stimulus) • Neck or back injury with paralysis • Suspected open, depressed or basal skull fracture • Amputated limb • Open long bone, midfoot or hind foot fracture • Crushed, degloved or mangled limb • More than 1 proximal long bone fracture • Sustained respiratory rate <10 or >29
Stroke	Via ED	08:30-16:30 Monday-Friday	FAST positive patients/ suspected stroke Direct to CT pathway is available for patients where symptom onset is <6hours	Refer to CG20 for details of alternative pathways outside of these acceptance times
Paediatrics	Via ED	09:00- 19:00 Monday-Friday	• Patients >28days and <16 years • Patients should be conveyed to WEGH ED, rather than Seashore Unit, unless specifically stated within their personalised treatment plan.	• Children who are likely to require surgical intervention or paediatric anaesthetics are inappropriate for conveyance to WEGH at any time. • Patients under the age of 28 days are not accepted at WEGH unless in arrest/ peri-arrest
Maternity	**Ashcombe ward:** 01934 647082	In hours: 22:00-08:00 During the OOH period, you will be directed to Switchboard. Please request to speak with the on call midwife.	All patients in normal labour, booked with Ashcombe Ward. Patients with a gestation of **≥20** weeks may still be conveyed to Weston ED during opening hours where **all** of the following criteria are met: • The primary diagnosis is unrelated to the pregnancy. • The patient and the lead ambulance clinician have no current pregnancy related concerns. • The condition is not likely to need admission.	• Pregnant patients **≥20** weeks gestation presenting with abdominal pain, PV bleeding or fits.

Service/Specialty	Contact number	Hours of operation	Inclusion Criteria	Exclusion Criteria
Ambulatory Emergency Care Unit	01934 881273	**Monday- Friday:** 09:00 – 19:00 (last referral at 17:00) **Weekends and Bank Holidays:**10:00 – 17:00 (last referral at 15:30)	Please consider AEC as a first option before ED. Example of conditions suitable for AEC are: • Cellulitis (lower limb) • Hypertension, • Atrial Fibrillation • Palpitations <120 bpm • Pulmonary Embolism • Lower limb DVT • Pleuritic chest pain/ Pleural effusion • Painless obstructive jaundice • Asthma exacerbation (PEFR >50% predicted best)/COPD • Urinary tract infections • Lower respiratory tract infections	• HR >120 • RR >25 • Systolic BP <100 • SpO2 less than 95% (or less than 88% for known COPD patients), • Potential cardiac chest pain, • Severe sudden headache/?subarachnoid haemorrhage • CVA/TIA • Asthma exacerbation with PEFR < 50% of best/predicted PEFR • Abnormal ECG changes • Deliberate self-harm/acute psychiatric conditions/overdose • Paediatrics • Infection control issues • Non-ambulant
Vascular Emergencies				• Patients with a suspected ruptured abdominal aortic aneurysm (rAAA) or acute limb ischaemia are not accepted at Weston ED at any time. Refer to CG25-vascular emergencies for criteria and further information
Cardiac/ Acute Coronary Syndromes				Any patient fitting acceptance criteria for pPCI: • ECG with ST segment elevation in two or more anatomically contiguous leads (1mm raised in limb leads or 2mm in chest leads • LBBB with history and symptoms of acute myocardial infarction.
Burns	Via ED		• Minor extremity or torso burns with <5% body surface area coverage	• Any burns in children aged <16 years • All burns >5%BSA must be conveyed to the nearest hospital of Musgrove Park or Southmead
PV bleeds	Via ED		• Patients presenting with **minor** and **stable** PV bleeds are accepted at Weston ED. • Blood loss <500ml	• Signs of hypovolaemic shock • Deteriorating physiological observations. • Blood loss >500ml

Healthy Weston Pre-Consultation Business Case

Appendix 3: Summary of Clinical Evidence for Urgent and Emergency Care

Evidence for centralisation of emergency surgery (1/2)

Area of care	Evidence
▪ Adult emergency surgery – Weekend consultant cover and access to diagnostics	▪ In a UK study of >4m emergency admissions, risk adjusted mortality was 10% higher (OR 1.10, 95% CI 1.08 to 1.11) in patients admitted at weekends compared with patients admitted during a weekday (p<0.001). Overall crude mortality rate of 5.0% (5.2% for all weekend admissions and 4.9% for all weekday admissions) ▪ Weekend admission at an acute medical admissions unit with consistent staffing levels and 24-hour access to diagnostics across week days and weekends (at the Royal Infirmary of Edinburgh), not associated with higher in-hospital mortality, readmission rates or increased length of stay compared to the weekday equivalent for any of six conditions (COPD, cerebrovascular accidents, pulmonary embolism, pneumonia, collapse and upper gastrointestinal bleed)[2]
– Consultant involvement in patient care	▪ Delays to consultant reviews and a lack of senior involvement in patient care consistently linked to poor patient outcomes:[3, 4, 5, 6, 7] – Consultants should be freed from other duties when responsible for emergencies – First consultant review of a patient should occur within 12 hrs – Consultants should undertake 2x daily ward rounds 7 days a week to review acutely ill patients
– Consultant involvement in the operating theatre	▪ Consultant surgeon presence in the operating theatre significantly improves outcomes and poor outcomes are associated with unsupervised non-consultants performing major emergency surgery [3, 6, 8, 9]

1 Aylin et al, Weekend mortality for emergency admissions: a large multicentre study, 2010, Quality and Safety in Health care, 19, 213-7
2 Schmulewitz et al, The impact of weekends on outcomes for emergency patients, 2005, Clinical Medicine, 5(6), 621-5
3 NCEPOD, Emergency admissions: a step in the right direction, 2007
4 Nafsi et al, Audit of deaths less than a week after admission through and emergency department, Emergency Medicine Journal, 2007, 24, 691-5
5 NCEPOD, Caring to the end? Review of patients who died within 4 days of hospital admission, 2009
6 Royal College of Surgeons, Emergency surgery: standards for unscheduled surgical care, 2011
7 Royal College of Physicians, Acute medical care: the right person in the right setting first time, 2007
8 ASGBI, Emergency surgery survey, ASGBI Newsletter, 2010, No, 31
9 NCEPOD, An age old problem: elective and emergency surgery in the elderly, 2010

Evidence for centralisation of emergency surgery (2/2)

Area of care	Evidence
▪ Adult emergency surgery	
– Consultant anaesthetist involvement in theatre	▪ The presence of a consultant anaesthetist in the operating theatre improves patient care and outcomes[1] ▪ 20% of anaesthesia-related surgical mortality involved the grade of the anaesthetist being too junior or the failure of junior staff to seek senior advice[2]
– Timely 24/7 access to diagnostic radiology	▪ Timely access to diagnostic services and competent interpretation of results are crucial to providing a safe and efficient emergency services to patients[3] ▪ Significant proportions of inaccurate reporting are due to misinterpretation of results by non-specialists[4] or trainees[5, 6]
– 24/7 access to modern surgical techniques	▪ Where clinically appropriate, laparoscopic surgery is associated with a shorter length of stay and fewer complications than non-laparoscopic surgery [7, 8, 9,10, 11]
▪ Catchment population required for adult emergency surgery service	▪ Catchment population for an acute general hospital providing the full range of facilities, specialist staff and expertise for both elective and emergency surgery is 450,000 - 500,000[12]

1 Royal College of Anaesthetists, Guidelines for the provision of anaesthetic services, 2009
2 McFarlane, The Scottish Audit of Surgical Mortality: review of areas of concern related to anaesthesia over 10 years, Anaesthesia, 2009, 64, 1324-31
3 Royal College of Radiologists, Standards for providing a 24-hour radiology diagnostic services, 2009
4 Kripalani, Williams, Rask, Reducing errors in the interpretation of plain radiographs and CT scans, in Shojania et al, Making healthcare safer: a critical analysis of patient safety practices, Agency for Healthcare Research & Quality, 2001
5 Hillier, Trainee reporting of CT examinations: do they make mistakes and does it matter, Clinical Radiology, 2009, 59(2), 159-62
6 Briggs et al, Provision reporting of poly-trauma CT by on-call radiology registrars: is it safe? 2010, Clinical Radiology, 65(8), 616-22
7 Gilliam, Day case emergency laparoscopic appendectomy, Surgical Endoscopy, 2007, 22, 483-6
8 Cochrane Review, Laparscopic surgery for appendicitis, 2002
9 Ingraham et al, Comparison of 30-day outcomes after emergency general surgery procedures: potential for targeted improvement, Surgery, 2010, 148(2)
10David et al, Management of acute gallbladder disease in England, British Journal of Surgery, 2008,95, 472-6
11Law et al, Impact of laparoscopic resection for colorectal cancer on operative outcomes and survival, Annals of surgery, 2007, 245(1), 1-7
12RCS, Delivering high-quality surgical services for the future, 2006

NHS Five Year Forward View

Key Policies

The Five Year Forward View sets out the following policies in relation to urgent and emergency care:

1. Across the NHS, urgent and emergency care services will be redesigned to integrate between A&E departments, GP out-of-hours services, urgent care centres, NHS 111, and ambulance services. Smaller hospitals will have new options to help them remain viable, including forming new partnerships with other hospitals further afield, and partnering with specialist hospitals to provide more local services. Midwives will have new options to take charge of the maternity services they offer. The NHS will provide more support for frail older people living in care homes.
2. Developing networks of linked hospitals that ensure patients with the most serious needs get to specialist emergency centres – drawing on the success of major trauma centres, which have saved 30% more of the lives of the worst injured.
3. Roll-out of standardised new 'Urgent Treatment Centres' which will open 12 hours a day, seven days a week, integrated with local urgent care services. They offer patients who do not need hospital accident and emergency care, treatment by clinicians with access to diagnostic facilities that will usually include an X-ray machine. We anticipate around 150 designated UTCs, offering appointments that are bookable through 111 as well as GP referral, will be treating patients by Spring 2018.

Source: Five Year Forward View NHS England https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf
Five Year Forward View Next Steps NHS England https://www.england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf

NHS Long Term Plan

Key Policies

The NHS Long Term Plan sets out the following relevant policies in relation to urgent and emergency care:

1. We will fully implement the Urgent Treatment Centre model by autumn 2020 so that all localities have a consistent offer for out-of-hospital urgent care, with the option of appointments booked through a call to NHS 111. UTCs will work alongside other parts of the urgent care network including primary care, community pharmacists, ambulance and other community-based services to provide a locally accessible and convenient alternative to A&E for patients who do not need to attend hospital.
2. New diagnostic and treatment practices allow patients to spend just hours in hospital rather than being admitted to a ward. This also helps relieve pressure elsewhere in the hospital and frees up beds for patients who need quick admission either for emergency care, or for a planned operation. This is a model co-developed by the Royal College of Physicians and the Society of Acute Medicine, which is being successfully deployed in an increasing number of hospitals. As a result, reported growth in non-elective hospital ‘admissions’ are now disproportionately being driven by so-called ‘zero day admissions’ (patients who are not actually admitted to an inpatient overnight acute bed)

Source: NHS Long Term Plan https://www.longtermplan.nhs.uk/wp-content/uploads/2019/01/nhs-long-term-plan.pdf

The Royal College of Surgeons – reshaping surgical services (1/2)

Principles to be followed

The RCS supports the reshaping of services when it is based on clinical evidence. The list below sets out **the principles that we believe any proposals to reshape surgical services** must meet.

1. Reshaping of services should be based on sound **clinical evidence that it will be beneficial to patients and staff**, rather than it being considered for purely economic or administrative reasons.
2. There is clinical evidence that **concentrating specialist surgical services into fewer, larger centers of excellence can save lives in certain circumstances**. It is right that the NHS should look at the long-term benefits when considering any reorganization.
3. Reshaping of surgical services should only take place where **improvements in the quality of care are needed and can be realized**. In some cases, there will be an evidence base that suggests service change will produce better outcomes for patients; in other cases, the reshaping of services might need to occur because surgical units are unable to meet minimum standards for safe service provision.
4. More consideration needs to be given **to how to support communities in rural areas who need access to good emergency surgery**. Strengthening of **ambulance** services and **emergency** care networks will ensure that patients needing immediate access to emergency surgery or other specialized services can be routed appropriately and promptly.

Source: The Royal College of Surgeons: Reshaping surgical services. January 2013. Reshaping surgical services - The Royal College of Surgeons

The Royal College of Surgeons – reshaping surgical services (2/2)

Principles to be followed

5. The requirement for, and implications of, service change needs to be thoroughly and exhaustively researched. If services are to be changed, the **whole pathway of care for patients with specific conditions must be considered**. This should encapsulate how a patient would **access services from primary care**, to initial **secondary care referral**, **diagnostic tests, hospital treatment, discharge, follow-up** and **rehabilitation**.
6. The **views of patients** must be sought early on. Patients must be involved not just in responding to a consultation about service change, but in understanding and building the case for change and putting together the potential options for consultation.
7. **Patient transport** is key to the public's sense of security and belief in the reshaping of services. The most common cause for concern is transport links between the 'local' hospital and an element of the service that may be moved to another location. It is important that a transport infrastructure is in place for any reshaped service.
8. Commissioners and providers involved in service change need to ensure that the **quality of service** is maintained **before, during and after** the service change takes place. This may involve offering services in parallel, in two or more separate locations, while the service change is implemented. Commissioners also need to ensure that any removal of services brought about by reshaping does not affect the stability of related services.

Source: The Royal College of Surgeons: Reshaping surgical services. January 2013. Reshaping surgical services - The Royal College of Surgeons

The RCS has developed generic standards for future models of delivery for emergency general surgery

Standard

- Delivering an effective emergency general surgical service requires the entire team to be free of all other commitments, except in a few hospitals with low emergency workloads.
- The location of emergency patients within a single area greatly facilitates an effective service and enhances patient safety.
- Adequate consultant numbers required for a modern service, with junior or specialist nurse support.
- Immediate emergency theatre access required and in preference to elective work whenever necessary
- Adequate critical care support as needed (levels 1, 2 and 3)
- Be supported by a consultant based 24/7 diagnostic CT scanning service with GI specialist leadership
- Have access to a Trust wide or network interventional GI radiology service 24/7 on a published rota.
- Resuscitation should not delay surgery in patients in class 1 or 2. Resuscitation should be conducted in the anaesthetic room or similar.
- A consultant surgeon and consultant anaesthetist are present for all cases with predicted mortality ≥10% and for cases with predicted mortality >5% except in specific circumstances where adequate experience and manpower is otherwise assured.
- A consultant surgeon (CCT holder) should be present for all unscheduled returns to theatre.

Best Practice Patient Grading

- In order to minimise avoidable harm, patients require definitive treatment by surgery or similar intervention (most commonly interventional radiology) with an urgency which is graded and escalated according to the degree of illness.
  - On-going haemorrhage requires immediate surgery.
  - Septic shock patients who require immediate surgery are operated on within 3 hours of the decision to operate as delay increases mortality significantly.
  - Severe sepsis (with organ dysfunction) which require surgery, to be operated on within 6 hours to minimise deterioration into septic shock.
  - Patients with sepsis (but no organ dysfunction) who require surgery should have this within 18 hours.
  - Patients with no features to indicate systemic sepsis can be managed with less urgency but in the absence of modern and structured systems of care, delay will result in unnecessary hospital stay, discomfort, illness and cost.

SOURCE: Emergency Surgery: Standards for unscheduled surgical care, RCS, 2011

RCS generic standards for emergency urology services

- 24/7 consultant availability for immediate advice and can be on site within 30 minutes
- All emergency cases, especially those where operative intervention is planned, must be discussed with the consultant on call.
- A modern, effective emergency urology service requires adequate theatre access, senior radiological support (including interventional radiology), senior anaesthetic support and critical care facilities.
- Immediate 24/7 availability of:
  - CT scanning and ultrasound scanning with capacity for intervention in suspected urosepsis.
  - CT scanning for patients with suspected urinary tract trauma.
  - Senior trainee (ST3 or above) or consultant urologists to manage the obstructed bladder, which cannot be managed by urethral catheterisation alone.
  - Senior trainee or consultant urologist to operatively intervene for suspected torsion.
- Where an operation is required, a theatre team with adequate experience of urological surgery must be available.
- Outcomes of emergency treatment should be regularly audited.
- Patients with septic shock and evidence of obstructive uropathy require immediate intervention within three hours of the decision to operate as delay increases mortality significantly.
- The on-going care of inpatients/post-operative patients is managed by senior trainees and consultants, on appropriate urology wards with specialist-trained nursing care.
- Daily ward rounds carried out by senior trainees and/or consultants, including weekends.

SOURCE: Emergency Surgery: Standards for unscheduled surgical care, RCS, 2011

RCS generic emergency ENT standards and best practice care

- There is a dedicated ENT unit with immediate transfer to operating theatres.
- Emergency beds are available in the ENT unit for acute admission of either sex.
- Endoscopic cautery, suction and irrigation are available 24/7.
- Training in emergency ENT incorporated into nurse training modules
- Adequate facilities on paediatric ward or ED.
- Departmental protocols are in place detailing whether patients requiring resuscitation attend the ward or ED, with a clinically competent individual to be awaiting their arrival.
- There is a local, time- framed protocol detailing procedures from first contact to theatre, with or without flexible endoscopy referral. 90% of oesophageal foreign bodies are removed within 24 hours.
- 90% of sharp foreign bodies are removed within six hours.
- There is a written hospital protocol for initial management of ED or inpatient epistaxis prior to contacting ENT.
- At admission or next morning endoscopic examination is performed by ST3 or above/equivalent doctor, patients are treated and discharged if possible. Daily consultant management decision is recorded.
- Department has agreed written pathway for referral for angiography and embolisation including out of hours.
- Written guidelines of shared care between ENT and paediatrics are in place detailing provision of IV access, phlebotomy, daily review etc.
- Antibiotic treatment starts without delay once decision is made.
- Patients with orbital cellulitis require urgent ophthalmology opinion and CT scan with or without general anaesthesia available to manage complications
- Ability to carry out CT scan under general anaesthetic and transfer to theatre for drainage of parapharyngeal or retropharyngeal abscess.

SOURCE: Emergency Surgery: Standards for unscheduled surgical care, RCS, 2011

RCS generic Trauma and Orthopaedic Standards and Best Practice Metrics

- 7 day access to routine trauma lists which are independent of general emergency theatres. **Best practice**: An additional theatre is immediately available for urgent and complex orthopaedic problems, such as open fractures and those with neurovascular compromise.
- Trauma patients managed within regional trauma network. Complex injuries treated in centres with appropriate volumes within the region –this does not have to be the regional centre. **Best practice**: Appropriate triage by the ambulance service to minimise secondary transfers.
- Consultant led the trauma team 24/7 in all units receiving seriously injured patients.
- If CT scanning is to be performed in patients with multiple injuries, routine use of 'top to toe' scanning is recommended in the adult trauma patient if no indication for immediate intervention exists. **Best practice**: Within 30 minutes.
- Standardised transfer documentation of the patients' details, injuries, results of investigations and management with records kept at the dispatching and receiving hospitals. Include documentation for acute transfer and standardised documents for repatriation to the base hospital for continued therapy and rehabilitation.
- Hip fracture care is in accordance with the British Orthopaedic Association Standards for Trauma (BOAST 1) and data is submitted to the National Hip Fracture Database. **Best practice**: Compliance with the best practice tariff for fragility hip fracture care:
  1. Time to surgery within 36 hours from arrival in an emergency department, or time of diagnosis if an inpatient, to the start of anaesthesia.
  2. Admitted under the joint care of a consultant geriatrician and a consultant orthopaedic surgeon.
  3. Admitted using an assessment protocol agreed by geriatric medicine, orthopaedic surgery and anaesthesia.
  4. Assessed by a geriatrician in the preoperative period: within 72 hours of admission. Postoperative geriatrician-directed multi-professional rehabilitation team.
  5. Fracture prevention assessments (falls and bone health).
- Pelvic and acetabular fracture care in accordance with BOAST. **Best practice:** Regional protocols for initial emergency management.
- On identification of patients with a fracture of the pelvis or acetabulum in a non-specialist centre, referral is made within 24 hours. **Best practice**: Within an established trauma network, patients suspected of having sustained these injuries will be transported direct to the regional centre.
- Severe open lower limb fractures care is in accordance with BOAST aiming to achieve timely, specialist surgery rather than emergency surgery by less experienced teams. **Best practice:** Specialist orthoplastic care within a trauma network.
- Centres that cannot provide combined plastic and orthopaedic care for severe open tibial fractures have protocols in place for early transfer to an appropriate specialist centre.

SOURCE: Emergency Surgery: Standards for unscheduled surgical care, RCS, 2011

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Healthy Weston Pre-Consultation Business Case

Appendix 4: Weston A&E Temporary Closure 6 month review and updated data after 12 months

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Weston A&E Temporary Overnight Closure - Detailed Summary

6 Month Review

Created by
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Contents & Introduction

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This report has been prepared at the request of BNSSG system CEOs to understand the impact and learning from the Weston A&E Temporary Overnight Closure. It has been drawn together at the 6 month point based on data to December 2017. The data has been stable across the 6 months and there is need for further update after the winter pressures.

Background

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The sustainability of the Emergency Department at Weston Area Healthcare Trust (WAHT) has been a significant concern for a number of years. Since 2016 there have been a number of issues including:

- Withdrawal by the Deanery of some training doctor posts when a consultant is not present
- Poor 4 hour performance across six winter months, culminating in a critical incident due to ED overcrowding at New Year 2016
- Visit from the National Director of Urgent Care highlighting need for urgent change
- NHS Improvement commissioned independent review of the issues at Weston ED and the wider emergency system. This concluded that 'the situation at Weston ED is unsustainable and considerably compromises patient safety….a partial and temporary closure gives both the system and the Trust itself some time to develop a safer and sustainable ED'
- Care Quality Commission Warning Notice issued 24 March 2016 highlighting need for improvement in patient flow
- Fragility of the medical rota

In light of this the BNSSG CCGs developed the operational contingency and implementation plan to temporarily close Weston ED overnight from 4 July 2017.

Timeline & Governance

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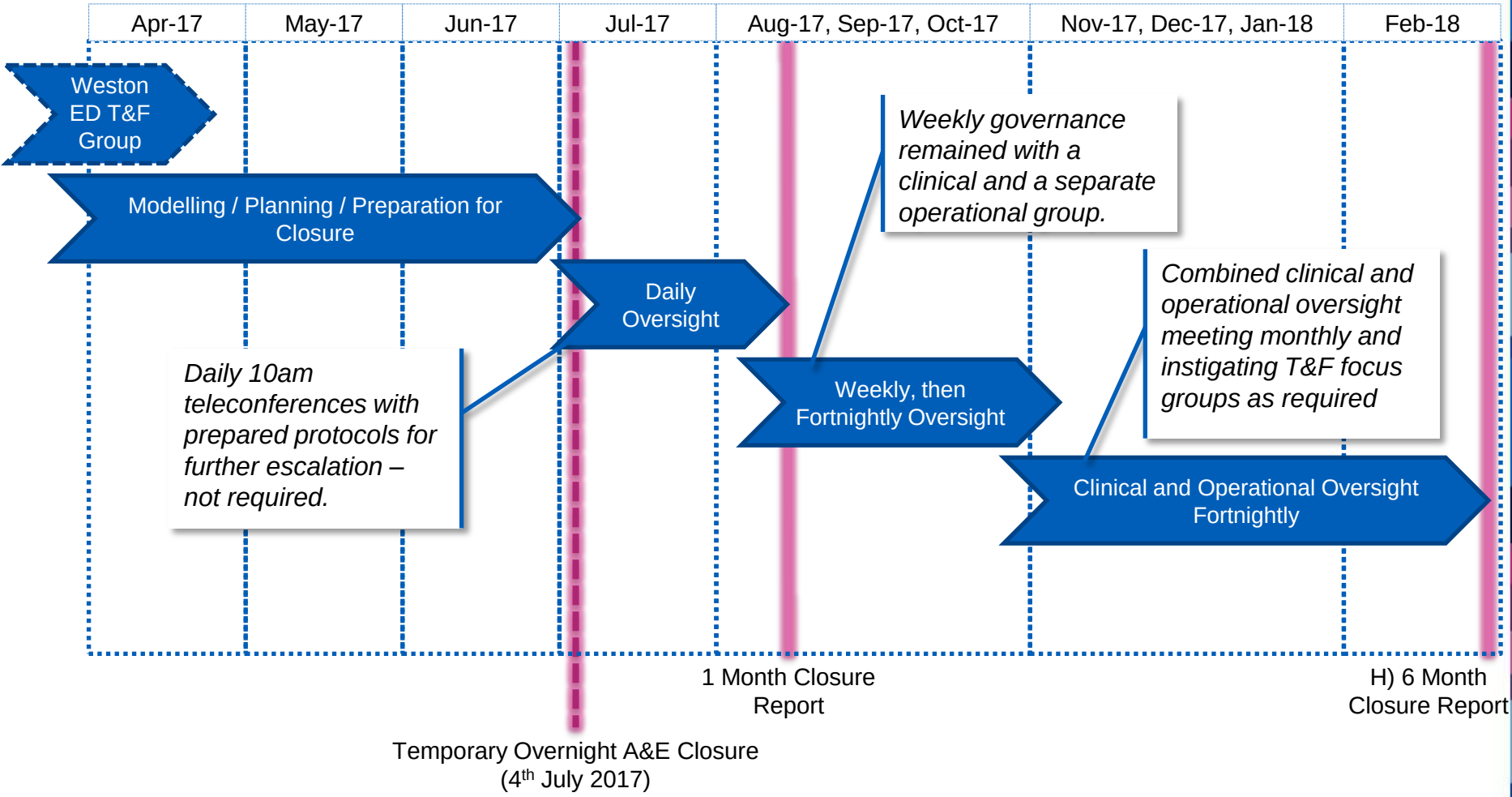

Activity Summary

Comparison to mitigated model

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- Overall, daily **ambulance arrivals** have been slightly lower than modelled with activity at Musgrove Park being higher than the mitigated model, whilst Southmead was much lower
- More **Walk-ins** have been observed than the mitigated model suggested. Much of this is due to higher than expected activity at Musgrove Park
- **Emergency Admissions** are slightly lower overall than the mitigated model suggested, largely due to lower than modelled admissions at Southmead; however admissions at Musgrove Park are higher than modelled
- There are more **beds** in use at receiving trusts than the mitigated model suggested, with bed use at Musgrove Park and BRI being higher than modelled
- **BRI** have seen more walk-ins, ambulance conveyances and admissions than the mitigated model suggested

Activity Summary

Comparison to mitigated model

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- **Southmead** have seen fewer walk-ins, ambulance conveyances and admissions than the modelling suggested
- **Musgrove Park** have seen more walk-ins, ambulance conveyances and admissions than the modelling suggested
- **Overall**, Walk-ins are higher than modelled, ambulance conveyances and admissions are lower than modelled
- **NSCP** have seen very little change in average daily numbers for any monitored metrics
- **BrisDoc** have seen an increase of 2 face to face NS contacts per day. Other metrics are unchanged

Modelling vs Actuals

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Figures are per day. All figures compare impacts, ie suspected diverts or variance between pre- and post- closure		Modelling		Activity Tracker	PAS Dump		WOCIG agreed estimates (1mth)	WOCIG agreed estimates (2-5 mth)
		Unmitigated	Mitigated		Main Weston Catchment	Out of Area & Somerset & North Som CCGs		
BRI	ED - Walk-Ins	6	0.4	0.8	0.9	1.1	1 to 2	1
	ED - Ambulance	5	4.0	4.3	3.9	6.7	4 to 5	4 to 5
	EM Admits	2.8	2.8	2.9	1.9	1.4	3	3
	Beds	20.3	5.5	7.0				7
	Repats	0	1.2	0.9			1	
Southmead	ED - Walk-Ins	7	0.5	0.4	0.4	0.9	Less than 1	Less than 1
	ED - Ambulance	6	4.5	0.9	0.9	1.8	1 to 2	1
	EM Admits	3.2	3.0	0.5	0.2	0.2	Less than 1	Less than 1
	Beds	25.8	6.1	2.0				2
	Repats	0	1.5	0.2			Less than 1	
Taunton	ED - Walk-Ins	2	0.1	1.3	0.2	-0.8	1 to 2	1 to 2
	ED - Ambulance	2	1.4	3.3	0.5	3.0	3 to 4	3 to 4
	EM Admits	0.9	0.9	2.1	0.3	3.5	1	2
	Beds	6.3	1.9	9.4				10
	Repats	0	0.4	0.3			Very few to date	
Total	ED - Walk-Ins	15	1.1	2.6	1.5	1.3	4 to 5	3 to 4
	ED - Ambulance	12	10.0	8.5	5.4	11.4	9	8 to 9
	EM Admits	7.0	6.7	5.5	2.3	5.2	5 to 6	5 to 6
	Beds	52.5	13.5	18.4				
	Repats	0	3.1	1.3			1 to 2	

Out of Hospital Care(1)

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Provider	Impact from the Weston temporary overnight closure
NSCP	For the Weston Temporary Overnight Closure NSCP ensured there was an enhanced night service to take referrals from BrisDoc and SWAST to prevent patients attending A&E overnight. There was additional resource put within the clinical hub to support out of hours admission avoidance. Over the 5 month period NSCP have seen no impact on their Rapid Response or Clinical Hub services since the temporary overnight closure. This continues to be monitored on a monthly basis through WOCOG (Weston Operational and Clinical Oversight Group). Any issues are escalated when necessary.
BrisDoc	BrisDoc enhanced their GP OOH service to provide a service from Locking Road which was open and clinically staffing all night. Over the 5 month period BrisDoc have seen no impact on their service resulting from the Weston Temporary Overnight Closure. This continues to be monitored on a monthly basis through WOCOG (Weston Operational and Clinical Oversight Group). Any issues are escalated when necessary.

Out of Hospital Care(2)

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Provider	Impact from the Weston temporary overnight closure
AWP	AWP enhanced their night cover at the Bristol Crisis team to assess Mental Health service used to BRI / Southmead ED and Bristol S136 suite. • They enhanced a joint protocol between North Somerset AWP and Somerset Partnership Mental Health Services at night covering Musgrove Park and Somerset S136 suite. • There was an agreed protocol with BrisDoc and AWP MH Intensive Team for triage of MH service users who make contact via Weston ED phone / NHS 111. • There was agreed access to Locking Road OOH GP service to jointly assess MH service users with North Somerset Intensive Team • There was an agreed protocol with WGH security to alert the Crisis Team of vulnerable service users in Weston General Hospital grounds at night Over the 5 month period AWP have seen no significant impact on their service resulting from the Weston temporary overnight closure. This continues to be monitored on a monthly basis through WOCOG (Weston Operational and Clinical Oversight Group). Any issues are escalated when necessary.
Care UK 111	111 ensured there was clinical validation of all BNSSG ED dispositions & use of updated DOS to ensure patients avoid use of neighbouring EDs wherever possible. Over the 5 month period 111 have seen no significant impact on their service resulting from the Weston temporary overnight closure. This continues to be monitored on a monthly basis through WOCOG (Weston Operational and Clinical Oversight Group). Any issues are escalated when necessary.

Quality Summary

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Contacts Incidents and Patient Experience

- Consistently reviewed by WOCOG. 26 have been received, 10 of these were attributable to the temporary overnight closure and none were serious un-towards incidents or resulted in patient harm.

Quality and Safety Metrics / Visits

- Metrics actively monitored and reviewed across the 3 BNSSG acute hospitals. No deterioration in safety metrics at hospitals which neighbour WAHT.
- BNSSG quality assurance visits also demonstrated no deterioration in patient safety due to the overnight closure.

QIAs / EIAs

- Each organisation has refreshed and completed a QIA. Following an initial system EIA screening, we will now proceed to a full EIA incorporating protected characteristics into mitigating risks, issues and actions.

Contacts & Incidents

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- Incidents and complaints are reviewed and a system response agreed at each WOCOG meeting.

Measure	Count
Total number of reported incidents and PALS contacts	**26**

- WOCOG have reviewed all 26 reported incidents and PALS contacts. Whilst many related to SWAST and WAHT, only 10 could be directly attributable to the overnight closure.

- None were serious untowards incidents; with some being general comments and feedback.

- A number of these have resulted in changes to pathways and processes (e.g. Urology and Stroke pathways)

WAHT SHINE

WAHT SHINE data

NHS Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group

Some changes in the SHINE data at Weston, deterioration attributable to winter pressures rather than overnight closure

Trend since closure	SHINE Measure	Commentary
→	**NEWS Scores**	NEWS Scores recorded on admission to ED have remained above 80% since closure .
↓	**Hourly Observations**	Remained at 100% during summer period, but noted decrease in the winter period (not due to overnight closure)
↑	**Pain Scores**	Data is variable, there has been some slight improvements but this has not been consistent.
↑	**Communication with Next of Kin**	Improved since overnight closure, consistently rated as green
→	**Cannula Management**	Remained at 100% for 3 months following closure and % compliance has dropped but remained above 80%
↓	**Dignity & Nutrition**	Refreshments offered within 2 hours of admission were rated as 100% in July and have since ranged from 55% to 85%.
→	**Chest Pain**	2 metrics regularly rated green since closure with a recognised area for improvement in December-2017
↑	**#NOF**	Of the sample , these have been at 100% in December
→	**Sepsis**	Concerns over this have been addressed directly at WAHT following 2 months of decreased performance in Oct & Nov. Otherwise scoring 100%.

UHB SHINE

UHB SHINE

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UHB quality has remained steady with a recent exception in #NOF.

Trend since closure	SHINE Measure	Commentary
→	**NEWS Scores**	No deterioration, maintained or slight improved performance.
↑	**Hourly Observations**	Brief dip in performance in July-17 following a peak in June, but an improving use of NEWS recording on admission to ED in 2017.
→	**Pain Scores**	Dip in 2 performance indicators for pain in July-17 [Pain Score at Triage (Within First Hour) & Analgesia administered at Triage (if appropriate)]. Since July-17 all indicators have remained green rated and shown improvement.
↑	**Communication with Next of Kin**	Communicate with NoK within 2hours at approx. 90% of the time, an improving trend since before temporary overnight WAHT A&E closure.
→	**Cannula Management**	100% complete in July-17, and maintained above 94% since
→	**Dignity & Nutrition**	Varied between 86% and 92% between July-17 and Dec-17
↑	**Chest Pain**	Improving performance with recording ECG within 10 minutes of arrival between July-17 and Oct-17 – from 89% to 97%, remaining at 94% for Nov/Dec-17. Doctor review of ECG within 30 mins remains steadily above 97%
→	**#NOF**	Varying performance for completing the #NOF pathway, immediate improvement following WAHT A&E closure for X-Rays completed within 30 minutes.
→	**Sepsis**	Improving performance between July-17 and Nov-17 with a dip in Dec-17

NBT SHINE

NBT SHINE data

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Overall, for NBT the SHINE scoring has remained generally consistent compared with last years data.

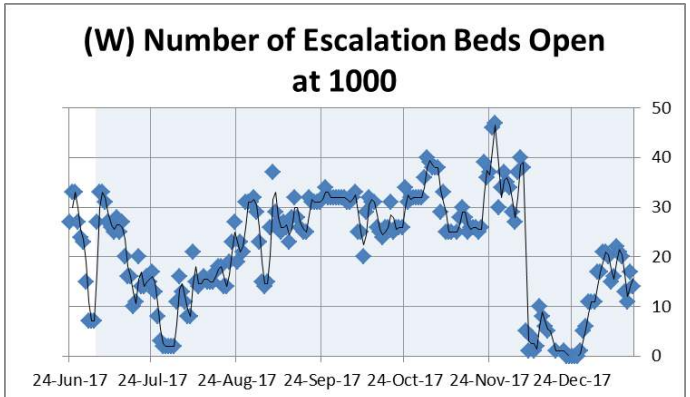
Trend since closure	SHINE Measure	Commentary
→	**NEWS Scores**	Recorded for patients in ED and remained at 100%
↑	**Hourly Observations**	Since closures, NBT have seen an improvement compared with last years data and are now consistently reporting green for each associated measure.
→	**Pain Scores**	Generally remaining green since July, with the exception of 1 measure rated Amber at 76% in Dec-17: “Pain re-assessed in an hour”.
→	**Communication with Next of Kin**	Remained consistent, but noting 2 dips in Oct / Nov 17 from 100%
↑	**Cannula Management**	Seen an improvement overall noting that Nov 17 dipped to 99%.
↑	**Dignity & Nutrition**	Seen a large increase compared with last years data and have consistently reported green for the last four months.
→	**Chest Pain**	Remained green but has seen an overall improvement in the last 4 months.
→	**#NOF**	Generally remain green, with exception of a dip in “Analgesia , 20 minutes” in Nov-17 / Dec-17. “Admission, 2 hours” remains consistently red with a slight improvement in Sept -17.
→	**Sepsis**	Seen a reduction in the last 3 months for both triggers.

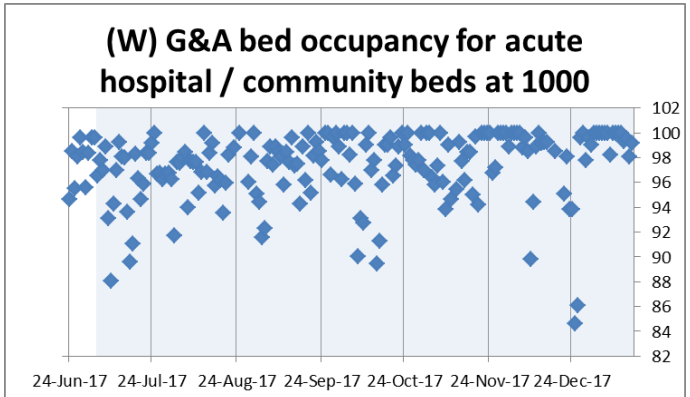
WAHT ED Safety

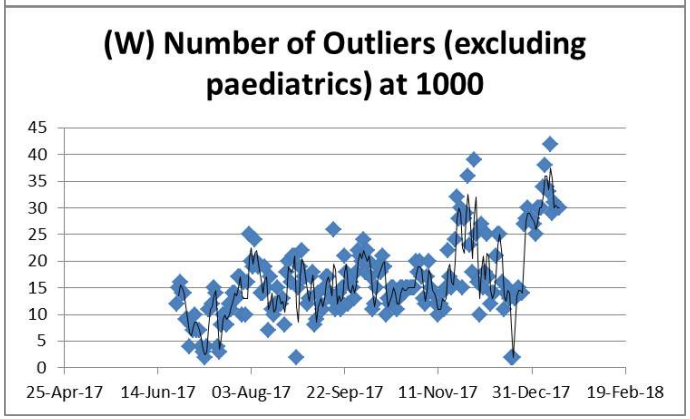
NHS
Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group

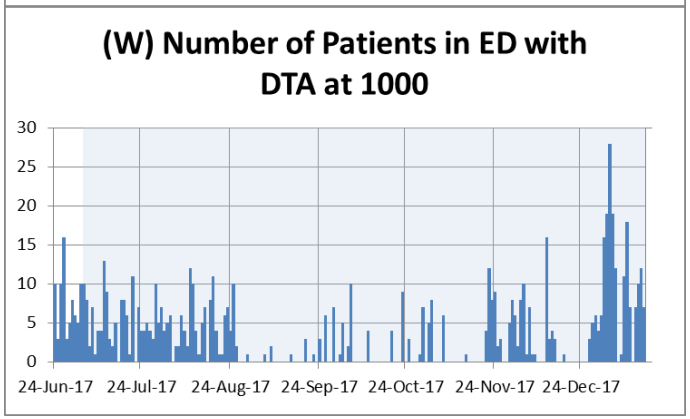
ED Safety metrics agreed between 3 BNSSG acute hospitals and consistently monitored since the Weston A&E overnight closure. No deterioration following the 2-3 months following A&E closure. Metrics are continually assessed (daily) during busy winter periods and recent changes in performance have been attributed to expected winter pressures. Escalation beds saw a rise in November-17 due to Infection Control (Norovirus).

WAHT ED Safety Metrics







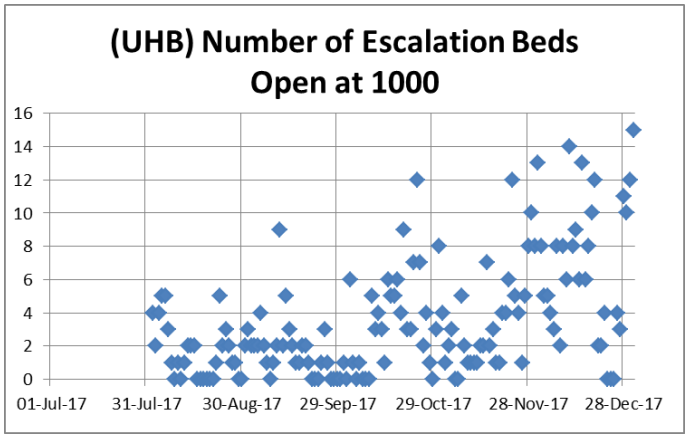


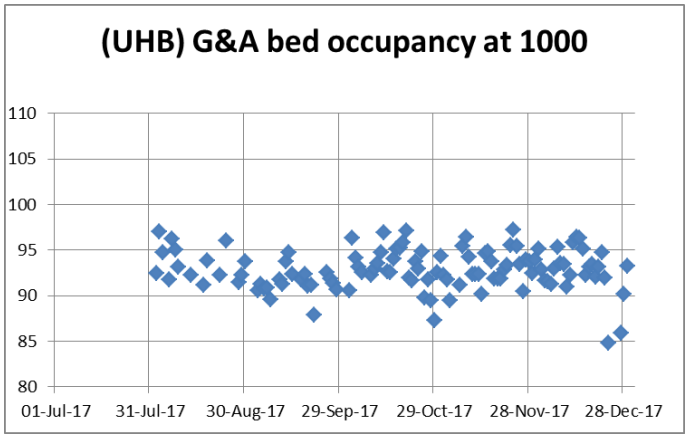
UHB ED Safety

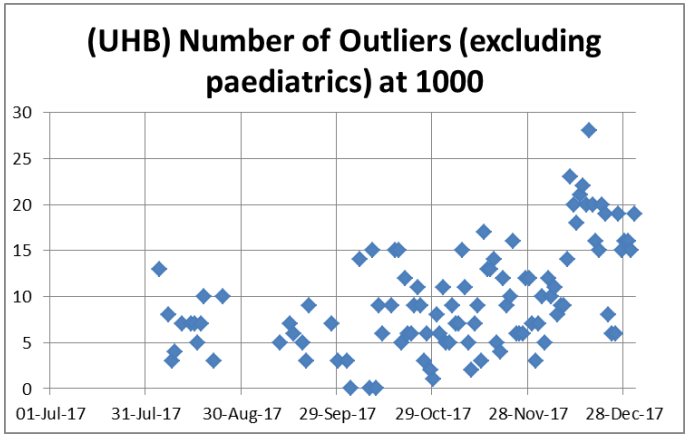
Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group

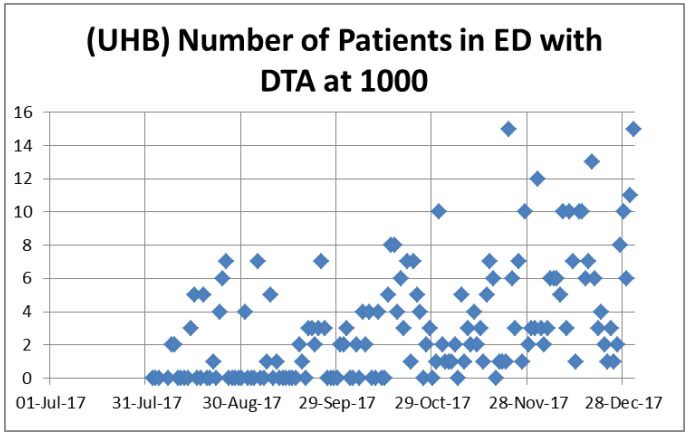
Variation in safety metrics attributable to winter pressures rather than solely by the overnight closure.

UHB ED Safety Metrics







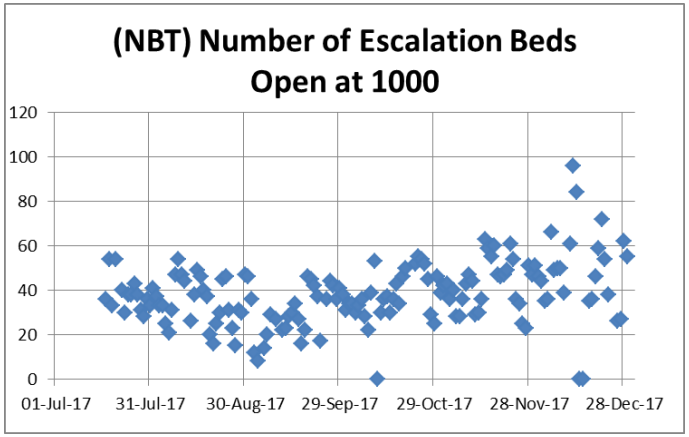


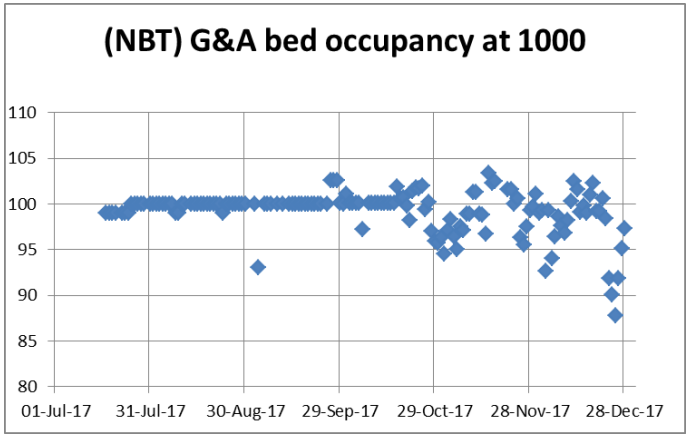
NBT ED Safety

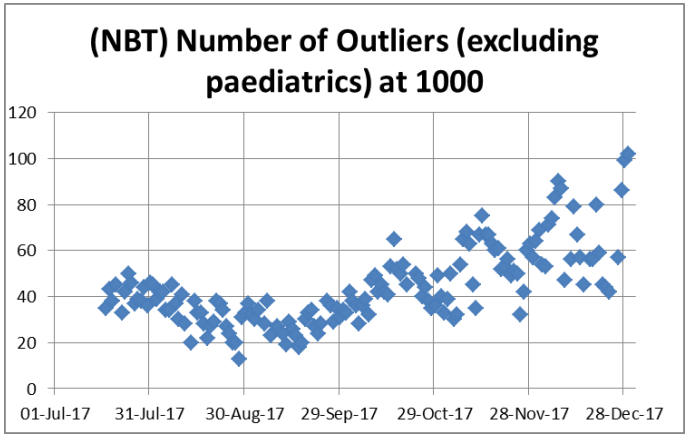
NHS
Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Group

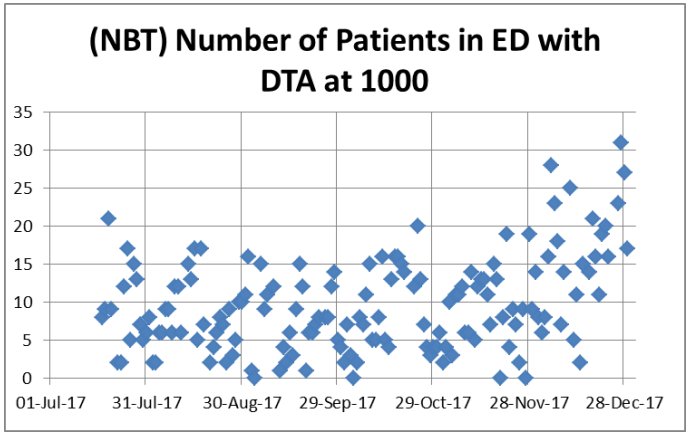
Months following closure saw no impact attributable to the overnight closure. The increase in outliers, and other variations (e.g. in bed occupancy) are all attributable to winter pressures and WAHT overnight A&E activity at NBT remains below expected levels.

NBT ED Safety Metrics









EIA Summary

NHS
Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group

- **Jun-17**: EIA completed by WAHT identified, male, non white, British individuals who have a primary diagnosis of mental health are 5% more likely to attend the WAHT Emergency Department out of hours. No other characteristics were flagged.

- **Aug-17**: WOCOG 1 month closure report concluded it was too early to complete a full system EIA.

- **Dec-17**: The experiences of at risks groups were reviewed by WAHT. Ongoing qualitative assessments are required (WAHT and AWP will continue this work). Existing mental health service provisions were deemed appropriate following the recommendations of a specific task and finish group.

- **Feb-18**: Following the initial EIA screening, we will now proceed to a full EIA incorporating protected characteristics into risks, issues and actions.

UHB QIA Highlights

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Clinical Commissioning Group

Patient Safety

- There has been an impact on all aspects due to the compounding effect of an increased number of attendances from Weston, with the overall increased pressure on emergency care.
- This has led to overcrowding in UHB Bristol ED departments particularly at peak times.
- The impact on patient safety has been mitigated as much as possible with the use of increased staffing to support patients in the queue, use of 'rapid assessment' protocols and 'boarding of patients in wards.

Patient Experience

- There has been significant impact due to operational pressures on services and additional transfers for patients between hospitals. However few patients have raised complaints regarding the need to be seen at UHBristol overnight or the transfer back to Weston with no incidents formally reported.

Clinical Outcomes

- Increases in cancelled operations have been seen as well as an impact on elective day care procedures due to the use of the Day Unit as extreme escalation capacity. This has occurred during the winter and was not an issues earlier in the overnight closure period.

There have been no serious incidents or complaints related to patient safety, and where issues have been raised these have been dealt with promptly through the BNSSG system group and local internal operational group

NBT QIA Highlights

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Clinical Commissioning Group

Patient Safety

- A minor impact on NBT of attendances from Weston.
- There have therefore been no safety concerns attributable specifically to the Weston Temporary Overnight Closure.

Patient Experience

- There has been no patient experience concerns attributable specifically to the Weston Temporary Overnight Closure.

There have been no serious incidents or complaints related to patient safety, and where issues have been raised these have been dealt with promptly through the BNSSG system group and local internal operational group

WAHT QIA Highlights

NHS
Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group

- WAHT ensured there was a range of mitigations for expected impact on patients and activity.

- Mitigations were put in place to ensure that patients that required attention during the period of ED closure will be able to access services.

- The risk to patient experience is currently assessed as moderate.

Patient safety
- The risk to patient safety is low

Patient experience
- The risk to patient experience is moderate

Clinical Outcomes
- There is no evidence to show improvements or deteriorations in clinical outcomes

SWAST QIA Highlights

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Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group

ORH were commissioned by SWASFT to analyse and model the impact of the service change at Weston ED. ORH concluded that one DCA (double crewed ambulance) operating from Weston Station from 2200-0800 (7 days a week) is sufficient to mitigate the impact of the ED closure.

Staff are reporting an increase in overruns, a number of which they believe are due to the closure, particularly with shifts finishing at 2200 and 2300. This is a very challenging data set to accurately capture and report but does present a risk around staff lost time, financial cost and lost operational time. **(*work continues to analyse shift overruns)***

Furthermore there is believed to be local operational impact due to resources being out of area due to the closure. Again this is challenging to evidence however it is vital that this is reported as it could result in increased response times to patients.

Patient Safety

- There is a risk of an increase with delayed responses resulting in an increased patient safety risk. This remains despite the additional DCA being funded as operational demand is inherently variable and an increased number of resources are transporting patients out of area.
- There is a potential for increased risk to be taken by clinicians when assessing patients due to the known long journey time and a reluctance to travel unless absolutely necessary. This risk is also true of patients not wishing to travel due to the need to go out of area, whereas they would previously have been happy to go to Weston ED.

Patient Experience

- Potential impact due to increased response times due to vehicles being out of area.

Clinical outcomes

- Risk of adverse clinical decision making due to closure and distance to alternative EDs. This could be both staff factors and patient factors but the usual escalation/ reporting processes and professional standards remain in place.

Risk Management

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Clinical Commissioning Group

System risks are consistently and reliably reviewed between system operational and clinical colleagues. The risks remain controlled and ongoing controlling mitigations are in place and being developed. The risks with the current highest scores are extracted below.

WAHT A&E Overnight Closure Risk Log

Low Risk	0- 3
Meduim Risk	4- 7
High Risk	8- 12
Extreme Risk	15- 25

Version 1.18

		Pre Mitigation Score				Post Mitigation Score					Live Risk Score		
Ref.	Risk	Probability	Impact	Risk Score	[action owner] Mitigations	Probability	Impact	Risk Score	Last Update	Commentary / Updates	Probability	Impact	Risk Score
9	• Sustainability of WAHT ED staffing as result of temporary changes. E.g. through loss of trainees and other staff & inability to recruit at senior and specialist levels. Cascade of further staff leaving.	4	5	20	1. [WAHT] Staff comms and engagement, daily briefings 2. [WAHT] Engaging and using substative recruitment company to fast track middle grade and consultant recruitment 3. [WAHT] Regular staff engagement with future plans for urgent care services including outputs from Healthy Weston and UHB partnership board 4. [WAHT] Prioritisation of ED staff for development of ACP roles.	3	4	12	03-Apr	**31/07/2017:** Some recruitment has taken place although 6 nursing staff have left. Planned to level out further into the process. **23/10/2017:** Changed risk to 4x4=16, probabilty increased due to recent nursing staff resignations. Following prolonged period where ED has not re-opened predicted further staff may follow. **18/01/2018:**Risk reviewed, proposed probabilty moved to 3 due to ENP risk. 1 x substantive consultants left, along with long term locum. Probabilty held at 4. **03/04/2018:** Risk reviewed medical staffing has improved (with the appointment of all substantive middle tier posts subject to VISAs and competency checks) Score should remain the same as recent band 5 nursing turnover has increased.	4	4	16
26	• Risk of adverse impact on WAHT staff. Staff fatigue, low morale, leading to sickness and turnover above existing pressures.	4	4	16	1. [WOCIG] Further contingencies identified to manage demand as part of single operational plan. 2. [COG] Monitoring of staff survey results through Quality subgroups and escalation through COG.	3	4	12	03-Apr	**31/07/2017:** P.Collins detailed WGH are loosing some staff but gaining others. Staff fatigue potentially less but morale fragile until next steps described. Link risk into workforce issue/risk. **23/10/2017:** Risk to remain live. **18/01/2018:** Risk to remain live, unchanged **03/04/2018:** Increased nursing staff turnover currently. Staff survey results for 2018 show poor scores but departmental analysis in currently being analysed for themes/trends	4	4	16

Risk Log v1.18

Finance Summary

NHS
Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Group

Month 10 Financial Impact Assessment

- Year to date adverse impact of £2m; driven primarily by additional bed capacity in other hospitals and additional transport costs.
- The impact is primarily in Weston Trust (£2.1m adverse) due to significant reduction in emergency admission impact, but limited reduction in capacity and costs.
- Overall hospital activity is marginally lower, mainly A&E attendances leading to a small saving to the commissioner of £254k.

Latest Findings

Impact YTD	Description of Activity
£2.0m Increase	in 19beds at average per bedday direct cost
£0.4m Increase	in Transport / BrisDoc / NSCP
(£0.4m) saving	in Weston A&E staffing costs
£2.0 m total increase	**Based on these assumptions**

Impact On Commissioners:	Impact On Weston:	Impact On Other Hospitals:	Impact On Other Providers:
(£0.3m) Reduced activity (A&E attendances)	(£2.5m) reduced activity against June baseline	This is differential due to the reported average length of stay	The impact on other providers is cost neutral as commissioners have picked up these costs.
£0.4m Increase in Transport / BrisDoc / NSCP	£0.4m saving in Weston A&E staffing costs	UH Bristol (2.8 days), NBT (5.5 days) and Taunton (4.4 days)	
Total: £0.1m Saving	**Total: £2.1m Cost**	**Total: £0.3m Marginal Gain**	**Total: Cost Neutral**

Comparison to planning assumption

The previous plan assumed a cost pressure for year to date of £3.1m. The reduction of £1.1m is caused mainly by £0.7m lower out of hospital costs; and removal of A&E Dept cost premiums from the analysis

Issues

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Clinical Commissioning Group

Ref.	Issue	WCOOG Resolution
1	**Discussion regarding what is the clinical governance around patients advised to attend, and then do not present.** BrisDoc to send WAHT the details of the patient that requested a direct admit but was refused by WAHT (BrisDoc told that Weston didn't admit patients after 10pm).	2 x Clinical SOPs developed and shared across BNSSG for management of patients outside of opening hours.
2	**Overnight repatriations issues:** --sent back to WAHT reportedly at 3am from neighbouring hospitals --Incorrect form being used (not updated) --Confusion at ward level regarding the difference between normal repatriations, and those organised due to WAHT overnight A&E closure.	Repatriation SOP revisited, and re-communicated to system partners. Included in staff communications and FAQs, neighbouring Trust reflected appropriateness of any repatriation undertaken at 3am and updated internal policies.
3	**Simplified cardiac pathways** to be taken through COG, reducing numerous conveyance options after 17:00.	COG reviewed and direct conveyance pathways to UHB (BHI) agreed, rather than separate drop off times at varying locations.
4	Reported **increase in activity presenting at MPH/UHB** due to WAHT A&E overnight closure (above site specific modelling, below total modelling).	Shift in modelled activity which presented at MPH and UHB, lesser volumes presenting at NBT. Data to be validated and presented in 6 month review.
5	111 phone outside WAHT A&E department, **111 call volume reported as unusually quiet** and difficulties with potential patients being unable to hear.	Resolution through WAHT and local telephony provider, issue identified as cabling within local area.
6	**Stroke pathway concerns** in regards to schedule of opening and drop off points across BNSSG.	Proposed to ensure all stroke pathways after 10:00 pm are directed to NBT. Small T&F addressed this and presneted to BNSSG clinical overisght group for system resolution, extends beyond the scope of WOCOG.
7	**Urology pathway concerns,** regarding suitability of patients conveyed to UHB.	Task & finish group agreed all known urology patients to be directly conveyed to NBT
8	Appropriate **internal hospital escalation revisited** and communicated - due to misunderstanding of specific repatriation agreement.	WAHT site teams trained accordingly, and confirmed escalation through Dir. of Operations and WOCOG representatives
9	**Transport not bookable for repatriating patients without a receiving ward code**. WAHT unable to provide ward code immediately.	WAHT adopted a portable phone for site team usage, for othr Trusts to directly contact and obtain ward code/confirm repatriation possible.
10	Clinical concerns regarding **#NOF patients being transferred between hospitals.**	WAHT consultants drafted a SOP, in agreement with SWASFY and WOCOG for adopting a direct admission pathway for #NOF patients.
11	Pre allocated patient **transport times was not matching allocated demand.** Patients were being referred later in the morning.	WOCOG agreed the pre allocated transport should be shifted to a later period.
12	**Experience of OOH MH users in WAHT** cause for concern OOH, identified in WAHT EIA.	Activity levels did not identify exceptional activity. MH subgroup established to present findings and recommendations, activity deemed as managed. Agreed that this is to be revisited at a later juncture and report back to WOCOG.
13	GPs sending **patients from Weston catchment postcodes into MPH during WAHT A&E opening hours.**	Specific communications issued to general practices to address

Next Steps

NHS
Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Group

1. Ensure completion of full system EIA
2. Design and development of capturing patient experience measures
3. Continued engagement with the Healthy Weston programme
4. Ongoing governance and metric monitoring through WOCOG
5. Workforce reviews through WOCOG and COG
6. Focus on system wide communications
7. Completion of ongoing reviews (as required)

Appendices – (data)

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To ensure data is ready and approved for the 6 month review, 5 months worth of data has been used.

WOCOG – 5 month review

Summary of modelling and activity (M1)

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Figures are per day. All figures compare impacts, ie suspected diverts or variance between pre- and post- closure		Modelling		Activity Tracker	PAS Dump		WOCIG agreed estimates
		Unmitigated	Mitigated		Main Weston Catchment	Out of Area & Somerset & North Som CCGs	
BRI	ED - Walk-Ins	6	0.4	1.5	1.4	3.8	1 to 2
	ED - Ambulance	5	4.0	4.5	3.6	6.3	4 to 5
	EM Admits	2.8	2.8	3.3	2.8	3.3	3
	Beds	20.3	5.5	7.0			
	Repats	0	1.2	1.0			1
Southmead	ED - Walk-Ins	7	0.5	0.3	0.3	2.2	Less than 1
	ED - Ambulance	6	4.5	1.5	1.2	2.3	1 to 2
	EM Admits	3.2	3.0	0.9	0.5	0.3	Less than 1
	Beds	25.8	6.1	2.4			
	Repats	0	1.5	0.4			Less than 1
Taunton	ED - Walk-Ins	2	0.1	1.5	0.1	1.6	1 to 2
	ED - Ambulance	2	1.4	3.2	0.6	2.9	3 to 4
	EM Admits	0.9	0.9	1.9	0.3	0.3	1
	Beds	6.3	1.9	6.3			
	Repats	0	0.4	0.1			Very few to date
Total	ED - Walk-Ins	15	1.1	3.3	1.9	7.6	4 to 5
	ED - Ambulance	12	10.0	9.3	5.4	11.5	9
	EM Admits	7.0	6.7	6.1	3.6	3.9	5 to 6
	Beds	52.5	13.5	15.7			
	Repats	0	3.1	1.5			1 to 2

The above table shows agreed activity at the **one month** review position.

WOCOG – 5 month review

Exec Summary – Overall and Acute

NHS
Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Group

The table to the right shows the headline position changes for daily activity, showing change between: Month 1 (Jul) and mitigated model; Months 2-5 (Aug-Nov) against Mitigated Model and Months 2-5 against Month 1.

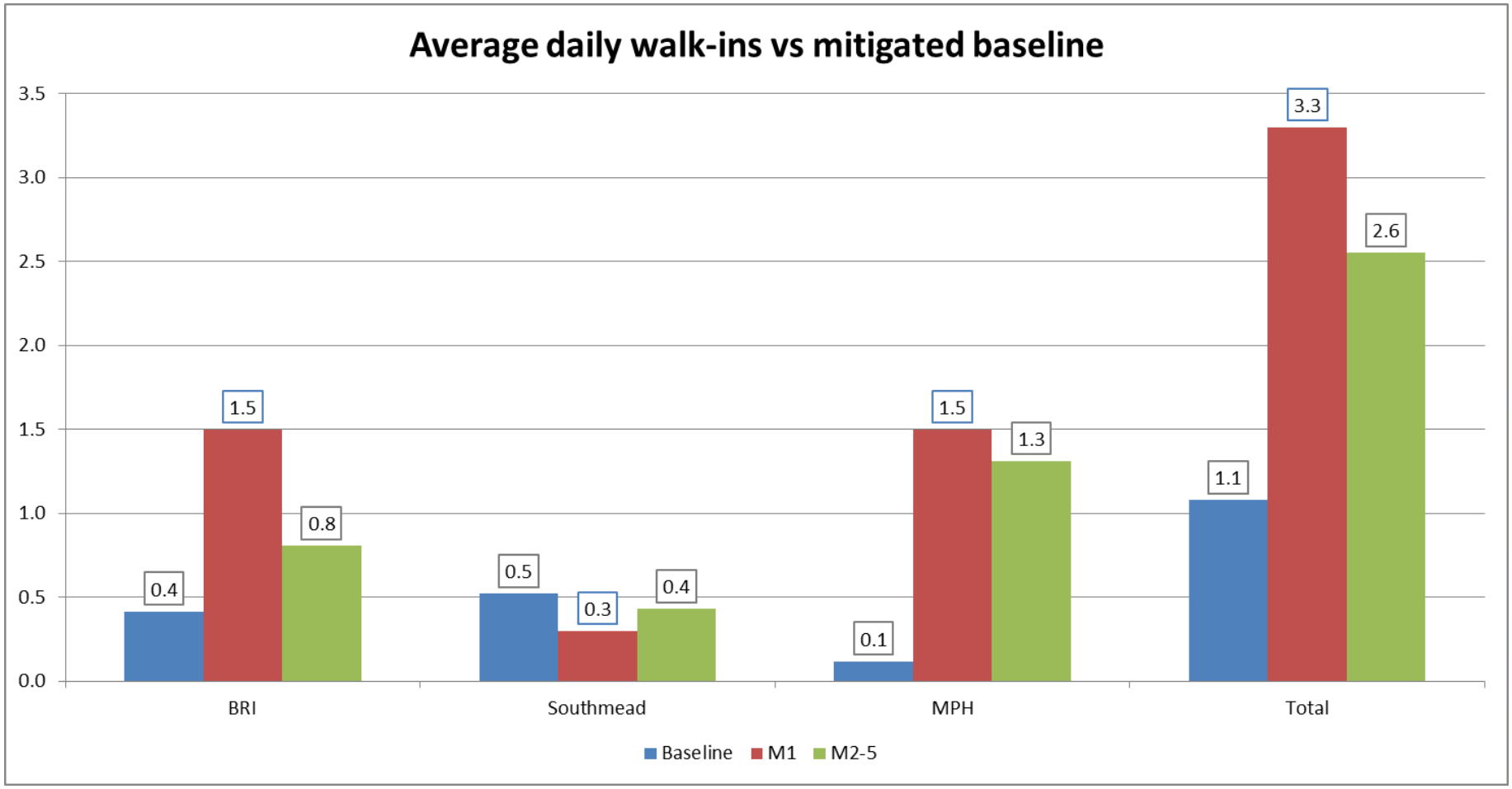
Further information detailing the average daily activity values and change is available on later slides.

Provider	Measure	M1 Compared to Mitigated Model	M2-5 Compared to Mitigated Model	M2-5 compared to M1
System	**ED - Walk-Ins**	**Higher**	**Higher**	**Lower**
	ED - Ambulance	**Lower**	**Lower**	**Lower**
	EM Admits	**Lower**	**Lower**	**Lower**
	Beds	**Higher**	**Higher**	**Higher**
	Repats	**Lower**	**Higher**	
BRI	ED - Walk-Ins	Higher	Higher	Lower
	ED - Ambulance	Higher	Higher	Lower
	EM Admits	Higher	Higher	Lower
	Beds	Higher	Higher	No Change
	Repats	Lower	Higher	
Southmead	ED - Walk-Ins	Lower	Lower	Higher
	ED - Ambulance	Lower	Lower	Lower
	EM Admits	Lower	Lower	Lower
	Beds	Lower	Lower	Lower
	Repats	Lower	Higher	
Taunton	ED - Walk-Ins	Higher	Higher	Lower
	ED - Ambulance	Higher	Higher	Higher
	EM Admits	Higher	Higher	Higher
	Beds	Higher	Higher	Higher
	Repats	Lower	Higher	

WOCOG – 5 month review

Activity Tracker - Walk-Ins

NHS
Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Group

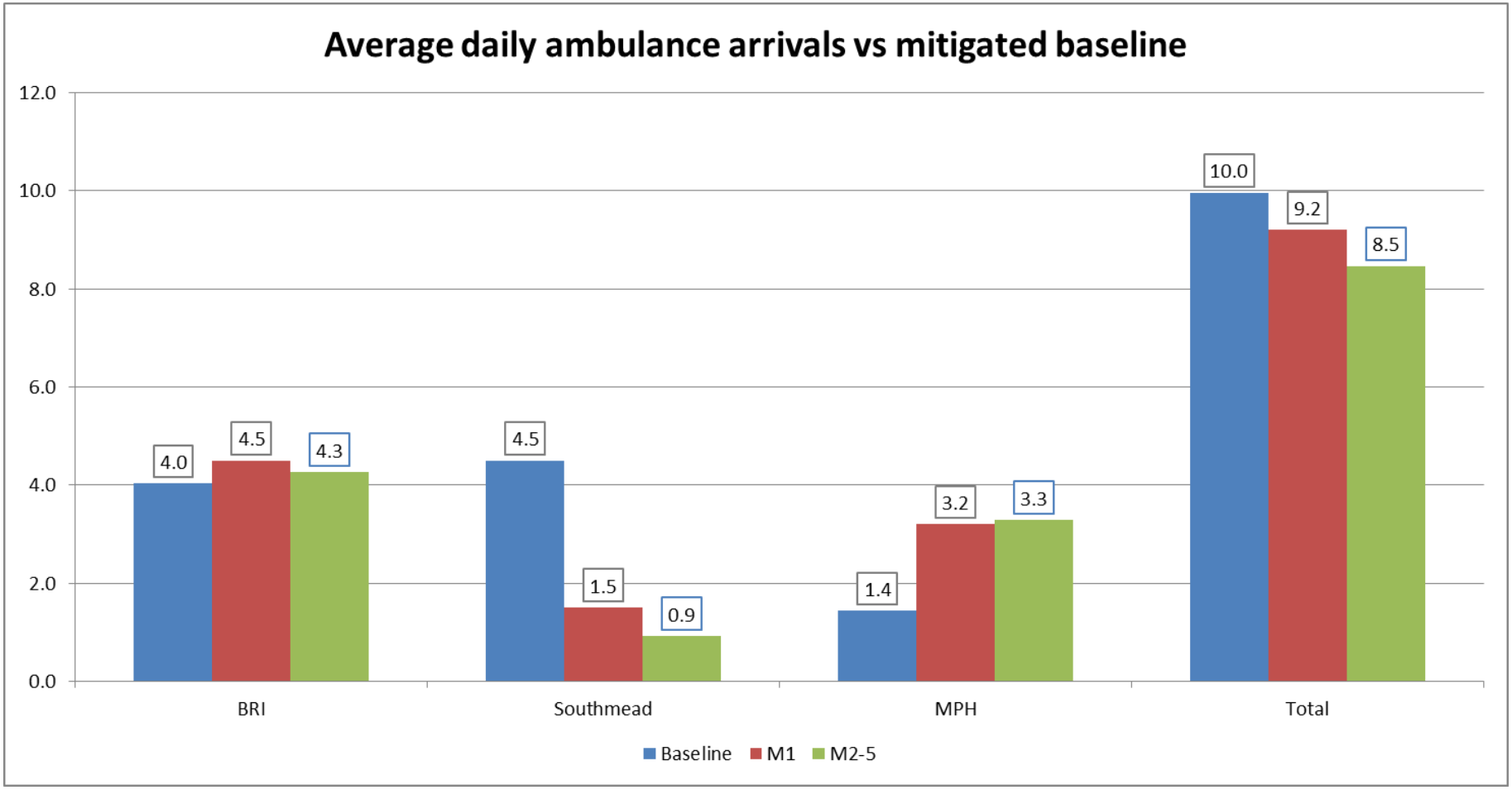


The above chart shows the daily walk-in average mitigated baseline position and average daily activity for M1 and M2-5

WOCOG – 5 month review

Activity Tracker - Amb arrivals

NHS
Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Group

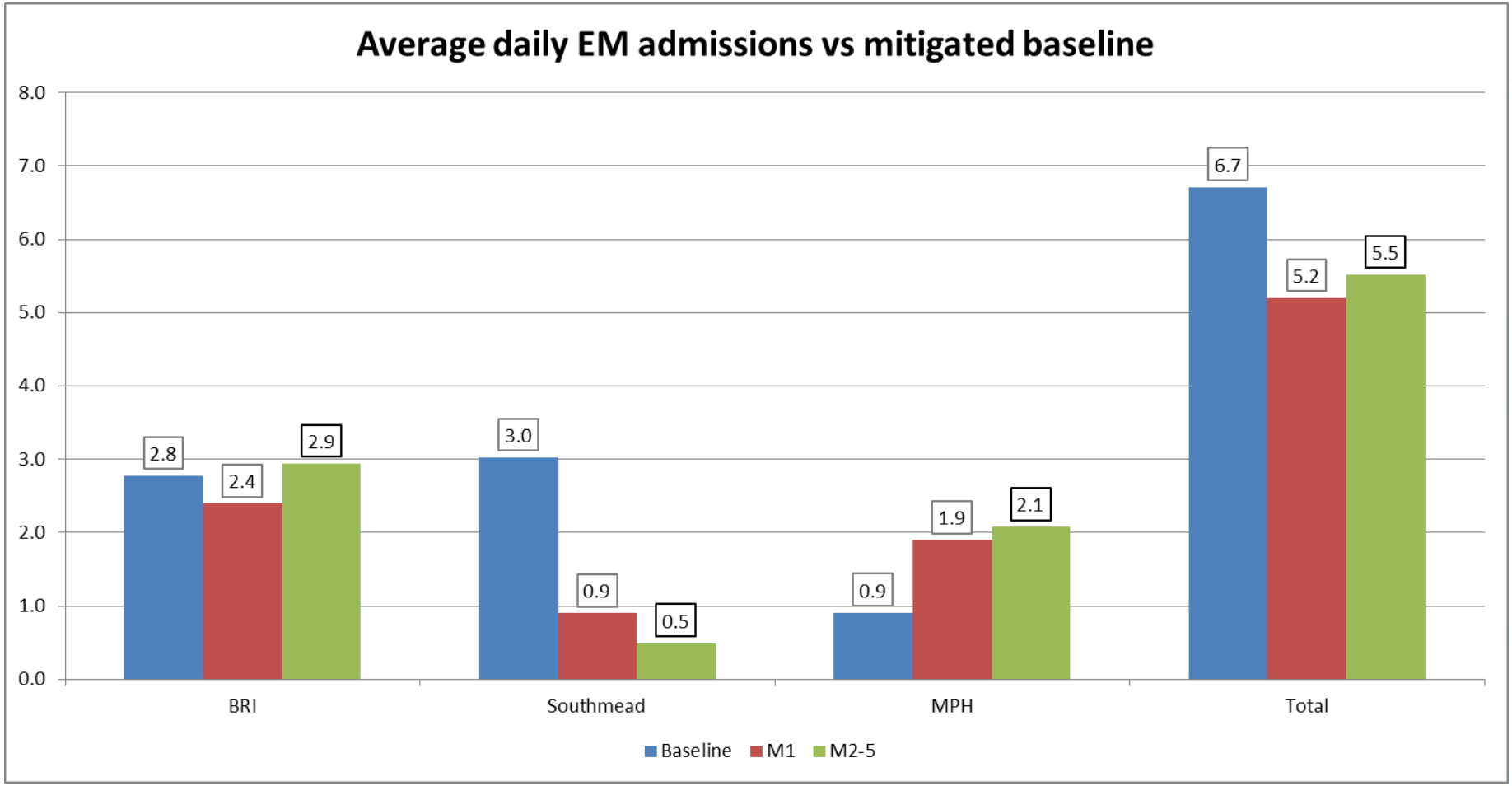


Shaping better health

WOCOG – 5 month review

Activity Tracker - Admissions

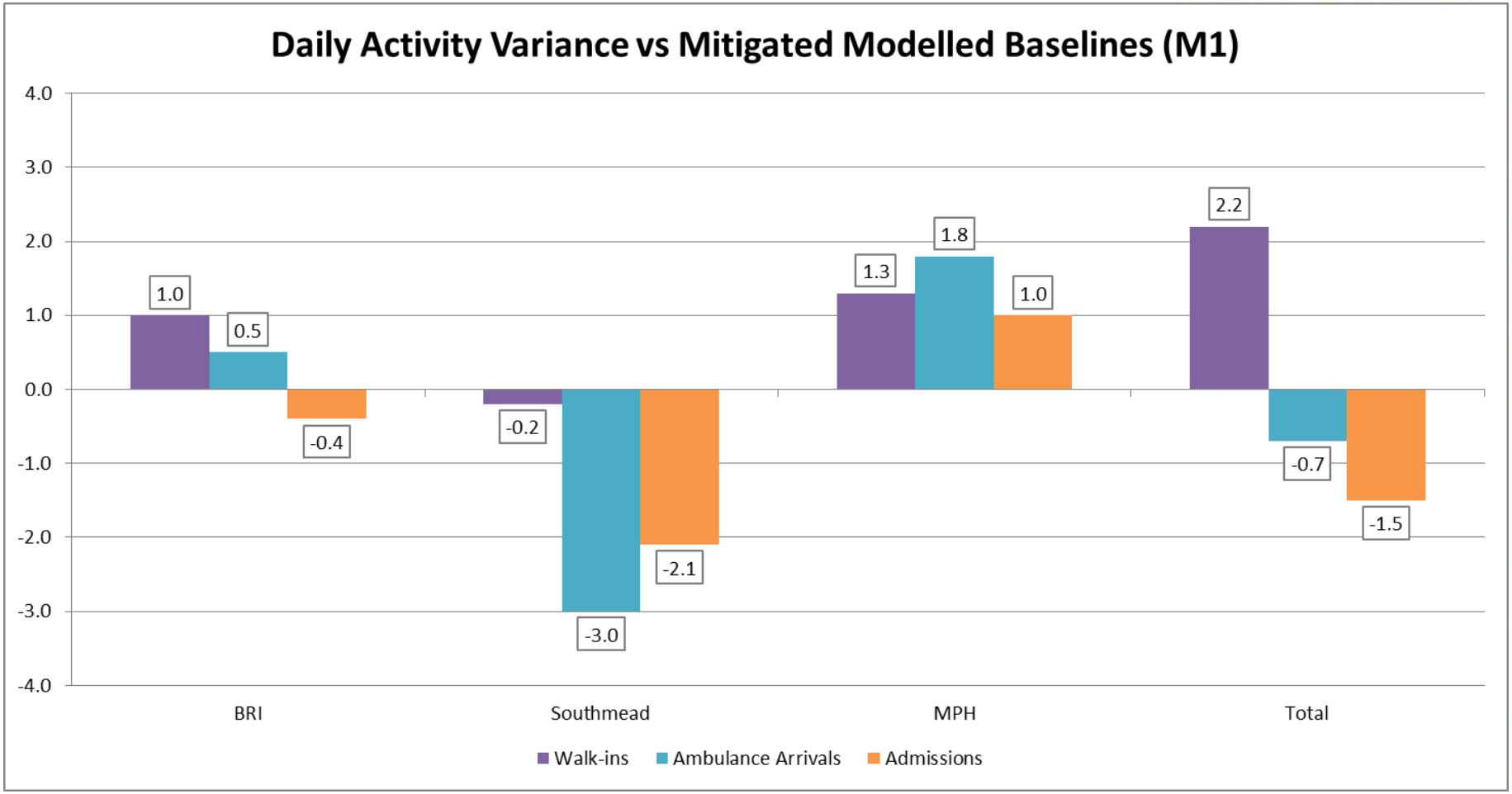
NHS
Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Group



WOCOG – 5 month review

Activity Tracker - Run-rate vs unmitigated baseline

NHS
Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group



The above chart shows the variance between the M1 daily activity and the baseline, showing walk-ins, ambulance and arrivals and admissions by provider. For example, Walk-ins at BRI were 1.0 daily activity higher than the baseline.

WOCOG – 5 month review

Activity Tracker - Run-rate vs unmitigated baseline

NHS
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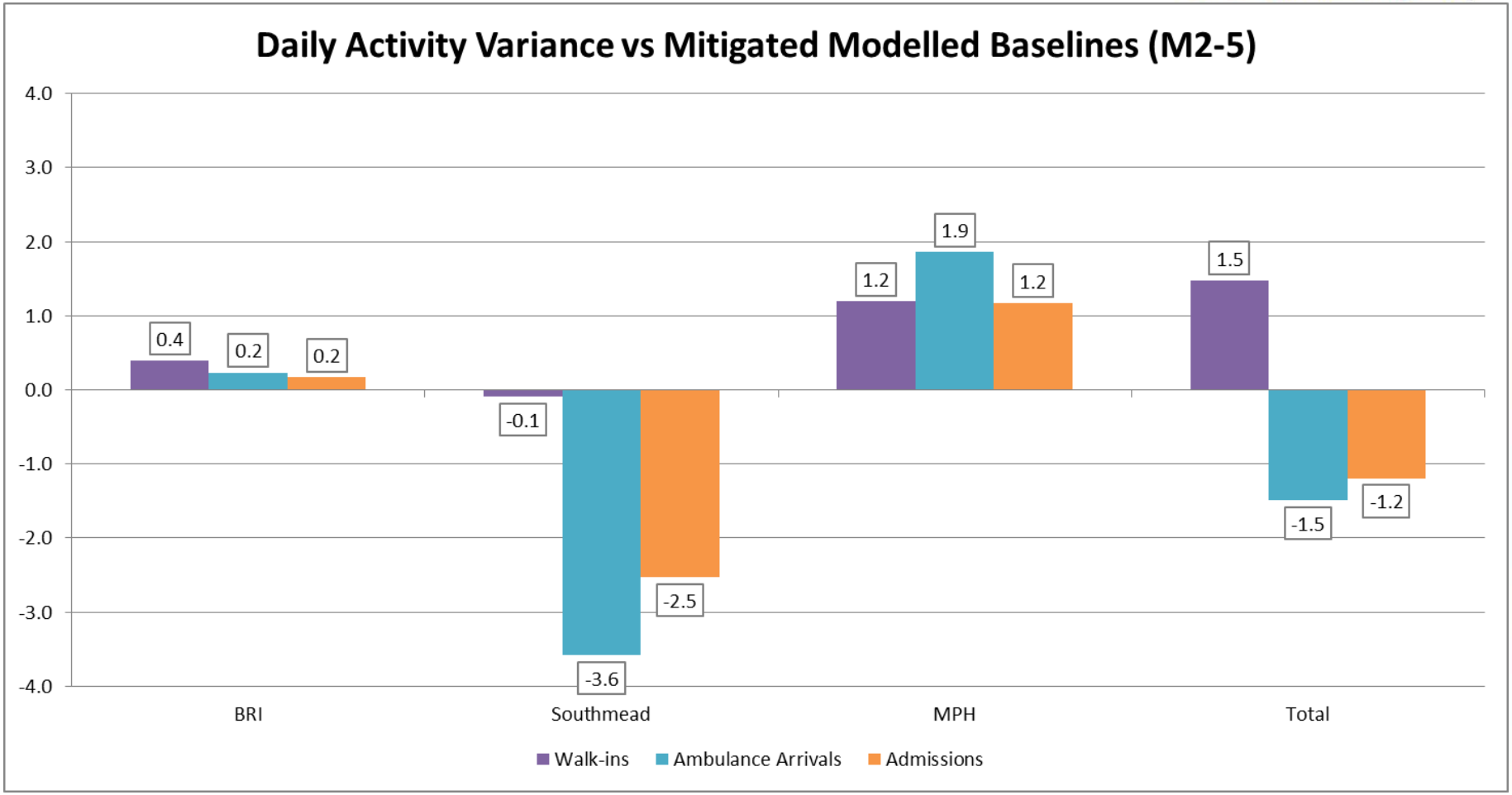


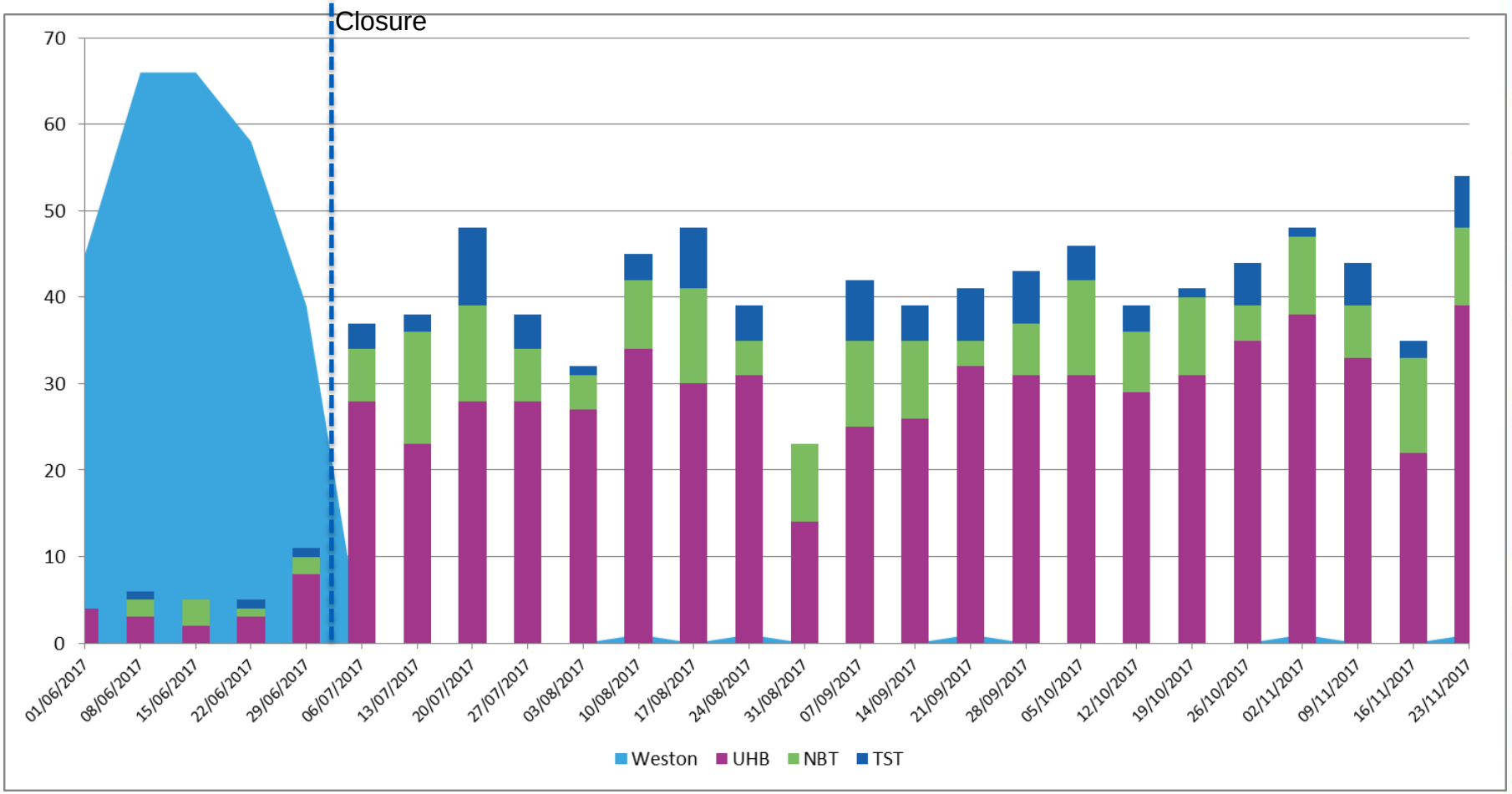
The above chart shows the variance between the M2-5 daily activity and the baseline, showing walk-ins, ambulance and arrivals and admissions by provider.

WOCOG – 5 month review

PAS Data

ED Attends via ambulance at Weston catchment postcodes

Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group



Those postcodes closest to Weston show very few ED attends at neighbouring providers until the overnight closure on 4th July. The majority of these have gone to UHB (+4.2/day compared with the pre-closure June average), with smaller numbers at NBT (+0.9/day) and TST (+0.6/day).

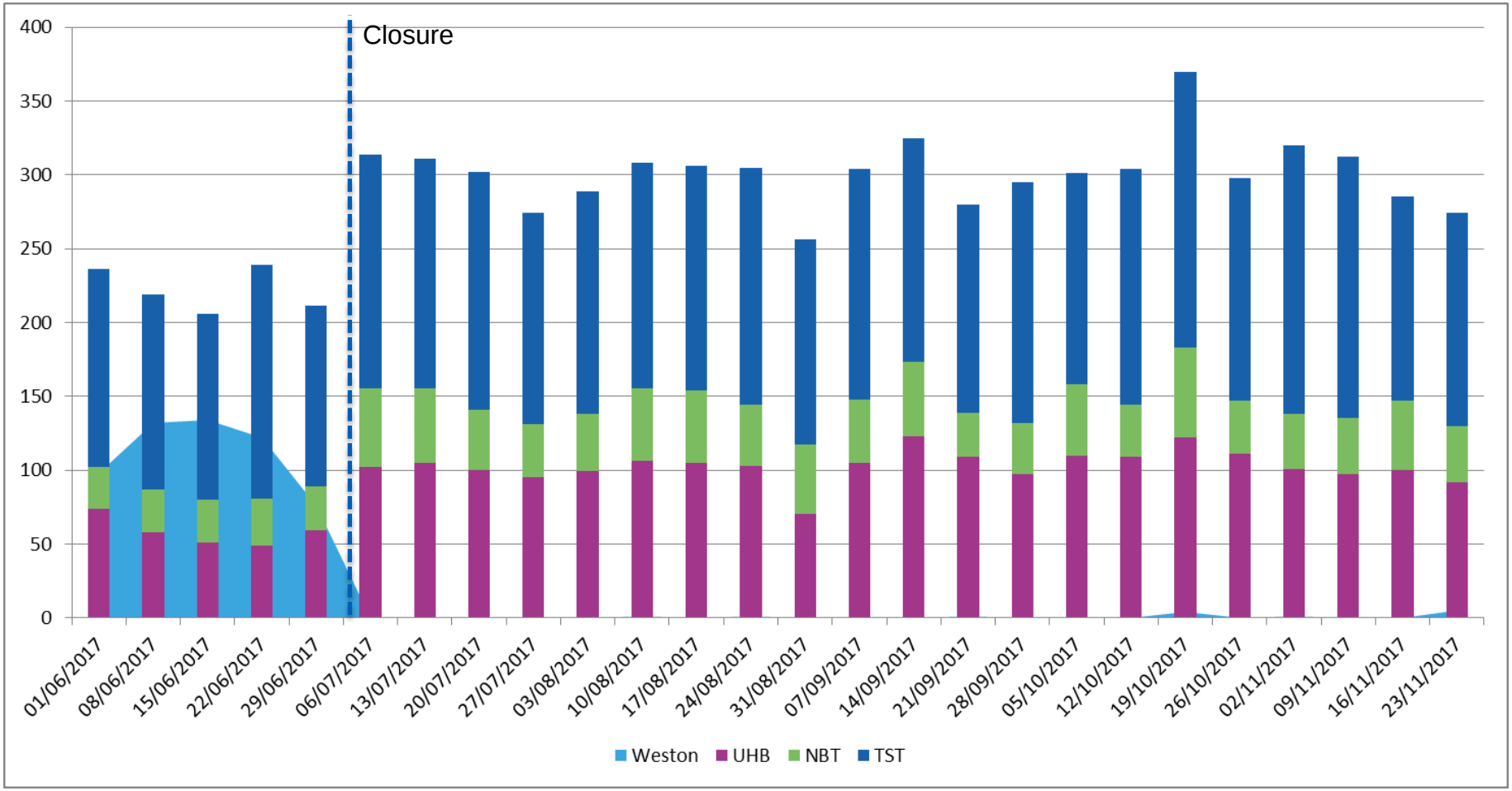
Data via provider PAS dumps, showing for postcode sectors BS22, BS23, BS24, BS25, BS29 & BS49

WOCOG – 5 month review

PAS Data

ED Attends via ambulance for Out of Area* & Somerset &

NHS
Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group



UHB's take of out of area & Som/North Som CCG patients has increased by 6.4 attends per day compared to June with NBT and TST seeing increases of +1.8/day and +2.9/day respectively.

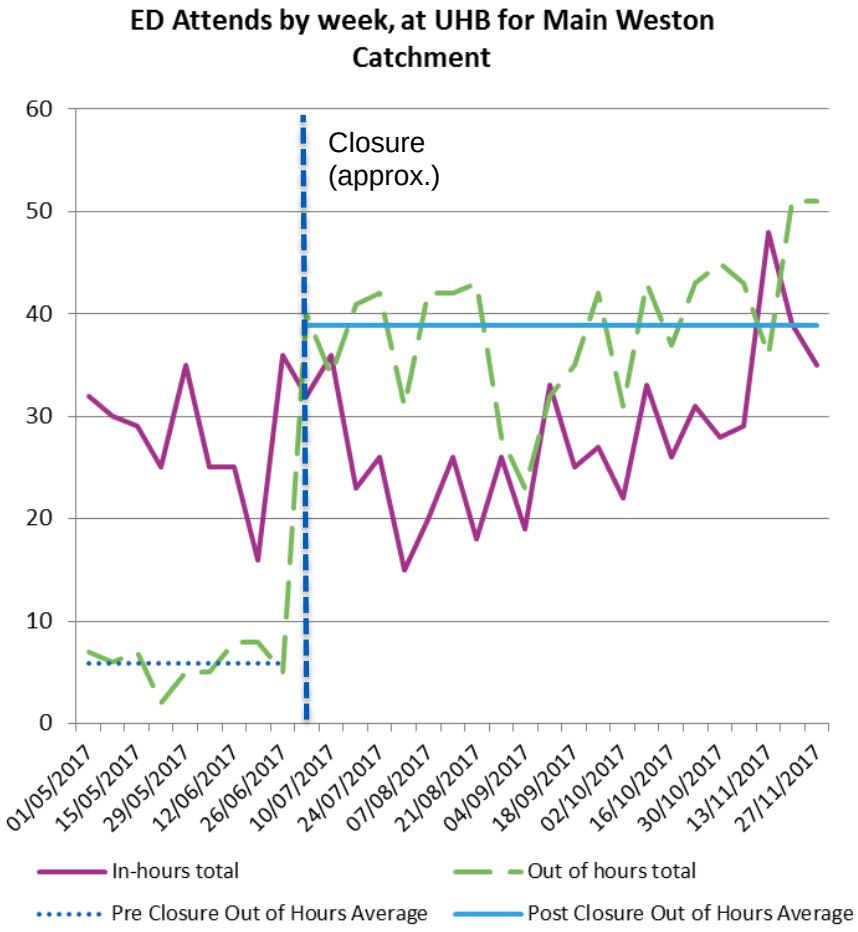
Data via provider PAS dumps, showing for out of area patients and those registered at Somerset CCG and North Somerset CCG GP practices. *Out of area defined as patients living in a non-BS or non-TA postcode sector

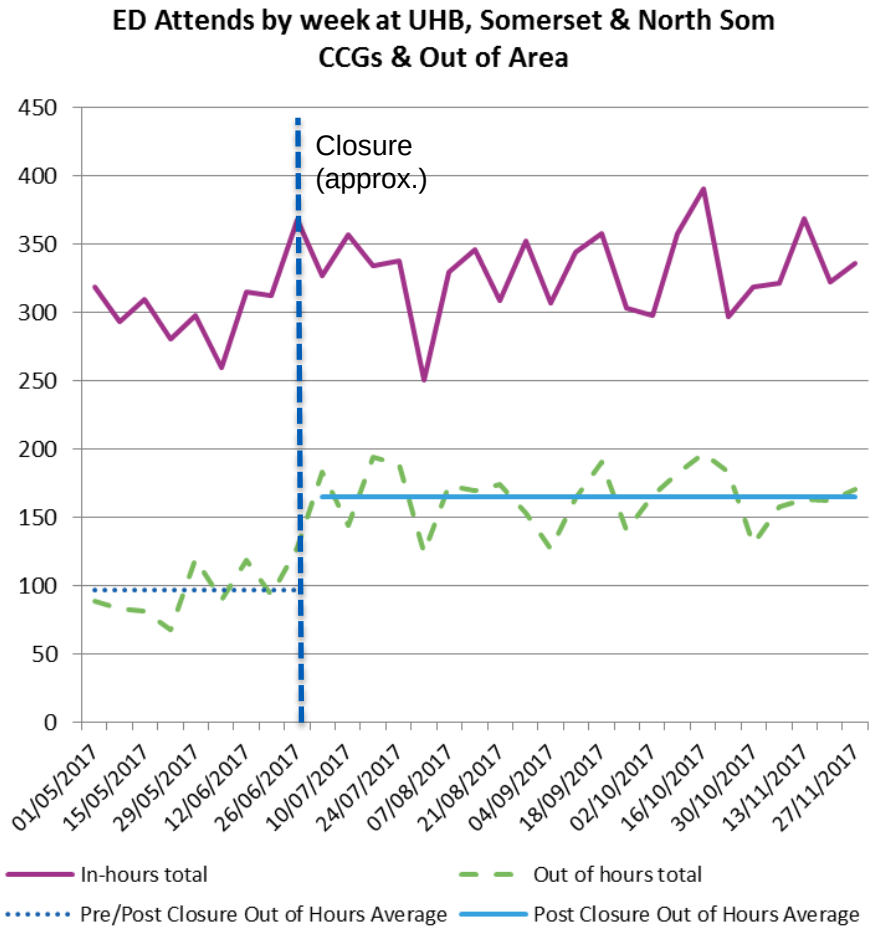
WOCOG – 5 month review

PAS Data

ED Attends – In hours & out of hours

Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group





At UHB, the number of out of hours patients travelling from the Weston catchment postcode sectors has clearly risen since the closure, with a small spike in in-hours attends observed in more recent weeks. Similarly, both the out of hours attendance numbers for Out of Area & Som/North Som CCGs' patients rose noticeably following the closure. - (add average line)

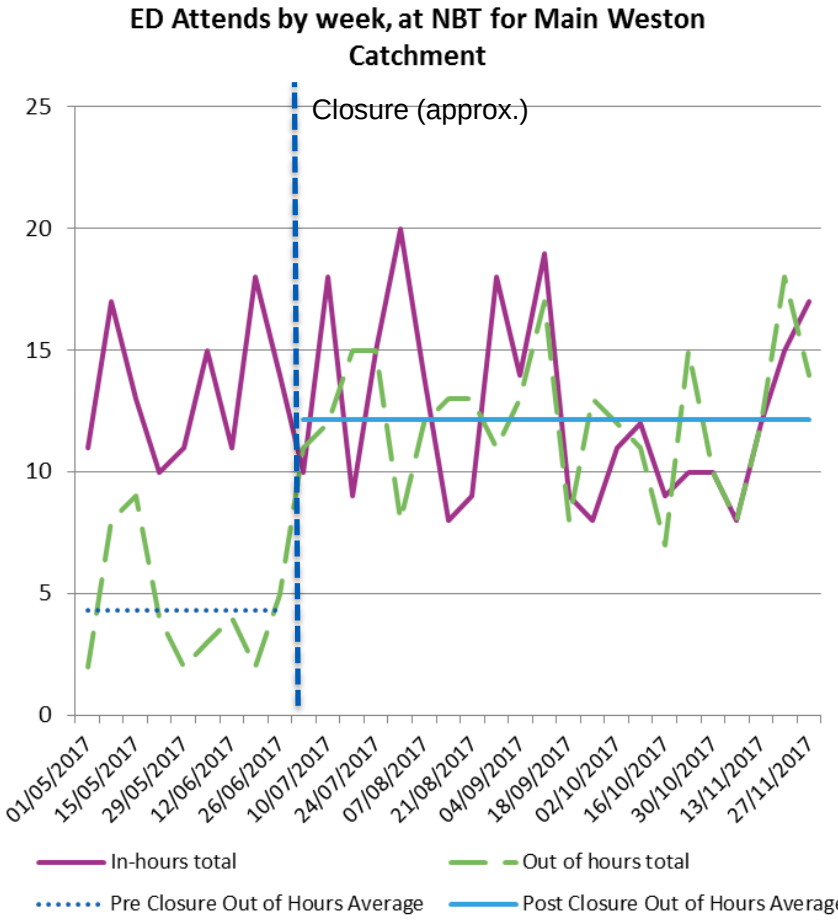
Data via provider PAS dumps, showing for patients from the six main Weston postcode sectors, or out of area patients and those registered at Somerset CCG and North Somerset CCG GP practices. *Out of area defined as patients living in a non-BS or non-TA postcode sector. Patients under 16 excluded.

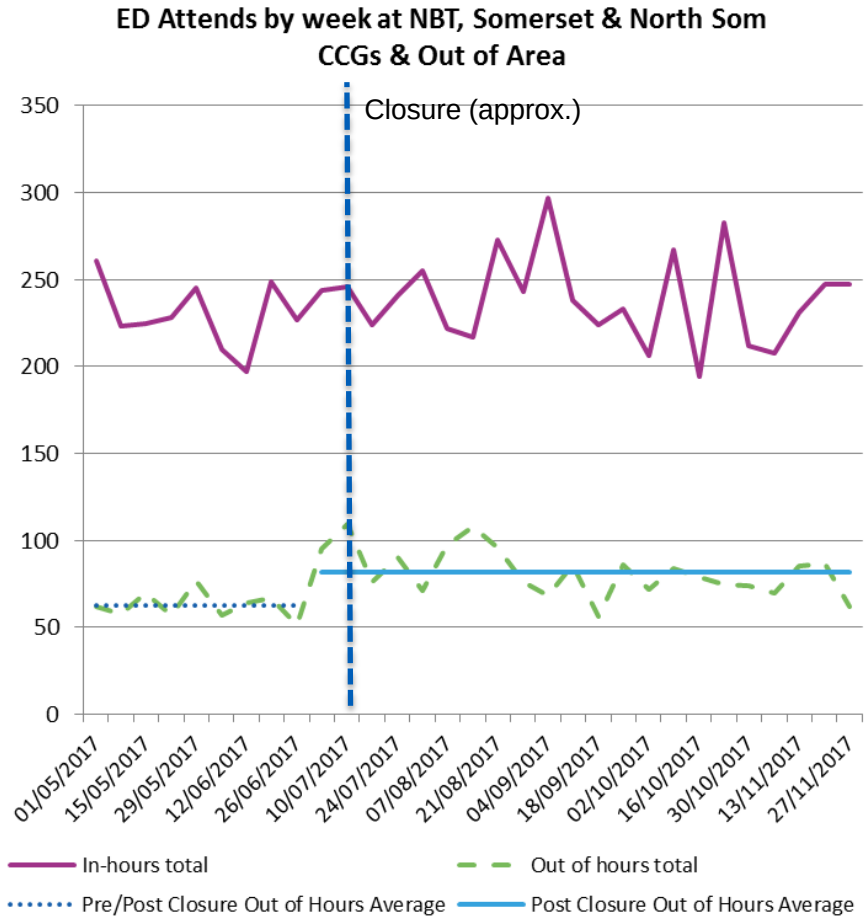
WOCOG – 5 month review

PAS Data

ED Attends – In hours & out of hours

NHS
Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Group





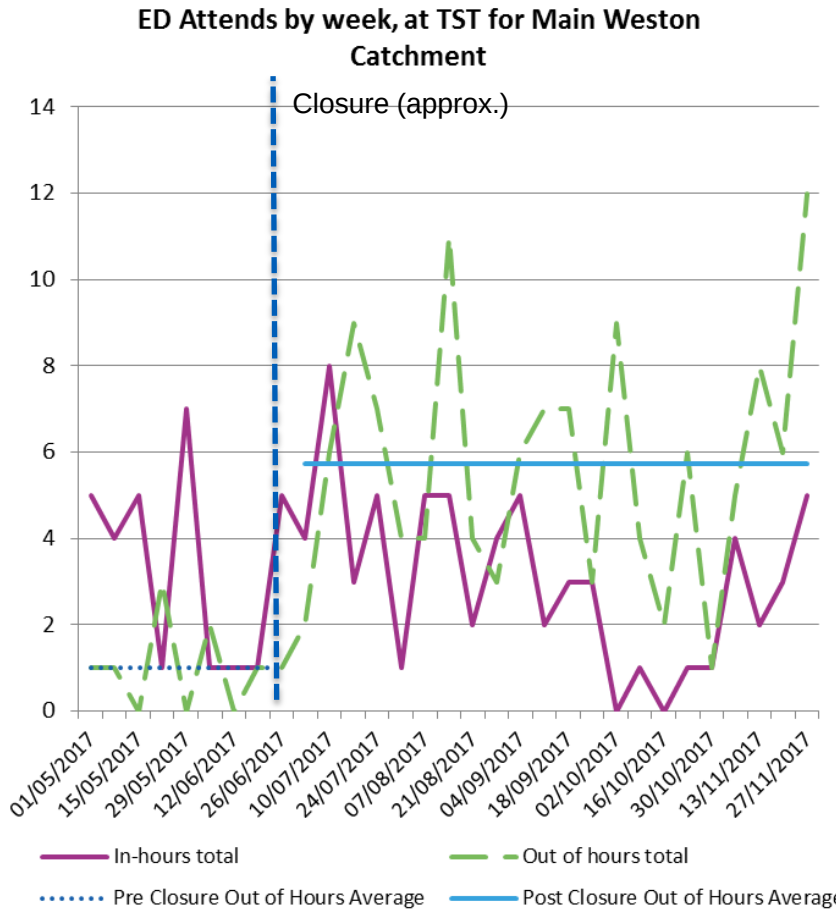
- At NBT, the number of out of hours patients travelling from the Weston catchment postcode sectors has risen since the closure. In-hours attends show weekly variation, though volumes are relatively low.
- Similarly, the out of hours attendance numbers for Out of Area & Som/North Som CCGs patients rose following the closure – attends were higher over the summer months, and have shown reductions towards June levels in Oct/Nov.

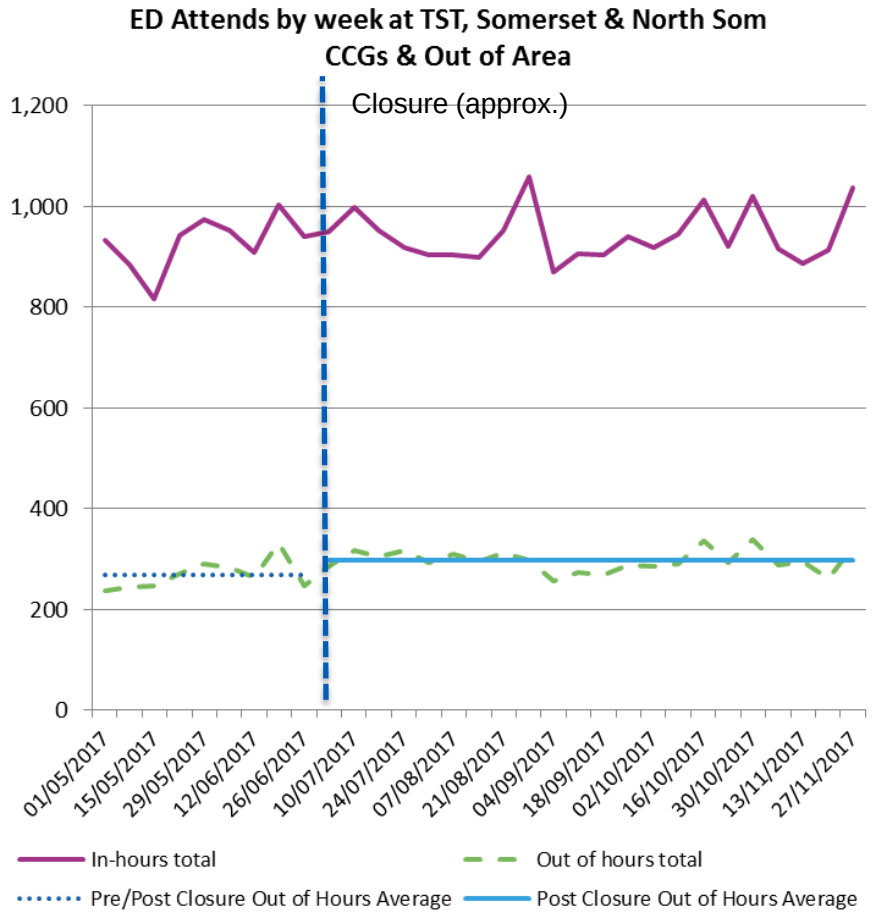
WOCOG – 5 month review

PAS Data

ED Attends – In hours & out of hours

NHS
Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Group





- At TST, the in-hours numbers continue to fluctuate in line with the May and June position. Higher volumes were observed in late July/August compared to May/June, though volumes have since declined. Out of hour attends initially rose noticeably into August, they have subsequently declined to May/June levels. The number of attendances Taunton are seeing from Out of Area & Som/North Som CCGs patients has also increased compared to June with volumes remaining slightly higher than the May/June levels.

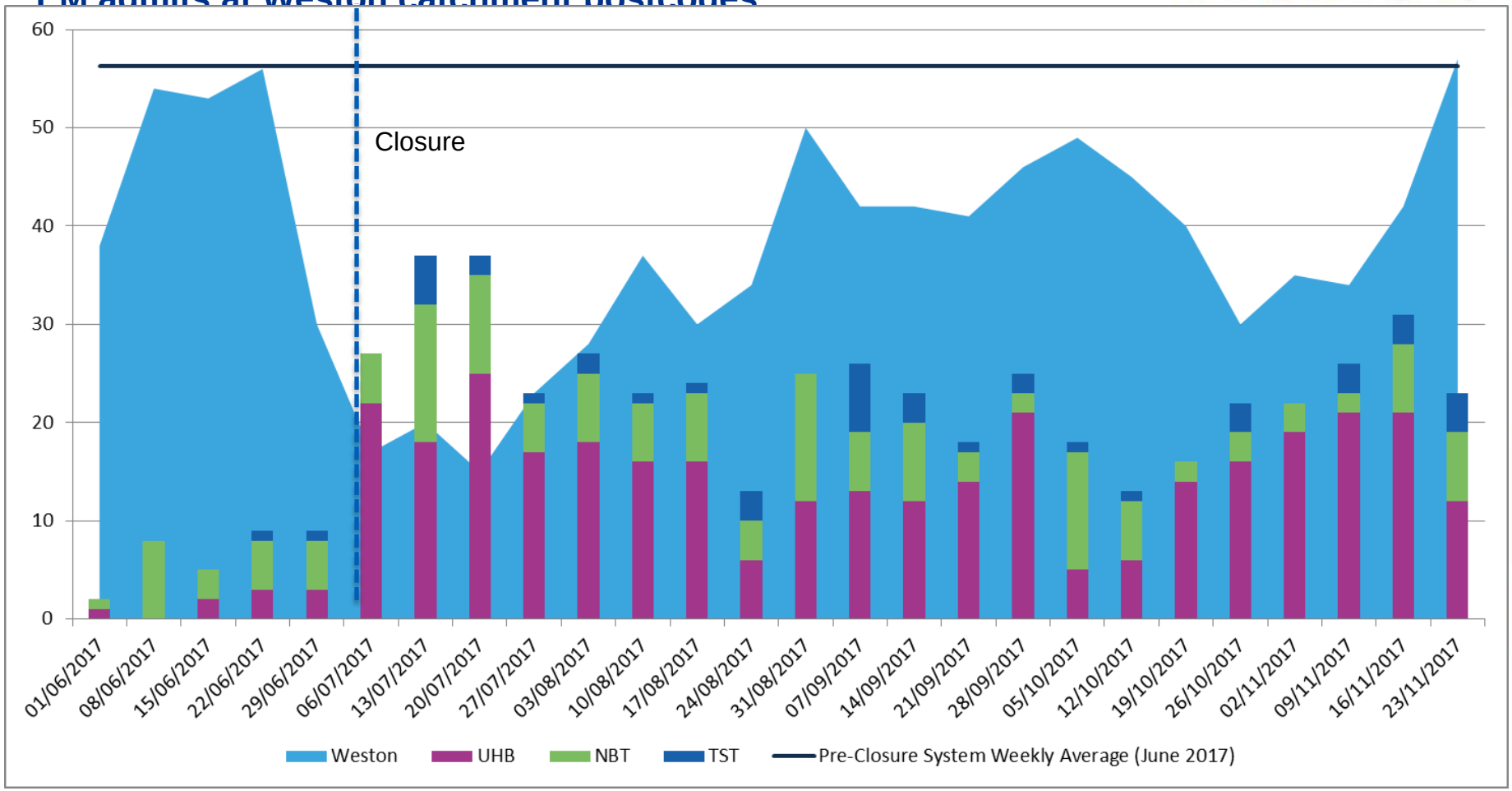
Data via provider PAS dumps, showing for patients from the six main Weston postcode sectors, or out of area patients and those registered at Somerset CCG and North Somerset CCG GP practices. *Out of area defined as patients living in a non-BS or non-TA postcode sector. Patients under 16 excluded.

WOCOG – 5 month review

PAS Data

EM admits at Weston catchment postcodes

Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group



Those postcodes closest to Weston show very few EM admits at neighbouring providers until the overnight closure on 4th July. Following the closure, there was an increase in activity at other providers, though this dropped slightly going into August. The greatest impact is observed at UHB, where there are around 2.1 admits per day (+1.8 compared to June). A number of admits remain at Weston, this is likely due to patients in AE at 22:00 who are subsequently admitted.

Shaping better health

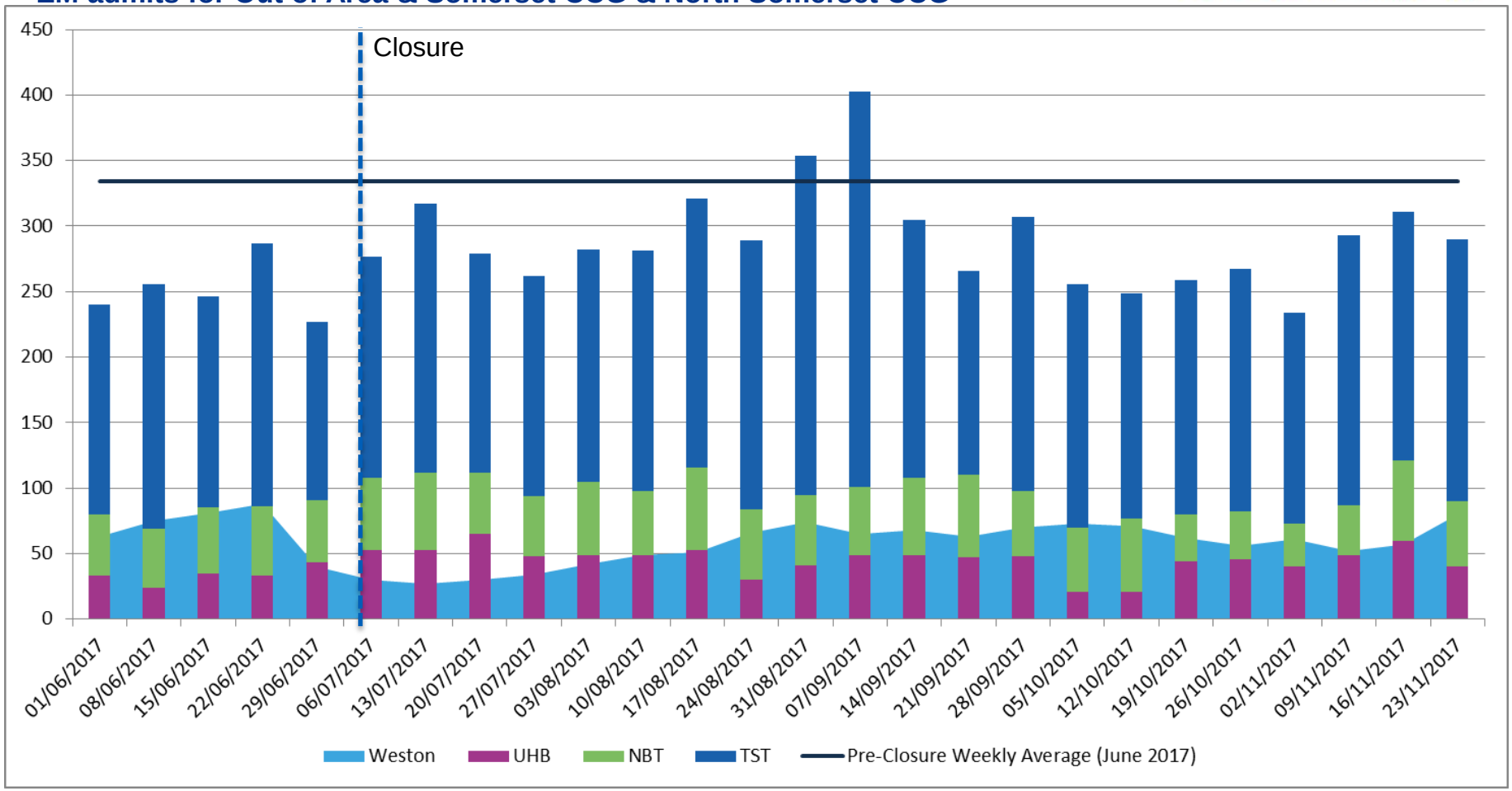
Data via provider PAS dumps, showing for postcode sectors BS22, BS23, BS24, BS25, BS29 & BS49

WOCOG – 5 month review

PAS Data

EM admits for Out of Area & Somerset CCG & North Somerset CCG

NHS
Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group



Out of hours admissions for Out of Area & Somerset & North Somerset CCGs have increased to 28.2 per day at TST (+3.7/day), where the majority of the activity is. UHB have seen an increase of 1.4/day compared to pre-closure (June 2017)

Data via provider PAS dumps, showing for patients out of area patients and those registered at Somerset CCG and North Somerset CCG GP practices. *Out of area defined as patients living in a non-BS or non-TA postcode sector. Patients under 16 excluded.

WOCOG – 5 month review

Definitions and notes

Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group

2 data sources have been used – the Sitrep activity tracker, and weekly activity dumps from the providers. **All activity is for the time period 2200 to 0800 unless explicitly noted otherwise**.

- The **daily Sitrep activity tracker** (appendix A) is a **subjective** measure as it uses colleagues' best understanding of divert impacts.
  - Data for the one month review ran from 4th July to 31st July – four full weeks
  - Data for the 2-5 month review runs from 1st August to 3rd December
- The **weekly PAS activity dumps** (appendix B) is an **objective** measure as it is criteria based, and shows all activity at the providers, according to whichever filters have been set (either by postcode or CCG of GP registration).
  - This means the data are objectively comparable between providers but may not include all Weston closure diverts – whichever way the data is cut, some diverts may not be included in that selection of filters, or some patients who were not diverted may be.
  - Date ranges have been clearly labelled on each slide and often run from before or after the four week period used for the activity tracker, to give an idea of the existing activity numbers.

Comparisons have been made against the modelled baseline, both original position and post-mitigation position, on a daily basis. For example, the modelling suggested Southmead would see 0.5 walk-ins per day, and in reality it has been 0.3

Weston Catchment Postcodes has been defined as the postcode sectors where historically 60% or more of the emergency activity has gone to Weston.
Out of area has been defined as patients living in postcode sectors other than TA (Somerset) and BS (Bristol) who are not registered with Somerset or North Somerset CCG.

WOCOG – 5 month review

Appendix A - Activity tracker detail

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W/C	BRI					BRHC				NBT					MPH					Total				
	Att	Adm	Amb	Walk-in	Current IP	Att	Adm	Walk-in	Current IP	Att	Adm	Amb	Walk-in	Current IP	Att	Adm	Amb	Walk-in	Current IP	Att	Adm	Amb	Walk-in	Current IP
04-Jul	46	20	27	19	7	6	0	6	0	11	4	9	2	0	14	4	9	6	11	77	28	45	33	0
10-Jul	33	11	28	5	39	4	0	4	0	12	9	12	1	15	31	15	24	10	27	80	35	64	20	81
17-Jul	41	19	32	9	52	1	0	1	0	9	10	13	2	22	42	18	30	11	54	93	47	75	23	128
24-Jul	38	14	32	6	35	3	0	2	0	11	1	8	3	14	40	16	26	14	71	92	31	66	25	120
31-Jul	37	20	32	4	55	4	0	4	0	9	5	6	3	8	36	17	22	12	70	86	42	60	23	133
07-Aug	48	22	39	9	48	2	0	0	0	9	5	6	3	10	32	20	22	10	92	91	47	67	22	150
14-Aug	43	26	36	7	57	2	2	0	0	8	2	6	2	10	30	10	22	8	57	83	40	64	17	124
21-Aug	47	26	41	6	66	4	1	4	0	11	3	7	4	8	17	5	9	8	27	79	35	57	22	101
28-Aug	34	20	24	9	41	2	0	2	0	11	8	10	1	23	26	10	18	10	49	73	38	52	22	113
04-Sep	26	11	22	2	51	0	0	0	0	13	6	8	5	12	33	22	27	6	72	72	39	57	13	135
11-Sep	18	8	16	2	31	6	3	6	3	11	3	8	3	7	28	14	26	2	80	63	28	50	13	121
18-Sep	35	25	23	6	42	2	1	2	1	9	3	5	4	4	35	17	28	7	59	81	46	56	19	106
25-Sep	41	26	35	4	43	0	0	0	0	13	3	4	9	17	30	11	20	10	41	84	40	59	23	101
02-Oct	27	14	20	6	32	0	0	0	0	13	4	6	7	27	39	16	30	9	67	79	34	56	22	126
09-Oct	39	23	31	8	43	0	0	0	0	8	2	5	3	14	30	14	18	12	65	77	39	54	23	122
16-Oct	33	25	31	2	49	0	0	0	0	13	3	9	4	18	38	17	31	7	93	84	45	71	13	160
23-Oct	42	20	30	11	48	0	0	0	0	10	3	9	1	10	35	11	25	10	60	87	34	64	22	118
30-Oct	40	17	35	5	39	0	0	0	0	6	4	5	1	18	27	16	19	8	40	73	37	59	14	97
06-Nov	36	21	33	3	50	0	0	0	0	6	2	6	0	13	26	14	19	7	59	68	37	58	10	122
13-Nov	33	22	26	7	58	0	0	0	0	8	2	7	1	22	45	16	24	21	77	93	41	59	30	166
20-Nov	36	22	32	4	60	0	0	0	0	5	2	2	3	11	38	15	32	6	79	81	40	69	12	145
27-Nov	44	25	35	8	62	6	0	1	0	7	3	6	1	22	31	16	20	11	95	88	43	61	21	178

WOCOG – 5 month review

Appendix B - Modelled baseline estimates

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			Audit Outcomes						
Activity Category	Provider	Base Case 10pm Weston 2016	Wait Until Morning	Alt Pathway Community	Alt Pathway OOH	Direct Admit GP SWAST Ref	Subtotal	Repatriation LoS >3	Total Incl. Repatriation
Walk-ins	**Total**	**15**	**-6.5**	**-2.5**	**-5**		**1.1**		**1.1**
	Southmead	7	-3.1	-1.2	-2		0.5		0.5
	BRI	6	-2.5	-1.0	-2		0.4		0.4
	Taunton	2	-0.7	-0.3	-1		0.1		0.1
	Other	0.3	-0.1	-0.05	-0.1		0.0		0.0
Ambulance arrivals	**Total**	**12**			**-1.4**	**-0.9**	**9.9**		**9.9**
	Southmead	6			-0.7	-0.4	4.5		4.5
	BRI	5			-0.6	-0.2	4.0		4.0
	Taunton	2			-0.2	0.0	1.4		1.4
	Other	0.3			-0.03	0.0	0.2		0.2
Total Arrivals	**Total**	**27.3**	**-6.5**	**-2.5**	**-6.5**	**-0.9**	**10.9**		**10.9**
Admissions	**Total**	**7.1**				**-0.4**	**6.7**		**6.7**
	Southmead	3.2				-0.2	3.0		3.0
	BRI	2.8				-0.1	2.8		2.8
	Taunton	0.9				0.0	0.9		0.9
	Other	0.1				0.0	0.1		0.1
Beds required	**Total**	**55**				**-2.9**	**52**	**-39**	**13.1**
	Southmead	26				-1.3	24	-18	6.1
	BRI	20				-0.5	20	-14	5.5
	Taunton	6				-0.1	6	-4	1.9
	Other	2				-0.002	2	-1	0.6

Excludes FNOF
LoS 0-3 no repat
LoS >3 50% 2 days
LoS >3 50% 5 days

1) Findings from Quality ED visits at WAHT, UHB and NBT.

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Key Findings

The CCG observed and heard many positives examples of good practice across all the emergency departments visited, including:

Safety Checklist: All three Acute Trusts have implemented the safety checklist. During the visits, review of a random sample of patient documentation confirmed that these were being completed hourly. Staff in all three emergency departments were able to advise how concerns were escalated. On the day of the visit the CCG was pleased to note that the Bristol Children's Hospital had developed and launched that day a paediatric safety checklist.

Staff Experience: The CCG saw evidence of good leadership. Consultants were present in all 3 EDs. Safety ward rounds took place 2 hourly in Southmead and Bristol hospitals. Weston Hospital undertook a safety round at 5pm. Junior doctors in all three Trusts confirmed that they received good support and feedback from the Consultant. Clinical staff confirmed that they had received an appraisal within the last 12 months. Evidence of feedback and learning from serious incidents was in place and safety information / bulletin was shared either verbally or electronically.

Patient Experience: Patients were complimentary of the care they received in all emergency departments. Initial triage was prompt in all departments. The CCG saw good examples in relation to information for patients such as the wall slides in UH Bristol.

Areas where improvements could be made

Escalation Corridors: Similar issues regarding management of capacity and flow were seen in the EDs at Southmead, Bristol, Royal Infirmary and Weston General Hospital. Escalation corridors are in public access areas which provide challenges in terms of managing infection prevention and control and privacy and dignity, particularly as patients were placed in close proximity to each other, hand gels were not readily available and corridors could not be closed off from being a thoroughfare.

Whilst the BCH ED does see surges in demand, during the out of hours period it is able to use the outpatients department or alternatively following assessment young patients can be moved back to the waiting room to sit on their carer's lap to free up cubicles for other patients to be assessed..

Acute Medical Units: Challenges were also present for managing privacy and dignity and infection control in the AMUs at NBT and WAHT. At NBT patients were nursed on trolleys in the reception area outside the main ward whilst waiting for beds to become available. Again issues of patients being in close proximity to each other, in a thoroughfare and hand gel not being evident were apparent. AT WAHT the unit was extremely cluttered with equipment blocking hand basins, gels and fire exit. However it was noted that the unit was shortly to move ward following work being undertaken within the hospital, therefore these issues should be addressed.

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Weston A&E Temporary Overnight Closure - Executive Summary

12 month data review

This report has been agreed by the BNSSG A&E Delivery Board to represent the agreed system position / impact of the temporary overnight closure in terms of activity

The data has been stable across the 12 months

Created by
Chris Waller
Keith Robertson
Claire Thompson

Modelling & actuals

NHS
Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Group

Figures are per day. All figures compare impacts, ie suspected diverts or variance between pre- and post- closure		Modelling		M1				M2-5				12mth (04/07/2017-30/06/2018)			
					PAS Dump				PAS Dump				PAS Dump		
		Unmitigated	Mitigated	Activity Tracker	Main Weston Catchment	Out of Area & Somerset & North Som CCGs	WOCIG agreed estimates	Activity Tracker	Main Weston Catchment	Out of Area & Somerset & North Som CCGs	WOCIG agreed estimates	Activity Tracker	Main Weston Catchment	Out of Area & Somerset & North Som CCGs	WOCIG agreed estimates
BRI	ED - Walk-Ins	6	0.4	1.5	1.4	3.8	1 to 2	0.8	0.9	1.1	1	0.9	0.7	2.6	1
	ED - Ambulance	5	4.0	4.5	3.6	6.3	4 to 5	4.3	3.9	6.7	4 to 5	4.2	3.2	7.8	4 to 5
	EM Admits	2.8	2.8	3.3	2.8	3.3	3	2.9	1.9	1.4	3	2.5	1.4	1.6	3
	Beds	20.3	5.5	7.0				7.0			7	6.9			7
	Repats	0	1.2	1.0			1	0.9							
Southmead	ED - Walk-Ins	7	0.5	0.3	0.3	2.2	Less than 1	0.4	0.4	0.9	Less than 1	0.3	0.1	0.9	Less than 1
	ED - Ambulance	6	4.5	1.5	1.2	2.3	1 to 2	0.9	0.9	1.8	1	0.8	0.7	2.3	1
	EM Admits	3.2	3.0	0.9	0.5	0.3	Less than 1	0.5	0.2	0.2	Less than 1	0.4	0.3	0.1	Less than 1
	Beds	25.8	6.1	2.4				2.0			2	1.8			2
	Repats	0	1.5	0.4			Less than 1	0.2							
Taunton	ED - Walk-Ins	2	0.1	1.5	0.1	1.6	1 to 2	1.3	0.2	-0.8	1 to 2	1.3	0.2	2.1	1 to 2
	ED - Ambulance	2	1.4	3.2	0.6	2.9	3 to 4	3.3	0.5	3.0	3 to 4	3.1	0.2	3.4	3 to 4
	EM Admits	0.9	0.9	1.9	0.3	0.3	1	2.1	0.3	3.5	2	2.1	0.2	3.4	2
	Beds	6.3	1.9	6.3				9.4			10	8.6			10
	Repats	0	0.4	0.1			Very few to date	0.3				0.3			
Total	ED - Walk-Ins	15	1.1	3.3	1.9	7.6	4 to 5	2.6	1.5	1.3	3 to 4	2.5	1.0	5.6	3 to 4
	ED - Ambulance	12	10.0	9.3	5.4	11.5	9	8.5	5.4	11.4	8 to 9	8.1	4.1	13.5	8 to 9
	EM Admits	7.0	6.7	6.1	3.6	3.9	5 to 6	5.5	2.3	5.2	5 to 6	5.0	1.9	5.1	5 to 6
	Beds	52.5	13.5	15.7				18.4				17.3			
	Repats	0	3.1	1.5			1 to 2	1.3							

* Activity Tracker is based on daily reported activity by Providers since closure and shows the average for the reported period.

Weston Area Health NHS Trust

University Hospitals Bristol NHS Foundation Trust

Healthy Weston PCBC Appendix 5

Acute Service Model Review (Carnall Farrar) Report

Summary of Findings

June 2018

Weston Area Health NHS Trust

University Hospitals Bristol NHS Foundation Trust

Acute Care Modelling Project

Background:

- **Ongoing challenges surrounding sustainability of WAHT**, in particular:
  - **Fragility of services**, i.e. A&E, maternity, critical care
  - **Challenges with recruitment and retention** both medical and nursing
  - **Deteriorating financial position** in 2016/17 and 2018/19
- UH Bristol and WAHT Board **approval of Strategic Outline Case** recommending a more formal partnership arrangement (including merger) announced on 31 January 2018

Acute Care Modelling Project:

- **Carnall Farrar commissioned** by the University Hospitals Bristol and Weston Area Health NHS Trust Partnership Management Board to undertake an acute care modelling project
- Aim to **advise on how to improve productivity and optimise clinical and financial sustainability** of Weston Area Health Trust
- Project commissioned to **support further development of the formal partnership** between the 2 Trusts and inform the **Healthy Weston programme**
- Programme commenced on 15 January 2018 with the final draft report issued on 25 May 2018

Acute Care Modelling Project - Scope

Project was broken into four phases of work, delivered in two blocks:

Phases 1 & 2 (Interim Report – 23/03/2018)

- Identify the current **baseline** of activity, capacity, income and cost for all specialties
- Test **alignment of capacity and demand** for theatres, outpatients and inpatients to the CCG contract
- Identify the achievable **scale of opportunity that exists to maximise the efficiency** of the current acute service delivery in theatres, outpatients, inpatients and workforce

Phases 3 & 4 (Final Draft Report – 25/05/2018)

- Identify **opportunities to redesign** an acute care model that optimises utilisation of the estate through reconfiguration of services within the local acute and, where relevant, within primary and community networks, through:
  - Assessment of **'local care' out of hospital** opportunities
  - Testing **new models of care** to address the residual gap
  - Identification of **new services** that can be brought onto the WGH site

Phase 1 & 2 – Key Deliverables

1) **Establish the 'do nothing' baseline** based on 24/7 A&E provision

2) **Analysis of capacity and demand to 2022/23** including impact on financial position of WAHT

3) **Identification of productivity and efficiency opportunities** with quantification of achievable impact

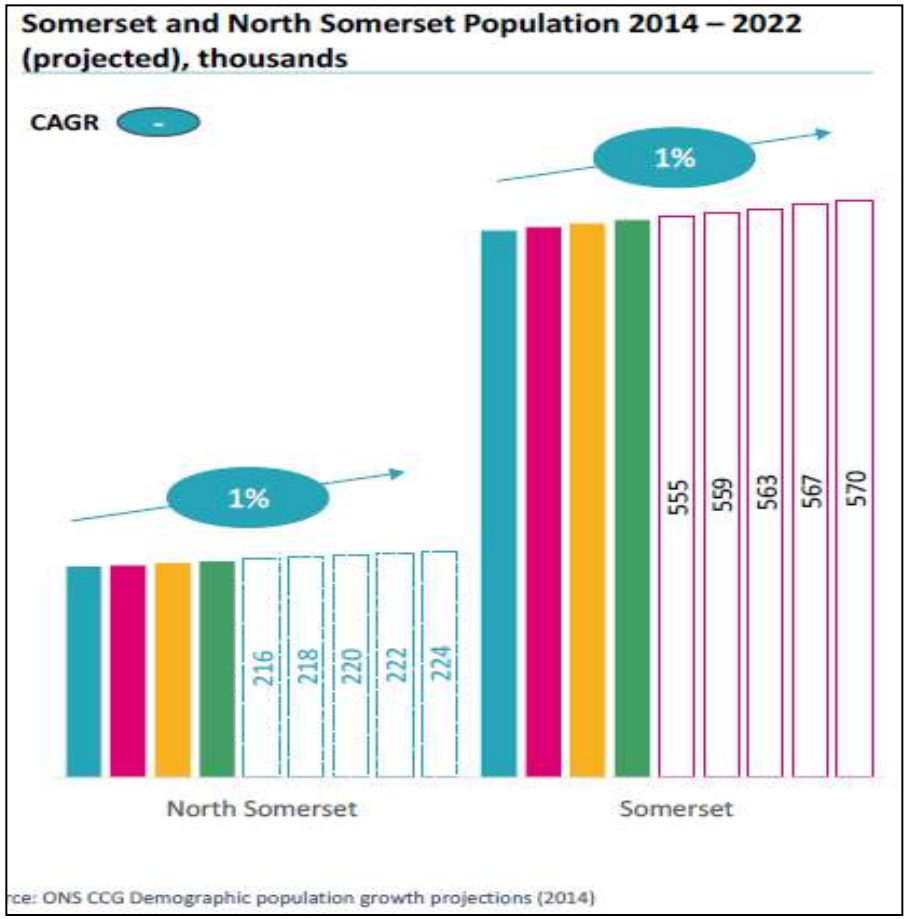
4) **Interim report**

Phase 3 & 4 – Key Deliverables

1) **Develop 'do something' local care baseline** – desktop analysis identifying activity currently provided in acute hospital setting which could be undertaken outside hospital
2) **Review of elective realignment opportunities** – identification of activity that can be brought onto the WGH site including quantification of impact for WAHT and NBT/UH Bristol
3) **Review of repatriation opportunities –** analysis of activity that could be repatriated from shrinking catchment area identified in phase 1 & 2 report based on travel time analysis
4) **High level assessment (clinical & financial) of Healthy Weston acute model proposals –** excluding those already assessed in deliverables 2 & 3
5) **Final Draft Report of Acute Service Models**

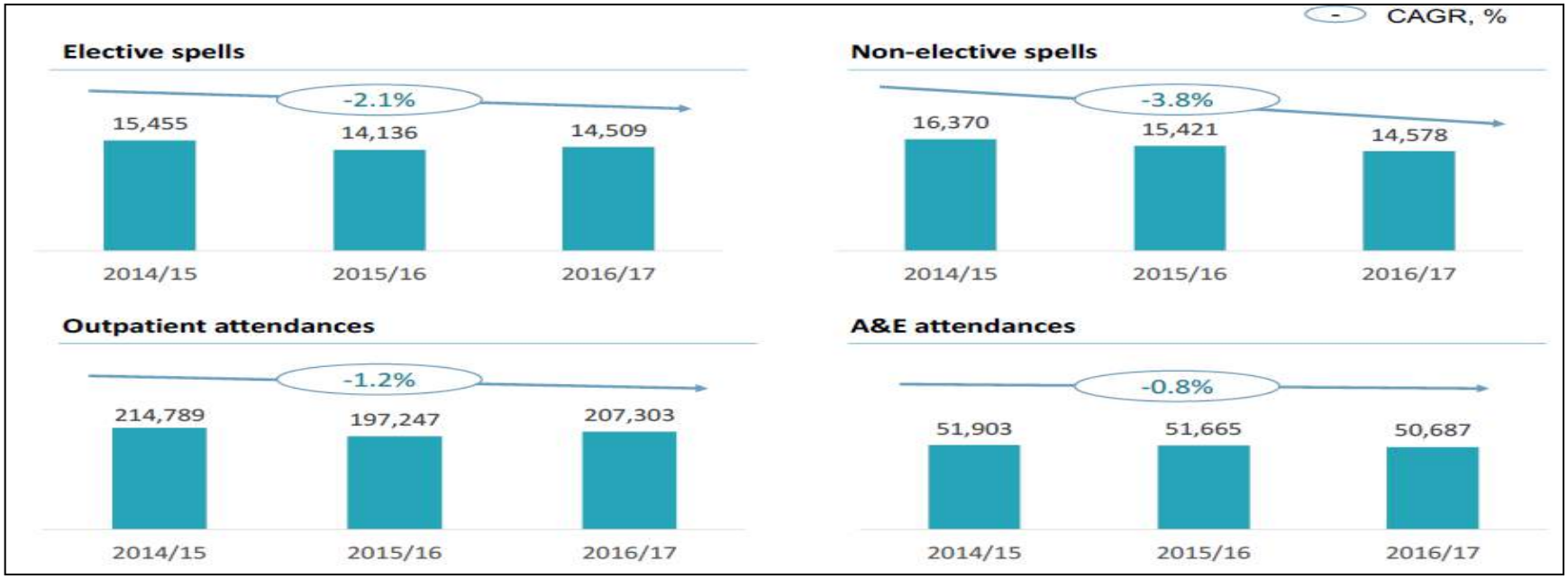
‘Do Nothing’ Baseline Position – Population Growth

- **Population growth in North Somerset and Somerset** projected at 1% per annum
- Alongside expected demographic growth, **housing developments** around Weston will bring an **additional 8,700 new homes by 2036**



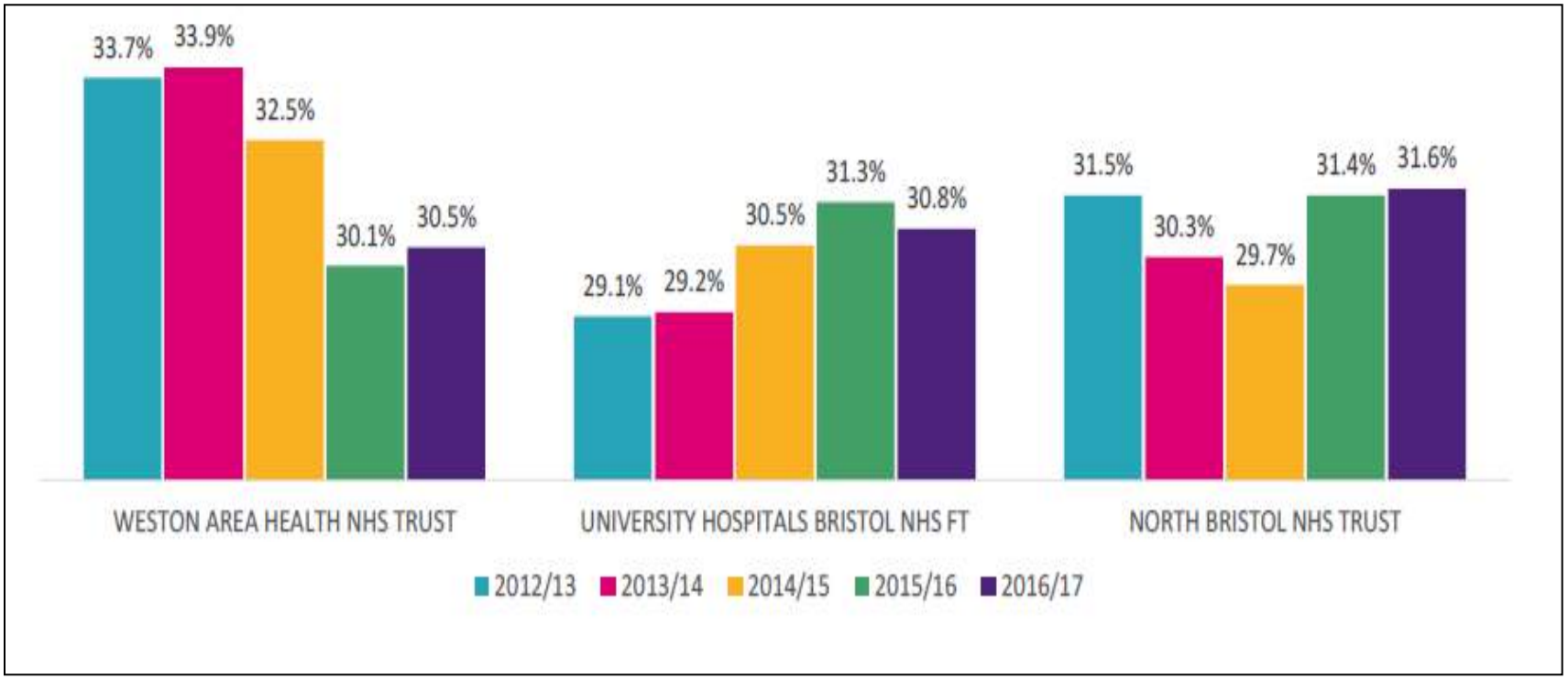
'Do Nothing' Baseline Position – Activity Trends

- **Activity at WAHT reducing** across all points of delivery since 2014/15; baseline case modelled for this trend to continue to 2022/23 despite predicted population growth



‘Do Nothing’ Baseline Position – Shrinking Catchment

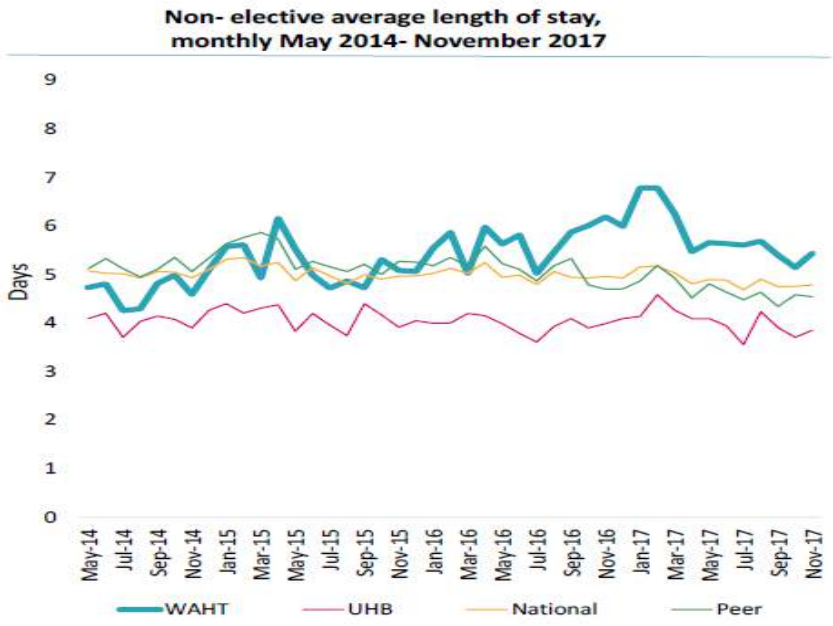
- **Loss of market share**, excluding impact of A&E overnight closure, primarily to UH Bristol and NBT from Weston catchment area

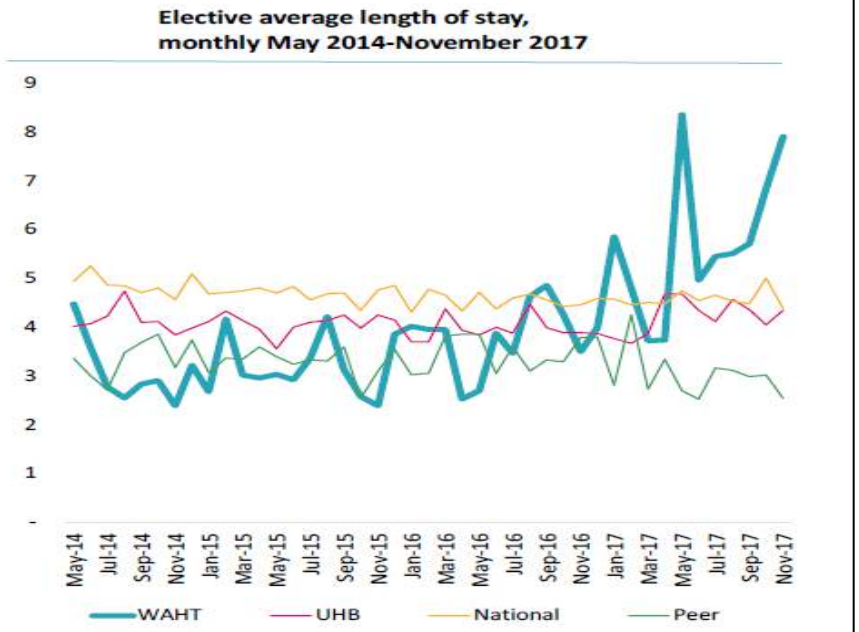


'Do Nothing' Baseline Position – Length of Stay

- WGH site operating at full capacity and high occupancy due to **increasing length of stay** (3% increase in non-elective and 17% increase in elective)

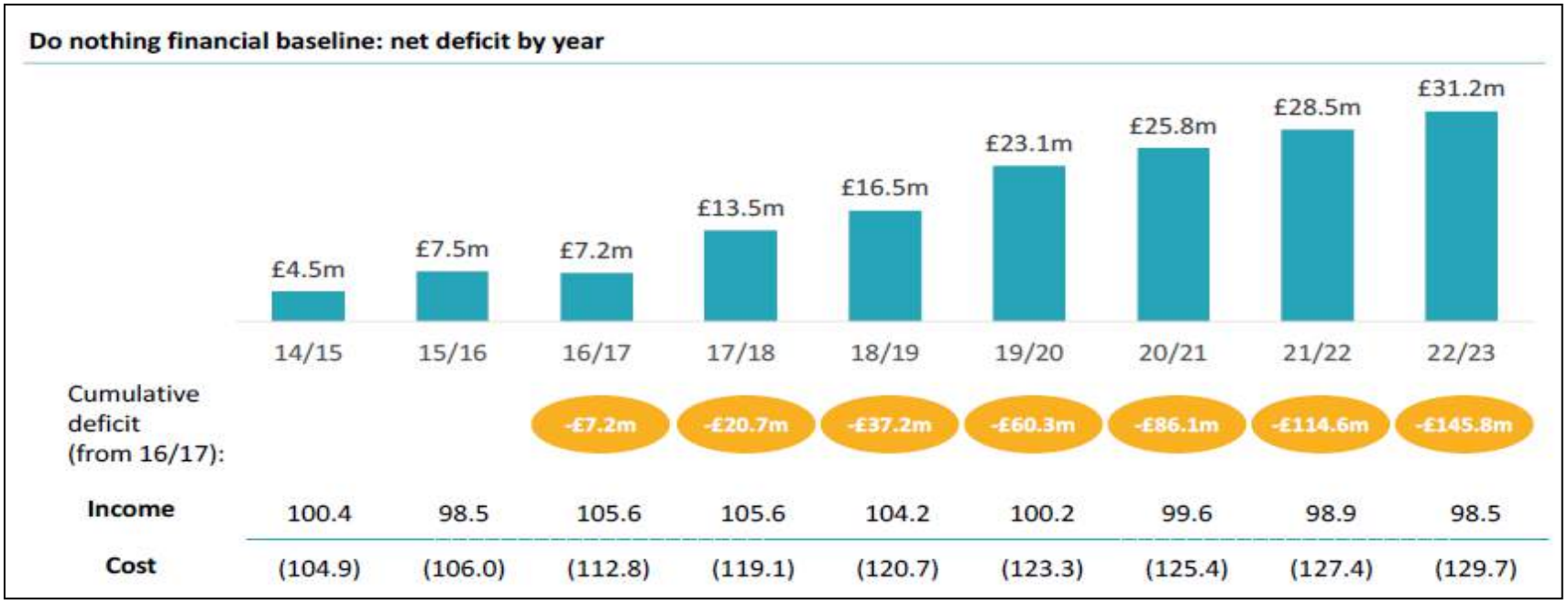
On average, length of stay is increasing at Weston, whilst nationally it has fallen over time





‘Do Nothing’ Baseline Position – Financial Projection

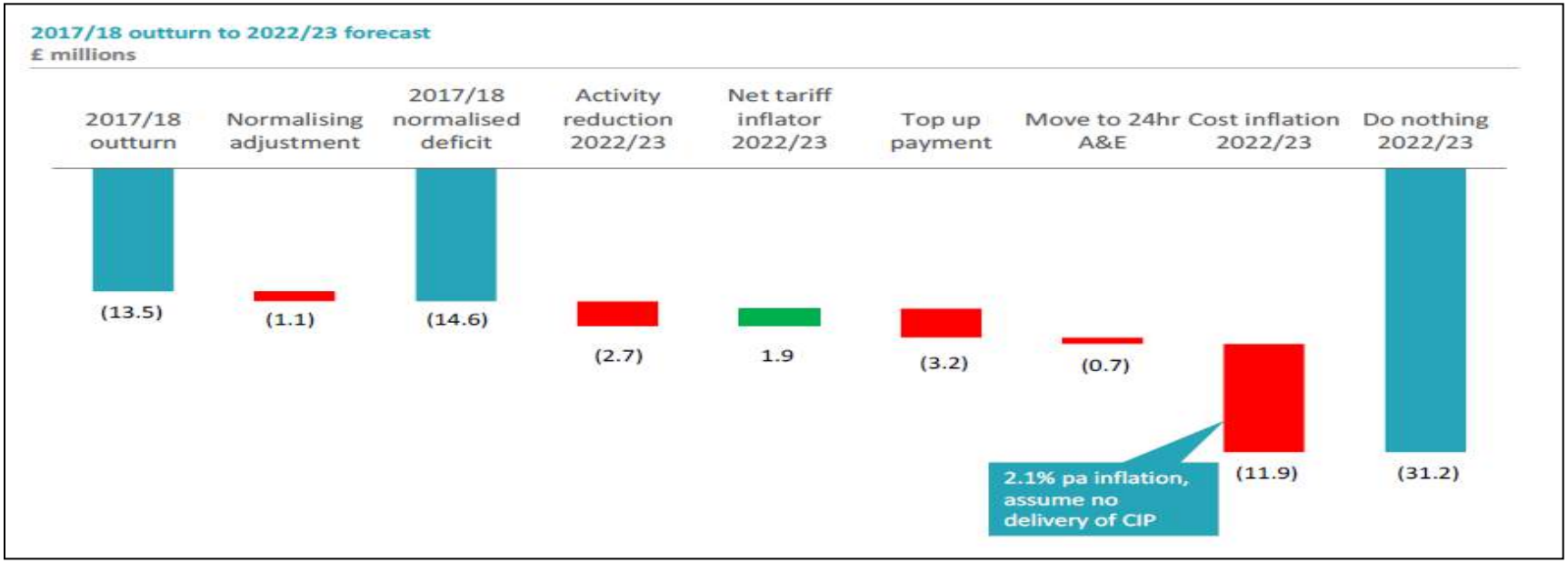
- Factors highlighted have a **detrimental impact on financial position**:
  - **‘Do nothing’ (worst case) scenario** predicts financial **deficit increase to £31.2m by 2022/23**



N.B. Baseline includes 24/7 ED provision but excludes £3.2m top-up payments from CCG

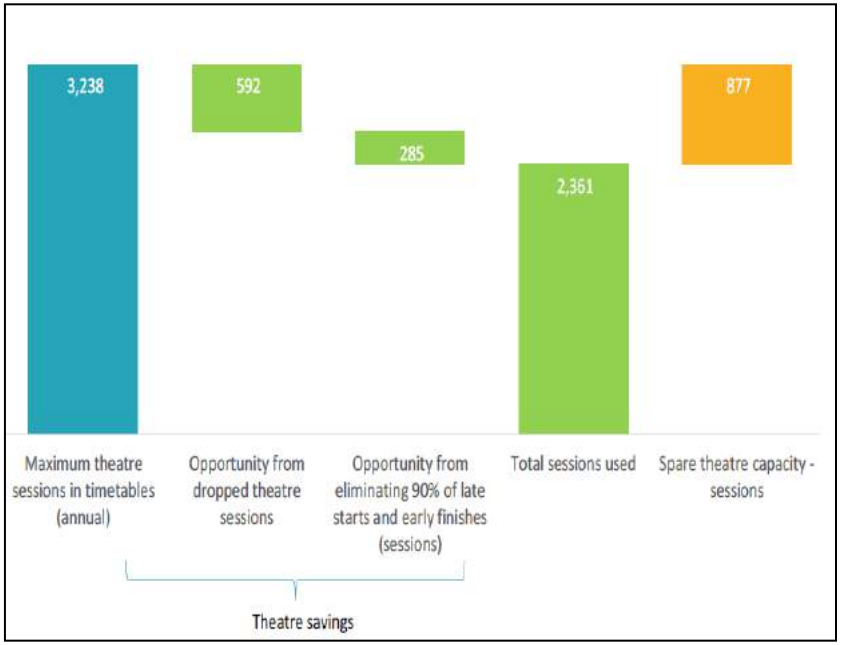
‘Do Nothing’ Baseline Position – Financial Projection

- **Baseline scenario assumed 24/7 ED**, with the cost pressure for this being £0.7m
- Using the spare capacity identified through **productivity and efficiency** at Weston could generate an **opportunity worth up to £9.6m**. Options to realise this opportunity were tested in phases 3 & 4
- Overall **‘best case’ financial position** at end of phases 1 & 2 identified as **£17.4m adverse**



Productivity & Efficiency Opportunities

- **Productivity opportunity** ranging between £5.2m and £9.6m identified, through:
  - Reduction in **length of stay**
  - Improvement in **theatre list utilisation**
  - Reduction in nurse and medical staff **vacancy rates and agency spend**, from 20% and 27% respectively



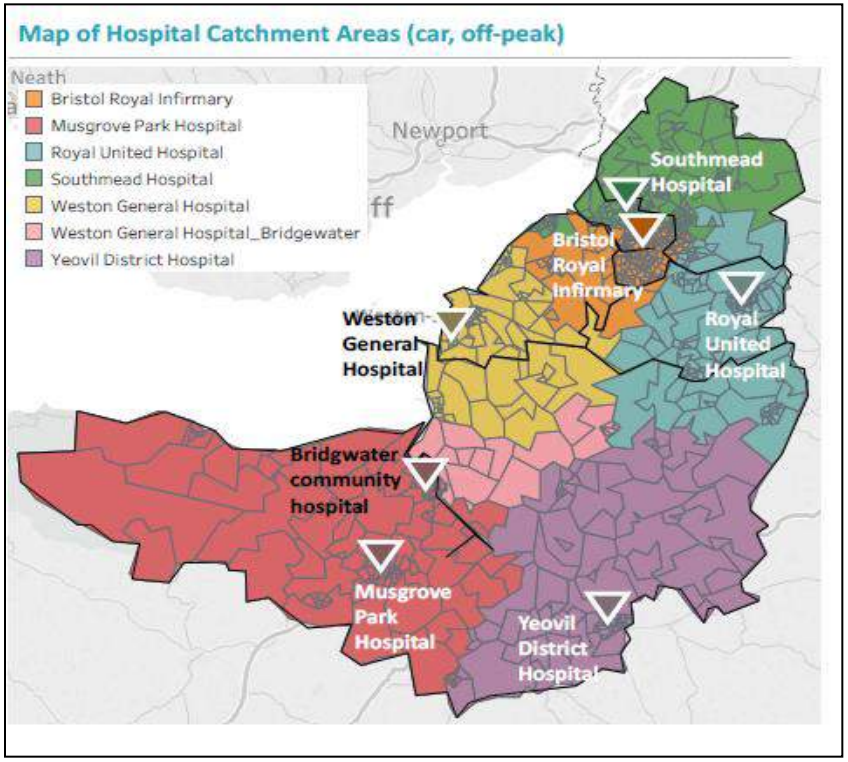
Realising Productivity Opportunity - Activity Transfers onto Weston Site

Opportunity to **bring new activity onto the Weston site** was assessed as follows:

1. Assessment of **repatriation** within Weston's catchment area for existing services provided at Weston General Hospital
2. Identification of **elective consolidation opportunities for non –complex activity** currently performed at UH Bristol and NBT for:
    - Orthopaedics
    - Urology
    - Benign Upper GI Surgery
3. Assessment of **repatriation of day case activity** for services not provided at WGH:
    - ENT
    - Ophthalmology
    - Plastic Surgery
    - Dermatology
4. High level assessment of **Healthy Weston initiatives** including impact of14/7 ED

Activity Transfers onto Weston Site - Repatriation

- **Catchment area** for Weston spans 3 CCG areas and covers a **population of 155,000** excluding patients who can locate another site in under 5 additional minutes
- Based on adjusted catchment area, **7,264 spells could be repatriated by 2022/23**



2016/17: Total spells from within Weston's catchment area performed at alternative providers

POD	Weston General Hospital	Bristol Royal Infirmary	Southmead Hospital	Musgrove Park Hospital	Yeovil District Hospital	Royal United Hospitals	Independent Sector	Total activity going out of area
Non-elective	11,262	312	544	843	101	153	-	1,953
Elective	970	141	335	192	14	15	306	1,001
Daycase	8,814	784	1,140	1,159	37	57	783	3,960
Total spells	21,046	1,237	2,019	2,194	152	225	1,089	6,914

2022/23: Total spells from within Weston's catchment area performed at alternative providers

POD	Weston General Hospital	Bristol Royal Infirmary	Southmead Hospital	Musgrove Park Hospital	Yeovil District Hospital	Royal United Hospitals	Independent Sector	Total activity going out of area
Non-elective	12,127	338	590	884	106	161	-	2,078
Elective	862	124	296	174	12	13	273	894
Daycase	9,653	854	1,244	1,238	39	62	854	4,292
Total	22,642	1,316	2,130	2,296	157	236	1,127	7,264

Weston Area Health NHS Trust

University Hospitals Bristol NHS Foundation Trust

Activity Transfers onto Weston Site – Elective Consolidation & Day Case Repatriation

- **Consolidation of non-complex elective** inpatient **orthopaedics, urology and upper GI Surgery** could lead to an extra 5,586 cases at Weston
- **Repatriation of day case activity** for specialties not provided at Weston could lead to an extra 3,489 cases at Weston
- **Two models were used** to assess financial impact for activity transfers

1 Full transfer of selected services at UHB/NBT to WAHT

- Direct transfer of activity to Weston from UHB or NBT. Assumes staff move from these trusts to Weston, or Weston is able to recruit more staff to service the model
- Weston takes the full income and additional costs associated (assumption remains that patients are cared for in existing resources freed as a result of the productivity improvement)

2 Franchise model

- In this scenario the space is simply 'leased' and thus Weston gets a contribution to overheads through a hosting fee but no other financial benefit
- In terms of cost impact of new activity brought on to Weston, the theatre staff and consumables etc. are provided by the 'sending' trust.

		Spells	Theatre sessions	Beds	Upper bound contribution: Full transfer	Lower bound contribution: Franchise model
Repatriation of existing services	Non-elective activity	2,078	204	25	£2.0m	-
	Elective activity	894	307	7	£2.3m	-
	Daycase activity	2,233	909	-	£1.3m	-
Elective inpatient consolidation	Non-complex orthopaedics	3,321	1,107	21	-	£2.0m
	Non-complex urology	1,750	357	9	-	£0.7m
Repat-riation of new services	Repatriation of additional daycase activity	3,489	488	-	£1.4m	-

Healthy Weston – Impact of 24/7 v 14/7 ED

- Net impact of a 24/7 ED vs a 14/7 ED was assessed
- The **cost pressure of running a 24/7 ED** was assessed as **£700,000**, driven predominantly by increase in staff costs. The **cost pressure of running a 14/7 ED is £300,000**, driven by reduced income resulting from loss in emergency surgical activity.

Maintaining a sustainable 24/7 Emergency Department	**Impact** **-£0.7m**	**Initiative 9: Running a more sustainable 24/7 ED: (£280k)** The emergency department has been closed overnight between the hours of 10pm and 8am since July 2017. This change was made in response to concerns about safe staffing levels – moving to a 14/7 service did not therefore translate to a corresponding reduction in staffing levels. Maintaining a safe and sustainable a 24/7 service is estimated to require additional workforce. To estimate the cost of this, the current cost of a 14/7 ED has been extrapolated, adjusting for a fully substantive workforce and a less intensive staffing rota overnight. **Initiative 8: Increase sustainability of current 24/7 emergency surgery: (£389k)** Emergency surgery is currently provided on a 24/7 basis, however, there are staffing and safety concerns with regards to the current service. In order to reach a safe level of service provision, clinicians across Weston have identified that four additional middle grade doctors would be required.
Provision of a 14/7 service	**Impact** **-£0.4m**	**Initiative 10: 14/7 emergency surgery service – no complex surgical activity: £56k** Reducing the emergency surgery service from 24/7 to 14/7 provision will reduce income, because of a loss in activity overnight. However, there is also a corresponding reduction in marginal cost of consumables and diagnostics, staffing costs and bedday costs. **Initiative 11: Reducing ED hours and running a 14/7 ED: (£463k)** For 14/7 A&E there would be a reduction in income and cost associated with attendances and admissions. Since the service is currently provided safely, no additional workforce would be required. Much of the income lost could be recouped by providing direct admission for patients overnight through clearly defined pathways; this would require much less additional staffing than the provision of a 24/7 ED service

Weston Area Health NHS Trust

University Hospitals Bristol NHS Foundation Trust

Impact of Local Care

- Local care **is proactive approach to managing the health and well-being of a population**
- Begins with **identification of population needs** through segmentation analysis and **assessment/ design of care models** to meet needs base on national/international best practice
- Evidence to support acute activity reduction in **frail elderly and complex needs segments**
- **11 care interventions identified** and assessed to support more proactive, coordinated care
- Local care strategy could **reduce income at Weston by £6m and free up 21 beds**

Repatriation & Elective Consolidation

Achieving the **repatriation and elective consolidation** opportunities will require a **significant programme of work** at Weston.

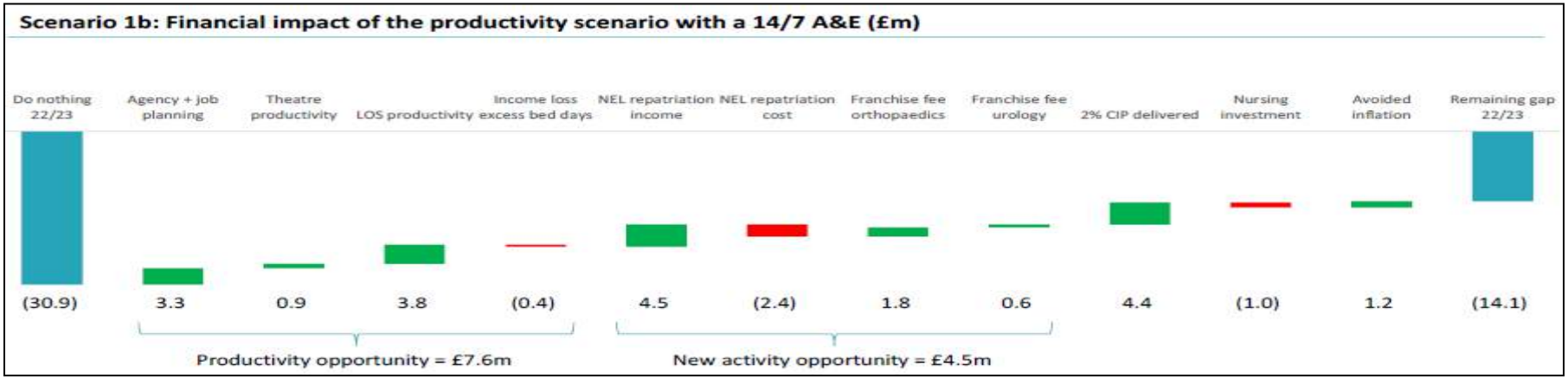
Whilst the opportunity presented thus far is a theoretical maximum, **Carnall Farrar believes that it would be feasible to achieve this opportunity**, given that:

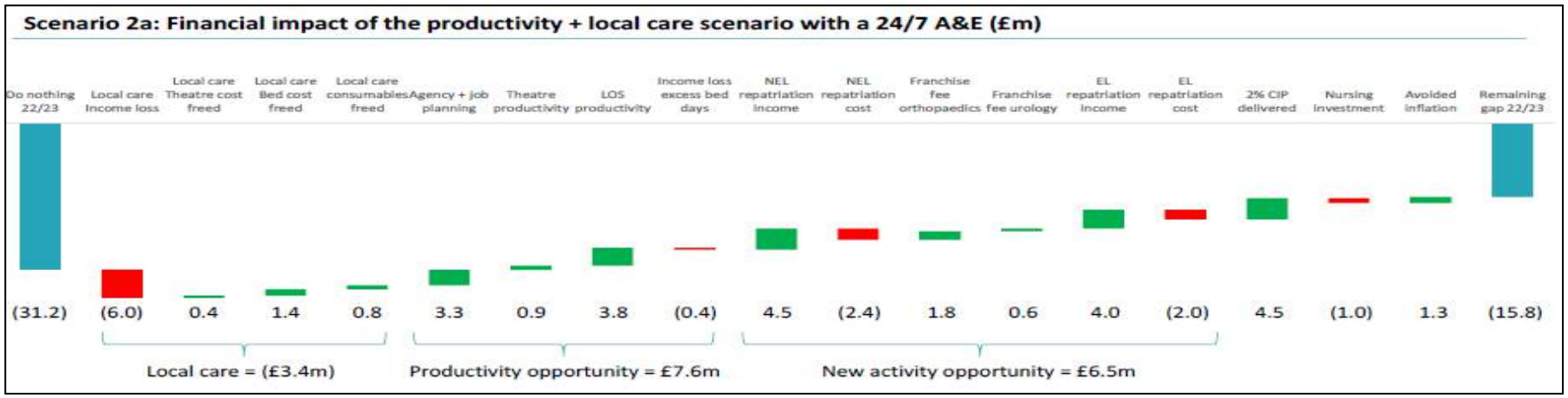
- Proposals for repatriation have been modified to reflect a more practical level of the opportunity
- Elective transfers are for specialties where examples of these types of models exist elsewhere and the feasibility of their transfer is accepted by local clinicians
- The productivity opportunity has been based on what Weston's peer group is currently achieving
- The local care opportunity is evidence based and has been shown to be achievable in other systems

However, at the heart of the opportunity lies the ability to use spare bed and theatre capacity at Weston General Hospital. At present, the **programme of work within Weston to operationalise the productivity improvements outlined in phases 1 and 2 is in early stage of development**. Completing this is therefore a crucial next step.

Revised Financial Analysis

- If productivity improvements and local care developments are realised **the residual financial gap** is expected to reduce to **between £14.1m and £15.8m**





Revised Financial Analysis

- If productivity improvements and local care developments are realised **the residual financial gap** is expected to reduce to **between £14.1m and £15.8m**
- Realising the additional income from repatriation and elective consolidation is feasible within Weston's bed base but would **require implementation of some 3 session days in theatres**

Scenario	Description	Scenario	Bed used*	Theatre sessions used**	Residual gap
Scenario 1: Productivity	• Spare bed capacity is created through productivity • A cost pressure has been applied to account for increased staffing to safe levels for a 24/7 ED • This cost pressure is revised in the 14/7 scenario • The activity brought onto the WGH site remains the same in both scenarios	a 24/7 ED	255	4,055	(£14.4m)
		b 14/7 ED			(£14.1m)
Scenario 2: Productivity + Local care	• As above • And in addition, capacity is released through admissions avoidance from a CCG local care strategy	a 24/7 ED	241	4,002	(£15.8m)
		b 14/7 ED			(£15.5m)

Conclusion and Next Steps (1)

- **Achieving productivity, repatriation and elective/day case consolidation opportunities is challenging** and will require a significant programme of work at Weston but the **Report identifies that this is achievable**

- **Productivity improvements** close the gap from the 'do nothing scenario' deficit but **do not eliminate the deficit which has been assessed as at least £14m**

- The **residual deficit continues to stem from the fact that to provide a sustainable full emergency centre model**, **Weston Area Health NHS Trust needs to provide safe, sustainable services in the core areas** of the Emergency Department, acute medicine and healthcare of the elderly, and emergency surgery, along with support services including radiology and level three critical care. The **level of activity needed to support this infrastructure is not sufficient**

Conclusion and Next Steps (2)

A scenario where additional capacity could be built economically that could close this gap, is not feasible therefore **leaving two options**:

1. **Permanent top-up payments** from the CCG for the £14m deficit (unlikely to be feasible)

2. **Consider alternative models for the WGH site** that will have a material impact on the cost base:
    - Change model of care on the Weston site moving to an integrated 'care campus' model with urgent care and enhanced direct admissions and non admitted pathways for patients appropriate to their needs
    - Pursue the local care opportunity and bring together primary, community and acute care providers to develop a more comprehensive local care strategy

Healthy Weston revised programme now being developed to support detailed analysis of these options

Healthy Weston Pre-Consultation Business Case

Appendix 6:

Integrated Frailty Service Design

Designing an Integrated Frailty Service

This document outlines the context, description and resourcing of the Integrated Frailty Service that will support the growing frail older population of the Weston, Worle & the Villages locality and the wider catchment population of Weston General Hospital.

The health and social care needs of the population of North Somerset are continuing to change and the demand for health and social care is increasing. In particular, care provision for the older person living with frailty, a significant part of the population, remains fragmented resulting in poorer health outcomes and high use of hospital-based care which leads to deterioration of function. Over recent months the Frailty Steering Group, composed of a range of care providers across the Weston area, have been working together to jointly define a new care model for frail older people and their carers**.**

1.1 POPULATION HEALTH NEEDS

The majority of healthcare use, and hence of costs, stems from individuals with long-term conditions and consequences of ageing[1]. The need to improve the treatment and management of long-term conditions (LTC) is one of the most important challenges facing the NHS[2]. This section describes the health and social care needs of the local older population in the catchment area of Weston General Hospital, and Weston, Worle & the Villages (WWV) locality in particular. While the service to be designed will first be introduced in WWV, we also review data for the entirety of North Somerset where it is available at this level. There is an expectation that any frailty service developed will be expanded beyond WWV to the rest of North Somerset and BNSSG as a whole.

Data in this section largely focuses on the needs of the over 75 year old population as the target for a frailty service, however some of the data available may reference other age brackets (e.g. over 65s) due to availability. Nonetheless all analyses support to the same conclusions about the needs of the older population.

1.1.1 Population demographics

North Somerset faces significant demographic challenges with a population which is both aging and growing. It will see around a 32% increase in the number of people aged over 75 in the next 5 years compared to the national average of 11%.[3]

Within the Weston, Worle & the Villages locality, there is a rapidly growing aging population, many of whom have complex healthcare needs. The catchment

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[1] NHS RightCare 2016

[2] Kings Fund, 2013

[3] North Somerset JSNA

population of Weston General Hospital (WGH) is growing at ~1% per year, with over 60% share of absolute population growth from 2018 to 2025 in over 75s. The current and projected population are also older than average, with 14% over 75 years old by 2025, compared to 10% for England overall.[1]

Furthermore, the average age of admissions at WGH is significantly higher than the England average (64.3 years vs. 55.6 years) – although this is skewed somewhat as Weston Area Health Trust has no in-patient paediatric service.[2]

1.1.2 Approach to identifying frailty

The changing needs of the population underscore the value of high quality consolidated service provision for the frail older population, through establishment of a centre of excellence. The Frailty Steering Group agreed that patients over 75 should be used as a proxy for high complexity needs population. Although it was recognised that some patients under 75 can also have complex needs and loss of resilience, population analyses show significant increases in multiple long term conditions after the age of 75.[3] Therefore data for over 75s has been used in the modelling of volumes and activity levels for the service.

Frailty is theoretically defined as "a clinically recognisable state of increased vulnerability resulting from aging-associated decline in reserve and function across multiple physiologic systems such that the ability to cope with everyday or acute stressors is comprised"[4]. It has multi-factorial influences including elements of physical health (e.g. cardiovascular and respiratory disease, neurological disorders), psychological health (e.g. cognitive and mood disorders) and social / general wellbeing (e.g. loss of mobility, poor nutrition) which can all impact upon each other.

Approximately 10,600 people in the Weston, Worle & the Villages locality are over the age of 75. Of these, 65% have been assessed by general practitioners against the electronic Frailty Index[5] (e-FI) and received frailty scores. This e-FI categorises the population into 4 risk groups: Fit & well, Mild Frailty, Moderate Frailty, and Severe Frailty. This was extrapolated to the entire population of over 75s to produce a risk stratified cohort of patients (see Exhibit 1 below).

This extrapolation suggests that approximately 62% of over 75s in Weston, Worle & the Villages can be considered to be at least mildly frailty. The population proportions and frailty risk levels are shown in Exhibit 2 below.

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1 ONS 2016-based Sub National Population Projections

2 Getting It Right First Time, Emergency Medicine Report 2018

3 Royal College of General Practitioners 2016; General Lifestyle Survey, 2009

4 Xue, 2011, *The Frailty Syndrome: Definition and Natural History.* Clin Geriatr Med

5 https://www.kingsfund.org.uk/sites/default/files/media/Healthy-Ageing-Collaborative-Electronic-Frailty-Index_2.pdf

EXHIBIT 1

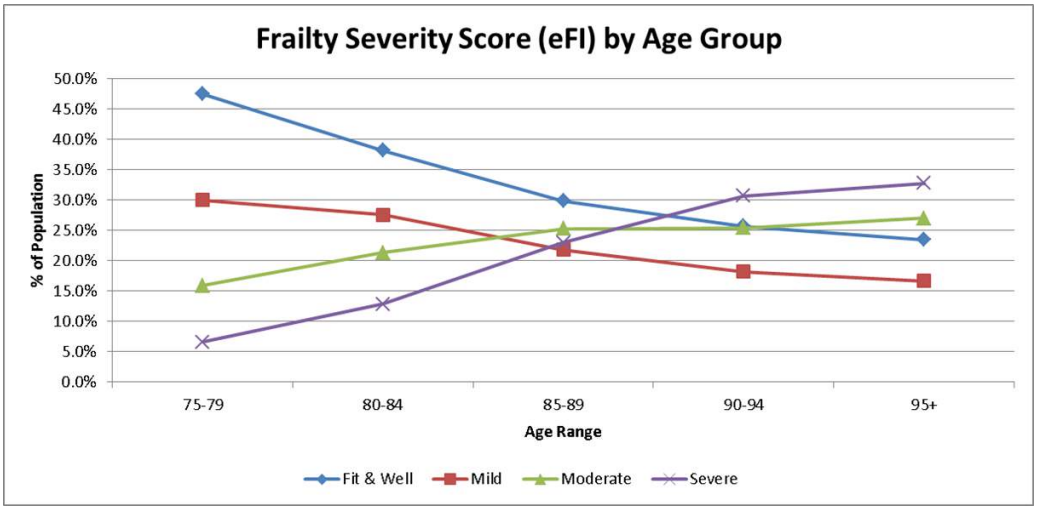


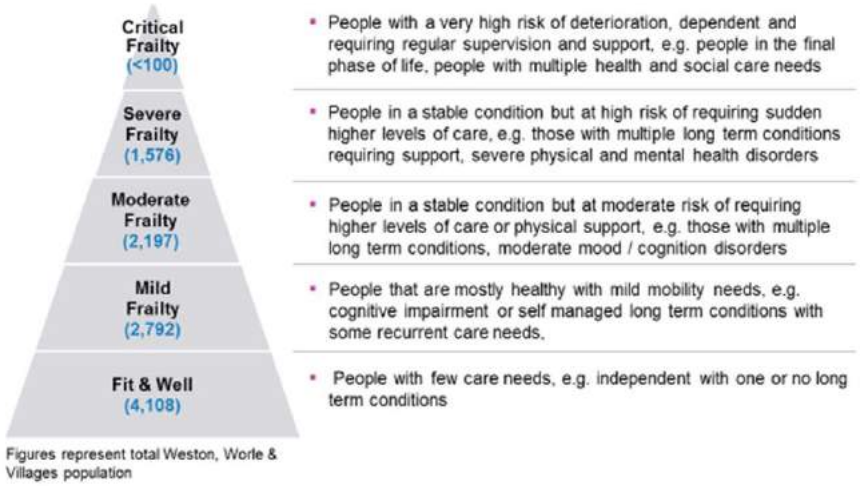
EXHIBIT 2

Age Range	Frailty Severity Score (%) Measured by eFI on EMIS				Population Numbers			Frailty Severity (Numbers) Total			
	Fit & Well	Mild	Moderate	Severe	Weston & Worle	Woodspring	North Somerset	Fit & Well	Mild	Moderate	Severe
75-79	47.5%	30.0%	15.9%	6.6%	4,094	5,158	9,252	4,395	2,775	1,471	610
80-84	38.2%	27.6%	21.3%	12.9%	3,144	3,801	6,945	2,653	1,917	1,480	896
85-89	29.9%	21.8%	25.3%	23.0%	2,095	2,399	4,494	1,343	980	1,137	1,034
90-94	25.7%	18.2%	25.4%	30.7%	988	1,021	2,009	516	366	510	616
95+	23.5%	16.7%	27.0%	32.8%	351	318	669	157	112	181	219
Total					**10,672**	**12,697**	**23,369**	**9,064**	**6,150**	**4,779**	**3,375**
Proportion								**38.8%**	**26.3%**	**20.5%**	**14.4%**

1.1.3 Understanding needs of individual patients

The e-FI clinical frailty tool enables classification of the over 75s into 4 risk categories as described above. An additional 5th category of 'critical frailty' was added to represent a small number of particularly complex patients who become very acutely unwell or are at the highest risk of deterioration. The needs of patients in these risk segments are broadly described in Exhibit 3. Overall level of dependence and risk level is always determined by the patient's highest level of need (whether physical, psychological, or social).

EXHIBIT 3



Perspectives from public engagement also support changing care services for the frail elderly[1]. Several workshops undertaken over the course of 2017 and 2018 highlighted frail older people as one of the top priority population groups. More specific engagement with members of the public, carers, health professionals, social services, the voluntary sector, mental health services, care homes and others considered how health and care services could better meet the needs of frail older people. Suggested priorities included:

- focusing on joining up existing services, streamlining and sharing information to support more holistic care
- support for carers to support patients
- services to tackle social isolation and loneliness
- proactive preventive care to keep people more independent and well at home
- addressing issues related to public transport and difficulties travelling
- learning what has worked and not worked in other areas, and why
- promoting the community hub widely
- considering a hub, with services that travel to the local population if required
- working with care homes to reduce admissions and do advance care plans
- ensuring that staffing requirements are thought through for all services
- having realistic timeframes and implementation plans for Healthy Weston

Furthermore, support was expressed for clusters of general practices working together and for a community hub. These priorities can be addressed by an integrated frailty service that consolidates care, shares information between services, allows patients to be better managed at home or in the community, and avoids clinical reconditioning or deterioration from unnecessary hospital admissions and prolonged lengths of stay.

The clinically led design phase (led by the Clinical Design and Delivery Group (CSDDG)) which developed options for the future of Weston General Hospital

[1] Healthy Weston Public dialogue and codesign themes (October 2017-March 2018)

concluded that a frailty service should underpin and enable all of the options put forward in the pre-consultation business case.

1.2 CURRENT SERVICE PROVISION FOR THE FRAIL POPULATION

1.2.1 Primary care

The prevalence of multi-morbidity nationwide is on the rise, with 44% of people over 75 now living with more than one long-term condition.[1] A significant proportion of over 65s will also be living with frailty, a long-term health condition characterised by loss of physical, emotional and cognitive resilience as a result of the accumulation of multiple health deficits.[2]

Primary care appointments utilised by patients aged 75 and over have increased from 116,000 in 2017 to 132,000 in 2018 (13.4%). Of these, around 65% were utilised by patients identified with a frailty score by their GP.

The older population locally in WWV means that the primary care consultation rates will be higher than the national average.

1.2.2. Acute care

The health needs of the older population place a significant burden on acute services. As in other parts of the country, over 75s in the WWV locality are significantly more likely to attend ED and be admitted than their share of the population suggests – 20% of ED attendances and 40% of non-elective admissions at WGH in 2018 were in over 75s, although this age group account for approximately 12% of the WGH catchment population.[3]

Notably, ED attendances by over 75s as a proportion of total ED attendances at WGH (20%) is higher than the average for all Trusts in England (13%) as well as for neighbouring Trusts (University Hospitals Bristol 10%; North Bristol Trust 17%; Taunton & Somerset 17%). ED conversion rates at WGH are also rising for over 75s, from ~33% in September 2017 to ~37% in March 2018 – this is in the context of a temporary ED overnight closure in July 2017.

The rate of hospital admission increases significantly with age so that in North Somerset, 1 in 3 people aged over 85 were admitted to hospital as an emergency in 2016/17 compared with 1 in 13 aged 65-74.[4] 1 in 3 over 85s were admitted more than once in a year for an unplanned admission and 1 in 6 of over 75s.[4] Non-elective bed days per 1000 weighted population over 75 is ~322 days in North Somerset compared to an average of ~281 days for the CCG peer group, and ~261 days England average.[5] At the Trust level, 65% of the bed days in Weston Area Health Trust for non-elective admissions were occupied by people who are 75 or over in 2017; this compares to 44% across all Trusts in England.[5]

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[1] Royal College of General Practitioners 2016

[2] NHS England Toolkit for General Practice in Supporting People Living with Frailty (2017)

[3] WAHT activity projections; ONS population projections

[4] BNSSG STP data 2017

[5] Hospital Episodes & Statistics 2016/17

The average non-elective length of stay for over 75s at WGH is 10.2 days, compared to 9.0 for all Trusts in England on average.[5] As such, without changes in acute management of this population and the intervention of community and primary care based schemes, the expected increase in the older population would equate to a significant increase in hospital bed days.

A large proportion of acute care demand, and therefore costs, are from individuals with long-term conditions and disabilities of ageing. NHS RightCare (2016) analysis has identified relatively high spend on emergency care for complex co-morbidities due to falls/fractures, UTI/urology, pneumonia /respiratory conditions which typically relate to frail older people.[1]

1.2.3 South West Ambulance Services Foundation Trust (SWASFT)

There were ~35,000 ambulance incidents in North Somerset in 2017/18, with over 75s accounting for 37% of these (although over 75s account for ~10.6% of the North Somerset population)

Of the incidents involving over 75s, 65% were See & Treat, 27% See & Convey, and 8% Hear and Treat. 35% of over 75s conveyances from North Somerset incidents were to Weston General Hospital.

Overall, patients from North Somerset are more likely to be conveyed to hospital (~69%) compared to the average for SWASFT (61%).

1.2.4 Community care

Across North Somerset Community Partnership (NSCP), patients over 75 accounted for a significant proportion of the caseload in the majority of services in 2017/18. The services with the highest proportion of over 75s were: Residential Care (94%), Frailty (87%), the Community Matrons (82%), Discharge to Assess (80%), and the Community Nurses (80%).

Frail patients are more demanding of clinical time within the community; three times more patients over 75 years old were seen at home than those aged 50 to 75 in 2017/18. Additionally, between April 2017 and March 2018, appointments for the over 75s increased by 8.3% - reflecting an overall increase of 18%.

93% of contacts made with patients over 75 years old were follow-up consultations, indicating complex needs requiring a high amount of repeat clinical visits.

This is also indicative of demand. In a recent study undertaken by NSCP, patients with 5 or more active diagnoses required an average of 3 contacts per month, versus those with fewer than 5 diagnoses who required an average of 1 contact per month.

1.2.5 Social care

75% of the total bed capacity in North Somerset is in Care Homes. There are 110 care homes (69 residential & 41 nursing), and 3000 beds in North Somerset, of which 38% are in Weston town.[2] This equates to a care home bed rate of ~12.8 beds per

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1 https://www.england.nhs.uk/rightcare/products/ccg-data-packs/focus-packs/focus-packs-for-cvd-neurological-respiratory-maternity-april-2016/

2 BNSSG STP data 2017

100 people over 75, which is higher than the England average of 10.4 beds per 100 people over 75.[1] The high number of care homes has the consequence of making the region a net importer of frail older people.

People resident in care homes are significantly more likely to have emergency admissions to an acute hospital; 40% of those admitted from care home to hospital die within 6 months of admission, while pneumonia, dementia and epilepsy are 3 times more common in admissions from a care home than in admissions from home. Analysis of 2014/15 data by North Somerset CCG found that the rate of admissions from the care home population is almost double that of the non-care home population (approximately 500 and 250 respectively per 1000 population).

It is commonly accepted that the population of people resident in care homes (residential and with nursing) have complex health and care needs and are often living with multiple long-term conditions, significant disability and high levels of frailty. There is evidence that the complexity of the care home population has increased while in parallel there is a high turnover of staff and variability in the level of support available from the wider health and social care system. The British Geriatrics Society (2011) recommends a multi-disciplinary approach to healthcare for care home residents including consistent access to specialist community nursing and a range of allied health professionals.

1.2.6 Mental health

Up to 4000 people in North Somerset, with an average age of 81 years, have been in contact with mental health specialists for cognitive impairment related conditions – this accounts for 40% of the North Somerset mental health cohort.

Despite making up only 5% of the population, patients with mental health conditions represent a much higher percentage of emergency attendances and admissions across the BNSSG CCG (14% of ED attendances, 20% of emergency admissions). According to a yellow paper commissioned by the BNSSG STP[2], over £20M could be saved across the system by reducing mental health patients' (all ages) use of the acute care system to a level closer to that of their peers nation-wide.

1.2.7 Voluntary sector

The local voluntary sector offering is very diverse, ranging from large national charities to small volunteer-run support groups. For example, Age UK plays a major role in supporting the local older frail population. All of these organisations play a key role in health and wellbeing – reaching into communities, keeping people well and sometimes picking up the pieces where other initiatives haven't worked.

There is a large volume of evidence to suggest that social determinants – such as housing, education, employment and social connectedness – have a greater impact on health and wellbeing than services delivered by the NHS.[3] The Kings Fund has made the case for strengthening connections between the NHS and other services to create 'population health systems' to tackle these social issues.

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[1] National End of Life Care Intelligence Network, 2017

[2] "Making the case for integrating mental and physical health care" yellow paper, May 2017

[3] Marmot et al., 2010

Voluntary services are an important and underutilised resource, but they are also fragmented and can be difficult to coordinate with more formal services. It is essential to align the support from these organisations with the local needs of the population and the other services that are accessed by the frail population (i.e. primary, community, mental health, social, and acute).

The NHS Five Year Forward view signalled the need for local commissioners and providers of NHS funded health services to recognise the value that the voluntary and community sector bring to supporting the health and wellbeing of local communities and in doing so, redefine the 'boundaries' between the statutory sector and VCSE. In practice this means a greater understanding of who is best placed to deliver locally based services.

Within each locality it is critical to create system of care in an identified 'place' that supports people to stay healthy, well and independent in the community. This could include:

- Meeting the specific needs of the local population
- Establishing the community as the default setting for all of a person's care
- Building an alliance amongst all 'providers' in the community to join up around individuals and families
- Optimising our capacity to respond to demands and challenges
- Mobilising the community

To support this, the CCG will explore Community 'anchor' organisations embedded in each locality and a voluntary, community and faith sector conference is being planned for January 2019 to co-design solutions

1.2.8 Summary and implications

Overall, the data on current service provision suggests that the management of over 75s in the WWV locality demands a significant portion of the health resources for the local population. Crucially, the use of acute services in this population is greater in the WWV locality than the national average. These findings emphasise the need for a service which provides high quality, integrated and resource efficient care for the older frail person.

The sections to follow will describe the Integrated Frailty Service which has been co-designed for the local population to meet these needs.

1.3 DESIGNING AN INTEGRATED CARE MODEL TO ADDRESS FRAILTY

1.3.1 Existing pathways and population in scope

Frail older patients are disproportionally using acute services, where they experience less continuity of care, and are at higher risk of negative outcomes.

The current acute care pathway at WGH can be split by entry point for these patients:

- There were 10,187 ED attendances for over 75s in 2017/18 (adjusted post-temporary overnight closure)
    - 30% major, 52% standard, 18% minor
    - 63% were referred by ambulance
    - 54% were admitted to a ward from ED, 12% were referred elsewhere (e.g. clinics, outpatients), 34% were discharged (half with no follow up)
- There were 4,307 acute medical admissions for over 75s in 2017/18
    - 94% from WGH ED, 3% from other EDs and 2% from GP referrals
    - Average length of stay was 8.9 days
- There were 1,049 emergency surgical admissions for over 75s in 2017/18
    - 93% from WGH ED, 4% from other EDs and 1% from GP referrals
    - Average length of stay was 12.4 days

Additionally, there are currently many services across social care, health care and the voluntary sector supporting frail older people. While there are efforts at cross-working between different services to provide effective care, these services are largely fragmented with little formal integration. This lack of a holistic approach to patient needs results in a greater likelihood for patients to deteriorate and for use of acute services when this happens.

The primary objective of the Integrated Frailty Service (IFS) is to provide person centred care for people over 75 and living with frailty. This will bring together hospital and community resources in a new way to help treat frail people more effectively – helping to avoid unplanned admissions, reducing their length of stay when patients are admitted but – most importantly – work proactively with frail patients to keep them well and at home and so they do not need to access hospital services.

The IFS will initially be designed to support the population of Weston, Worle & the Villages locality and also patients from North Sedgmoor who utilise acute services in Weston General Hospital. However it is expected that this full service will be expanded across BNSSG to support the wider population. For other patients who attend WGH ED from out of area (a common occurrence in the summer months), the acute frailty service will also be offered at the front door and patients will be discharged to their own primary care afterwards (i.e. they will not be referred into the full IFS).

1.3.2 Proposed interventions and care plans for patients and for their carers

The Integrated Frailty Service (IFS) will encompass a number of care models and interventions which together support new pathways of care for patients in different frailty risk segments. Routine primary care and urgent care for low risk patients will continue to be managed by general practitioners who will also manage the transition of patients between risk levels, alongside dedicated wellness navigators (role described in section 4). GPs will identify patients over 75 requiring the specific IFS services once the eFI is in the mild frailty category or above, but wherever possible primary care will be maintained at a locality level, with in-reach from the IFS as needed for extra advice or support. The proposed care models are summarised

below and in Exhibit 4. Importantly, these models would work as one service, with patients receiving the right intervention at the right time:

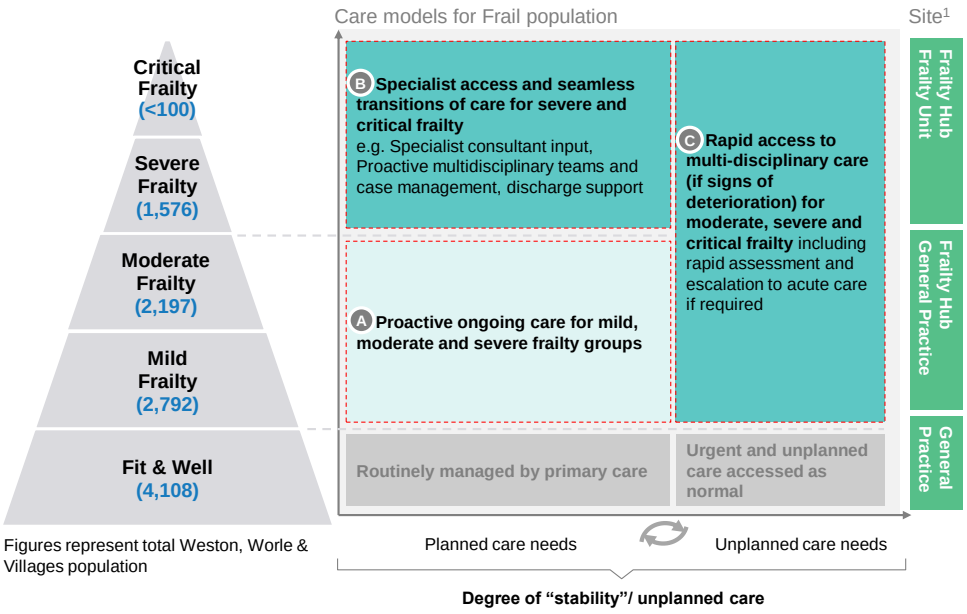
a) **Proactive ongoing care for patients** - to support people in the *mild*, *moderate* and *severe* frailty segments in ageing well
    - MDTs to proactively discuss patients who are at risk of requiring increasing input
    - Individualised patient-centric care plans (including advance care planning)

b) **Specialist access and transition of care support for severely frail patients** – to support people in the *severe* and *critical* frailty segments
    - Access to specialist input (e.g. from specialist consultant/ GPwSI or nurse specialist)
    - Case management with high intensity care coordination to reduce risk of crisis events
    - Community and social care in-reach to support early assessment and discharge (with appropriate intermediate care if required)

c) **Rapid access to multi-disciplinary care in case of deterioration** - to support people in the *all* frailty segments
    - Rapid response team to assess patient and provide support to prevent hospital admission when appropriate
    - Access to an acute frailty unit (AFU) or geriatric ED for patients who deteriorate significantly and require acute management

EXHIBIT 4

Care models for the Frail population



1 MDT meetings will occur across all sites but staff will predominantly be in the Frailty Hub/Unit at the hospital site

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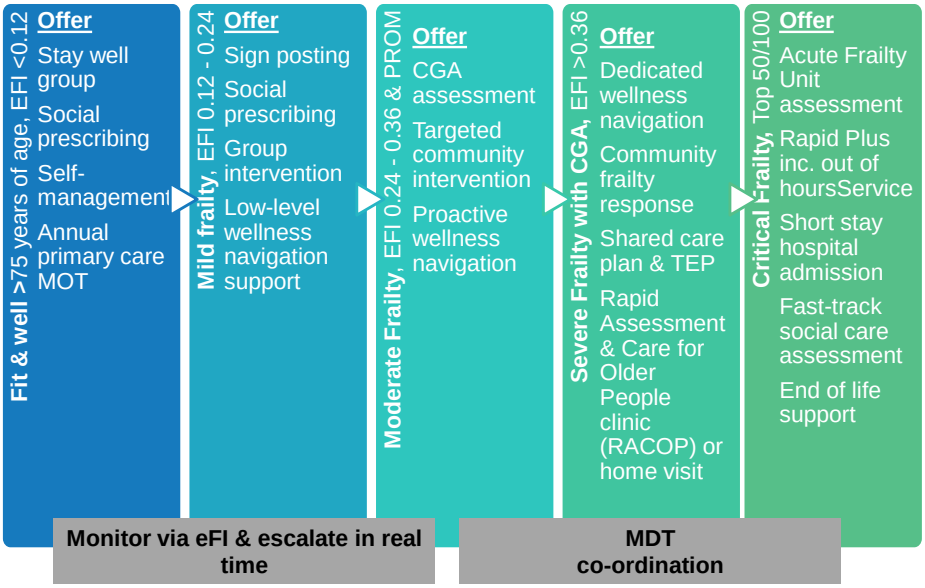
Examples of interventions for patients in different risk segments are shown in Exhibit 5.

EXHIBIT 5

Example interventions offered at each level of Frailty



People with varying levels of frailty will be identified proactively by screening all over 75s in the population using the Electronic Frailty Index scores on EMIS. Patients will be access the Integrated Frailty Service from primary care or other health and care professionals (e.g. out of hours or 111 services) before an episode of illness, to enable an ongoing proactive management of their health risk through appropriate frailty pathways. Guidelines recommend routine screening for identification of frailty, in order to provide evidence based treatment and the e-FI has been proven to have robust predictive validity for outcomes of mortality, hospitalisation and nursing home admission.[1]

Use of the e-FI in primary care enables practices to identify people with frailty and signpost them into the most appropriate part of the IFS pathway. All patients will continue to have a named GP who will help to identify those who would benefit from the IFS pathways. Although the e-FI is effective at a population level, it is less reliable at the individual level, with high rates of false positives. Therefore for most patients, a proactive Comprehensive Geriatric Assessment (CGA) will be performed by a multidisciplinary team to assess the patient's level of dependency, place them into the relevant risk segment and ensure an holistic assessment of their needs and shared personalised care plan is developed. To determine patients who require a CGA, additional frailty scores may be performed such as the clinical frailty score (CFS, also known as Rockwood score) in acute settings or the Edmonton frailty scale in community settings. The shared care plan, based on the CGA, will be accessible to

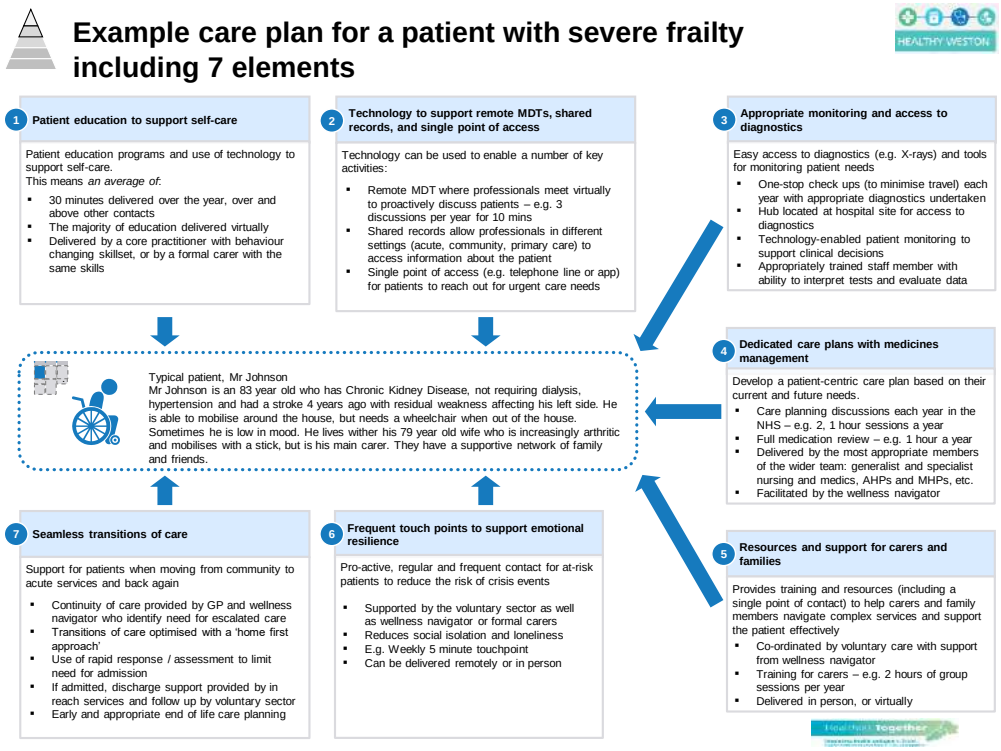
[1] Clegg et al., 2016 *Development and validation of and electronic frailty index using routine primary care electronic health record data.* Age and Ageing

the IFS, primary care and other relevant partners, including the patient and their relatives. Care plans should be co-developed with input from patients and their carers, and follow up assessments of patients should be agreed at specified intervals (e.g. quarterly). All patients will have an allocated wellness navigator (role described in section 4) who will support their care journey and ensure they access the IFS and locality pathways in a timely way. The underlying principle is that of a proactive integrated approach, rather than one that waits and responds to when a person becomes unwell.

To be effective, all patient care plans will be supported by 7 elements:

1. Patient education to support independence / self-care, ageing well and patient responsibility
2. Use of technology to support remote consultations and virtual MDTs, patient self-care, shared records, and a single point of access
3. Appropriate testing and monitoring with local access to diagnostics
4. Dedicated care plans including medications management
5. Provision of resources and support for carers, families, friends (e.g. through the voluntary sector)
6. Frequent touchpoints to support emotional resilience for at risk patients and reduce risk of adverse events
7. Seamless transitions of care (e.g. when moving from community to acute services and back again, end of life care) led by dedicated wellness navigators with a ‘home first’ approach

EXHIBIT 6



Multi-Disciplinary Team (MDT) meetings will be held for the high-risk patients. People identified as moderately or severely frail following frailty assessment will be discussed at an IFS MDT meeting. The focus of the IFS MDT will be discussion of complex cases, and development of shared management plans (with patient and carer involvement when possible), including onward referral where necessary. These interactions will be recorded on the patient's shared health record. Attendance at the MDT meetings will be from a variety of disciplines from the IFS including (but not exclusively) GPs/specialist doctors, community nursing, pharmacists, therapists, mental health practitioners, social care, wellness navigators, voluntary service organisations (VSOs) and other specialists as required. Where possible, MDTs will be held virtually for the majority of less complex patients with the aid of technological solutions. In addition to IFS MDT meetings, locality MDT meetings will take place in primary care and the community (with the wellness navigators acting as a link to the IFS). These locality MDTs may result in a request for a more complex IFS MDT to enable specialist input or provide advice for continued routine management in primary/community care.

Patients who deteriorate will initially be supported with rapid assessment with the aim of keeping them at home if safe and appropriate to do so. Patients whose care needs escalate further will be seen in an Acute Frailty Unit (AFU) and managed there if their condition can be managed safely. This unit will be led by an acute frailty specialist doctor and work together with the IFS team to support all frail patients who are acutely unwell. Some critically unwell and highly complex patients will need to be transferred from the AFU to more specialist centres if required, as per established protocols.

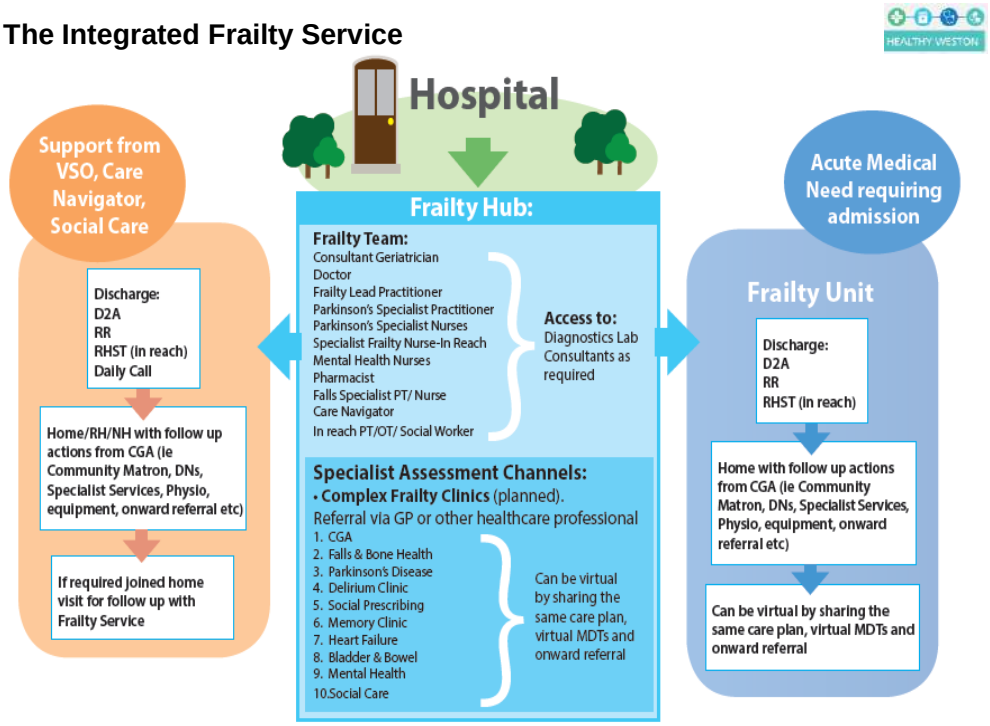
The AFU will receive patients who are triaged at the front door based on age (over 75) and frailty score, or patients who are part of the IFS and are referred for acute support. Exclusion criteria would include patients who do not meet the frailty criteria (CFS and clinical assessment) and patients who are very acutely unwell and need to be transferred to more specialist centres (e.g. gastrointestinal bleeds, suspected myocardial infarction/pulmonary embolism, acute kidney injury, sepsis etc.). The major aims of the AFU will be faster initiation of treatment by a multidisciplinary team following a CGA, reduction in avoidable admissions, and direction of patients into more appropriate care settings (e.g. discharging a greater proportion home within 72 hours if appropriate). Key to delivery is collaboration as part of an IFS which will enable close multidisciplinary working across hospital services, community services, primary care, social services and with the voluntary sector. This will be promoted by good communication, and 'trusted assessment' between teams.

The objective of the IFS will be to improve and maintain the wellbeing and health of patients, supporting a whole programme of ageing well and keeping people at a lower risk level by applying the appropriate care plans. With appropriate support in the community and self-empowerment, patients can be discharged from the IFS and back to routine primary care if their risk level is assessed to be reduced appropriately. End of life care will also be reinforced with advance care plans and coordinators providing high quality support to enable as many people as possible to die in their preferred place.

The various parts of the frailty service which work together in the IFS are shown in Exhibit 7.

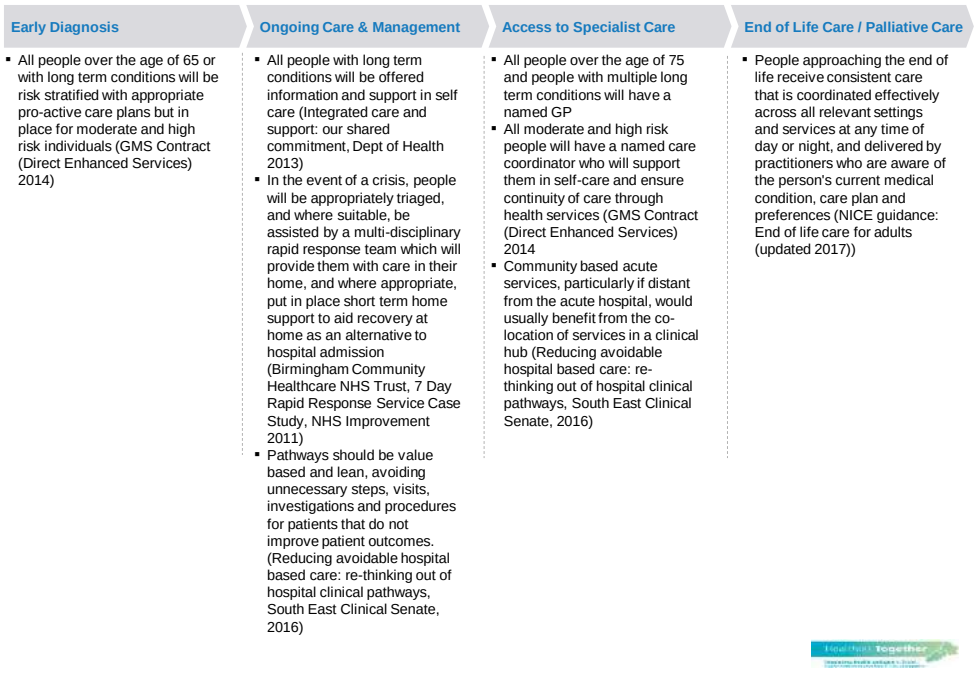
Exhibit 7

The Integrated Frailty Service



1.3.3 Clinical evidence base for services proposed

Clinical guidance supporting the principles which underlie the integrated frailty service is outlined Exhibit 8 below: Exhibit 8: clinical standards and best practice evidence for management of frailty and long-term conditions



In addition, there is significant evidence nationally and internationally that support the importance of establishing integrated care services such as the IFS. The King's Fund proposed a number of practices that improve continuity of care for elderly patients, including a named key worker, a care plan, a complete electronical health record, and support from a multidisciplinary team.[1] A further report summarised lessons in integrated care for older people with complex needs from a number of international case studies. The key summary was that improved coordination of health and social care, and use of multidisciplinary team support led to lower incidences of functional decline in older patients, longer time spent in their own homes, as well as annual improvements in mortality.[2]

Overall, systematic reviews of findings from such programmes suggest that self-empowerment and education, multidisciplinary teams, care coordination, and individualised care plans are the most effective interventions for improving care plans and reducing hospitalisation. Examples of international organisations which have delivered similar integrated care outcomes include ChenMed (38% reduction in hospital days for over 65s), CareMore (56% reduction in hospitalisation for congestive heart failure patients), and Ribera Salud Grupo (26% reduction in costs).

1.4 WHO DELIVERS THE CARE

1.4.1 Roles descriptions

The Integrated Frailty Service (IFS) will comprise a multi-disciplinary team including advanced frailty practitioners (nurses and therapists) frailty doctors (consultant geriatrician, GP, other senior clinicians), social care staff, mental health nurses, pharmacists, falls specialist physiotherapists and nurses, wellness navigators and volunteers. Exhibits 9 and 10 describe the staffing and role descriptions required for the IFS. Effective navigation and coordination and targeting of MDT's are key elements of delivering coordinated, person-centred care and support.

[1] The Kings Fund, *Continuity of care for older hospital patients*, 2012

[2] The Kings Fund, *Providing Integrated care for older people with complex needs. Lessons from seven international case studies*

EXHIBIT 9

Integrated Frailty Service Staffing Roles (1/2)

Staff Group[1]	Role included	Role description
Frailty practitioner	▪ Consultant frailty practitioner	• Early identification of frailty in primary and secondary care • Management of frailty 'as a long-term' condition • Inclusive and comprehensive urgent care response for unwell patients • Understand and manage coexistent mental health disorders in the context of frailty • Recognition and understanding of when an individual's frailty trajectory is approaching the terminal phase, and support to ensure they stay in their preferred place of care • Development and implementation of frailty MDT process • Timely, responsive and holistic care to support people in their 'preferred place of living' throughout their frailty trajectories, using a multi-professional and interagency approach • Understand and overcome challenges of negotiating traditional boundaries in the delivery of care
Medical	▪ Community Geriatrician ▪ Acute clinician ▪ GP with frailty interest	
Nursing	▪ Advanced practitioner ▪ Community matron ▪ Registered nurse ▪ Nurse assistant	• Work collaboratively with other health care professionals in primary/secondary care, and voluntary services to develop pathways that support avoidance of ED attendance and admission to hospital • Providing highly specialised care within the community to patients with unscheduled care needs • Raise and develop the profile of frailty within community settings and with partner agencies • Recognise patients needing escalated care and provide urgent care to unwell patients if required • Provide expert advice and clinical leadership to ensure the needs of the patient are met by leading, challenging and changing practice within acute community settings • Lead on development of skills and competencies of staff identifying and managing frailty, support staff in developing additional skills in managing patients in their own home • Pro-actively support and maintain patients within the community and care home setting • Develop clinical pathways and protocols, leading on clinical audit and research • Recognise and act as advocate for patients and carers
Therapy	▪ Advanced practitioner ▪ Physiotherapy ▪ Occupational therapist ▪ Dietitician ▪ SALT	
Wellness navigator		• Provide support and care to people living with frailty who have complex health problems. • Maximise independence and prevent avoidable hospital admissions, by sourcing and delivering a range of health, social and voluntary care services in collaboration with local communities • Work with and co-ordinate care across primary, community, secondary, social and voluntary care • Identify deteriorating conditions, or social circumstances at an early stage, and help navigate for the most appropriate health, social care or voluntary person to review the patient • Refer, or advise family members / carers and service users to external agencies and specialists • Carry out a range of non-clinical and basic clinical assessments and interventions to identify and respond to clients' needs under the direct/indirect supervision of a registered practitioner (e.g. gaining consent; baseline observations; dressings and topical treatments; venepuncture; spirometry and peak flow; blood monitoring, ECGs; 24 hour BPs)

1 This is not a complete list, but represents the staff groups delivering the majority of services that would benefit from integration

EXHIBIT 10

Integrated Frailty Service Staffing Roles (2/2)

Staff Group[1]	Role included	Role description
Pharmacy	▪ Acute ▪ Community	• Medication reviews • Advice to MDT re: medications • Medicines optimisation • Facilitator of personalised care for people with long-term conditions (ltcs) • First port of call for episodic healthcare advice and treatment • Neighbourhood health and wellbeing hub • Case finding
Social Care	▪ Frailty team social worker ▪ North Somerset council social worker ▪ Integrated discharge team	• Support to live well at home or homely setting • Assess: informal support; opportunity for social activities or access; care resources; community connections; readiness to change • Potential interventions: welfare assessment and income maximisation; carers assessment; community assets (befriending and active health classes; technology to support health and wellbeing; referral to social work services; key worker; risk enablement
Mental Health	▪ Admiral Nurse ▪ Community Mental Health practitioner	• Cognition mood, fears and anxiety • Assess: changes in memory or mood; cognitive assessment; delirium; fear of falling; for signs of infection; any recent medication changes; loneliness and isolation • Potential interventions: referral to community mental health teams or GP; dementia services; assistive technology assessment; locality support (leisure and day services); advocacy; counselling and wellbeing services
Voluntary Services	▪ Red Cross ▪ Home from Hospital ▪ Carer support ▪ Curo	• Community Connect – support to maintain people to stay living at home • Time limited support for people to move back home following a hospital admission • Ensure home suitable, e.g., Adaptions and equipment, heating, food • Signposting to local services and agencies • Social prescription • Link with Wellness Navigator
Patient	Understands own health	▪ Provided physically and mentally able, should be empowered to lead their interaction with the health system
Relative or supporter	Patient's advocate	• Where the patient is unable to take the lead, acts in the patient's best interests and acts as a conduit for information whilst empowering the patient

1 This is not a complete list, but represents the staff groups delivering the majority of services that would benefit from integration

Within the model, wellness navigators will work with primary, community and voluntary care services to identify people with frailty that may benefit from additional support. This role will require competency training and be undertaken by non-professionally registered staff who will be performing delegated duties under the supervision of the registered professionals in the IFS. Each wellness navigator will have a caseload of patients within the Integrated Frailty Service with the higher risk segment patients allocated to more experienced navigators. Whilst not being able to provide clinical diagnosis, they will have enhanced skills to enable them to provide a range of activities including advice, signposting and access to activities, baseline assessment skills enabling them to proactively identify issues and help arrange for a clinician to see the patient and contributing as a key member of the MDT. Baseline assessment skills will include nutrition, pressure sore risk, frailty and vital signs. They will use personal anticipatory care plans taking advantage of clinical, voluntary and patient led services specific to each individual. For the patient they will provide continuity and a key contact for them throughout their journey, including if a hospital admission is required.

The voluntary sector also plays a crucial role in helping people to get the right support, at the right time to help manage a wide range of needs. The care and support they offer to patients will be rehabilitative and shaped around what is important to the patient and built on the patient's personal skills, resources and the individuals and the community around them. Their work can also help to develop the role of a wellness navigator. The range of services offered by the voluntary sector include:

- Signposting
- Support hospital discharge (e.g. Red Cross takes patients home, settles them in and helps with shopping, welfare call or visit a few days after discharge etc.)
- Social prescribing
- Support and advice for carers
- Supporting patient activation
- Health coaching
- Peer support

Integral to the IFS is the upskilling of staff across health, social and voluntary care sectors in ageing well and frailty care. This will be achieved through formal learning and practice based learning via MDTs to ensure that staff have the necessary skills and competencies to deliver the integrated frailty pathway. Importantly, the workforce supporting the IFS will act as catalysts to upskill other staff across community based care services in the management of frail older patients.

As part of a wider piece of work in the area called the 'Locality Transformation Scheme', the IFS will also ensure all providers of services in the community work together in a more integrated way. This will be enabled by contractual alignment (led by host organisation) as well as shared performance metrics between providers.

1.4.2 Workforce resource requirements

Current workforce

There is currently fragmented staff provision for frail patients – with staff variably covering all patients in North Somerset, and also non-frail patients. Dedicated frailty support in the community is led by 1 WTE Frailty lead practitioner, two 0.5 WTE registered nurses and 1 consultant across all of North Somerset. This team is further supported by the Weston, Worle & the Villages integrated care team (26 nurses split across North Somerset and with responsibility for frail and non-frail patients), as well as residential home support team, rapid response, community matrons, pharmacy, social services, mental health and the voluntary sector, all of whom provide a large portion of care for frail older population.

In the acute Trust, there is currently one dedicated frailty specialist physician providing the acute frailty service 2 days a week to prevent admissions from ED where appropriate. There is also a 0.8 WTE social worker based at the hospital but not covering patients at ED; this role provides access to social services records but is not decision making and is not specifically for the frail patients. but this role is again not dedicated to frail patients. The WGH discharge team consists of 4.5 WTE qualified social worker and 6.5 unqualified social care staff covering hospital discharges (all ages) from WGH and other hospitals across the region. However, only the frailty specialist physician currently coordinates discharges from ED.

Future workforce requirements

The workforce requirements for the IFS were calculated from an estimated frail population of ~6500 patients in Weston, Worle and the Villages (Mild, Moderate and Severely Frail patients in Exhibit 11) who are expected to access the full IFS offering. The Frailty Steering Group agreed assumptions for staff contact time for typical patients at each frailty risk level, as a proxy for requirements for proactive pathways. Representatives from different services (e.g. social care, primary care) gave input on how frequently and for how long on average people in each risk segment need to be seen (e.g. a severely frail patient should be seen once a year for 30 minutes by medicines management). The assumptions with corresponding patient contact times and estimated staffing requirements are shown in Exhibit 11. In addition to the staffing requirements for proactive care pathways, an additional 1.5 WTE acute consultant, 1.6 WTE wellness navigators and 0.7 WTE advanced clinical practitioners are estimated to be required for unplanned care provision – based on expected activity managed by the acute frailty unit including anticipated acute activity from North Sedgmoor and out of area. Staffing for the routine primary care / locality model was not estimated separately as this is assumed to continue as present.

EXHIBIT 11

Integrated Frailty Service – workforce by tier

Proactive care workforce calculated based on patient contact time by tier per staff member

Frail >75 y/o population	Severe Frailty (1576 people)		Moderate Frailty (2197 people)		Mild Frailty (2792 people)		2019 Total Patient Contact (hrs)		2019 Staffing
Staff	Visit Frequency	Visit duration (mins)	Visit Frequency	Visit duration (mins)	Visit Frequency	Visit duration (mins)	Annual hours	Hours /week[1]	FTEs
GPwSI / Consultant	2	30	1	20	1	15	3,006	37.5	2.9
Adv. clinical practitioner	10	30	0.8	20	0	20	8,466	37.5	8.1
Wellness navigator	2	8	8	8	1	8	3,136	37.5	8.4
Medicines mgmt	1	30	0.5	30	0	0	1,337	37.5	1.3
Social care	4	60	1	60	0	60	8,501	37.5	11.3
Therapist	2.5	25	0.8	25	0.02	25	2,397	37.5	2.3
Mental health pract.	6	30	1.5	30	0	15	6,376	37.5	6.1
Voluntary care	1	60	1	60	0.3	30	4,192	10	15.0
MDT coordinator							2,080	37.5	1.4
Palliative Care							156	37.5	0.1
Receptionist							4,368	37.5	2.9

- Reactive / unplanned care provision for **acutely unwell patients** requires additional 1.5 WTE acute physician, 1.6 WTE wellness navigators and 0.7 WTE advanced clinical practitioners
- Additional 1 Admin staff and 1 Manager will be required to manage the physical location

1 Assuming 40 weeks p.a., with 70% target patient facing time

Although the details of the incremental workforce required will need to be validated, there is evidence that a significant amount of the care needs required can be met by an existing workforce, working in a more joined up and effective way. New investment will be required for some roles (e.g. wellness navigators) - costings and corresponding savings are considered in section 5. The business case to recruit a team for the acute frailty unit has already been approved by Weston Area Health Trust and posts are now being recruited to.

The IFS will also be an important programme for attracting new staff (e.g. new general practitioners and emergency medicine physicians) who are excited about working in different locations (e.g. acute, community, patients homes) and sub-specialties. Current GPs will be better able to support patients with access to comprehensive care plans and the ability to escalate care quickly and seamlessly with clear pathways in place; they will also be supported to provide proactive care by wellness navigators. In addition a group of GPs with an interest in portfolio careers can be recruited to dedicate a portion of their time to managing frail patients alongside community, social, and voluntary care as part of the IFS.

1.5 WHERE WILL CARE BE DELIVERED

The Integrated Frailty Service will provide care in the most appropriate physical location for patients, enabled by technology where possible. Effort will be made to provide care in patients' homes or usual place of residence (e.g. residential homes).

In parallel, a Frailty Hub will be designated as the base for staff to work from and for patients to attend for a range of clinical and social activities. Alongside the hub will be an acute frailty unit which will support care provision for patients with acute medical needs or who arrive at the ED. Patients who are at reduced risk will continue to be managed in primary care by their GP and with the range of community and social care services already available.

1.5.1 Proactive care and rapid assessment in the Frailty Hub

It is anticipated that the Frailty Hub will be located at Weston General Hospital and be the coordinating centre for the IFS. It will provide proactive support and a one stop multidisciplinary rapid assessment and treatment service for frail elderly patients who are not urgent, but who will ideally be seen within 4 working days, or who are steadily deteriorating without cause. The hub aims to:

- operate as the centre of excellence for management of high risk frail population – including organisation of patient meeting groups (held on site or in community areas), educational classes, and health checks
- see patients who require rapid MDT assessment and diagnostics for on-going care
- manage the patient at home or as near home as possible (team will go to the patients)
- avoid an acute hospital admission where possible
- operate a step up/step down service from other pathways
- streamline pathway through hospital including supporting timely discharge for frail patients who have been admitted

Basing the Frailty Hub on the Weston General Hospital site will mean the Integrated Frailty Service will have access to, and work closely with, other services provided within the hospital such as Specialist Long Term Conditions services as well as secondary care services and diagnostics. This will enable seamless transfer of care across sectors. Community services will in-reach into the frailty hub and unit to facilitate early discharge, management of risk and links to practice based MDT meetings. It will also ensure proactive discharge planning and co-ordination and continuation of the CGA, initiated in hospital followed up into the community.

Where home care is not practical, access to the hub will be supported by establishing transport infrastructure (for example taxis or buses to bring patients to the hub for group sessions). The enhanced Residential Home Support Team will provide in-reach for all care home services; this service will be scaled up alongside on a model of education and support for the homes to enable them to also support their residents proactively.

1.5.2 Escalation of care in the Acute Frailty Unit

The acute frailty assessment service will be based alongside the Frailty Hub at the hospital site in a new purpose built acute frailty unit (AFU), a self-contained unit in the ED footprint with assessment and treatment bays that are furnished with chairs rather than beds.

1.5.3 Care Home Support

The Residential Home Support Team (RHST) will be part of the Integrated Frailty Service and will help to embed the frailty model across care homes in Weston, Worle & the Villages in partnership with the care homes (all residential and nursing homes).

This will be achieved through:

- Standardised approach and information to staff on how to best meet the nursing and care needs of residents in the care homes, e.g. using the assessment framework within the 'Blue Book'[1]
- MDT Meetings to be held in care homes
- Easy access to virtual Integrated Frailty Service expertise when required
- Specialist support to care homes
- Comprehensive assessment of new residents on admission
- Person-centred care planning
- Regular reviews
- Provision of training to care home staff
- Improved pathway access to existing community and primary care services
- Pharmacist support
- In-reach – facilitate early supportive discharge

Furthermore, recent changes in primary care in WWV have enabled allocation of a named GP to each nursing home around the patch in order to support continuity of care; this process is also being implemented for care homes in Weston, Worle & the Villages.

X.5.4 Estates required

The quality and design of facilities in the Frailty Hub and unit will be important to help provide the right environment for frail patients who may have mobility problems or other impairments (e.g. visual, cognitive). The designs will take into account advice provided by the Alzheimer's Society to ensure it is appropriate for patients with dementia and cognitive impairment. Chairs and equipment will be selected by the therapy team to ensure suitability for frail older patients

Initial evaluation of space requirements suggest that at least 350 m^2 will be required for the hub (see Exhibit 12). Space for this on the hospital site is expected to be freed up by reduced and shifted activity in the newly configured Weston General Hospital. It is expected that the IFS will then reach an arrangement with Weston Area Health Trust to pay for utilisation of the freed up / allocated space.

[1] This is an educational tool which care homes can use to help them meet the care needs of their residents

EXHIBIT 12

Real estate requirements

Frailty hub

Room type	2019 number required[1]	2019 space required[5] m²	2019 implied fixed cost[6] £'000s
Consultation rooms[2]	13	232	600
Therapy room[3]	1	48	124
Offices[4]	3	76	197

1 Calculation based on total hours room is available (12 hours a day, 5 days a week), target utilisation of room of 80% and total time required by different staff members estimated based on contact time
2 Assumes consultation rooms are required for patient contact time for all staff except therapists
3 Therapy room only required by therapist
4 Offices used for non-patient facing work or for admin staff
5 Assumes 18 sqm for consultation room, 48 sqm for therapy room and 30sqm for an office for 6 people. Includes 3x scaling factor for circulation space
6 Assumes £2,500 fully loaded cost per sqm per year

1.6 FINANCIAL IMPLICATIONS

The Integrated Frailty Service will require investment for estates, staff, as well as diagnostics and other variable costs. An initial assessment of these investment costs has been performed and is described below. This assessment does not include any additional investment that may required in primary care restructuring, creating social care capacity or optimising discharge to assess pathways. These will all be critical to support an effective frailty services.

- Total workforce costs are estimated at approximately £2,000,000 (assuming all IFS roles will need to be recruited) per year. However, the staffing cost for the Frailty Service will be mitigated by redirection of existing community resource, with the exception of additional funding required for new posts such as the Wellness Navigators (estimated at £310,000 by 2024).
- Variable costs are estimated at approximately 15% of staff costs (approximately £300,000)
- In additional fixed costs will need to be incorporated for the estates utilised on the Weston General Hospital site (approximately £920,000)

Based on various lines of evidence from other parts of the country and the world (e.g. South Manchester pilot model in the community, Partnerships for Older People Projects (POPP)) where similar services have been set up, it is estimated that an IFS will reduce ED attendances of frail over 75s by up to 25%, assuming that the workforce is available to deliver the service. This is projected to result in a reduction in ED attendances by approximately 1,600 by 2024. Using average ED tariff for this population, this leads to an estimated spend reduction of approximately £300,000.

In addition to the reduction in ED attendances, the provision of more effective acute frailty care and in-reach services are expected to reduce admissions for the frail over 75s by 50%. This assumption is supported by two local audits (one over 6 weeks and another over a week) of the acute frailty service which showed reductions in admissions of this magnitude. Therefore, even without accounting for additional length of stay changes, non-elective spells are expected to reduce by more than 1,500 by 2024, freeing up approximately 25 beds. Using average non-elective tariffs for this population, this leads to an estimated spend reduction of approximately £4,500,000.

As such, the investment for this service is expected to be funded by reduced costs associated with hospital avoidance and reduced non-elective admissions. It should be noted that any additional capacity increases required in social care to support the IFS have not been costed.

1.7 ENABLERS REQUIRED FOR SUCCESSFUL IMPLEMENTATION

There are a number of general enablers that will be essential for the successful implementation of the IFS:

- Integrated information systems enabling appropriate and timely sharing of electronic patients records, images, notes and reports across care settings to ensure seamless communication and adoption of new technology
- Contracts, regulation and tariffs to align incentives across the health economy for health i.e. primary, secondary, community care, mental health and prevention (Public Health England / Local Authority) and social care to build care around the individual, rather than current fragmented system (this requires support from the CCG to move to outcomes based commissioning)
    - For patients who attend WGH ED from other Trusts, an agreement will need to be reached on a payment model (e.g. using ED tariff for care provided in the acute frailty unit and referral back to primary care in Somerset CCG)
- Better, more consistent performance across providers (e.g. standardisation of primary care) to ensure more consistent delivery of high quality care
- Better structure for risk-stratification towards delivery of the right services at the right time in the right place
- Patient education and information sharing
- Training and education for all staff – e.g. upskilling staff using frailty bundle training, and also entrenching a cultural mindshift required to facilitate change

1.8 IMPLICATIONS ON PRIMARY AND COMMUNITY CARE SERVICES

Re-organisation of primary and community services to address the needs of the entire population are already underway and will be critical in supporting both the Integrated Frailty Service and wider changes proposed for Weston General Hospital.

- Primary care in Weston, Worle & the Villages is moving towards a corporate general practice model – this provides primary care at scale while allowing practices to retain significant autonomy
- As part of an Intensive Support Scheme, the region has been awarded £400,000 by NHSE to improve the recruitment and retention of GPs (due to high proportion of GPs over 55).
- The Intensive Support Scheme has been used as a transformative platform to fund a new “digital front door” in primary care providing an e-consult tool for patients, to drive a radical redesign of general practice and optimise the workload for GPs
- New innovative models of community care including increasing the role of rapid response nurses, and integrating district nursing more efficiently are proposed as part of the re-procurement of adult community services

Additionally, some design elements of Integrated Frailty Service can be incorporated into the design of wider community based services

- Understanding the needs for the whole population based on levels of risk
- Proactively planning of care (e.g. for long term conditions) and increasing access to urgent care
- Consolidation of care delivery – e.g. GP locality hubs with benefits of scale for the provision of urgent primary care, community care centres enabling increased integration across patch
- Increasing access to primary care (e.g. extended hours)
- Ensuring appropriate social care capacity and timely assessment of care needs for high risk patients

Further work is required to describe the future of primary, community and mental health services that encompass future of frailty care. A comprehensive review of demand from all patients for out of hospital care should be worked up for the current state and into the future. There will need to be choices made about how primary care is arranged, with respect to patient caseloads and GP roles – for example, primary care could be arranged with GPs focused on specific patient cohorts or patient pathways (such as frailty care, planned care, long term conditions management).

As part of the additional work, it will also be important to understand resources that will be freed up by the frailty service in core primary and community care. This can be reconciled with current resourcing levels and staff competencies in order to understand what (if any) additional recruitment and training will be required to implement the Integrated Frailty Service successfully.

Healthy Weston Pre-Consultation Business Case

Appendix 7: Healthwatch North Somerset Report

Weston General Hospital
at the
Heart of the Community

Public and Staff Engagement

A Feedback and Data Analysis Report
from Healthwatch North Somerset
for NHS North Somerset Clinical Commissioning Group

30th June 2017

Contents

Foreword

Weston General Hospital is a crucial part of the local NHS in the South West. It is in the heart of the main community it serves, has excellent resources and caring staff.

However, being part of the smallest acute Trust in England, the hospital has struggled with increasing demand for services, the long-term recruitment of doctors in some specialties and delivering services within the money available. Many of these issues have been ongoing for years despite intense efforts locally and regionally to resolve them.

As with any hospital, the services provided are part of a wider system of care and all partners are committed to making Weston General Hospital a success and a permanent part of the local health system.

There is no doubt that things need to change because some services are not sustainable in their current form and all the services needed to support a growing population cannot be provided from one relatively small hospital.

NHS North Somerset Clinical Commissioning Group need a solution that makes the best use of the hospital facilities, with the best mix of staff that gets the best outcomes for patients.

Working with health and social care partners, NHS North Somerset Clinical Commissioning Group developed 'four ideas' and two initiatives that they are confident will help secure the future of the hospital - but they are not fixed plans and they held eight weeks of engagement to hear what local people and staff thought of them[1].

This report provides independent analysis by Healthwatch North Somerset of the feedback received during the eight weeks of engagement undertaken by NHS North Somerset Clinical Commissioning Group which took place from 9th February 2017 to 6th April 2017.

Introduction

Weston Area Health NHS Trust provides a wide range of acute and rehabilitation hospital services, as well as some community health services primarily to residents of the North Somerset area. Services are provided on a contractual basis to local health bodies that are responsible for purchasing health care for the resident population.

The Trust serves a resident population which, in 2011, was estimated to be 202,566 people (source: 2011 census), with over 70% of people living in the four main towns of Weston, Clevedon, Portishead and Nailsea. A further 3.3 million day trippers and 375,000 staying

[1] https://www.northsomersetccg.nhs.uk/get-involved/wgh-engagement/

visitors increase this base population each year. The Trust also provides services to North Sedgemoor which has an estimated population (April 2012), of 47,825. The largest town is Bridgwater, followed by Burnham-on-Sea and Highbridge.

NHS North Somerset Clinical Commissioning Group is the Trust's main commissioner accounting for approximately 69% of Trust healthcare income, with NHS Somerset accounting for circa 16% of income. In addition, the Trust receives other non-patient related income including education and training monies. The age structure in North Somerset is older with fewer younger dependents and people aged under 40. One in five people in North Somerset are aged over 65 compared to 18% in England. The total North Somerset population is expected to increase by 40% by 2033 (national average growth is 18%).[2]

Some of the challenges[3]:

- There are lots of older people and people with lots of different health needs in the community.
- It can be hard to recruit doctors for some departments in the hospital.
- There is not enough money to deliver services the way they are now.

NHS North Somerset Clinical Commissioning Group, working with health and social care partners, developed 'four ideas' to address the issues at Weston General Hospital[4]. The Clinical Commissioning Group and the partners are confident that the ideas will help to secure the future of Weston General Hospital.

The work on developing the 'four ideas' brought together local health and social care organisations who formed the North Somerset Sustainability Board.

Representatives on the Board include:

NHS North Somerset Clinical Commissioning Group / NHS Somerset Clinical Commissioning Group / Weston Area Health NHS Trust / NHS Bristol Clinical Commissioning Group / Healthwatch North Somerset / North Bristol NHS Trust / NHS England / NHS Improvement / North Somerset Community Partnership / North Somerset Council / One Care Consortium /NHS South Gloucestershire Clinical Commissioning Group / South Western Ambulance Service NHS Foundation Trust / Taunton and Somerset NHS Foundation Trust / University Hospitals Bristol NHS Foundation Trust

NHS North Somerset Clinical Commissioning Group and NHS Somerset Clinical Commissioning Group are the consulting authorities for the work, with NHS North Somerset Clinical Commissioning Group taking responsibility for the overall co-ordination.

[2] http://www.waht.nhs.uk/en-GB/About-The-Trust/Our-Standards/Trust-Annual-Report-and-Quality-Account/
[3] https://www.northsomersetccg.nhs.uk/get-involved/wgh-engagement/
[4] https://www.northsomersetccg.nhs.uk/get-involved/wgh-engagement/

NHS North Somerset Clinical Commissioning Group undertook an eight-week period of engagement with the public in North Somerset and with Weston General Hospital staff from 9th February to 6th April 2017, to hear and collect views on the 'four ideas':[5]

1. **Change the urgent and emergency care service model overnight from 10pm – 8am**

2. **Bring day to day non-complex planned operations back to Weston General Hospital**

3. **Transfer some emergency surgery to other hospitals**

4. **Increase the number of beds in the critical care unit on the Weston General Hospital site**

> *"Weston General Hospital is a crucial part of the local NHS but faces particular challenges because of its size.*
>
> *We want people to come to our public engagement events so we can hear their views and listen to their experiences of services at Weston General Hospital"*
>
> Dr Mary Backhouse, Local GP and Chief Clinical Officer at NHS North Somerset CCG

It is envisaged that the 'four ideas' solutions would make the best use of the facilities at the hospital with the right mix of staff to ensure patients have the best outcome.

NHS North Somerset Clinical Commissioning Group with their partners, proposed two initiatives in addition to the 'four ideas', which will help services work together more effectively. Those currently being explored are:

1. ***Integrated working within acute care.*** The collaboration consists of the three local hospitals (Weston Area Health NHS Trust, University Hospitals Bristol NHS Foundation Trust and North Bristol NHS Trust) as well as community partners.
2. ***Working more closely with services in the community***. Local partners would work with Weston General Hospital to develop better ways to manage patients being admitted and being discharged (patient flow) from hospital, working closely with community partners and social care.

NHS North Somerset Clinical Commissioning Group outlined the ideas during the engagement period to keep Weston General Hospital at the heart of the community. These were to ensure the hospital provides the best possible health and care services for patients, carers, their families, and staff for decades to come.

[5] *See* Appendix 1

Why do NHS North Somerset Clinical Commissioning Group and partners need to engage with local communities?[6]

The Health and Social Care Act 2012 introduced significant amendments to the National Health Service Act 2006 (section 14Z2), especially in relation to how NHS commissioners function. These amendments include two complementary duties for Clinical Commissioning Groups with respect to public involvement and consultation by Clinical Commissioning Groups.

- Patients and carers to participate in planning, managing and making decisions about their care and treatment through the services commissioned by Clinical Commissioning Groups.
- The effective participation of the public in the commissioning process itself, so that services reflect the needs of local people.

NHS England guidance:

- Transforming Participation in Health and Care 'The NHS belongs to us all' (September 2013)
- Planning and delivering service changes for patients – A good practice guidance for commissioners on the development of proposals for major service changes and reconfigurations (December 2013).

The NHS Constitution for England[7]

NHS Constitution (2015)

3a. Patients and the public – your rights and NHS pledges to you

***You have the right to be involved**, directly or through representatives, in the planning of healthcare services commissioned by NHS bodies, the development and consideration of proposals for changes in the way those services are provided, and in decisions to be made affecting the operation of those services.*

The NHS also commits:

to provide you with the information and support you need to influence and scrutinise the planning and delivery of NHS services (pledge)

4a. Staff – your rights and responsibilities (pledge). The NHS commits:

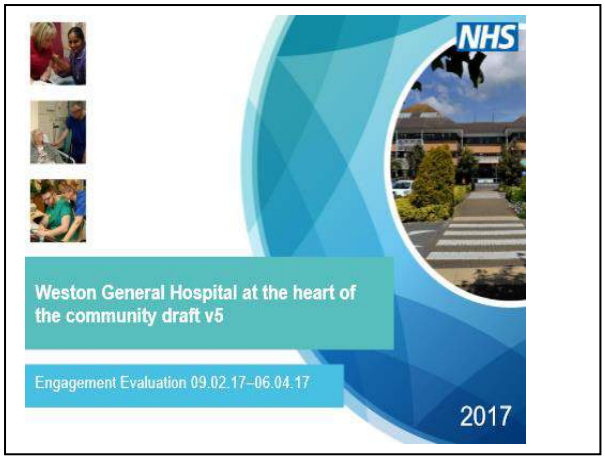
[6] Patient and public participations in commissioning health and care: Statutory guidance for clinical commissioning groups and NHS England Publications gateway reference 06663

[7] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/474450/NHS_Constitution_Handbook_v2.pdf

"to engage staff in decisions that affect them and the services they provide, individually, through representative organisations and through local partnerships working arrangements. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families".

NHS North Somerset Clinical Commissioning Group Engagement Methodology

Public engagement



NHS North Somerset Clinical Commissioning Group provided a wide variety of options for the public and staff to engage in the process and inform them of the methods available to feed back their views on the 'four ideas'.

- Social media (Twitter and Facebook) –daily updates and retweets by 'partner' organisations
- Weston Mercury Facebook live feed question and answer session (14th March 2017) - contacts to put their questions directly to the NHS North Somerset Clinical Commissioning Group
- NHS North Somerset Clinical Commissioning Group website – dedicated area on site with access to information resources and the online survey
- Links were made from local organisation websites to the survey
- Distribution of marketing packs, information booklets, feedback cards and paper surveys[8]
- Extensive engagement with local groups, attendance at meetings and pop up stands[9]
- Email; dedicated email address wgh.engagement@nhs.net
- Letter
- Telephone
- Media: Press releases; online articles; radio broadcasts and interview
- Advertisements in the local media: The North Somerset Times, The Weston Mercury
- Advertisement in North Somerset Council publication "North Somerset Life" which is distributed to every household in North Somerset
- Three 'Have your say on services at Weston General Hospital' public events (**7pm until 9pm):**
    - 28th March: Oaktree Arena, Highbridge, TA9 4HA
    - 29th March: St Andrew's Church Centre, Clevedon, BS21 7UE

[8] General Practices, Pharmacies, Libraries, Sports Centres, Children Centres and Care Homes
[9] See Appendix 1 for details

- 30th March: For All Healthy Living Centre, Weston-super-Mare, BS23 3SJ

Weston Hospital Staff Engagement

Weston Area Health NHS Trust informed and engaged with the staff of Weston General Hospital in conjunction with NHS North Somerset Clinical Commissioning Group. Staff were informed of and provided with opportunities to enable them to give their feedback. Several methods were used and are listed as follows: -

- Staff were given a feedback form and a Trust info sheet attached to payslips
- Ask James! special events
- Executive special departmental briefings plus discussions with senior nursing staff via Ward Wednesday
- Weekly email bulletins to staff with links to all information and briefing notes
- Weekly promotional features in an internal newsletter sent to 2000 staff
- Screensaver promoting engagement in situ for the duration of the engagement
- Posters displayed around the site
- Postcards and booklets. Front desk staff briefed to actively give out materials to the public and staff
- Discussion forum.

External staff engagement

NHS North Somerset Clinical Commissioning Group also undertook internal staff engagement with:

- NHS North Somerset Clinical Commissioning Group
- Taunton and Somerset NHS Foundation Trust
- North Somerset Community Partnership
- North Somerset Council

Full details of all engagement activities carried out by North Somerset Clinical Commissioning Group can be found in the document: Weston General Hospital at the heart of the community draft v5: Engagement Evaluation 09.02.17-06.04.17

Independent Analysis
of
the feedback received from the engagement undertaken by NHS North Somerset Clinical Commissioning Group (9th February - 6th April 2017)

30th June 2017

Introduction

Healthwatch North Somerset is the independent voice for people in our local community, helping to shape, challenge and improve local health and social care services.

Healthwatch North Somerset does this by providing local people with the chance to feedback their experiences of local health and social care services and to influence how services are commissioned and delivered. Healthwatch North Somerset seeks to engage with people in local communities from a wide range of backgrounds, including those who are socially isolated or seldom heard. It provides a focal point for the articulation of the views of local people and for them to be listened and responded to by health and social services commissioners and providers, to challenge and influence change.

The opportunity for the public to express their views is inherent in NHS Guidance (see page 7 of this report) and during the eight week engagement period, NHS North Somerset Clinical Commissioning Group undertook a wide and varied range of engagement activities with the public of North Somerset and Somerset and with staff of Weston Area Health NHS Trust. All were provided with a variety of ways to feedback their views on the 'four idea' proposals for Weston General Hospital.

The compilation of this report was undertaken independently by Healthwatch North Somerset and provides an evaluation of the engagement processes undertaken by NHS North Somerset Clinical Commissioning Group and of the feedback received.

Healthwatch North Somerset would like to thank to everyone who contributed and provided information and feedback for this report.

Results and Findings

Healthwatch North Somerset received access to the bulk of the scanned data feedback information from NHS North Somerset Clinical Commissioning Group on 24th April 2017 with additional scanned and other data forwarded by separate emails until 2nd May 2017.

In total, approximately 800 pieces of feedback were received; some documents contained multiple feedback e.g. Weston Area Health NHS Trust (WAHT) provided 298 comments in one document. Each survey response had the potential to generate 17 entries to the data field, in total, a potential of over 6600 data fields to input, read and analyse within a time frame of 2 weeks from receipt of data. Most of the data was received in scanned protected pdf format which could not be cut and pasted and needed to be manually input into a spreadsheet. One spreadsheet of 189 survey responses which did not require manual input was provided.

The data received from NHS North Somerset Clinical Commissioning Group was printed out, categorised, reviewed, prepared and input into a spreadsheet by the Healthwatch

North Somerset team and volunteers over a 4 day period. This allowed analysis and report writing to take place over the following eight days.

The following data was received:

- Scanned copies of feedback forms received by post, by hand and by email
- Copies of Weston Area Health NHS Trust staff feedback forms
- Comment lists from Weston Area Health NHS Trust
- Scanned copies of public meeting notes and annotated meeting flip chart comments
- Scanned copies of email responses from the public
- Summary transcripts of phone calls
- Summary transcript of face to face meetings
- Online survey results spreadsheet
- Feedback summaries from Weston Area Health NHS Trust staff meetings
- Twitter feeds via Storify to access Twitter comments
- Facebook feeds to access comments from the Weston Mercury Live Facebook blog
- Scanned copies of letters printed in local press
- Summary notes of feedback from voluntary sector and community engagement meetings
- Summary notes of Question Card feedback

The data included:

- 391 online and paper survey (questionnaires) responses
- 346 WAHT staff feedback in two one line comment documents
- 55 'other' contacts feedback (including Healthwatch North Somerset, emails, letters,1:1 & telephone conversations)
- 12 Question Cards
- 128 Social Media comments (Facebook and Twitter)
- 5 newspaper letters
- 46 comments from 31 people who attended Clevedon public event
- 75 comments from 23 people who attended Highbridge public event
- 46 comments from 67 people who attended Weston public event
- 105 comments from 14 voluntary sector and community organisations

Where possible the comments and feedback were allocated to the 'four ideas' proposed and the two initiatives as outlined by the NHS North Somerset Clinical Commissioning Group.

It should be noted that the engagement feedback process generated ideas, observations, thoughts and comments from respondents on a wide range of issues that were outside of the parameters of the 'four ideas' and two initiatives. There were also a number of comments regarding wider Weston General Hospital services.

Additional responses received included issues and observations on:

- The provision of Children's Mental Health Services (CAHMS)
- Access to and service's response to people with hearing loss
- Appreciation of care received by specific hospital specialities
- Access to GP services.

Much of the data was not easy to categorise within the parameters of the 'four ideas' as requested by NHS North Somerset Clinical Commissioning Group, however Healthwatch North Somerset is mindful that respondents took the opportunity to provide their feedback and it will be collated and provided by Healthwatch North Somerset to the relevant service providers and included in a summary document.

For ease of analysis and reading the feedback has been separated into the following Data Analysis Groups:

- **Group 1**:
  Surveys (online and paper) (pages 13-20)

- **Group 2**:
  Email, Letters and Telephone Conversations (pages 20-22)

- **Group 3**:
  Meetings – North Somerset Council - Groups - Drop in sessions – face to face engagement (page 21)

- **Group 4**:
  Open Public Meetings (pages 22 – 24)

- **Group 5**:
  Weston General Hospital Staff Feedback (pages 24 – 29)

- **Group 6**:
  Questions and Answers from Live Session at Mercury (Facebook and Twitter feeds) (pages 29 – 30)

- **Group 7**:
  Question Cards (pages 30 – 31)

Data Analysis Group 1: Surveys (online & paper)

391 survey responses

The key method of providing feedback during the engagement process for public and staff was an on-line survey which could be accessed through the NHS North Somerset Clinical Commissioning Group website[10].

The survey was also made available in paper copies which were distributed at health service sites, meetings or for individuals to print off directly from the Clinical Commissioning Group website.

Both online and paper responses are included in the Group 1 data set analysis.

The feedback data was collated and coded according to the YES /NO / NOT STATED response to each of the questions.

Many of the responses included additional comments and many were unrelated to the 'four ideas'. It is possible that survey respondents were unclear about what the question required from them as a response.

In total 391 people took time to complete the survey either on-line or on paper.

The questions asked in the survey and responses provided

Q1. Do these reasons make sense to you?

A total of 274 YES or NO responses were received to Question 1.

117 respondents did not provide a response and were therefore not categorised.

Other comments unrelated to the 'four ideas' were noted; some examples are below:

- *I am concerned for older very ill people.*

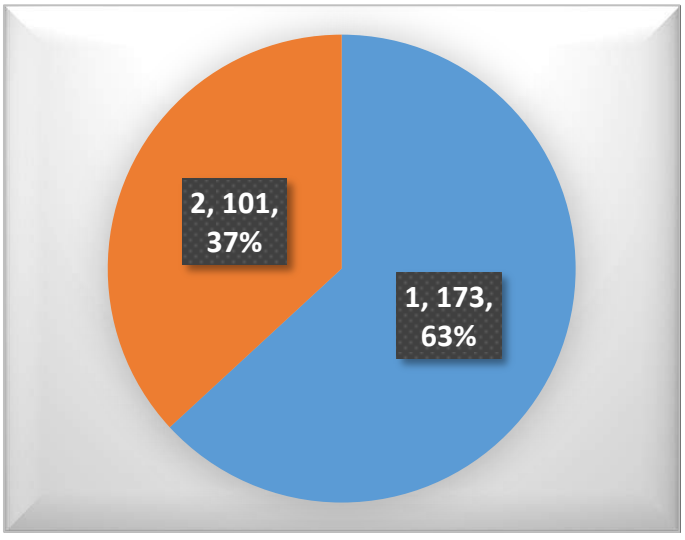


Figure 1 - Do these reasons make sense to you?

[10] Appendix 2

- *Challenge is to centralise in the hospital those things needed on site and take other things out to GP surgeries and home, which technology now allows to be done safely there.*

- *But there is a hidden reason - lack of money. This country can and must spend more on its health and community services. You should be open about this.*

Q2. Do you think we need to change? If not, why not?

A total of 391 responses were received in response to question 2. Of these, 208 responded with YES.

44 respondents said NO.

139 did not provide a response to this question.

103 made additional comments and several respondents stated they thought change was needed … however they added **"but …".**

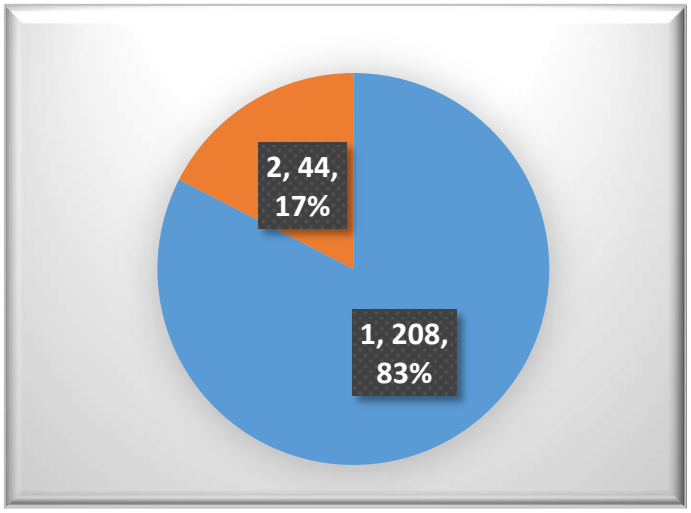


Figure 2 - Do you think we need to change?

- *I understand they need to save money, but after receiving treatment at Weston General I wouldn't want them to change. I would hate to be taken to another hospital if taken ill at night.*

- *It does make sense, but it looks like short term plans.*

- *I fully understand the need to recruit staff and to save money, but I am finding it hard to reconcile this with the fact that Weston has a growing population and in summer months this increases considerably. Surely there is a need for better facilities to meet this demand.*

Of the 44 who answered NO to question 2, 36 provided additional comments. These comments have been categorised as below:

- Increasing population
- Hospital needs to be bigger and better funded
- Impact of journey times to other hospital
- Insufficient information to make comment
- A&E is needed 24/7
- Transport

Q3. Have we presented our ideas clearly? If not, what further information would be helpful?

A total of 221 responses were received to question 3.

154 agreed that YES, the ideas had been presented clearly; of these 112 added comments.

67 did not agree the ideas had been presented clearly.

170 did not provide a response to this question.

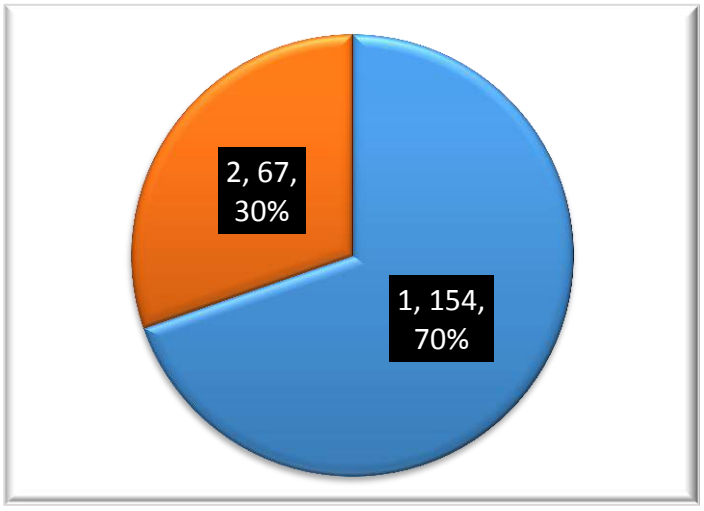


Figure 3 – Have we presented our ideas clearly?

Examples of the comments added when stating YES:

- *I would clarify your proposals for extended day and 7 day working. I hope your elective care plans are for 12 hour operating across at least 6, ideally 7 days to maximise capacity. Also, what about outpatients and rehab/re-enablement?*

- *Enabling strategy of community working is too non-specific. The challenges of NS Local Authority are well known locally, but your relationship with primary care and the VCS are important too.*

- *Ideas are presented clearly but sound too simple. I expect anyone who works in healthcare will have a different opinion and a feeling of helplessness that the plan is already made. The legality states that this process has to happen but the deal is done which will be revealed in 3 months. I really would love to think that my opinion would actually count!!!*

Of the 67 who responded NO to question 3, many provided feedback suggesting they did not consider the ideas were clearly presented.

63 NO respondents provided comments. Some comments suggested that the decision about the hospital had already been made.

- *You are hiding the ultimate goal which is to close the hospital.*

- *The ideas presented are more of a fait accompli than an options proposal, the option to close or scale down is not considered.*

On reviewing the comments, one comment raised a concern on patient outcome:

- *I don't understand why you clarify that non-seriously ill patients recover quicker closer to home. Does this not apply to seriously ill patients as well?*

28 responded that they would have liked further information on:

- Costs
- Population
- Impact assessments of each idea
- Statistics on the numbers affected by the ideas

9 wished for better communication and clarity of the ideas:

- *More information about why these proposals have been made would be helpful.*
- *Very jargony in your articles in the Mercury. Nobody knows what you're trying to say. Be Clear.*
- *I think your ideas are very vague and misleading, the titles don't reflect exactly what you're trying to say, for example increasing the number of ITU beds then saying you are going to take the intensive care part of it away and send the patients to larger hospitals leaving Weston to only deal with HDU patients. I think your explanations needed to be more in depth.*

Q4. What issues do these ideas (any or all of them) raise for you, that you would want us to explore before any decisions are made?

67% of respondents provided additional comments

A total of 261 completed responses were received to question 4.

124 did not provide a comment.

It should be noted that a small number referred to their previous or following answers.

This question prompted several comments and provided a variety of issues that respondents wanted raised and explored. Below are examples of comments:

- *You should consolidate public's views and publish the frequently occurring and best suggestions. The public can then be asked to comment further.*
- *I recognise the value of utilising planned surgery - particularly in view of a new theatre and a lot of surgeons sat around kicking their heels when electives are cancelled. However, my concern would be having a significant drive towards more planned surgeries whilst the situation in ED is not solved. My worry is that there will be a significant promotion of WGH's ability to do more non-complex elective surgeries but that the hospital will still cancel these when in Opel 4 thereby*

reducing public confidence in the hospital to meet the needs of the community.

- *Are there innovative ways of overcoming the distance from home whether it's helping family visit, returning patients to their homes - for those without transport?*

Q5. Are there other ideas for change that we should be exploring which would make services more viable (better quality, more affordable)?

A total of 232 comments were received, of these 142 did not provide a comment.

232 contacts (60%) provided ideas for change

As with the previous question a number respondents answered this question by making reference to their previous comments, or putting 'not applicable' or 'not enough knowledge to answer this question'.

Below are some of the ideas put forward:

- *For years now health professionals have been the victims of negligence claims to the extent that as soon as anyone presents at an A&E dept. The doctors and nurses seem to err far too much on the side of caution. Whilst thoroughness is a virtue it can sometimes assume the status of the proverbial "Jobs Worth award" and thus take up a lot of time with its attendant expense.*

- *Invest in acute frailty services e.g. older people's advice and liaison services, or integrated acute frailty teams.*

- *We need to make better use of IT and this will cost money and investment but it could take treatments into people's homes - there needs to be a real understanding that investment this way can save money in the end - keeping people out of hospital and healthy is cost effective. However, the movement of money out of Trusts does affect how they can deliver their services so Trusts must be part of designing these pathways and it must be a conversation with clinical teams not just managers who have never been clinicians making decisions when they don't really understand the barriers to the "good idea".*

Q6. Are there any of these ideas we simply should not be considering and why?

A total of 187 complete responses were received.

187 comments received

36 of the answers were simply NO or not applicable.

Below are the responses received for Question 6 and categorised under the 'four ideas':

Idea 1:
Change the Urgent and Emergency Care Service Model Overnight From 10pm – 8am

- *Shutting A&E 2200-0800hrs to ambulances is utter madness. It will risk patient health.*

- *Over a quarter of our emergencies seen at Weston General are between the hours of 10pm and 8am. 28% is a lot of poorly people. Anyone presenting at 2am is probably poorly enough for a doctor.*

70 comments stated 'do not close A&E'

- *Closing the emergency department, what happens when you can't get a GP appointment for 3 weeks and become so ill that you have to attend A and E to get help. Only to find the department has no doctors. What happens then, I have no car, and buses don't run that time of night so I phone an ambulance to take me to another hospital that if they're not already waiting outside the other hospital due to lack of hospital beds.*

Idea 2:
Bring Day To Day Non-Complex Planned Operations Back To Weston General Hospital

There was a smaller response to this idea, below are examples of comments which could be attributed to this idea:

- *Weston General Hospital is already very good at providing surgery when beds allow, so to imagine this will improve is fantasy.*

- *If more operations at Weston General Hospital are being considered then occasionally things don't go quite as planned and patients need some major aftercare. It seems therefore unwise to consider not providing some limited ITU capability.*

- *I know you've said there would be High Dependency beds, but I would be worried about having surgery in a hospital that didn't have an intensive care unit. If something went wrong, I would not want to travel 20 miles, or more by ambulance to another hospital.*

Idea 3:
Transfer Some Emergency Surgery To Other Hospitals

There were very few direct answers to idea 3. Below are direct references to the transfer of emergency surgery:

- *Transfer emergency surgery - no one will want to work for the Trust and recruitment will be difficult, meaning more locums and higher cost.*

- *Stopping emergency surgery at Weston Area Health Trust - this work helps attract staff into posts.*

Idea 4:
Increase The Number Of Beds In The Critical Care Unit On The Weston General Hospital Site

In total, 177 responses relating to this idea were blank. When analysing this question and looking through the responses it appears that the public and staff focus was on the closure of ITU.

This is reflected in one of the examples below:

- *Cutting back on ITU, why would you do that, if anything it should be increased, from personal experience I can tell you having a loved one far away from Weston, i.e. Bristol, puts untold strain on the family and can result in more casualties, driving whilst upset, or trying to make it to the hospital before they pass away is unexplainable, you don't think about others, wrong as that is, your mind is taken over by your grief.*

- *Increasing the size of the ITU. Too expensive.*

- *No, definitely should concentrate on HDU beds, and option to take ITU to other specialist units.*

Q7. Is there anything else important that you think we have missed?

A total of 199 comments were received to question 7. A number did not respond directly to this question and referenced back to the previous comments they had made in the survey.

199 comments received

Of the 39 who said NO to the question, a number of respondents provided additional comments:

- *No, pretty well covered all aspects that I'm aware of.*

- *Not sure what is happening to CAMHS? Under-resourced vital team for children of North Somerset.*

- *Not that I can think of, although the ITU does also need to be refurbished as it is so dated compared to the rest of the hospital!!*

Other comments in response to this question include:

- *As previously suggested you should consolidate all public comments, then provide a list of the best suggestions, then ask for public comment. The current approach seems rushed and does not take into account forthcoming UK changes (EU, local population). Publishing the predicted savings for review should also be done.*

- *Narrow the gap with community services and discharges. Have one clear admission prevention team and one clear integrated discharge team. Make the patient flow co-ordinator part of these two teams so that everything is co-ordinated for the patients as soon as they arise.*

- *At the earliest possible stage, it is important to have clarity as to who will be making the crucial decisions, the question regarding staffing and workload and how these plans will not burden other Trusts, who also have similar pressures regarding bed occupancy.*

Q8. Do you have further ideas, comment or views that you would like to have included with the feedback?

This question received 152 comments.
213 respondents did not comment and 26 respondents provided responses such as 'see above', 'no not at this time', 'no' or 'see previous answers'.

Examples of comments received are shown below:

- *Are there any services that could be moved to Burnham-on-Sea hospital or Clevedon hospital instead of Weston so we would have more space in Weston as the hospital is much too small even now?*

- *What assurances are there that the CCG (having been rated as inadequate, and being put into special measures) has the means and ability to deliver on these proposals and programme of work?*

- *Very poor, virtually non-existent notification of this consultation in the community with Somerset....it looks as if you don't want to know what 20 percent of Weston's patients think. I think it could well be challenged..."*

Those completing the survey were also asked for their demographics these can be viewed in Appendix 3.

Observations of the survey feedback received

Respondents appeared to be unsure of the where to place their answers when completing the questions.

Several respondents used the opportunity to use the survey to thank Weston General Hospital for the treatment and care they received, as well as for other comments.

Other issues were raised in relation to current Weston General Hospital services that were not part of the discussion around the 'four ideas' being proposed.

Data Analysis Group 2: Email, Letters and Telephone Conversations

NHS North Somerset Clinical Commissioning Group received postal and email correspondence and had telephone conversations during the engagement period.

31 Responses

Transcripts of the telephone conversations and scans of the letters and emails were provided with confidential information deleted.

Thirty-one responses were received, however not all comments were relevant to the 'four ideas' proposed.

Many responses mirrored the same concerns as those from the survey respondents:

- Transport
- Risk to patients in being transferred
- Risks to services at the hospital
- Ambulance provision
- Increasing population
- Ability of other hospitals to cope with the extra patients

Several in this group of respondents agreed with the 'four ideas' and could see the need for change:

- *To make better use of resources in current climate and opportunity to improve efficiency.*

- *Staff allocated to achieve maximum support to patients within budget and bed turnover.*

- *Opportunity to redesign for improved efficiency.*

- *Want detail of any new model and clear timetable for implementation and clinical impact analysis and communication and engagement plan.*

- *Look at opportunities for best practice from models of care. Looking at arrangements for direct overnight admissions perhaps to combined surgical and medical admissions unit.*

Data Analysis Group 3: Meetings, Groups, Drop in Sessions, Face to Face Engagement

Representatives from the NHS North Somerset Clinical Commissioning Group, Healthwatch North Somerset and North Somerset Council attended and hosted meetings and stands at several local venues.

This engagement enabled face to face contact with 1596 people to raise the awareness of the engagement and ideas being proposed and provided them with the opportunity to feedback their views[11].

Engaged with 1596 people

Note: Feedback was not received from every person that representatives engaged with. Not all feedback received related to the four ideas.

105 comments were recorded from this engagement activity, a sample of these are below. It should be noted that the concerns relating to the four ideas are similar to those expressed throughout the feedback provided.

- *Downgrade of A&E worries me. Won't have doctors just nurses during those hours. It's not known whether there are enough ambulances to take people to Bristol or Taunton Hospitals. How can people get home from these hospitals on public transport in the early hours? People will be abandoned to the streets of Bristol.*

- *Indifference, poor management, lack of transparency, public and frontline staff consultation, public accountability and scrutiny and understanding of reality have brought healthcare in North Somerset to such a level as to be a dangerous place to live in. A disaster waiting to happen. The answer to North Somerset health issues is not continual cuts in service provision, hospital beds and moving patients up and down the motorways. The answer is being imaginative, make decisions based on facts and not wishful thinking and talk to and act on advice of frontline staff not on the ideas of those who have created the issues.*

[11] Data received from North Somerset Clinical Commissioning Group

- *Once services removed they never come back.*

Data Analysis Group 4: Open Public Meetings

NHS North Somerset Clinical Commissioning Group arranged three public meetings during the last week of the engagement period.

These were held in Highbridge (Somerset), Clevedon and Weston-super-Mare (North Somerset) on 28th, 29th and 30th March 2017.

Key speakers attended the meetings and voluntary sector representation and Healthwatch North Somerset were engaged in the meetings.

The public were offered an opportunity to find out more about the 'four ideas' and there was an opportunity for question and answers and a facilitated table discussion. The total number of attendees at the three meetings was 121.

Due to the number of Questions and Answers at Weston following the presentation by the panel, the planned facilitated table discussions were unable to take place during the public engagement event.

On reviewing the comments made at all three meetings the themes from the Q & A sessions were:

- Staff
  - Skills and investment
  - Recruitment and training
  - Impact of locums
  - Numbers and staff covering the A&E at night
- Population
  - Increase in population
  - New homes and increasing numbers at colleges
  - Younger people not able to access GP more likely to go to A&E
  - How to instruct the population that the A&E is closed to some types of treatment

- Patient Choice
  - Referrals – Weston appears to be at the end of the list for choice
  - Bring work back to Weston to make the hospital sustainable
  - Proposals will impact on areas of depravation
  - Need to remember those who live in Mendip area – Taunton is an important choice

- Beds
  - Review of the spread of the beds across the area
  - The number of patients suitable and not able to be discharged, impact on surgery
  - Critical care
  - Clevedon Hospital beds
  - Transport and ambulance
  - Public transport difficult
  - Impact on relatives
  - Impact on patients – adding travel time to their treatment
  - Number of ambulances available

- Hospital Services
  - Concerns for diagnostic services
  - If sharing Consultant – what is the likelihood of cancelled clinics at Weston due to pressure at other hospitals?
  - 24/7 services for everything – clinical hubs
  - Stabilising patients
  - Cancelled operations
  - Mental Health access
  - With the other hospitals taking the Weston patients, what would be their waiting times?

- Finance and timescales
  - What money will be saved?
  - What are the timescales?
  - Are these ideas long term?
  - How does Weston sit with the STP?
  - How far are we into the STP plan?

Other comments:

- How are you going to let me know about your plans?

- Be clear what is engagement and what is consultation.

- How are you engaging with young people?

- You need to find out what we require most out of Weston.

- Change to media interpretation - recent article said 280 walked out of A&E - would be useful to know what they came in for.

- Of the 'four ideas' only one appears to attract comment – changes to the A&E.

In two events, Highbridge and Clevedon, there was an opportunity for involvement in round table discussions so attendees could add their ideas, views and feedback.

Overall, these reflected the comments raised in the discussions as above. The "anything we missed?" question provided the following key issues from attendees:

- Outpatients appointments
- Increase clinic capacity
- Local advertising of jobs
- Pharmacies
- Social care
- Care homes
- Mental health
- Work with other agencies – Police, housing, social services, voluntary sector, charities (agency & Red Cross working with hospitals)
- Population
- GP surgery enhanced practice staff – not just see the GP
- Educate people how they need to value health and social services
- Educate patient in hospital as well as their families about treatment and aftercare
- GP service at Weston Hospital
- Oncology services more local
- Want a BRI at Weston

Feedback received about future communication:

- Keep local people informed about what is going on and being considered
- Local media given reports on what is being done
- Weston Hospital website
- Local GP surgeries letting patients know
- Joined up communication

Data Analysis Group 5: Weston General Hospital Staff Feedback

Weston Area Health NHS Trust (WAHT) staff took part in the engagement process and used a variety of methods to provide feedback on the 'four ideas'. This section of the data analysis refers specifically to responses provided from the hospital during group discussions.

Staff also had the opportunity to fill in the on-line survey and their responses are included within Data Analysis Group 1.

Weston Area Health NHS Trust undertook a series of team briefings/discussions and direct communication with their staff including:

Ask James Event ¦ Feedback form and Trust info sheet attached to employee payslips ¦ departmental briefings ¦ Weekly email briefings ¦ promotional features in staff newsletter ¦ Discussion Forum ¦ Screensaver

Feedback from these meetings was provided to Healthwatch North Somerset (in the form of an electronic copy) with key points listed under each of the 'four idea' headings.

A total of 298 pieces of feedback were received and analysed. They have been categorised below under the 'four ideas'.

Idea 1:
Change The Urgent And Emergency Care Service Model Overnight From 10pm – 8am

In total 140 comments were made that related to Idea 1. The key themes were ambulance, transport for patients/relatives, staff training, staff retention and recruitment and concerns about the capacity of other receiving hospitals to cope with additional patients.

A selection of feedback under these key themes is shown below. It should be noted that staff suggested several alternatives to the idea proposed for the Emergency Care Service model.

Ambulance	What happens to patients or ambulances turning up a few minutes before 10pm?
	Will increase calls to the ambulance service – many people in Weston don't drive or have access to cars
	Concerns regarding number of ambulance transfers and cost and subsequent availability to respond to 999 calls
	If there are more deaths in the department due to waits for ambulance transfers out there will be a significant emotional impact on staff which no one has thought about
	Ambulance service believe 3 hour turnaround for transfers
	Not an easy journey to Bristol or Taunton even for blue light ambulances
	Risk that people will just call 999 if changes are made overnight
	Concerns regarding cost of additional ambulances required for this and other proposals – put the money into the Trust or into local nursing homes to improve flow

Transport	Elderly relatives will be transported to hospitals which are difficult for relatives to reach for visiting particularly if elderly themselves
	How will parents pick up their drunk kids from Bristol in the middle of the night?
	How do patients get back from Bristol at 3am post discharge from ED?
	What about those who don't drive – real concern as many in Weston don't drive or own cars
	Relatives find visiting around work and home commitments difficult even when hospital is local – having to travel to Bristol or Taunton will make this even more difficult
	Journeys to ED at night often made at short notice due to emergency - likely to leave house partially dressed and/or limited money. How do we get back from Bristol or Taunton in the middle of the night
	Concern regarding distance to Taunton or Bristol in an emergency and difficulty of getting to Bristol or Taunton and then getting back again in the middle of the night if taken in by ambulance – not dressed, no money etc.
Training	Will it be expected that we rotate through Bristol hospitals as ANPs, ENPs?
	Need to start developing staff now – training undertaken in minor illnesses but need experience/exposure
	Primary skills are minor injuries – no set course for ANPs and need extra training and support for minor injuries services
	Challenges regarding ED staffing issues are recognised but the department needs to stay fully open to meet the growing population and changing demographic (also need to review paediatric provision in ED and within the Trust more widely in light of the changing demographic).
	Concern regarding impact on trainees within the hospital if ED closes overnight or changes staffing model (risk of losing all trainees?) – in Cheltenham on calls are split between Cheltenham and Gloucester to overcome this problem
Recruitment & Retention	Will we be told that we have to apply as an ANP or lose our job or have to work on a ward or go onto pay protection
	These proposals will not help us attract/recruit staff especially nursing staff (already asking about worth of coming to the Trusts ED dept to work if going to change)
	This and other proposed changes (loss of emergency surgery and potentially ITU) will make Trust recruitment even more difficult as jobs will look uninteresting and wont attract the best
	Still need all the current nursing staff to support ENPs/ANPs
Receiving Hospitals	How will Bristol cope – it isn't coping at the moment
	Already queues and waits at Bristol ED departments – this will make them worse
	This will put pressure on other hospitals who are already under pressure – this is just moving the problem

Consider Alternatives	Close ED overnight to walk in patients – they can be seen by GP following day or attend following day as they are minor. Focus clinical resource at night on majors only
	GP unit on site and navigator (used to have and worked)
	Lease an "ambulance car" to undertake low risk paed transfers between Weston and Bristol rather than relying on ambulance service
	Need GP service at the front door as a GP Practice, with appointments and seeing walk in patients– loss of previous GP service keenly felt
	Turn the idea on its head – keep open at night to majors but not to the walk-ins and put a GP in the hospital to divert minors
	Make AEC 24 hrs to support – with Doctors
	Use Ambulatory care more effectivity including use of unit to include community staff to offer integrated service
	Consider alternative staffing models for ED to include physicians and surgeons to alleviate recruitment problems in ED Drs and keep the unit open 24/7

Additional comments

- *Cheltenham and Solihull models are reported as working well. However, there is a need to recognise the close proximity of the receiving hospital i.e. distance between Gloucester and Cheltenham hospitals is approx. 9 miles.*
- *Local stabilisation prior to transfer of patients has been voiced as a concern if there are no Doctors in the Emergency Department?*
- *The interdependencies between departments is highlighted, by making changes in one would impact on others with the hospital.*
- *Risk to walk-in patients at night if only a MIU-type service is provided - what happens if the illness is beyond the ability of the ENP/ANP to manage? If they request support from the medical registrar, then this individual is taken away from the ward.*
- *Nurse and doctor transfers - how would the service be able to provide if a medical escort is required for a transfer.*
- *Violence and aggression - concerns regarding increase in violence and aggression when patients need to be transferred rather than being treated locally.*

Idea 2:
Bring Day To Day Non-Complex Planned Operations Back To Weston General Hospital

Fifty-four comments were made by staff in relation to the idea of undertaking more planned operations at Weston General Hospital.

There were several positive responses, however the majority expressed concerns on several issues. Examples of the comments are listed below:

- *Good idea, however where do we put the patients? – not enough beds.*
- *Good for Trust – provides a better balance between elective and emergency work and therefore supports the achievement of financial balance.*
- *The idea of centralisation is good for hyper-acute work but then patients will be returned to Weston.*
- *We need to decide what we are good at.*
- *Why would patients choose Weston? – our reputation although not deserved is not good.*
- *As a patient, I would worry if there was not emergency surgery for me at night.*
- *I am in support for the proposals – better for the hospital as this would help the flow through the hospital as the patients are elective and not acutely unwell medical patients.*
- *Additional Occupational Therapy and Physiotherapy will be required.*
- *Interdependency with other services i.e. pathology needs to be taken into account.*
- *This and other proposed changes will make Trust recruitment even more difficult as jobs will look uninteresting and we will not attract the best.*
- *Earning a bit more income won't be enough to bring budgets back into balance.*
- *No step-down facility to improve flow.*
- *Although cardiology in-patient work not affected by proposals there are concerns regarding current number of theatre sessions cancelled (e.g. pacemaker implant and cardioversion) and impact of more elective work being undertaken by the Trust – risk*

that more theatre sessions will be cancelled requiring more patients to be transferred to Bristol.

Idea 3:
Transfer Some Emergency Surgery To Other Hospitals

In the analysis of the staff comments, 34 were attributed to the transfer of emergency surgery. However, several of the comments are in parallel with the other ideas outlined in idea 3.

- *Agree that ITU should be a specialised service provided on a single site - Weston ITU does not operate as an ITU and we should focus on HDU beds.*
- *Currently difficult to get patients into the ITU at Weston – other ITU units would have accepted these patients (had the patients been in another hospital).*
- *ITU still required if doing surgery and for cardiac arrest and if going to have fully functioning ED during the day.*
- *If increasing the size of ITU, will this impact on Maternity Services.*

Recruitment and Retention

- *Anaesthetists likely to leave if ITU goes elsewhere – they won't just want to work in HDU.*
- *Proposals in general will create further recruitment and retention problems as the hospital becomes a less attractive place to work.*
- *Serious concerns regarding the potential loss of training registrars as a consequence of the proposals due to the lack of experience likely to be gained in the training post. Physio posts will be required in an expanded unit - services already stretched and there is a shortage of trained OTs.*

Staff Training

- *Need also to train up respiratory specialist nurses to upskill other ward staff within the hospital which would help to reduce LOS - too many patients unnecessarily put on bipap for example - would avoid misuse of HDU.*

Other feedback received from WAHT staff

In the data provided by the NHS North Somerset Clinical Commissioning Group, Weston Area Health NHS Trust had grouped a series of comments in a section classified as '**OTHER**'. In total, there were 70 'OTHER' - examples of the comments are listed below:

- *Link with UHB (University Hospital Bristol NHS Foundation Trust).*

- *Perceived benefits of merging UHB and Weston cardiology services under a single management arrangement.*

- *Really welcomed - they bring drive, academic rigour, experience, and skills which enthuses staff.*

The remaining 'OTHER' mirror several of the comments made in the previous sections. In addition, ideas for improvement were noted in the examples below:

- *Put GP into ED and GP and Consultant see all patients within half an hour. Those not needing to be in ED given a letter for their own GP date stamped by ED enabling them to attend their own GP immediately i.e. without going through normal GP booking processes. Patient may also be referred to pharmacist. This would reduce unnecessary work load in ED.*

- *Proposals not clear - need to engage with staff about all services not just those currently proposed.*

- *Trust is wrongly contracted for the work it undertakes - too much work relative to contract undertaken and insufficient remuneration for work undertaken - issue of Trust charging due to inaccurate data capture by Millennium (Bristol charge for all diagnostics and procedures).*

- *Our specialist nurses can empower primary and community staff to deliver some services - help to upskill.*

- *Ashcombe birthing needs to change model of delivery and move off site. Clevedon and Portishead residents healthier and more likely to use midwife led unit if located at Clevedon or Portishead rather than Weston population who are higher risk births. Clevedon also closer to Bristol if there is a problem.*

- *Staff feel vulnerable by proposals involving other Trusts - current evidence of staff being taken from Weston in some specialties (midwifery) when UHB is under pressure to keep services going.*

- *Build a step-down facility on site or community facility to relieve blocking within the hospital and to improve flow. This will relieve pressure on ED too.*

Data Group 6: Questions and Answers from Live Session at Mercury (Facebook and Twitter feeds)

NHS North Somerset Clinical Commissioning Group undertook Live Feeds on Social Media in conjunction with the Weston Mercury/North Somerset Times on 14 March 2017.

From the information provided by the CCG, their number of contacts through social media had been:

62 tweets generating 349 engagements, displayed 25,563 times in home feeds.

47 Facebook posts generating 252 engagements, displayed 7,663 times in home feeds.

Facebook live watched by 7,200 people and shared 72 times.

The live Facebook and Twitter Question and Answer session held at the Weston Mercury office prompted several questions and comments in relation to health services in North Somerset.

29 questions were posted on Facebook and Twitter to the Mercury before the live Q&A.

63 comments were made during the live session.

NHS North Somerset Clinical Commissioning Group responded to 14 of the questions/points made on the night.

Weston Mercury received 36 comments when they announced the launch of the engagement

In addition to these NHS North Somerset Clinical Commissioning Group was able to provide answers to questions which were published in the Mercury on 27th March 2017. (See Appendix 4)

Key questions from the live session and questions asked before the event:

- *Closure of the hospital.*
- *Had any consideration been given to extend the building or increase the bed capacity?*
- *Recruitment of doctors.*
- *Will there still be a 24 hour A&E?*
- *How many patients are treated overnight in A&E?*
- *For patients who are taken to Bristol or Taunton by ambulance, what will the extra 30 to 40 minute travel time mean for them? Will it lessen their chance of recovery?*
- *Will there be more ambulances available?*
- *How would people get back to Weston if they were treated elsewhere?*

- *How will the hospital cope when the population grows more?*
- *What about the elderly population?*
- *How will cutting beds in a growing population help local residents?*
- *What's going to happen to other services at the hospital, like the Sexual Health Clinic and Cancer Services … … … will they remain?*

Data Group 7: NHS North Somerset CCG – Question Cards

Questions cards were made available to the public and staff as part of the engagement process, 12 comments were received.

12 comment cards received

Below are the comments received, which are in part questions about the proposed ideas and descriptions of the current situation:

- *Although we already don't accept children at night or weekends we will accept children in peri-arrest or cardiac arrest. Will the same apply if ED shut to ambulances at night for adults? Or will they have to go to Bristol/Taunton with no stabilisation?*
- *Will there be enough ambulances able to respond quickly to the higher number of patients needing to transfer to other hospitals overnight?*
- *Junior Doctors have said WGH has nothing to offer. How is downgrading hospital going to help? If there is a partnership with Bristol, what is the possibility of sharing ED staff i.e. consultants/middle grade on a rotation basis?*
- *Only very few patients with heart attacks are transferred to Bristol, whether in day or night. Only life threatening heart attacks get transferred, rest all are treated safely in WGH.*
- *What investment will be made in paediatrics with the growing population?*
- *How is Bristol going to cope with increased capacity?*
- *Staff retention, growing population, financial, backlog of patients in ED, elective - why can't they move to Weston? Repatriation, consultant.*
- *I see no benefit for community from closing ED overnight. Could Out of Hours be back based at ED? We used to have CCU alongside HDU and ITU. Why reduce beds?*

There are no extra ambulances so there will be increased waits. How will ambulances get to meet the needs of the community in Weston as they will be dispatched to nearest emergency, likely to be Bristol or Taunton?

- *Time to change indeed. But what time scale is this? Does it allow time to train staff to match expectations?*

- *If no Doctors in ED overnight what will happen to those sick patients who come by car to the department because they know they will have to go to Bristol? We will be busier during the day as people will wait until 8am to come in for medical help. 111 frequently tell patients to go to their nearest hospital rather than giving them GP appointments. Where are the extra ambulances coming from to transfer these patients?*

- *On a daily basis, we are receiving patients who are having a stroke or MI - either to stabilise before transfer to Bristol or not suitable for thrombolysis. The budget will improve but outcomes for patients will not. Closure needs to be all or nothing. If there is an increased elective surgical patient where do they go after op - have no beds. Will 8 beds be HDU or ITU, and will it take intubated patients?*

- *Vacancies of specialities. Higher senior consultant vacancies. A hospital DGH unlikely to recruit all doctors 4 main ideas - what is the point of giving finances to the hospital when the patients cannot use it appropriately?*

Several issues and key points have been raised in the responses on the Question cards. Concerns about the level of care and patient safety are apparent, alongside staff recruitment and retention. The responses also mirror much of the response to engagement already indicated in this report such as the capacity at the other hospitals and that change is needed.

Key Points

- *Staff Engagement has provided the CCG with a wealth of information from the frontline which needs close consideration. Within this the staff have highlighted the issues as they see it, alternative ideas and their perception of impact on other services within the hospital.*

Several contacts made comments and observations on the details of the engagement process. Some comments are shown below:

- *A&E consultants, doctors and paramedics views at public meetings would alleviate fears more than senior management report written by external consultant.*

- *Disappointed at engagement event. Speakers spoke at people rather than with them. Wasted opportunity. Members of the panels should have joined the facilitated groups.*

- *Have all stakeholders been engaged with?*

- *We would like to know what the GPs views on these proposals are.*

- *What will the CCG do if there are other ideas and models?*

- *Document did not make clear that there were no Doctors in the Emergency Department overnight, it was understood that there were Doctors and ENP/Paramedics.*

- *Not enough information - is it an ENP led service? If so, needs to be ANP not ENP Led.*

- *Don't have confidence in the CCG to do this- they have not engaged with a wide enough range of appropriate staff - would have involved wider numbers of staff.*

- *Proposals not clear - need to engage with staff about all services not just those currently proposed.*

Conclusion

The Weston General Hospital at The Heart of the Community engagement based around the 'four ideas' and two initiatives provided the public of North Somerset and Somerset and Weston Area Health NHS Trust staff with an opportunity to feedback their views on the 'four ideas'.

During the eight week engagement period NHS North Somerset Clinical Commissioning Group undertook extensive engagement and promotion of the engagement providing a vast array of opportunities for local people to feedback and provide their views on the 'four ideas'. Full details of the extent of the engagement can be found in the NHS North Somerset Clinical Commissioning Group document 'Engagement Evaluation 09.02.17-06.04.17.

The response to the engagement generated in excess of 2000 comments. Many individual respondents provided several relevant comments and others provided comments that were outside of the parameters of the 'four ideas' which formed the basis of the engagement.

Opportunities for feedback were offered in a wide variety of formats and this created some challenges with analysing the data. Due to the wide variety of feedback and formats of feedback it is less easy to provide a quantitative analysis as the level of commentary

feedback leant towards a qualitative report. For example, it is not clear from the data received exactly how many individuals provided responses.

Several respondents used the opportunity to use the survey to thank Weston General Hospital for the treatment and care they received, as well as for other comments.

Other issues were raised in relation to current Weston General Hospital services that were not part of the discussion around the 'four ideas' being proposed.

Despite this, most importantly and at the heart of the process, local people and staff were provided with an opportunity to provide their feedback. All feedback, in whatever format received, and whether it was totally relevant to the process, reflects local voices and identifies issues that were key to them.

To ensure each comment is included, a supplementary document will be provided alongside the final report encompassing all the comments received reflecting the Healthwatch North Somerset principle that 'Your Voice Counts'.

We conclude on analysis of the data received from the engagement process that local people and WAHT staff acknowledge and recognise the need for change in order to sustain Weston General Hospital, but that the 'four ideas' and two initiative proposals were not widely supported.

Of key concern to those who responded to the engagement was closure of Weston General Hospital A&E. This was not one of the 'four ideas' and this, and other comments received, indicate that the public did not fully understand the 'four ideas'.

WAHT staff provided a wealth of feedback and insight – these have been incorporated in this report.

Recommendations

The following recommendations on future engagement with the public and Weston Area Health Trust staff are based upon the information provided through the engagement processes:

1. Future engagement and consultation would benefit from engaging local lay people to test the clarity and understanding of the questions in the questionnaire. This would ensure greater public understanding of the issues and provide consistency in responses. Respondents appeared to be unsure of the where to place their answers when completing the questions. There were a large number of questions which were collated as 'not stated' in the survey responses.
2. To ensure clearer communication regarding the interdependencies of the 'four ideas'. The responses received during the engagement process indicated that the public and staff considered each 'issue' in isolation.

3. To provide greater clarity of the issues that the public and staff were being engaged on. For example, there was a wide misconception that Weston Hospital A&E was at threat of closing completely.
4. To ensure a consistent message was given through all engagement. Some engagement provided feedback that gave very little indication of views about the 'four ideas'.
5. The variety and range of engagement and opportunities to feedback provided a vast range of types of feedback. This is welcomed as it enabled engagement with a wide range of local people. However, the methods of collecting feedback created some inconsistencies which made it very difficult to collate and analyse the responses. This meant that the report needed to be separated into seven 'Data Analysis Groups' in order to analyse the types of response rather than one overall analysis.
6. To organise the collection of engagement data more efficiently to allow sufficient time for the collation and analysis of the data and writing of the draft report. The data was still being received on 2nd May 2017 with a full draft report required by 9th May 2017.

Sue Stone (Freelance Worker) analysed the data and compiled the report, supported by Eileen Jacques, Chief Officer, Healthwatch North Somerset.

June 2017

Glossary

ITU	Intensive Therapy Unit
HDU	High Dependency Unit
NHSE	NHS England
CCG	Clinical Commissioning Group
WAHT	Weston Area Health NHS Trust

Appendix 1: 'four ideas' for change and two proposed initiatives

Change The Urgent And Emergency Care Service Model Overnight From 10pm – 8am

A 24/7 urgent and emergency care service will continue to operate from Weston General Hospital. A small number of patients who need specialist care overnight would need to be treated at larger hospitals nearby. In Weston General Hospital's case this already happens for stroke and heart attack patients, major trauma (e.g. severe injury from a car crash) and seriously ill children.
Why? A 24/7 urgent and emergency care service at Weston General Hospital is recognised by other hospitals and the regional NHS as being crucial to the health care system • The majority of patients use the department between the hours of 8am and 10pm • A different staffing model which made more use of nurses and paramedics would only impact a minority of overnight patients.
What would it mean? During the hours of 10pm and 8am any patient turning up at the hospital following a fall, with suspected broken bones, medical problems or needing stiches or an x-ray would still be seen and treated on-site.
If the illness or injury was assessed as being more serious, the patient would be transferred to a larger hospital nearby to be seen by a specialist team.
From our knowledge of attendances at our urgent and emergency care department this would mean that the majority of people who require the services during the night would still be treated at Weston General Hospital.
Anyone needing emergency, intensive medical support would be treated by a nearby hospital (there are three in close proximity to Weston) where they would be seen by specialist medical teams.

Bring Day To Day Non-Complex Planned Operations Back To Weston General Hospital

Why: • Weston General Hospital is good at delivering planned non-complex operations (and some more complex procedures) • Weston General Hospital has theatre capacity to do more planned surgery which would support greater patient choice, and ensure the hospital receives a bigger share of NHS funding • Evidence shows that patients who are treated closer to home, for less serious conditions, are more likely to have a better recovery and can go home more quickly.
What would it mean? We would be making best use of the hospital and its potential to treat more patients and make it easier for local residents to access services closer to where they live. We think that patient experience would improve as a result of these changes.

Transfer Some Emergency Surgery To Other Hospitals

Why: • Only a small number of patients need emergency surgery – particularly overnight – we know it's better for them to be treated in a hospital by specialist teams • For the last ten years patients requiring treatment for major trauma, stroke or heart attack, as well as children needing emergency care, are treated by specialist teams at Southmead Hospital, Musgrove Park Hospital, Bristol Royal Infirmary and the Bristol Children's Hospital during the night • Evidence is clear that for certain rare and complex problems, patients get better care being seen by a specialist team, this is in-line with the national health planning.
What would it mean? Patients in North Somerset who need emergency surgery overnight would be seen by a skilled team of specialists at a larger hospital close by.
Ambulances would take a patient requiring emergency surgery to the closest specialist team so they receive care quickly. This is the way all heart attacks, strokes and major trauma, as well as children's emergency care, is already dealt with in North Somerset overnight.
This would free up beds to enable Weston General Hospital to carry out more planned surgery, meeting the needs of the local population.

Increase The Number Of Beds In The Critical Care Unit On The Weston General Hospital Site

Why: • This would bring patients who needed the most care together in one place • The existing unit only has five beds which is smaller than experts advise to run an efficient service.
What would it mean? There are two types of beds in a critical care unit; High Dependency Unit (HDU) or Intensive Therapy Unit (ITU). Patients needing these beds have severe and often life threatening illnesses and injuries. They may need multiple organ support and very high levels of medical and nursing care.
While HDU offers a greater level of support, ITU requires the most intensive care and treatment for critically ill and highly dependent patients. The doctors and nurses that work in these centres have specialist training and need access to specialist equipment.
One idea would be to have a bigger, more diverse unit with a mix of ITU beds with extra HDU beds to enable Weston General Hospital to deliver a more efficient critical care unit making best use of staff and resources.
An alternative idea is to have more HDU beds and have ITU provided at larger, more specialist units in neighbouring hospitals.

Enabling Strategies (Initiatives) Integrated Working Within Acute Care

The Acute Care Collaboration consists of the three local hospitals (Weston Area Health NHS Trust, University Hospitals Bristol NHS Foundation Trust and North Bristol NHS Trust) as well as community partners. Four objectives have been agreed:
• To ensure the best use of capacity and resources across the three hospitals (staff, facilities etc.) • To develop strong effective clinical pathways (the patient's journey through all necessary health services) • To develop and support specialist services • To secure sustainable services at Weston General Hospital.
The three hospitals are committed to closer working and partnership in order to improve the efficiency and effectiveness of our services for the benefit of improved patient outcomes.
Why: Sharing doctors and nurses would support Weston General Hospital's ongoing challenges in recruiting to senior posts.
The benefit for staff would be an increase in job satisfaction, together with developing expert clinical practice in treating a high level of patients with similar conditions, which would get the best results for patients.
Making best use of staff across the area would ensure the best outcomes for patients and improve the efficiency and effectiveness of our local NHS services.
What would it mean? We can make better use of doctors who have rare skills and ensure their expertise is shared across the whole area.
Residents would be able to get more of the routine planned care that they are likely to need delivered at their local hospital in Weston.

Working More Closely With Services In The Community

Why: • North Somerset has a growing frail and elderly population. Sometimes patients get admitted to hospital when actually their care could be better provided in the community • When frail elderly people spend time in hospital they can experience a state called "deconditioning" where they lose their strength and mobility. Deconditioning is one of the reasons why it is so important that elderly patients do not go into or stay in hospital for any longer than is absolutely necessary • Evidence shows us that frail patients recover more quickly if they are treated in the community and physiotherapy when provided in the home gets better outcomes for patients • Ensuring adequate resourcing of social care will be an important part of this solution.
What would it mean? Local partners would work with Weston General Hospital to develop better ways to manage patients being admitted and being discharged (patient flow) from hospital, working closely with community partners and social care.
Working together to improve patient flow would also help free up beds for more planned care.

Appendix 2: On-line questionnaire

List of questions

1. Do these reasons make sense to you?
2. Do you think we need to change? If not, why not?
3. Have we presented our ideas clearly? If not, what further information would be helpful?
4. What issues do these ideas (any or all of them) raise for you, that you would want us to explore before any decisions are made?
5. Are there other ideas for change that we should be exploring which would make services more viable (better quality, more affordable)?
6. Are there any of these ideas we simply should not be considering, and why?
7. Is there anything else important that you think we have missed?
8. Do you have further ideas, comments or views that you would like to have included within the feedback?
9. Your sex
10. Your ethnicity

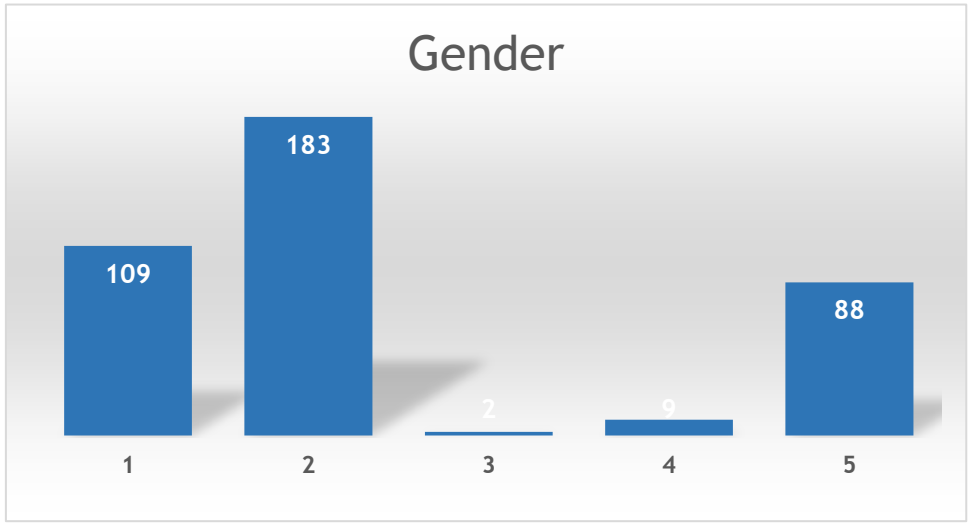
13 Your age group

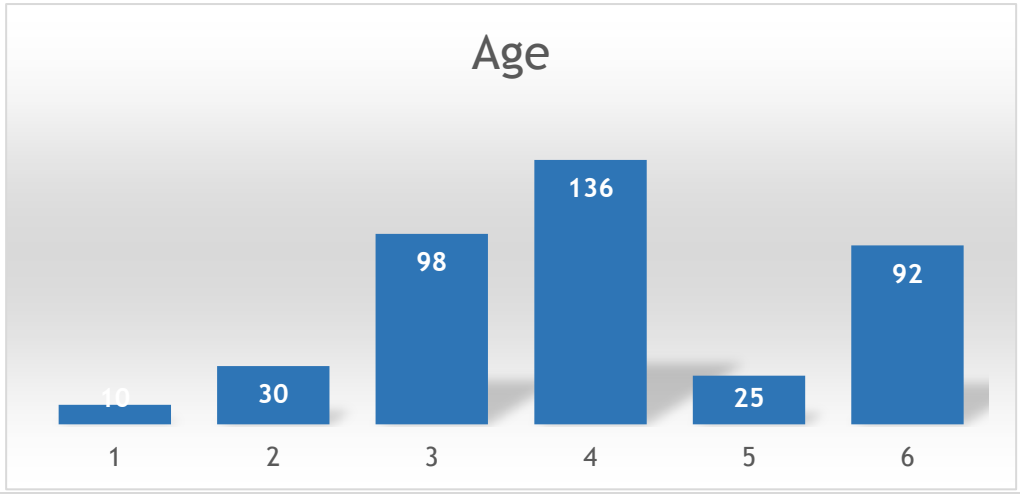
14 Where do you live?

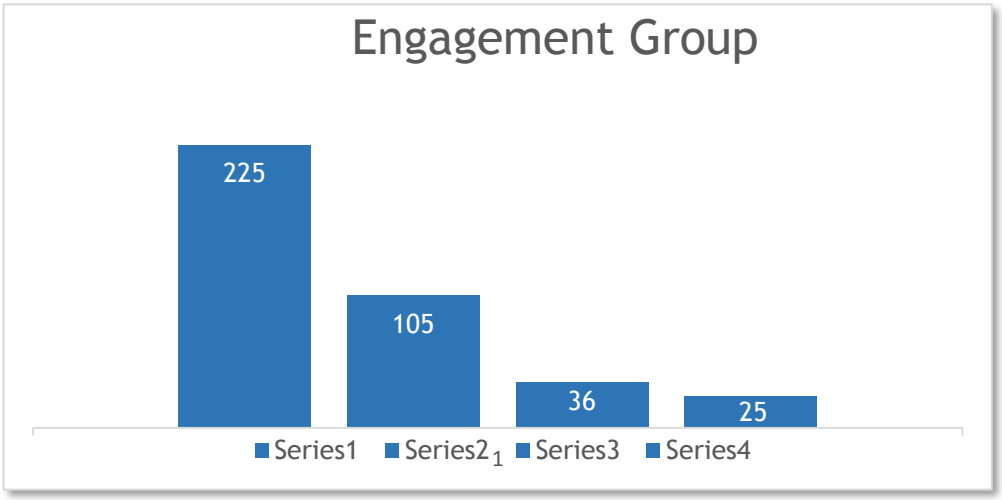
15 Are you disabled?

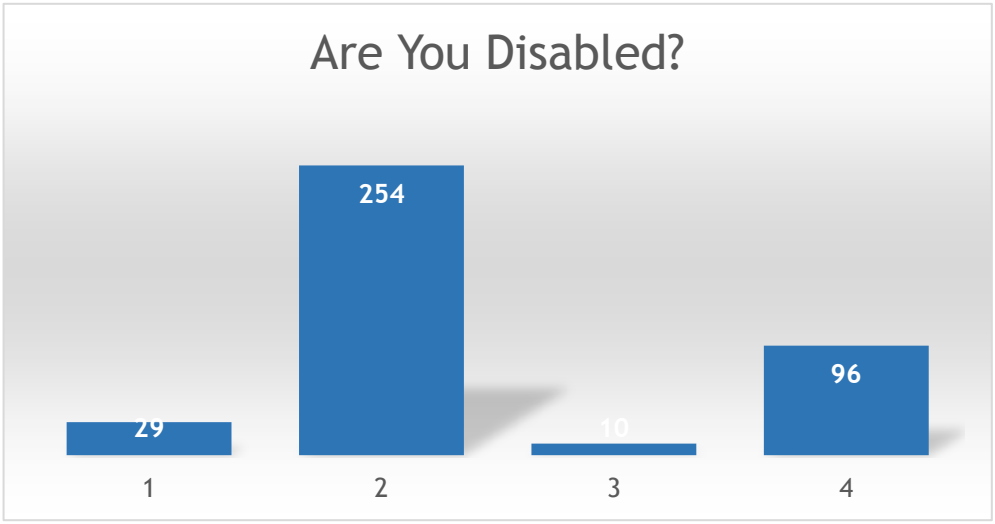
16 Please select which one applies to you (Public, WAHT Staff, other NHS Staff)

Appendix 3: On-line Survey Demographics









Ethnicity of Survey Respondents	
British	161
Irish	1
Any other White background	1
White and Black Caribbean	0
White and Black African	0
White and Asian	0
Any other Mixed background	0
Indian	1
Pakistani	0
Bangladeshi	0
Any other Asian background	1
Caribbean	0
African	1
Any other Black background	0
Chinese	0
Any other	1
Missing	224

Postcode Of Survey Respondents	
BS18	0
BS19	1
BS20	23
BS21	31
BS22	65
BS23	98
BS24	45
BS25	11
BS26	3
BS8	1
TA5	1
TA6	1
TA7	1
TA8	6
TA9	7
Other	49
Missing	43

Appendix 4: NHS North Somerset CCG responses to social media

Extract from publication in Weston Mercury (on-line and paper copy) 27 March 2017

Q: Will the hospital close?
A: No, Weston General is a key part of the local health and care system and will remain so.

Q: At any point while discussing the future of Weston General have you seriously considered building or extending Weston's bed capacity?
A: One of the main challenges is the recruitment and retention of specialist staff, which is particularly the case for the A&E department. Buildings and beds do not care for patients, staff do. Other hospitals have faced similar challenges and have made more use of specialist nurses to provide care for patients.

For some patients, outcomes are better when they are treated in specialist centres. This works well for Weston with a number of hospitals in close proximity, and we have been doing this for many years with all heart attacks, strokes, trauma and seriously ill children. Being taken directly to specialist centres to be seen by teams of specialist medical doctors, who have lots of training and practice, ensures patients get the best possible care.

Q: Why can't you recruit more doctors?
A: Shortage of doctors is a national problem, however as the smallest hospital in the UK Weston General has, for many years, struggled more than most to recruit and retain the required levels of staff in some speciality areas. Much of this work is focused around how we can best use limited numbers of highly-skilled doctors and nurses to ensure the population's wide range of health needs are best met in the future.

Q: Will there still be a 24-hour A&E?
A: The CCG needs to ensure there is ongoing 24/7 access to the urgent and emergency care system. The hospital's chief executive James Rimmer has previously told the Mercury 'the doors will remain open 24/7'. In the proposal, overnight the department would be staffed by highly-skilled nurses, as similar units are across the UK, for example in Cheltenham. This would mean a small number of sicker patients would need to be transferred to other hospitals and this is already the case for all strokes, heart attacks, major trauma and very ill children, and ladies in the later stages of pregnancy.
The hospital must make changes to ensure it has a viable future.

Q: How many patients are treated overnight in A&E?
A: The CCG's urgent care lead Dr Kevin Haggerty, who is a GP in Weston and has been working on the A&E proposals, previously told the Mercury an average of 140 people use

the A&E department every day, but just 40 of those arrive between 8pm and 8am. The proposals would see a reduced service between 10pm and 8am.

Q: For patients who are taken to Bristol or Taunton by ambulance, what will the extra 30-40-minute travel time mean for them? Will it lessen their chances of recovery?
A: Ambulance paramedics are highly trained and most seriously-ill patients already go by ambulance to specialist services in Bristol and Taunton. Evidence shows people get better outcomes when treated in specialist centres by specialist teams.

Q: Will there be more ambulances available?
A: South Western Ambulance Service has been working with the CCG on these ideas. Dr Haggerty previously told the Mercury: "The ambulance service is very good at monitoring activity and demand and ensuring they are where they need to be."
The hospital could change in four key areas.

Q: How would people get back to Weston if they were treated elsewhere?
A: We know there are concerns around transport provision and as nothing has been decided we can't answer this specifically at this stage of the process. Our aim is for every patient to be discharged back to their home and make sure more local people have their planned operations at Weston rather than further afield. We think Weston's population could benefit with more planned care being delivered from the hospital. We also know receiving care closer to home gets better outcomes for patients, and faster recovery times, so this is one of the ideas we are presenting.

Patients would still have a choice as to where they have their planned care delivered, as they do now, however, with a good track record in planned care and non-complex surgery, if this idea is developed we hope more people would choose Weston Hospital.

Q: How will the hospital cope when the population grows more?
A: The population growth is predicted to be mainly students and young families who have limited need of hospital services, they are more likely to need services in primary care and the CCG is also reviewing these. The solution has to be realistic in terms of the local health and social care economy; our ability to staff it, and it has to be affordable, within the funding available to us. We know the population increases will include both new and young families as well as retirees to the town and we will continue to review population need to ensure we meet patients' needs to national standards.

Q: What about the elderly population?
A: North Somerset's ageing population means the hospital is facing unprecedented demand. Part of these ideas involve focusing on pre-planned and non-complex operations, which the hospital's medical director Nick Lyons previously told the Mercury will likely make the hospital a 'centre of excellence' for routine surgery for the elderly population, and help it meet demand.

Q: How will cutting beds in a growing population help local residents?

A: The proposals don't include a reduction in bed numbers. The CCG wants to make sure beds are used efficiently to meet the needs of the population.

Q: What's going to happen to other services at the hospital, like the sexual health clinic and cancer services... will they remain?
A: The engagement is looking at four initial ideas, which have been developed with doctors and nurses. No decisions have been taken. Currently there are no proposals to change cancer or STI services.

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Healthy Weston Pre-Consultation Business Case

Appendix 8:

North Somerset Commissioning Context

NHS Bristol, North Somerset and South Gloucestershire

Clinical Commissioning Groups

Healthy Weston – joining up services for better care

A Commissioning Context for North Somerset

2017/18 to 2020/21

BNSSG Governing Body in-common

3rd October 2017

Contents

PREFACE

We are delighted to publish this Commissioning Context for 'A Healthy Weston'; our vision for comprehensive and excellent healthcare services for the people of North Somerset and specifically the 'place' of Weston. This document marks an important step in an intense period of partnership working and co-design across a wide range of key organisations that serve the needs of our local population.

This Commissioning Context sets out a bright and exciting future for our local healthcare system, taking advantage of a genuine desire on behalf of service providers, to break down organisational boundaries and work together in new and radically different ways to support people, help them stay well and live productive and healthy lives in their community.

Local groups of GP Practices will work more closely with each other, and with the wider community system, to provide improved access to services and proactively support priority and vulnerable groups. This will mean that there will be less of a need for patients to be admitted into hospital and, if they do go in, they will be supported to return home as quickly as possible. By working in this new, and more integrated way, we intend to deliver stronger and more resilient primary care services as well as an assured future for acute services at Weston General Hospital.

We intend to do this by better integrating primary, community and secondary care services, improving pathways of care and developing an integrated and co-located multi-agency 'Care Campus' model at the Weston General Hospital site. This 'Care Campus' approach, which has also been championed locally by Weston Area Health Trust, will provide a comprehensive and wide range of services for local people to better address their most common and immediate health needs. The ultimate objective is to build a healthcare system that is recognised as a centre of excellence for treating and managing priority and vulnerable groups. We also believe it will provide new and exciting opportunities for staff to work in a more holistic and patient centred way.

We do not underestimate the challenge in what we have set out to do in delivering this new model of care, but we are confident that the vision and direction of travel for services set out within this document is our best chance to build an excellent and robust healthcare system, that will be able to better serve the local residents living in and around Weston. To put it bluntly, "do nothing" is not an option. There are a number of significant challenges that we can only address by working together as a whole system.

Of course, we do not have all the answers yet - and nor should we - as we want this work to be a genuine partnership between commissioners, providers across all sectors, users of local healthcare services and the local population. It is vital that from the outset we involve patients, as well as carers and the front-line staff who deliver care. We are therefore developing a full programme of public and staff dialogue and co-design to support the delivery of the objectives contained within this Commissioning Context.

Given the clear and enthusiastic support that we have received so far in developing this Commissioning Context, and the willingness that providers have shown to change the way services are delivered, we are confident that we can follow through on the vision contained within and deliver a truly exceptional healthcare system for our changing and growing local population.

Julia Ross
Chief Executive
Bristol, North Somerset & South Gloucestershire CCGs (BNSSG)

Dr Mary Backhouse
Clinical Chair
North Somerset CCG

EXECUTIVE SUMMARY

In developing this Commissioning Context, the Clinical Commissioning Group (CCG) has set out to tell a clear and coherent story for the local population of North Somerset, with a focus on Weston and Weston General Hospital (WGH), set in the wider context of the Bristol, North Somerset & South Gloucestershire (BNSSG) system.

Within North Somerset, and specifically around the 'place' of Weston (which this document defines as the geographical area covering the town of Weston-super-Mare, the adjoining village of Worle, the village of Winscombe and the surrounding villages of the south Rurals), we have an exciting opportunity to transform local services to better meet the needs of the local population and to address a number of significant challenges with regards to clinical and financial sustainability.

Local population need & key priority groups

Although health service outcomes are good on average across North Somerset, there are some very marked health inequalities, particularly in Weston. While the main determinants of health are driven by social factors, reducing health inequalities is a key priority for the CCG. People in some parts of the south of the patch are significantly more likely to live with debilitating long term conditions and die many years earlier (in some cases up to ~18 years earlier) than people living only a few miles to the north. In particular, there are three groups that population level data shows are our main priorities if we are to provide more responsive services and tackle the health inequalities mentioned above:

1. Frail and Older People.
2. Children, Young People and Pregnant Women (including complex needs and young people's mental health).
3. Vulnerable Groups, for example people with mental health needs, learning difficulties and those who struggle with drug and alcohol addiction.

By working together in new and more effective ways; and integrating local services and pathways to join-up patient care, the CCG, in collaboration with local providers and stakeholders, can start to address these profound health inequalities and better meet the needs of the local population.

Challenges in service delivery

With regards to service delivery, providers currently have a number of clinical sustainability issues, most visibly at Weston Area Health Trust (WAHT), with challenges in clinical recruitment and retention in specific specialities, but also in some primary and community services where there are also challenges.

At the same time, the CCG and local providers need to reflect and plan for the Council's future ambitions for the town of Weston-super-Mare, which is already undergoing rapid expansion and change. Within the next 15-20 years, Weston-super-Mare's population will rise from approximately 81,000 to exceed 100,000. A major regeneration programme is underway in the town centre. Significant investment is being made by both the public and private sector; and physical regeneration is changing the face of the town which in turn is likely to change the demographic profile; for example, increasing the number of students. This will bring challenges, but also enormous long term opportunities to increase the well-being of residents by addressing the underlying causes of health inequalities.

Financial challenge

The local health economy is under significant financial pressure. The underlying North Somerset CCG deficit carried into 2017/18 was £13.3m, which based on current income and growth projections is expected to rise to more than £40m by 2021, assuming no corrective action. The CCG is also carrying a £25.3m cumulative deficit which will need to be repaid in the future. The underlying BNSSG system deficit (including provider deficits) is expected to reach £300m by 2020/21 reducing to £100m, assuming the existing savings plans in the BNSSG System Transformation Plan (STP) can be delivered. The Council is equally financially challenged. If these significant deficits are to be addressed, the service model and system of care in North Somerset, and indeed across BNSSG, will require radical transformation to deliver a solution that is both affordable and sustainable.

Vision for local services & a new model of care

The CCG's responsibility is to ensure the provision of effective services that meet the needs of local people. From the information and evidence presented in this document, it is clear that "do nothing" is not an option. As commissioners, we will work in close collaboration with local providers, key stakeholders, service users and the public to co-design a new and innovative model of care that will have three core elements:

1. **Primary Care (General Practice) working at scale & providing strong system leadership:** Over 95% of the patient contacts with the NHS take place in primary care, but primary care only accounts for 7% of the NHS's budget. Although people rightly want to know that there is a strong and resilient acute hospital system around where they live, the CCG wants to recast the conversation with residents to focus on the bigger picture. Therefore, we want to think about how we can support primary care to be more robust, working together more effectively with each other, the wider community system and secondary care services at WGH to proactively help people to stay well, independent and at home wherever possible. This includes assessing opportunities to reconfigure and enhance the primary care estate and exploring the opportunities for integration and co-location offered by the One Public Estate Programme. A significant dimension of this work will also be improving our messaging and support for patients to enable them to choose self-care options wherever appropriate.

2. **Stronger, more integrated community services supported by a 'Care Campus' model at the WGH site**: A key objective of the new model of care is to "defragment" the many community services and resources that are already in place. There is a clear need to develop a more integrated and efficient community provider landscape and service model centred around closer collaboration between primary care and the wider community system as a whole. This would be supported by best practice integrated care pathways that proactively focus on keeping people well and at home with the aim of ensuring that patients get the right service, in the right place, first time.

   To support the delivery of this new integrated community services model, the CCG, WAHT and other local providers intend to explore the opportunity to turn the WGH site into an integrated 'Care Campus' that will enable delivery of a multi-disciplinary approach to services wrapped around the local population – freeing up providers to work in a much more cohesive and flexible way. This in turn will mean that patients receive a more coherent, high quality and effective service which is proactive and responsive to their needs, rather than reactive once ill health has taken hold. Our ambition is to facilitate the delivery of this new model of care by creating an alliance of local providers, underpinned by a capitated payment model.

3. **A stronger, more focused Acute Trust and acute care model at WGH:** In order to address the financial and clinical sustainability challenges at WAHT, and to enable the delivery of the 'Care Campus' model, the current acute care model at WGH will need to change. Some hospital services will continue to be provided locally, whilst other services may need to move off-site to another acute hospital (where it makes sense to do so). Other services currently provided off-site could also be repatriated back to WGH. Further work is required by WAHT and the wider acute system as a whole to determine the best design for this model going forward.

Delivering the change

As described earlier, this Commissioning Context sets out a vision and direction of travel for a new model of care in Weston. It also outlines the commissioning levers and tools that the CCG will use to enable the delivery of a more affordable and sustainable local healthcare system, to better meet the needs of the local population. This work will help to inform future service development in Weston and in other parts of North Somerset, and will also further support local provider development. We are also working closely with our colleagues in Somerset CCG as the population of North Sedgemoor use WGH to a significant degree.

We are not starting from a blank sheet; we recognise that we are building on the good work that has gone on over a number of years and more recently through the BNSSG STP. We do, however, want to use our commissioning leverage to bring about a tangible step change in the way we organise and deliver services to realise the vision and aspirations of local people. All parties recognise the need to bring about a more integrated way of working across all elements of the local healthcare system, using shared resources more effectively. An important enabler of this work will be the Partnership Agreement between University Hospital Bristol (UHB) and WAHT. As commissioners, we will encourage this partnership working and support further acute care collaboration, as well as collaboration across the system as a whole. A BNSSG-wide Acute Care Services Plan will be developed by the acute providers to support this.

We are now at an exciting time when the ingredients to enable real change are starting to come together such as: a clear direction from the Five Year Forward View[1] and proven new models of care; local commissioners and providers working collaboratively to tackle the sustainability and transformation of the local health and care system; clinical leadership for the change; and active patient and public dialogue. In addition, with the bringing together of the three BNSSG CCG commissioning teams, the stronger commissioning organisation is looking at bold ways to support the local system in achieving the local vision.

Local partners have already secured funding, through the One Public Estate Programme, to explore the potential for co-locating a range of services in Weston Town Centre. The CCG are actively working with North Somerset Council to assess the opportunities to best meet local need that are clinically and financially sustainable.

The approach the CCG is taking in Weston will create a framework which can be rolled out to the other areas across BNSSG. This will support the implementation of the BNSSG wide objective of developing and strengthening community based integrated care, although the specific configuration of services may look different in other places (including the rest of North Somerset), due to local circumstances such as population need, the strength of existing provision and local workforce and estate challenges.

Next steps

[1] https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

As an immediate next step, the CCG has arranged a ‘whole system’ stakeholder event on the 18th October 2017. Assuming Governing Body in-common sign-off of this document, and regulator assurance, we have planned a 12 week period of public dialogue.

In parallel, and in close collaboration with local partners, the CCG has established a comprehensive programme of work to support the delivery of this new model of care. This programme, which consists of a number of workstreams focused on designing and delivering the various elements of the solution, will also include the development of an Acute Services Plan for the acute care components of the model.

Specific elements of the design will require input from patients, therefore a process of co-design will also be put in place to support this.

Further information on next steps and associated timelines can be found in Section 14.

Introduction & Background

Intended audience

Whilst this Commissioning Context is a public document, it is written primarily with a service provider audience in mind and therefore some specialist knowledge is assumed. This document is intended to set out the BNSSG commissioner vision of the future of local North Somerset services that will enable providers to respond with a set of proposals for service redesign. At times, it is necessarily detailed and technical, although we have tried to keep this to a minimum.

A supporting 'Communications and Public Dialogue Plan' will ensure that the content and objectives of this work reach as wide an audience as possible. BNSSG CCGs plan to put on a series of events over the coming months to start a conversation with a wider set of system stakeholders, including patients and public, to share and explain the proposed vision and direction of travel for local services in more detail and to seek feedback and input on specific aspects of the design. Regular and on-going staff dialogue will also be a core part of our work.

Purpose & scope

As commissioners, we need to demonstrate clear alignment between the needs of the local population, the work we are doing to transform and manage local healthcare services to meet those needs, and how we intend to do this in a manner that is both clinically and financially sustainable.

The purpose of this document is threefold:

- Firstly, to set out the needs of the local population, why the current healthcare system in North Somerset needs to change and our key priority areas of focus for system transformation;
- Secondly, to describe a vision for local services with a specific focus on the 'place' of Weston (which this document defines as the geographical area covering the town of Weston-super-Mare, the adjoining village of Worle, the village of Winscombe and the surrounding villages of the south Rurals), to improve the way we deliver health and care services to our local population; setting out our commissioning requirements for local service transformation; and
- Thirdly, to outline what will be different this time around versus previous unsuccessful attempts to reform the local hospital system, and how the CCG intends to explore new and innovative ways of encouraging greater collaboration across organisational boundaries and systems of care, to deliver the necessary changes.

This Commissioning Context has been developed with the engagement and support of a wide range of partners within the NHS and local authority as well as input from Healthwatch North Somerset and patient and stakeholder representatives (refer to Appendix 9 for details on the approach and the people involved).

This document brings together work that is already going on across BNSSG CCGs, and the wider health and care system, into a clear and coherent story for North Somerset; and in particular, the population living in and around the 'place' of Weston. This document is split into three parts.

- **Part 1** describes *'Where we are today'* and provides a summary of local population need, an overview of the local provider landscape, details of the CCG's financial challenge and projected financial envelope and sets out key priority areas of focus and a set of Commissioning Principles to underpin the intended direction of travel.

- **Part 2** describes the *'Vision for local services'* in Weston and the impact on the wider North Somerset system and sets out our commissioning requirements for local service transformation.
- **Part 3** describes *'Delivering the change'* and sets out the commissioning tools and levers the CCG will use to bring the system together to ensure delivery. It also provides an overview of the work required to deliver this exciting whole system transformation, and outlines the key next steps to move forward.

North Somerset CCG & BNSSG CCGs

North Somerset Clinical Commissioning Group (CCG) is responsible for planning, buying and monitoring the health services for a local population of approximately 212,000 (based on ONS 2016 mid-year estimates), spread over 140 square miles in both urban and rural communities (the same area covered by North Somerset Council).

The CCG, which was established in 2013, is a GP membership organisation comprising 18 local GP practices across North Somerset, supported by a team of clinicians and managers. The CCG is responsible for commissioning emergency and urgent care (including ambulance and GP 'out-of-hours service'), community health services, hospital services, maternity and children's services, mental health and learning disabilities services. While primary care services (GPs, dentists, pharmacists and optometrists) and specialised hospital services have historically been commissioned by NHS England, the CCG is working to take full delegation of General Practice primary care commissioning in due course. Specialised services[2] are currently commissioned by NHS England although the CCG is looking to take on this responsibility going forward.

The CCG is part of a wider commissioning collaborative known as 'BNSSG CCGs' which includes Bristol and South Gloucestershire CCGs. These CCGs recently appointed a joint Chief Executive; and are in the process of developing a single commissioning 'voice' and leadership structure across the BNSSG area, and are looking to merge into a single organisation[3]. In line with national policy, the BNSSG CCGs have come together with local partners to develop a joint Sustainability and Transformation Plan (STP), to support the delivery of the NHS's Five Year Forward View (5YFV) and GP Forward View (GPFV).

The 5YFV sets out how the health service needs to change by 2020/21, to address the significant challenge of a population that is both ageing and living with more complex long term conditions (LTC) such as diabetes and dementia, which need to be proactively managed, sometimes for decades. The 5YFV represents the shared view of the NHS' national leadership, and reflects an emerging consensus amongst patient groups, clinicians, local communities and frontline NHS leaders.

Initial outline plans developed by the BNSSG STP were published on the websites of the STP organisations, including North Somerset CCG, in November 2016. The BNSSG health system has developed a single STP approach for the services provided to a population of ~1 million people. The STP reflects a joint commitment by the leaders of local health and social care services in BNSSG to a collective effort to transform services and improve outcomes for the population.

Work to deliver the BNSSG STP and the 5YFV is already underway across North Somerset and the wider Bristol and South Gloucestershire system. The work that this document describes is aligned with the STP and will facilitate the delivery of the STP vision at a local system level.

[2] For a description of specialised services see https://www.england.nhs.uk/commissioning/spec-services/
[3] https://www.northsomersetccg.nhs.uk/news/statement-merger-proposal/

Our vision and ambitions for local residents

The CCG's vision is to improve the health of the whole population, reduce health inequalities and ensure NHS services are fit for the long term. The CCG works closely with a wide range of patient, public and voluntary groups, North Somerset Council, Local Community Boards and local delivery partners, to develop and deliver its plans.

The key themes the CCG hears consistently from North Somerset residents, local stakeholders and the wider workforce as to what is important to them include the following:

- Core services should be provided as locally as possible (care closer to home) and provided in a more integrated and joined-up way.
- The need to focus more resources on improving access to General Practice; and at primary and community services more broadly, to reflect the increased demand from an ageing and growing population.
- The need for a clear and sustainable future for Weston General Hospital and ensure other larger acute hospitals support Weston Area Health Trust in delivering sustainable services.
- Provision of 24/7 urgent and emergency services, including sufficient resources for South Western Ambulance Service.
- People are being treated in hospital for conditions that could be managed in a community setting. If a person is admitted, they should be better supported to come home as soon as possible.
- Collaborating more effectively to optimise support and services provided by our voluntary community and social enterprise sector.
- The need to create interesting and satisfying jobs and roles to address the gaps in the workforce; and create interesting and exciting opportunities for provider staff to work across organisational boundaries.
- Travel times are an important consideration for patients, particularly for those from deprived and/ or rural populations.
- The need to reduce variation in service pathways by adopting best practice from across BNSSG.
- Professionals and organisations should be better at sharing information (supported by integrated IT systems and shared medical records).
- Address patient need holistically, rather than a set of individual conditions to avoid repeating the same information to multiple professionals (i.e. say something once); and having needs re-assessed multiple times.
- Help to understand and navigate the 'system' and be kept informed about what is happening.
- Before any significant decisions are made, local people must be fully involved.

These themes, many of which were also raised in the recent engagement sessions at Weston General Hospital (WGH) earlier this year, are being addressed as part of the CCG's ambitions for North Somerset over the next two years, which are clearly laid out in the CCG's recently published Operating Plan for 2017/18 and 2018/19 and include:

- Better access to good quality services.
- Transforming care pathways to provide better outcomes and value for money.
- A resilient and financially sustainable health and care system.
- Better health through prevention and self-care.

The CCG's ambitions are also aligned with the 5YFV's 'Triple Aims' of:

1. **Improving the patient experience of care (including quality of healthcare):** We know that patients want a joined-up experience of care, close to home wherever possible; and focused on keeping them well and out of hospital.
2. **Improving the health of the local population:** By focusing on the causes of premature and avoidable mortality and disability, we aim to close the gap of health inequalities in the area.
3. **Achieving value and financial sustainability:** We are looking at how we can best use the resources we have in a joined-up way, removing perverse incentives and potential "cliff edges", when patients transfer from one part of the system to another.

The delivery of these ambitions is supported by having a single and strong commissioning voice across BNSSG. It is also aided by strong partnership working across key partner organisations including primary care, the wider community system, the voluntary sector, mental health, Local Authorities, Local Community Boards and NHS England. Involving the public, staff, patients and their families in the redesign of services is also key.

Weston Sustainability Programme: "Healthy Weston"

As described above, a central ambition of the BNSSG CCGs' Operating Plan for 2017/18 and 2018/19 is to build a resilient and financially sustainable health and care system for North Somerset. In common with much of the NHS, the local North Somerset health system has had increasing difficulty delivering NHS Constitution standards within the financial resources available. All organisations; including commissioners and providers, have encountered major challenges with respect to their operational and/or financial performance.

Specifically, in North Somerset, Weston Area Health Trust (WAHT) has been operating for a number of years as being unsustainable from both a clinically and financially perspective. This has caused a great deal of concern for patients, staff and the wider public, compounded by the fact that there have been a number of unsuccessful attempts to agree a package of reforms to find a longer term solution.

More recently, the leaders of the local health and social care system have come together to form a partnership called the North Somerset Sustainability Board (NSSB) and established a programme (Weston Sustainability Programme) to find a suitable solution. Work has been progressing as part of this programme and initial public engagement sessions were held in the first quarter of 2017 to explore possible options and solutions to the challenges at WAHT.

In parallel, work has been progressing with local GPs and stakeholders to transform primary care services within the Weston area (known as the Weston Primary Care Transformation Programme). This document highlights how these two important pieces of work have been brought together into the Weston Sustainability Programme.

In response to recent engagement activities at WGH, Healthwatch North Somerset published a report that summarised the feedback received from both the public and local staff. Their report clearly showed that while many people understood the need for change (83% of respondents said they recognised the need to change), there was a public appetite for more detail on what was being proposed. It was also apparent that the options to reconfigure WGH's emergency department needed to be better communicated within the wider context of a series of interrelated changes to the acute care model.

The process also told us that not enough focus was given to the challenges in the wider system, including primary care access and the capacity and capability of the wider out-of-hospital community system (e.g. integrated primary and community care, mental health, social care, public health and the voluntary sector).

This feedback has been taken on-board by the CCG. In response, it has developed this document, based on local population need to provide the underlying commissioning context to clearly describe the changes that need to be made to services in North Somerset, to meet the needs of the local population and the underlying rationale as to why. Appendix 10 sets out in more detail how we have listened and responded to the findings of the Healthwatch report within this document.

Why 'the place' of Weston is an opportunity

This Commissioning Context document deliberately focuses on Weston and the surrounding local system of care, as the area possesses a sense of place that naturally supports a coalescence of integrated local services and pathways. According to The Kings Fund, collaboration through place-based systems of care, offers the best opportunity for NHS organisations to tackle an ever growing set of challenges.

The paper 'Placed-based Systems of Care'[4] argues that providers of services should establish place-based 'systems of care' in which they work together, to improve health and care for the populations they serve. The place of Weston has a combined population of around 110,000, which is large enough to enable strategic system thinking in a manageable configuration of local services, and is in line with the locality model developing across BNSSG.

The key drivers for local service change in Weston are:

1) Better meet local population need and reduce health inequalities:

- The population of Weston is both ageing and growing, and doing so at a higher rate than the England average. These demographic changes will place a significant burden on local health services that are already overstretched and struggling to meet demand. As the town centre regenerates, there are likely to be changes in the socio-economic profile of residents. This presents a challenge for commissioners to plan for future needs.

- The level of health inequality in Weston is particularly marked and is often hidden behind more generalised health and care statistics for North Somerset, which mask the true underlying problems. The IMD2015 deprivation scores show North Somerset has the 3rd largest range of scores in the country; and the gap in life expectancy between the most and least deprived Wards in North Somerset is one of the highest in the country (~18 years), with the most deprived Wards being Central and South Wards in Weston-super-Mare.

2) Improve local Primary Care (General Practice) resilience:

[4] The Kings Fund – Placed-based systems of Care.

- There are challenges in meeting not only current need, but the growing and ageing population as described above. Improving local resilience and capacity to deliver improved access to primary care services is a key priority locally. We want GPs to take on a clinical leadership role, orchestrating the healthcare system in the community, seeing only the patients that their skill set requires and supporting other disciplines to provide a more prominent role in patient care as appropriate.

- This greater use of other staff groups will allow GPs more time to focus on the most complex patients. For certain groups of patients (e.g. frail and older people) the evidence suggests that continuity of care with a specific GP can reduce the chance of an unplanned hospital admission. By the same token, there are other groups of patients who use primary care infrequently who do not need to see a particular GP. As a system, we think we can do more to differentiate the needs of these different cohorts.

- We also need to ensure that the skills possessed in primary care are maximised across the locality. For example, if a particular GP has a special interest in a certain condition, it does not make sense that only patients who happen to be registered with his/her practice benefit. How can we share the range of special interest and knowledge local GPs have to the maximum benefit of the population?

- There is a need to ensure that the primary care estate in the Weston area (e.g. Central Weston and Worle) is fit for purpose in order to help resolve the resilience and capacity issues and to deliver services in the appropriate place.

- The new build housing at the Weston Villages' Airfield site will require careful analysis as to whether there is a case to rationalise and/ or build new primary care estate to meet the developing population's need.

- There is a requirement to work more collaboratively across GP Practices, to both improve the resilience of clinical services (given an ageing workforce and recruitment issues), and drive greater efficiencies from economies of scale (such as working more collaboratively to deliver clinical pathways and by sharing estate, back office functions, processes and systems).

3) Improve the sustainability of Weston General Hospital:

The CCG believes there is a great opportunity to use Weston General Hospital more effectively and efficiently, putting it at the heart of a local, integrated care system. Furthermore, we want to build WGH's reputation as a place where great care is provided for particular groups of patients; for example frail and older adults, outpatient cancer treatment and people needing the most common types of elective surgery. In taking this opportunity, there are a number of long standing issues that need to be addressed:

- The STP's projected "do nothing" annual deficit for WAHT will be £20.6m by 2020/21 (£7.4m if fully mitigated).

- The provision of A&E services is a high profile local issue. We must look carefully at population need to identify the most effective long term solution for local urgent care provision.

- The ability to recruit to key clinical specialties; and issues with trainee doctor placements (supervision and satisfaction) are significant challenges, putting service delivery at risk. This is

compounded by the continued delay in finding a longer term solution for the sustainability of WGH.

- The local Midwife led maternity service at WGH is not chosen by enough women to make it clinically or financially viable in its current form. The number of deliveries is currently ~170 per year, but the minimum level for a clinically appropriate unit of this type is considered to be ~ 500.

- There are questions as to whether other services may be more appropriately delivered elsewhere at scale, such as emergency general surgery and Level 3 ICU.

- Given the issues listed above, the CCG currently makes a number of premium payments, in addition to normal activity related payments, to support specific services that otherwise would struggle to be financially viable. e.g. A&E and critical care. This is clearly not sustainable and will need to change.

The following section describes *'Where we are today'*. It provides a summary of local population need, an overview of the local provider landscape, details of the financial challenge and projected financial envelope, sets out our key priority areas of focus from a population and specialty perspective, and lays out a set of Commissioning Principles to inform the transformation of local services.

PART 1: WHERE WE ARE TODAY

Our Local Population and their Needs

Based on ONS 2016 mid-year estimates, the population of North Somerset is approximately 212,000 (versus ~219,000 based on July 2017 GP Registered data) and is served by three Acute Trusts: Weston Area Hospital Trust (WAHT) in the south on the border with Somerset, and University Hospitals Bristol (UHB) and North Bristol Trust (NBT) in the north. Twenty-seven miles to the south of Weston General Hospital (WGH) lies Musgrove Park Hospital in Taunton, which is part of Taunton and Somerset NHS Foundation Trust (TSFT) and is commissioned by Somerset CCG. There is also a small community hospital and minor injuries unit (MIU) in Clevedon and another small community hospital and MIU at Burnham on Sea War Memorial Hospital, which lies just to the south of WGH. More detailed information on the local provider landscape, key challenges and service constraints can be found in Section 0.

Figure 1 below provides some key facts about North Somerset. Throughout this document and its appendices, we have used recognised data sources to describe the population, although different data sets (e.g. ONS and GP lists) are not always coterminous and samples taken from different points in time. Please see Appendix 1 for further information.

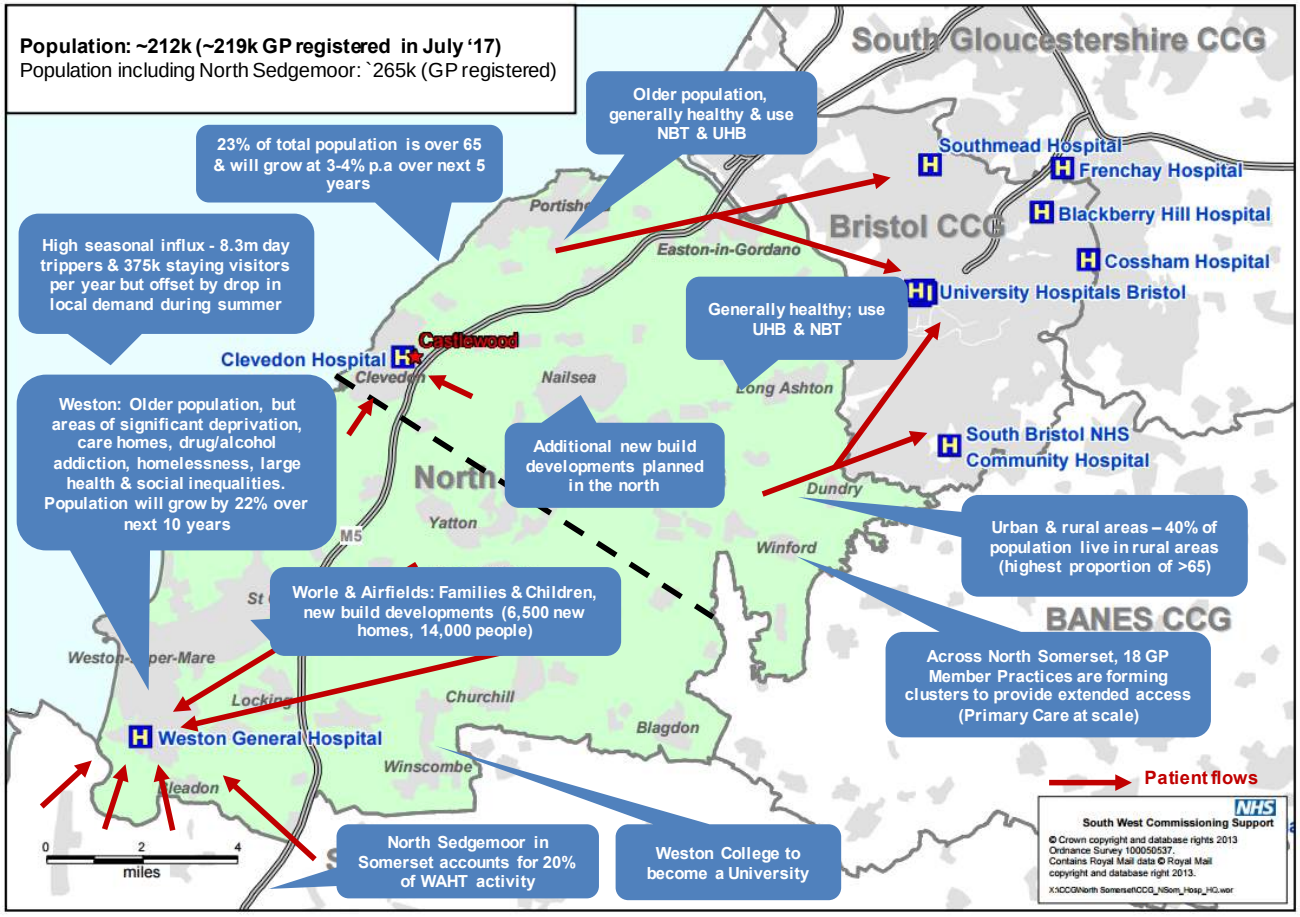

Figure 1: Key facts on North Somerset

Broadly speaking, there are two discrete health economies in North Somerset:

1. **The North** - the northern half of the patch has a total population of approximately 102,000 people centred around the towns of Clevedon (population: ~21,000), Nailsea (population ~15,500) and Portishead (population: ~22,500); and the top half of the GP locality known as 'the Rurals' (43,000). Residents of these areas tend to be healthier than residents in the south, and this population commonly look to UHB and NBT for their acute care needs.
2. **The South** - the south centres around the town of WsM; which according to 2015 ONS data has a


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popu lation of ~81,200, the adjoining villages of Worle, Winscombe and the surrounding villages that make up the southern half of the Rurals locality (total population ~110,000); where residents typically look to WGH for their secondary care needs. WsM currently has an older demographic, with fewer young people under 20. However, this disguises some key differences across Wards, as South Ward has a younger demographic than the North Somerset average and 1-in-10 residents are from non-white backgrounds. The population of Worle, which lies on the north-eastern edge of WsM, is younger compared with the average for North Somerset, and has the lowest percentage of people aged over 65 and 85 years (17.7% and 2.4% respectively).

If specialised commissioning (currently commissioned by NHS England) is excluded, around 64% of secondary care activity for North Somerset residents living in the south is provided by WAHT (with the remainder largely provided by UHB, NBT and TSFT). This percentage reduces to 20% for those residents living in the north.

There is a third area known as North Sedgemoor, which lies to the south of WsM and is within the boundaries of Somerset CCG. North Sedgemoor has a GP registered population of ~48,000, which accounts for ~20% of WAHT activity. It is a bespoke local area defined for commissioning purposes, and this document references specific North Sedgemoor data wherever possible. It should be noted that Somerset CCG has been fully involved in the development of this Commissioning Context and are supportive of the direction of travel.

Whilst North Somerset and North Sedgemoor effectively form the catchment area for WAHT services, this area is geographically wide-spread, and a high proportion of residents travel to neighbouring hospitals for treatment. So, although the combined GP registered population is approximately 265,000, the effective population currently using WAHT services is estimated circa 160,000 to 180,000 (Source: WAHT commissioned GE Finnamore Report, 2016). In addition to the local population, WsM attracts 8 million day trippers and ~500,000 staying visitors[5] each year and in peak season; up to 10% of emergency department attendances are by out-of-area tourists.

Although WsM has an older population demographic, with pockets of significant deprivation and large health inequalities, it is in the process of undergoing an exciting and major transformation programme, with significant new build housing developments at Winterstoke Village and Parklands Village in Central Weston; many of which will be for younger families, with implications for local services including primary care, maternity and children's services. Weston College has recently been granted University status; and so the demographic and fabric of the town is likely to change over the coming years to accommodate the increase in student numbers. Additional new build developments are also expected near Nailsea, Yatton and Portishead and between Long Ashton and Bristol.

[5]http://www.n-somerset.gov.uk/wp-content/uploads/2015/11/economic-impact-figures-2004-2014.pdf

Across North Somerset, the 18 GP Member Practices[6] have formed into four distinct clusters (Weston, Worle, Gordano and the Rurals). A 'cluster' is a term used to describe a number of geographically close practices working together to generate sufficient resilience and scale to be able to cope with the increasing demand for primary care services and to work together in more integrated ways to provide more locally relevant services in the community and closer to home.

This change in the way primary care services are delivered is especially important in Weston, given the expected growth in population and where services are already stretched. There is no existing real estate within the Weston Village development for any community provision, and the surgeries surrounding the development area do not have the physical capacity to deliver the required services. Central WsM faces the challenges of both a growing population and an aging estate. To address these challenges, a number of practice groups in Weston have formed a new organisation / alliance to provide the organisational form that will support delivering services differently and at the scale required to make a difference.

The key challenges that we have identified from a population needs perspective are summarised below. Further analysis of population need can be found in Appendix 2:

- The long-term projections based on ONS data suggest the population of North Somerset (and North Sedgemoor) will increase over the next decade at an annual rate of 1% across all age groups. These figures take into account planned housing developments, and are the same figures used by North Somerset Council's Planning Department.

- However, estimates obtained from Hampshire Council's small area population forecast[7] service, which takes into account housing development, suggests growth in the Weston locality in the 10-year period from 2014-2024 will be 22% (i.e. 2.2% per year on average), compared to background growth across the whole of North Somerset of 13%.[8]

- The largest increase in population over the next ten years is set to be in the 75-84 age group (50% vs. 36% in England), followed by the over 85s (~46% vs. 42% in England).

- In respect to the younger age groups, the population is projected to rise in the 0-14 age group by ~12% (vs. ~8% in England), which equates to an additional ~4,000 children in total in the next 10 years.

- Life expectancy varies considerably across North Somerset. WsM Central Ward has the lowest life expectancy, where the respective figures are 67.5 years for males and 76 years for females. Conversely, Clevedon Yeo has the highest life expectancy for both males and females, at 86.1 years and 92.5 years respectively. A gap in male life expectancy therefore between these wards of 18.6 years; the equivalent gap for females in this example is 16.5 years.

- The main causes of the gap in life expectancy are circulatory diseases (such as coronary heart disease (CHD) and stroke), cancers and respiratory disease (COPD).

- Using data from Public Health England, it is estimated that 46% of male deaths and 36% of female deaths in the most deprived areas were considered 'excess'; in other words, these deaths

[6] Note that further mergers are expected in the future.
[7] Hampshire Council. Small area population forecasts http://www3.hants.gov.uk/factsandfigures/population-statistics/pop-estimates/small-area-pop-stats.htm

[8] Comparisons between the towns of Weston-super-Mare and Bath are sometimes made in terms of population growth. The City of Bath has a population of around 89,000 and growing, compared to the WsM town population of between ~81,000 (based on 2015 ONS figures).

would not have occurred if all areas in North Somerset had the same mortality profile as the least deprived areas[9]. Standardised Mortality Ratios range from 57% in Clevedon Yeo to 161% in Central Ward – much better and much worse than England respectively.

- The leading causes of premature mortality in North Somerset are circulatory diseases, respiratory diseases (COPD), cancer and liver disease. These are also the leading causes of premature mortality and years of life lost in North Sedgemoor.

- The potential years of life lost from treatment amenable cancers, i.e. cancers that could possibly be prevented through early detection and treatment (including breast, colorectal and skin cancer) in North Somerset, have been increasing and are above national figures. Treatment amenable cancers are now the primary cause of years of life lost from amenable causes in North Somerset, representing more than a third of total years of life lost.

- Across North Somerset, the leading causes of disability adjusted life years (DALY) lost are cancer (neoplasms), mental health and behavioural disorders, musculoskeletal conditions and cardiovascular disease.

- Compared with 2015, it is estimated that by 2030 in North Somerset, there will be over 1,700 more people living with CHD; around 750 more people will have had a stroke; over 10,000 more people will be living with hypertension; 6,000 more people will have diabetes; and around 6,000 people will be living with COPD.

Population summary

As a result of the projected population growth rate across North Somerset; and in Weston in particular, coupled with the ageing profile of the local population, there will be a proportionally much greater rate of growth in people likely to need tailored and effective frailty services, including care home support and end of life care.

The growth in the numbers of children and young people is also significant and higher than the England average; and will therefore require proactive planning to ensure sufficient access to appropriate services.

Also, there are significant health inequalities in North Somerset, with the great majority of premature mortality and preventable morbidity centred around Weston. Therefore, in addition to developing new models of care to help address these inequalities, there is a need to be promoting healthier lifestyles and choices and specifically supporting the most vulnerable groups.

This situation, coupled with the imperative for reform of certain provider services, are some of the main reasons why BNSSG is focussing the work to reform services, and build a strengthened integrated community and acute care model in Weston as a priority.

[9] Public Health England: Longer Lives data tool: Available from http://healthierlives.phe.org.uk/topic/mortality

Supply-side Analysis - local provider landscape & key challenges

Figure 2 below provides an overview of the local acute and community hospital landscape. The North Somerset CCG footprint is highlighted in green, whilst the Somerset CCG footprint is highlighted in purple. Hospitals in Bristol are also shown for reference.

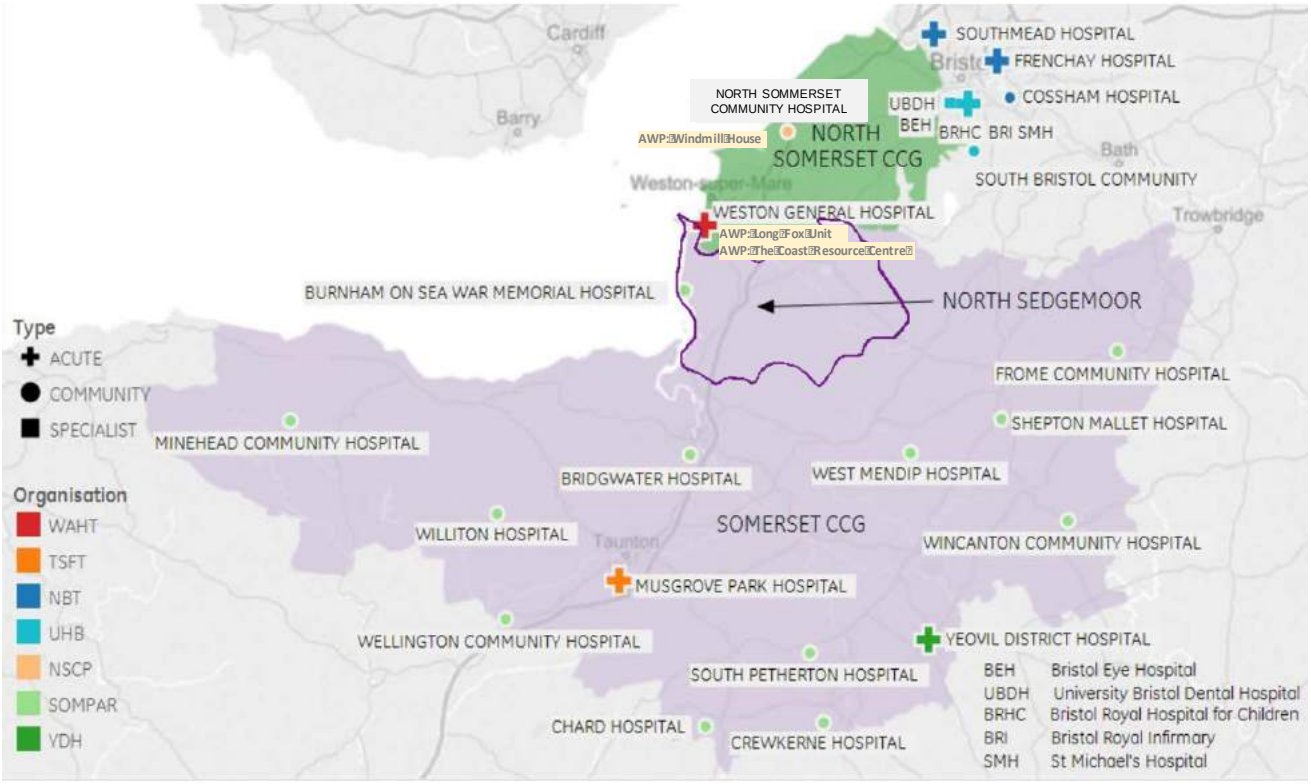


Figure 2: Acute and community hospitals in North Somerset, Bristol & Somerset

Our detailed analysis of the supply side situation, can be found in Appendix 3. It provides a set of short summaries of current service provision arrangements, overviews of current quality and performance against targets, and service delivery challenges (including workforce & capacity constraints) for key providers in North Somerset.

The key local providers include:

- **The local BNSSG Acute Trusts** - WAHT, UHB and NBT.
- **The Ambulance Service** - South Western Ambulance Service Foundation Trust (SWASFT).
- **Primary Care (General Practice).**
- **Primary Care (Out of Hours)** – BrisDoc Healthcare Services.
- **Community Services** – North Somerset Community Partnership (NSCP).
- **NHS 111** (Urgent care by phone) – Care UK.
- **Mental Health** – Avon & Wiltshire Mental Health Partnership NHS Trust (AWP).
- **Musgrove Park Hospital** - Taunton and Somerset NHS Foundation Trust (TSFT).
- **Local Authority** - North Somerset Council.
- **Voluntary Sector** – various local providers and services.

The key supply-side challenges that have been identified are summarised as follows:

- The supply side issues at WAHT are well understood locally; with challenges to clinical recruitment and retention in specific specialities (e.g. emergency medicine, acute medicine and gynaecology) creating long standing difficulties in providing the full range of services that have been historically delivered.
- In primary care, the recruitment and retention of GPs and other primary care clinicians such as nurses, is also a challenge (both in North Somerset and nationally) for both local practices and the out-of-hours provider. The primary care workforce is ageing with ~28% of local GPs and ~41% of primary care nurses aged over 55 and approaching retirement age. In addition to increased GP recruitment, and more collaborative working arrangements across GP Practices, alternative workforce models and the greater use of new and innovative roles are required to help address the gap. Refer to Section 11 for further information.
- Recruitment and retention is also a common issue across other providers and other local workforces: NSCP has challenges with regards to community nursing roles in specific localities and some specialist clinical roles such as community matrons. AWP also face challenges around clinical recruitment; particularly with regards to staffing on acute mental health in-patient wards. SWASFT has specific challenges with the recruitment and retention of specialist paramedics, paramedics and clinical hub call takers and clinicians. Many care homes have inadequate staffing levels and inappropriate skill mixes to meet resident's nursing and care needs; and domiciliary services also struggle to retain staff.
- There are some specific estates challenges in the primary care sector (e.g. ageing estate), particularly in the Central Weston areas as well as a potential imbalance of provision as the population expands in certain parts of the patch – particularly Weston Villages.
- There is an imbalance between demand and capacity for planned surgery at NBT. This has necessitated sending significant numbers of patients with non-complex elective needs to services outside of the NHS. There are opportunities to repatriate some of this activity to WGH as part of a revised acute model as the hospital has recently refurbished its theatres with Laminar Flow capability.

Supply-side summary

With regards to the supply side issues at WAHT, there is consensus amongst the North Somerset Sustainability Board that there is no "stand alone" solution for WAHT, hence the developing Partnership Agreement with UHB, the need for broader acute care collaboration with NBT, and the need to work in a more integrated way with the wider community system.

The CCG also believes that by bringing together disparate and fragmented services into a more integrated model of care; using the provider workforce across settings; involving a greater mix of skills (for example support from volunteers and non-professional staff to free up clinical capacity); and eliminating duplication (including sharing of back office functions and the use of trusted assessor models); many of the recruitment and workforce challenges above could be addressed by optimising the use of resources across the system.

The ability to move more flexibly across provider settings and organisational boundaries is also an attractive proposition for staff who would be able to get a much greater exposure to different aspects of the system without necessarily having to move employer.

The Financial Challenge

The Financial Gap 2017-2021

Over the next 4 years, the BNSSG health community as a whole faces the major financial challenge of recovering a substantial financial deficit and building a resilient and affordable health and care system for the future within the increasingly tight constraints on NHS funding. The only solution to this challenge is to transform the way healthcare services are organise and delivered.

The BNSSG community as a whole, including acute and primary care providers, has had difficulty containing expenditure within available resources for a number of years over which time the underlying deficits in the system have been growing.

Based on current income and growth projections, the underlying BNSSG system deficit (which includes provider organisations) is expected to be, before any corrective action is taken, in excess of £300m by 2020/21. The current BNSSG System Transformation Plan (STP) has identified savings plans, but even if these are fully delivered, there remains an unfunded gap of £100m. North Somerset Council has seen year-on-year reductions in government funding, with particular pressures on budgets for social care which have been significantly over-spent in recent years.

In North Somerset, successive commissioners have been unable to contain expenditure within their allocated funding while the gap between local acute provider costs and tariff income has continued to increase. The CCG carried an underlying deficit of £13.3m into 2017/18, which based on current income and growth projections and before any corrective action, is expected to rise to more than £40m by 2021. North Somerset CCG is also carrying a £25.3m cumulative deficit which will need to be repaid in the future.

Projected population growth in North Somerset of 1% each year equates to a cost increase closer to 2% each year as the largest increase is in the population aged over 75 who are the highest users of healthcare services. Demographic growth of 1% per annum will therefore add some £5m-£6m of cost each year.

To be financially sustainable, North Somerset CCG needs to not only plan for demographic growth, but also to create sufficient financial headroom to ensure future resilience. NHS business rules expect commissioners to have at least 2.5% of funding uncommitted at the start of each year, of which 0.5% must be available to support the wider NHS system and to plan for an annual surplus of 1%.

In recent years, commissioners have also become increasingly exposed to external service pressures largely generated by national policy imperatives which do not carry additional funding (e.g. Funded Nursing Care rates, changes to tariff and taking on additional unfunded commissioning responsibilities). Based on recent experience, commissioner plans should allow a further 1% headroom to meet continuing pressure from this source. The overall cost of providing this headroom is circa £4m per annum.

When headroom and debt repayment are factored into demographic growth projections, the CCG's income and expenditure gap before any corrective action, is expected to reach the £40m mark by 2021. Figure 3 below shows the CCG's overall financial gap associated with funding projected growth and providing the CCG with financial resilience.

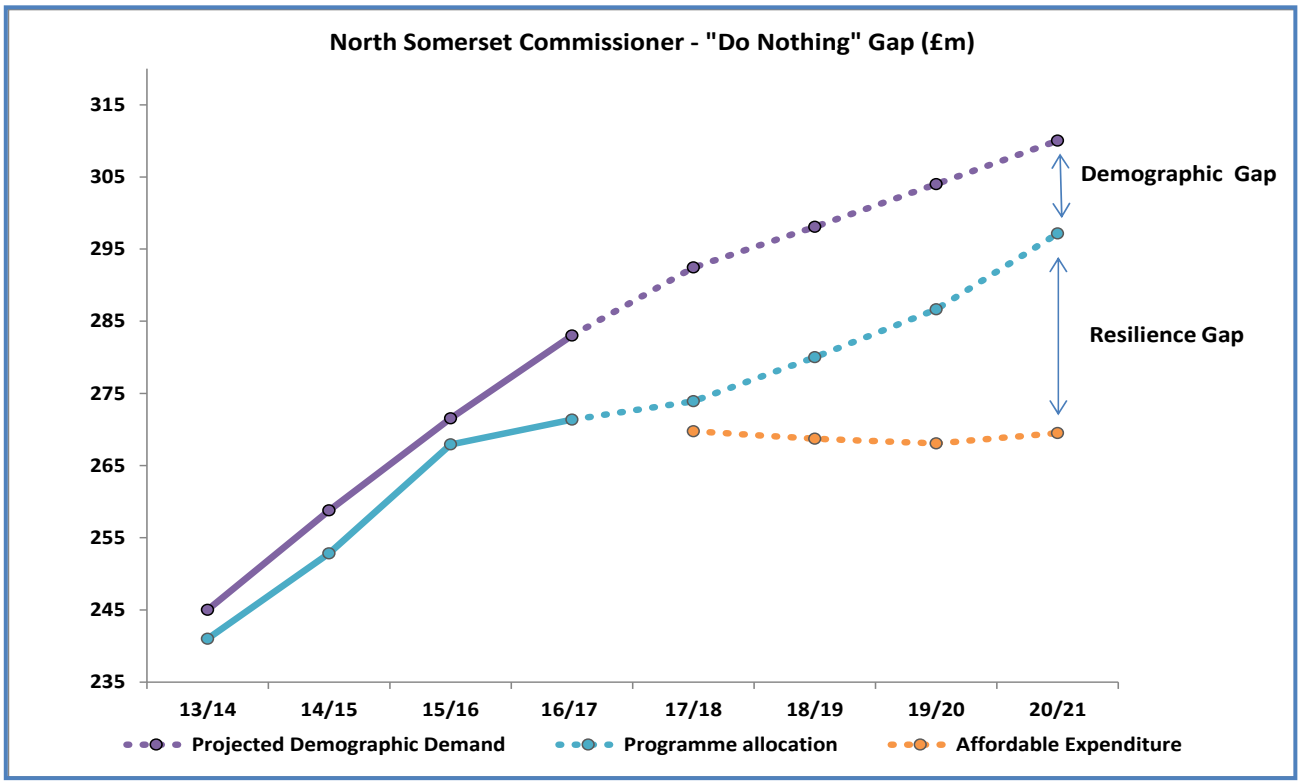


Figure 3: North Somerset CCG "do nothing" financial gap 2017-2021

Previous efforts to bring the system into financial balance have failed, largely because they were unable to overcome the structural and behavioural barriers to achieving savings at the scale and pace required. Recent developments in the local health and care system, including closer commissioner collaboration and an emerging system wide approach to transforming services, are beginning to successfully break down these barriers, but the system needs to go further and faster.

Affordable Services 2017-2021

Affordable spend 2017-2021

Figure 4 below indicates the level of affordable service expenditure for North Somerset CCG which is compatible with longer term financial resilience, moves the CCG from an underlying deficit of £13.3m to a 1% surplus, and starts to repay the cumulative deficit.

1% headroom is provided under NHS rules which consists of 0.5% available for non-recurrent use by the CCG and 0.5% to support the wider NHS system subject to NHSE direction. In line with NHS business rules, a 0.5% contingency is provided each year with a further 1% available to meet unfunded service pressures as required.

After providing for headroom, debt repayment and an annual surplus, funding of £269m-£270m is available to support service expenditure plans in each year. In effect, the CCG needs to reduce expenditure from £284m in 2016/17 to £269m-£270m and plan to hold expenditure at this level up to 2021. 1% will be available to meet unfunded service pressures as required, but should not be assumed in initial plans.

	Actual	Projected			
	16/17	*17/18*	*18/19*	*19/20*	*20/21*
	£m	*£m*	*£m*	*£m*	*£m*
Programme Allocation	270.30	273.9	280.0	286.7	297.1
Less:					
1.0% headroom		2.8	2.8	2.8	2.8
0.5% contingency		1.4	2.8	4.3	5.9
1.0% unfunded service pressures		0.0	2.8	5.7	8.9
Surplus/Deficit	13.30	0.0	0.0	2.9	3.0
Repayment of cumulative deficit		0.0	2.9	2.9	7.0
Service expenditure	**284.00**	**269.8**	**268.7**	**268.0**	**269.5**

Figure 4: Affordable expenditure for North Somerset CCG (2017-2021)

Figure 5 below shows projected "do nothing" increase in costs over the 4 years to 2020/21 compared with the growth in funding over the same period. A "do nothing" deficit of £22.7m in 2017/18 increases to £40.5m by 2021 based on building financial resilience as described above and allowing for annual growth rate in cost of 2% per annum.

	Actual	Projected			
	16/17	*17/18*	*18/19*	*19/20*	*20/21*
	£m	*£m*	*£m*	*£m*	*£m*
Baseline 2016/17	284.0	284.0	284.0	284.0	284.0
1.0% headroom		2.8	2.8	2.8	2.8
0.5% contingency		1.4	2.8	4.3	5.9
1.0% unfunded service pressures		0.0	2.8	5.7	8.9
Surplus/Deficit		0.0	2.9	2.9	3.0
Repayment of cumulative deficit		0.0	0.0	2.9	7.0
Demographic growth 2%		5.8	11.5	17.4	23.4
Non-demographic growth		2.6	2.6	2.6	2.6
Total projected demand	**284.0**	**296.6**	**309.4**	**322.6**	**337.7**
Funding	270.7	273.9	280.0	286.7	297.1
Surplus/(Deficit)	(13.3)	(22.7)	(29.4)	(36.0)	(40.5)
Annual increase in deficit		**(9.4)**	**(6.7)**	**(6.6)**	**(4.6)**

Figure 5: Comparison of affordable expenditure with projected demographic growth impact to 2020/21

Affordable spend at locality level 2017-2021

As described in Section 0, the North Somerset area falls broadly into two discrete health economies: one in the north looking to Bristol (UHB & NBT) for acute hospital services and one in the south looking to Weston (WAHT). Each area also falls broadly into three geographical localities based around General Practice populations (note that these locality definitions vary slightly from the definition of GP Practice localities in use today). **Figure 6** below shows how funding to support the affordable expenditure described above might be distributed across the local health economy based on relative health need. This distribution would form the basis of funding provider catchment areas and provide the basis for a capitated payment model as described in Part 3 of this document.

The distribution is based on the registered practice populations weighted for health need which are used in the national formula to set CCG funding targets (which takes into account factors such as deprivation). Comparison of capitation shares with 2016/17 actual expenditure shows a significant reduction in expenditure, falling more heavily on the south than the north.

Locality	Outturn	Affordable Service Expenditure			
	2016/17 £m	*2017/18 £m*	*2018/19 £m*	*2019/20 £m*	*2020/21 £m*
Gordano	38.8	38.7	38.5	38.5	38.7
Tyntesfield	37.3	35.9	35.8	35.7	35.9
Clevedon	31.5	29.6	29.5	29.4	29.6
North	**107.6**	**104.2**	**103.8**	**103.6**	**104.1**
Worle	46.7	41.9	41.8	41.7	41.9
Rural South	39.1	38.8	38.7	38.6	38.8
Weston	90.6	84.8	84.5	84.3	84.7
South	**176.4**	**165.5**	**164.9**	**164.5**	**165.4**
Total	***284.0***	***269.8***	***268.7***	***268.1***	***269.5***

Figure 6: Allocation of available resources to localities.

Affordable spend at provider level 2017-2021

Figure 7 below shows how the allocation of affordable expenditure to CCGs in **Figure 4** would flow into provider baselines. The allocation is based on the 2017/18 planned expenditure profile and no change in 2016/17 patient flows compared with CCG 2016/17 expenditure.

The total for each provider is indicative of the funding that would be available to support services in the current catchment population under a capitated funding model.

Affordable Expenditure 2017/18 Allocated to Providers								
Provider	***2016/17 Outturn***	***Clevedon***	***Gordano***	***Tyntesfield***	***Rural South***	***Weston***	***Worle***	***Total***
	£m	***£m***	***£m***	***£m***	***£m***	***£m***	***£m***	***£m***
Weston	68.8	4.5	1.3	1.6	10.4	29.6	15.5	62.9
UHB	42.6	3.7	6.5	11.7	5.2	7.5	4.6	39.2
NBT	34.1	6.0	12.8	5.0	3.0	3.8	2.3	32.9
ISTC	5.8	0.4	0.6	0.5	0.5	0.6	0.6	3.1
AWP	17.0	1.8	2.0	1.8	2.1	7.0	2.4	17.0
NSCP	24.6	2.6	3.6	3.3	4.1	7.5	3.5	24.6
Reserves	0.0	0.4	0.6	0.5	0.7	1.3	0.6	4.2
Other	91.1	9.9	11.3	11.4	13.5	27.5	12.3	86.0
Total	**284.0**	**29.2**	**38.7**	**35.9**	**39.5**	**84.7**	**41.8**	**269.8**

Figure 7: Allocation of available resources to locality and providers based on 2017-18 plan

Current Spending: factors that are driving the CCG deficit

Current spending patterns in North Somerset are characterised by a number of features which have contributed over time to the CCG's deficit and made it more difficult to achieve financial balance including:

- Lack of financial resilience.
- Over reliance on acute hospitals.
- Fragmented provision.
- Fragmented commissioning.
- Dis-economies of scale.
- Imported costs.

Lack of Financial Resilience:

North Somerset inherited a £11.7m underlying deficit in 2013/14. Over the following 3 years £34m of above average growth funding was fully committed each year while total CCG expenditure over this period increased by £37.6m leaving no financial flexibility to manage a series of substantial and unexpected cost pressures in 2016/17 and making no inroads into the deficit. As a result, an underlying deficit of £13.3m and a cumulative deficit of £25.3m were carried into 2017/18.

Over reliance on Acute Hospitals

The allocation of CCG resources to individual programmes in **Figure 8** below shows 57% of funding allocated to acute care.

Comparison of programme budget spend across CCGs is made difficult by the inconsistency in the reporting of spend against individual programmes and the lack of robust benchmarking data for non-acute services. However, the comparisons that are available all indicate, to varying degrees, above average spend on acute hospital care in North Somerset.

Comparisons include:

- **National programme spend 2014/15:** Acute spend accounts for 57.3% of total spend in North Somerset compared with 52.9% nationally amounting to £11.6m of additional acute spend locally.
- **Comparison with commissioning for value peer CCGs 2016/17:** Acute spend per weighted capita is 7%-9% higher than peer average amounting to additional acute spend locally of £9.7m - £13.6m when compared with Commissioning for Value top 10 peers.
- **RightCare Opportunities 2016/17:** The potential reduction in acute expenditure from a reduction in admissions only totals £9.9m.

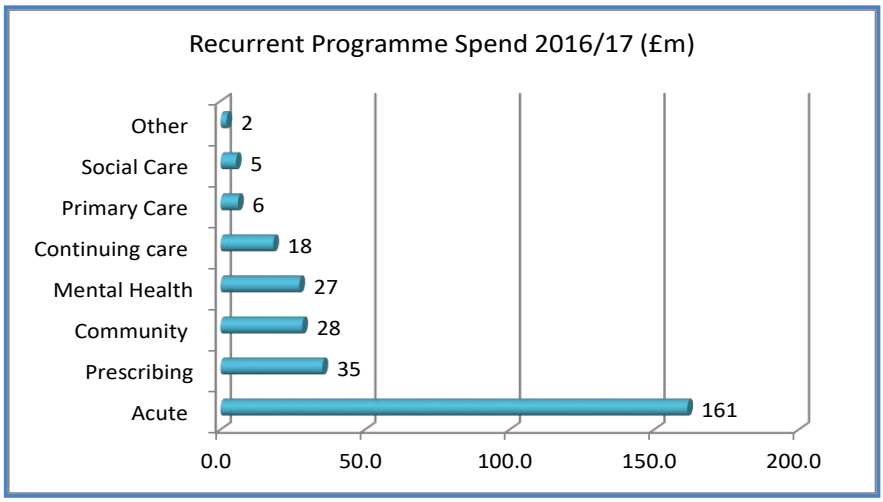


Figure 8: Programme spend 2016/17

Although varying in degree, all three comparators indicate above average expenditure in the acute sector ranging from £9.7m to £13.6m which equates to a reduction in 2016/17 acute spend of 6%-8%.

Local analysis of activity covered by the Payments by Results (PbR) tariff indicates that much of the additional cost is related to higher unit costs rather than higher overall volumes of demand driven activity.

Benchmarking of non-acute services, mental health and community and continuing care, is more problematic because of a lack of standardisation in the reporting against individual programmes. A high level comparison of 2016/17 reported spend by our 10 commissioning for value peers indicates higher acute spend as described above, but also indicates higher levels of spend on mental health /community services offset by an underspend on continuing healthcare (CHC). A more detailed comparison would need to be conducted with each individual CCG. Individual placements, often high cost, are variously reported as community, mental health or CHC so drawing conclusions around individual programmes may be misleading. Overall the CCG spend per capita on these three areas was 2% higher than peers equating to some £1.8m of additional cost per annum.

Whilst all the indicators point to over use of acute services, the 2016/17 comparison with peers suggests that there are also inefficiencies in non-acute services, albeit on a smaller scale, that should be taken into account in the funding of any service reconfiguration.

Further benchmarking detail is provided at Appendix 4.

Fragmented Provision

Whilst the northern half of North Somerset looks broadly to UHB and NBT for acute services, and the southern part looks to WAHT, there is a significant flow from Clevedon to Weston. All localities look to UHB and NBT for more complex care. Whilst the south looks to WGH for urgent care, the north has access to an MIU service in Clevedon. In addition, patients have access to 5-6 independent sector providers for elective care. All adult patients look to AWP and NSCP for mental health and community services respectively while WAHT provide children's community services including CAMHS and community paediatrics.

The number of organisations not only adds to the complexity of managing contracts and controlling costs, but also allows patients to "bounce" around the system leading to unnecessary duplication and increased cost. Whilst commissioning from a number of organisations, North Somerset is the lead commissioner only for WAHT and North Somerset Community Partnership (NSCP). This has historically reduced the influence that the CCG has been able to exert over the full range of commissioned services.

Fragmented Commissioning

The financial gap described above only relates to CCG commissioned services and excludes specialised commissioning and primary care provider costs. However, the fragmentation of commissioning since 2013/14 has made it more difficult for individual commissioners to manage commissioning costs across BNSSG prior to the engagement of all commissioners in the STP process.

Diseconomies of Scale

WAHT is the main acute provider for North Somerset providing 46% all non-specialised acute services delivered locally, but is also one of the smallest acute hospitals in the country making it extremely challenging to deliver the economies of scale achieved by larger hospitals, and upon which national payment tariff assumptions are based for all providers. Consequently, the commissioner is currently paying a premium each year to subsidise the current configuration of services on this site, most notably A&E and critical care services. Similarly NSCP, as a small community provider, will struggle to achieve the same economies of scale as their larger counterparts. As one of the largest mental health providers in the south west, AWP brings advantages in terms of economies of scale.

Imported Costs

The number of care homes in North Somerset providing care mainly for older patients with multiple morbidities and clients with learning difficulties is one of the highest in the country attracting clients from out of area who then become the responsibility of the North Somerset commissioner for both funded nursing care and for health services more generally. There is also a significant inflow of patients with alcohol and drug related mental health needs, in large part due to the high number of residential treatment facilities concentrated in Weston. Many of these patients subsequently stay in the local area following treatment.

Closing the Financial Gap (2017-2021)

Overview

North Somerset CCG's funding gap of ~£41m over the 4 years to 2021 is made up of:

- The current £13.3m underlying deficit brought forward from 2016/17.
- Additional £9.7m of unfunded costs in 2017/18.
- Additional unfunded costs of £17.8m from 2018/19 and 2020/21.

Closing the current financial gap (2017/18)

The 2017/18 financial gap of £22.7m is being addressed through the Turnaround process which is required to deliver an £82.3m saving after growth across BNSSG to meet the control total of £8m set by NHSE. Delivery is now being managed and measured on a BNSSG wide basis.

The North Somerset element of the BNSSG financial plan includes savings of £20.7m to be delivered in 2017/18 with a full year effect of £27m in 2018/19. The full year planned reduction in expenditure includes £19.3m (acute), £4.4m (non-acute) £2.8m (prescribing) and £0.4m (running costs). Most of the planned savings will impact on local provider income and require significant reductions in the provider cost base across North Somerset.

Comparison with peer spend in 2016/17 indicates that most, if not all, of the £20.7m savings target for 2017/18 could be met by matching current peer performance.

Closing the future financial gap (2018/9-2020/21)

To close the future financial gap, North Somerset will need to look beyond matching current best performance to meeting the challenging ambitions set out in the 5 Year Forward View. Over the next 5-10 years, the main pressures on services in North Somerset are expected to come from:

- A significant increase in the number of frail and older people over age 75.
- An expected increase in the demand on children's services in the south.
- Better meeting the needs of vulnerable groups within the population.

Based on the above assessment of what is affordable, the local system needs to work together to design and deliver a new model of care that better meets the needs of the local population within the available financial allocation. All providers will need to play their part, and hard choices will need to be made.

The over 75 population currently accounts for 30% of all admissions, 60% of beds and 40% of admitted patient costs. The rate of hospital admission increases significantly with age so that 1 in 3 people aged over 85 were admitted to hospital as an emergency in 2016/17 compared with 1 in 13 aged 65-74.

By far the largest pressure on services and costs is expected to come from growth in the older population living longer with long term conditions and increasing frailty. **Figure 9** below shows the expected population growth from 2017/18 to 2020/21. Whilst the over 65 population is expected to increase by less than 1%, the over 75 population is expected to grow by 14% to 16% over the period. Translated into absolute numbers, this represents an estimated increase of 3,522 adults over the age of 75.

Age Group	Population Increase	North	South	% Growth
65-74	154	66	88	0.6%
75-84	2489	1090	1400	15.8%
>85	1033	445	588	14.4%
Total	***3676***	***1601***	***2076***	***7.4%***

Figure 9: Population growth to 2021(Source: ONS projections applied to Registered Population of North Somerset over 4 year period (2017/18 to 2020/21)

The impact of projected growth in the older population is illustrated in **Figure 10** below. Overall, this represents an additional 20 hospital beds based on current lengths of stay with an estimated £2m increase in cost related to emergency admissions alone. If this is projected into the future an additional 65 beds would be required over the next 10 years. Even if we could afford the beds there may be insufficient clinical staff to service them.

Other costs related to elective admissions, outpatient attendances, community nursing and therapies, continuing and dementia care provision as well as GP prescribing, will put further pressure on an already unaffordable health system.

Age	Population Growth	Emergency Admission Rate 2016/17	Projected Increase in Emergency Admissions	Projected Increase in Beds	Projected Increase in Costs £000s
65-74	154	7.7%	12	0.3	98
75-84	2489	15.7%	390	9.4	1,176
>85	1033	31.7%	328	10.0	1,058
	3676		**730**	**19.6**	**2,234**

Figure 10: Impact of population increases on activity and costs to 2021

Whilst hospital admission rates for the older population in North Somerset are currently among the lowest in the south, they are almost certainly not sustainable into the future in the context of reduced funding and constrained capacity. Therefore, we need to focus our efforts and resources in supporting people to stay well and out of hospital wherever possible. We also need to work together to reduce the length of time people who are admitted to hospital stay. North Somerset residents currently spend longer in hospital (for both elective and non-elective spells) than residents in comparable CCG areas.

Summary

In summary, to achieve an affordable and sustainable service model for the North Somerset population, it will necessitate a radical transformation of the way in which health and care services are provided for local people. This will mean:

- A significant reduction in both commissioner spend and therefore provider income.
- Developing service models and provider configurations that address the weaknesses in the current system.
- Developing contracting models that are fit for purpose and incentivise both commissioners and providers to reduce costs and allow the money to follow the patient. This will help incentivise the movement of resource around the system where it can have the greatest impact for patients.
- Committing commissioner resources to building financial resilience and the non-recurrent flexibility to support transition costs.
- More “place” based commissioning cutting across organisational boundaries.
- Maximising the opportunities afforded by the Resilience, Transformation, and Improved Access allocations from the GP Forward View (GPFV) funding.

Commissioning Principles

To underpin the development of this Commissioning Context, a set of Commissioning Principles were produced which have been tested and refined with local partner organisations.

These principles are as follows:

1. **Driven by a systematic and evidence based assessment of population and patient need** – the Commissioning Context should be driven by the needs of the local population (both physical and mental health) and conclusions drawn from a thorough analysis of the data as opposed to organisational interest.

2. **Be commissioned at a scale that maximises the most effective use of resources** to deliver the required outcomes and to enable providers to develop workable systems of care - suggested to be at least 100k population.

3. **"Do Nothing" is not an option** – given the financial position of the CCG and the wider BNSSG system, "Do Nothing" is simply not an option. The CCG must go well beyond the current in-year financial recovery plan to achieve longer term clinical and financial sustainability across the health and care system.

   What this means in practical terms in North Somerset is:

   - Sustainable primary care and other constituent community organisations.
   - A sustainable Acute Trust that is 'right sized', and doing the work that only it can do.
   - Acknowledging and accepting the inescapable constraints of funding and staff shortages in some key areas and re-designing services accordingly.
   - A willingness of all providers and stakeholders to change the current model of care.

4. **Focus on the few priority areas where change is potentially most impactful** – we must focus scarce resources on those priority areas that will have the most impact from both a health outcomes and financial perspective. These priorities are based on a review of local population need and an analysis of local spending patterns benchmarked against the CCG's local and national peers (RightCare packs and associated analysis).

5. **A balance between community care and secondary care –** as described in Section 0, the vision for local services is built on the creation of an organised, coordinated and effective community provider environment that is seen as the main conduit for meeting a person's health and care needs. Within this vision, the community provider environment will work equally with high quality, specialist services in the main Acute Trusts, to develop seamless cross system pathways, build clinical networks and share expertise and advice to the ultimate benefit of patients.

   Figure 11 below summarises the spectrum of options that providers will need to consider to realise the vision of moving from an acute dominated, reactive service to a more balanced system blending both community and acute services.

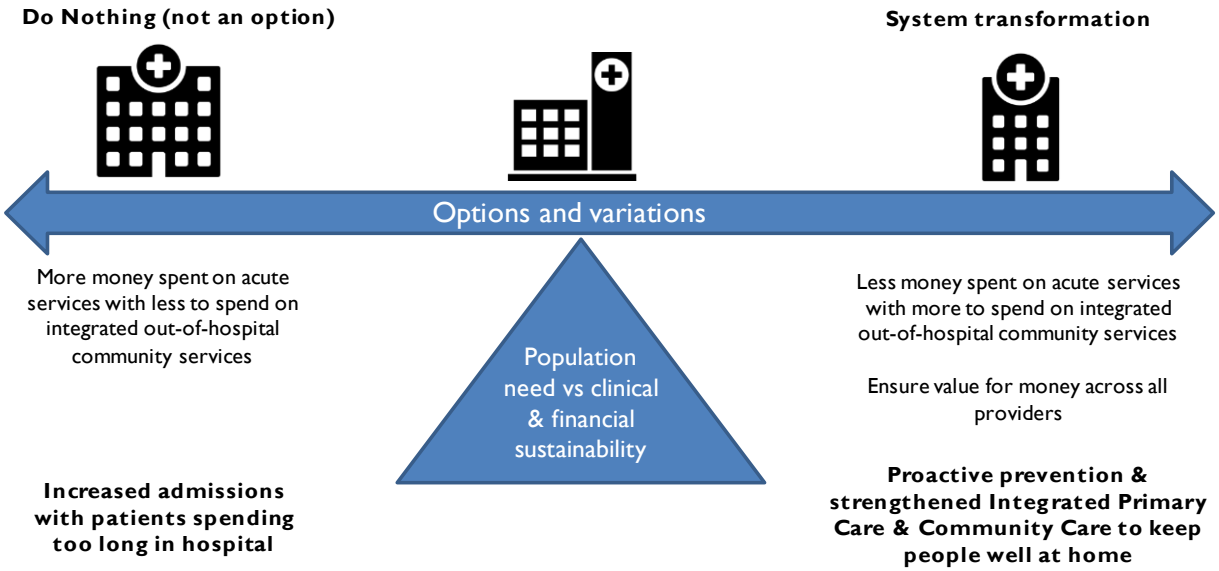


Figure 11: Rebalancing the system

6. **Greater cohesion and partnering across the community setting** – the vision is for General Practice to be at the very heart of the community system. This will involve:
   - Cluster-based working of GPs, coordinating patient care across the system.
   - Strong GP-leadership to build an integrated primary & community capability.
   - Providers spanning multiple settings of care.

7. **Greater collaboration across Acute Trusts** – working under the guidance of the Acute Care Collaboration workstream of the STP and further enabled by greater partnership working between UHB and WAHT and collaboration with NBT.

8. **Greater involvement of the Voluntary Sector** in the provision of local services.

9. **Maximise the use of technology and encourage and respond to patient and public digital literacy.**

10. All parts of the system, with the aid of the Voluntary Sector, actively supporting **self-care and health promotion** to keep more people safe and well at home.

11. Integration of **mental and physical** wellbeing at all levels and settings of care.

12. **Maximise the use of the existing estate** – the aim is to make best use of existing assets, including working with partners through initiatives such as One Public Estate where it is appropriate to do so. It makes financial sense to make best use of the assets we already have before looking to build new facilities to support the development of the community system. We should explore opportunities for co-location with partners, which could free up redundant estate for re-development – providing that long term revenue requirements can be met. The CCG is already leading a piece of work to assess the strategic estate options for primary care in Weston. However, it is expected that further work will be required to look at a broader range of strategic options to consolidate and optimise the use of provider and local authority owned estates.

Priority Areas of Focus

When considering the current population need in North Somerset as set out Section 0, we can see rising demand driven by age demographics, more people living with long term conditions and general population growth.

As set out in Section 0, the CCG is spending more per head of population than similar areas elsewhere in the country. This is compounded by supply side capacity constraints driven largely by staffing pressures across the system and rising costs of provision that are outstripping the level of funding available. Whilst this picture would be familiar to many health systems across England there are a number of key drivers impacting North Somerset and Weston in particular (refer to Section 1.6), that require a materially different response.

At the same time, the North Somerset Sustainability Board is agreed that some services delivered at WGH are not clinically or financially sustainable and are therefore in need of reform. While the Partnership Agreement between WAHT and UHB will help to improve the resilience and delivery of some aspects of service, overall there is a need for significant service transformation and whole system working to develop a new, more sustainable model of care that better meets the needs of the local population.

In developing this Commissioning Context, the local system came together in a series of workshops to review the population need, the demand for services, patient outcomes, service constraints, current spend and future need, and used this information and data to identify a number of key priority areas of focus where the need for service transformation is most urgent. The three key priority population groups that were identified are:

- **Frail and Older People.**
- **Children, Young People and Pregnant Women** (including complex needs and young people's mental health).
- **Vulnerable Groups**, for example people with mental health needs, learning difficulties and those who struggle with drug and alcohol addiction.

Appendix 5 summarises the data and analysis behind the identification of these priority population groups. The local system also identified the following key specialities as priorities:

- **Urgent & Emergency Care** (including Emergency Surgery)
- **Planned Care**
- **Cancer**
- **Stroke**
- **Liver Disease**
- **Musculo-skeletal conditions (MSK)**
- **Dementia**
- **Maternity**
- **Critical Care**
- **Mental Health**
- **Circulatory Disease**
- **Respiratory (COPD)**
- **Frailty**
- **Diabetes**
- **End of Life**

Appendix 6 summarises the data and analysis behind the identification of these priority specialty groups, which has also been tested with a range of stakeholders during this work.

PART 2: VISION FOR LOCAL SERVICES

A New Model of Care for Weston

The North Somerset health and care system is currently on a journey to shift the balance from a fragmented and dis-jointed out-of-hospital community provider environment, with minimal focus on proactive health management, to a model where the broader community based system and the secondary care system are more in-balance and working together in a more integrated and cohesive way, with strong central leadership and a focus on proactive health management across the entire system.

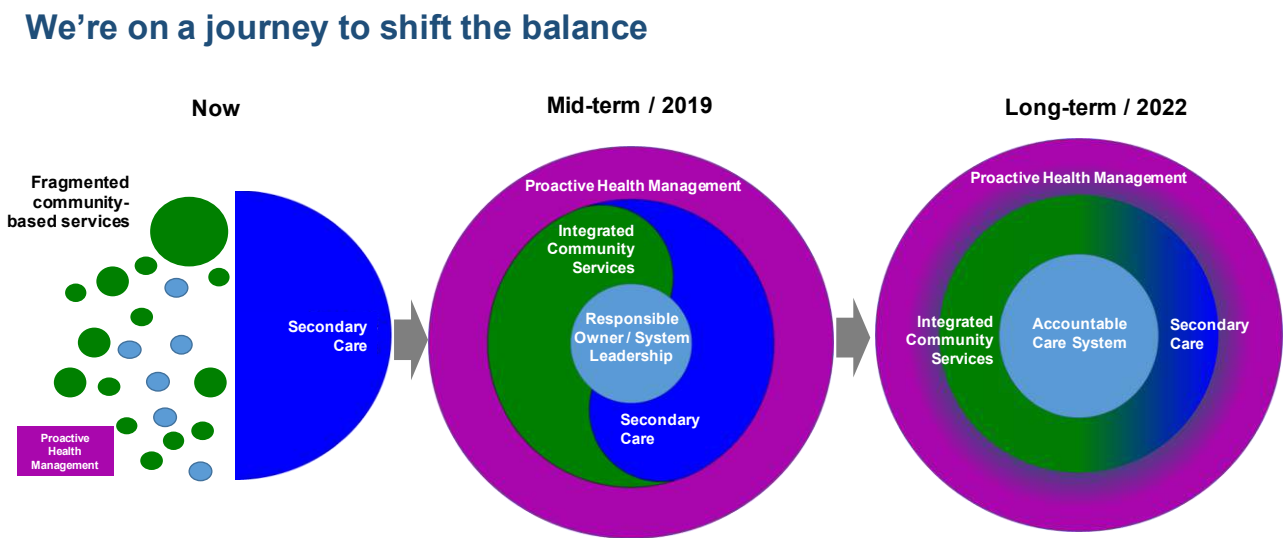


Figure 12: Shifting the balance

Over the next two years, the CCG, working in close collaboration with local providers, key stakeholders, service users and the public, will deliver a new and innovative model of care for the local population in Weston that will transform the way services are delivered and provide a framework for other areas across BNSSG.

This new and innovative model of care will not only be designed to better meet the needs of the local population, but it will also help to address the significant clinical and financial sustainability challenges that the CCG, and the system as a whole, currently faces.

The new model of care will also provide a better, and more cohesive, way of working for the local workforce by providing exciting and more varied job opportunities, including a stronger role for the voluntary sector, through the creation of new roles and the ability to work more fluidly across organisational boundaries.

At a summary level, the new model of care consists of three integrated elements as summarised below:

- **Primary Care (General Practice) working at scale & providing strong system leadership –** GP Practices working more collaboratively in locality based 'clusters' to improve practice resilience, deliver improved access to a broader range of services**,** and benefit from improved economies of scale. Cluster-based working will provide a stronger platform on which to deliver a more integrated community services model as summarised below. This includes exploring opportunities to make the most of the opportunities for integration and co-location offered by the One Public Estate Programme.

- **Stronger, more integrated community services supported by a 'Care Campus' model at the WGH site** - this will include the creation of a more integrated and multi-disciplinary community-based service model wrapped around clusters of local GP Practices and will develop the WGH site into an integrated 'Care Campus' with a co-located primary care led Community Hub providing integrated primary, community and acute services supported by a revised and more integrated acute care model.

- **A stronger, more focused Acute Trust and acute care model at WGH** – this will deliver a revised set of acute services to better meet the needs of the local population. This new acute care model will be delivered by working in closer collaboration with other Acute Trusts across BNSSG as part of a wider Acute Trust Network and will integrate closely with the co-located Primary Care led Community Hub.

These key elements of the new model of care are closely aligned with the BNSSG STP vision as shown in **Figure 13** below.

The STP's vision is to deliver 'whole system' integrated service delivery covering a geographical area providing high quality, affordable, community care. This includes prevention and self-care, providing alternatives to A&E and hospital admission, supporting hospital discharge and keeping patients well at home, as well as general medical services in and out-of-hours, covering seven days a week.

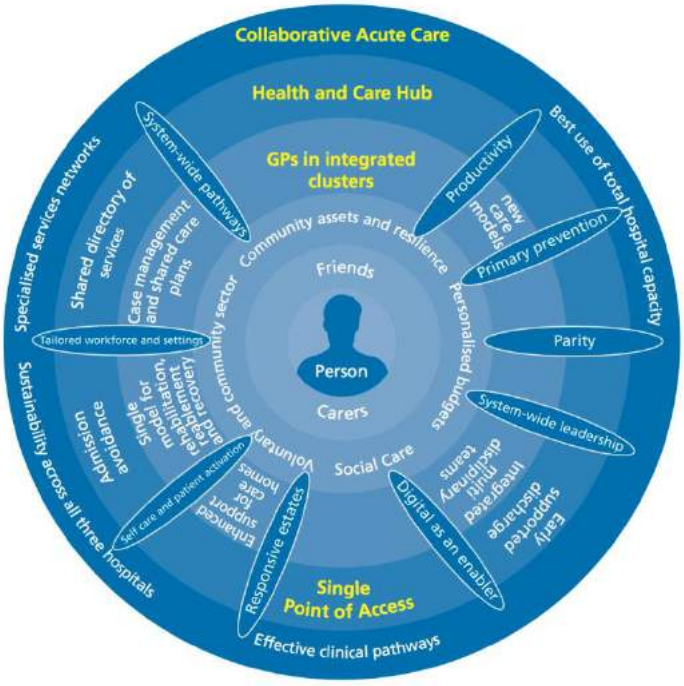


Figure 13: BNSSG STP vision for integrated delivery

In thinking about how this new model of care will address the needs of the three identified priority groups, this will mean:

- **Frail and older people:** a re-balanced system, with the Weston 'Care Campus' at its heart, will provide both proactive and reactive services to a clearly defined group of patients to keep them well and at home, with more of the services they need provided locally with less need to travel long distances out of area. If an individual is appropriately admitted to a hospital bed, the system will react quickly to pull them through the hospital system and will provide excellent rehabilitation and support services to help them get home as soon as possible.

- **Children, young people and pregnant women:** a more resilient integrated community and acute paediatric service will be able to offer more expert support and advice to the local urgent care system and address issues such as capacity and waiting times with an improved and more attractive service model, that is better able to recruit and retain expert staff; a comprehensive and appropriate maternity service that most efficiently meets the needs of the local population.

- **Vulnerable groups:** the 'Care Campus' approach offers an opportunity to provide more joined up packages of care, treating patients as individuals rather than thinking about their mental and physical health separately. This will aid sustainable recovery and protect against the risks to physical health that people with mental health and substance misuse problems are disproportionally at risk from.

The following sections describe the various elements of the new model of care in more detail and provide a set of key design principles to support future planning and design.

Primary Care (General Practice) at Scale & Providing System Leadership

With over 95% of the patient contacts with the NHS taking place in primary care, primary care is, and should continue to be, the foundation of the local NHS system.

As described in Section 3, local primary care in North Somerset is facing a number of significant challenges in the delivery of core primary care to patients such as estates challenges, an ageing workforce, workload, an ageing and growing population with complex medical needs and an expectation to deliver more care in the community. These challenges are particularly acute in Weston.

BNSSG CCGs' have developed a Primary Care Strategy that sets out a vision and direction of travel for local primary care services. The aim of the strategy is to ensure the sustainability of General Practice building on existing strengths and ensuring safe, effective and high quality care. The BNSSG Primary Care Strategy was developed in line with the General Practice Forward View (GPFV) and sets out, at a high level, how General Practice will be enabled to better support the delivery of the BNSSG STP Vision for Integrated Delivery as shown in **Figure 13**. The strategy has been shaped by discussions across the wider BNSSG system, not only between the respective BNSSG CCG member practices, but also with the public, GP Practices, their area representative bodies and partner services.

The strategy describes how GP Practices will address the challenges outlined above by working at scale in 'clusters'[10] and across larger geographical areas called 'localities'. While formal locality-based cluster-based working is still developing, the transition from today to this new way of working will require strong local GP leadership to deliver the required changes.

BNSSG CCGs are already working with NHS England to ensure that the funding that is available centrally from the GPFV, which includes estates, technology and transformation funding (ETTF), Improved Access funds, Resilience and Transformation funds, are utilised locally to maximise the benefit in supporting GP Practices to achieve the stepping stones necessary to deliver the vision. Provisional plans for the BNSSG Transformation Scheme (i.e. £3 per head funding over two years of 2017/18 and 2018/19) are being designed to support the development of GP Practice locality working.

Each GP Practice 'locality' has different population needs and priorities, and is at different stages of development. Whilst not intending to be prescriptive, nor to supress entrepreneurism, the expectation is that practices will need to develop local services under a number of key design principles as outlined below:

Key Design Principles for local Primary Care Development

- GP Practices working together at scale to better enable collaborative working with the rest of the health and care system. By joining up with other providers locally, this will help to optimise resources to create a step change in care delivery and patient experience/wellbeing. This could manifest itself, for example, in a more consistent and effective service to local care homes.
- Primary care operating at scale delivering consistent, resilient, high quality and safe care with all patients having access to a range of core services, but allowing sufficient flexibility to develop

[10] Defined here as the registered population of a specific group of General Practices based on a geographical location where different services work in an integrated way for the population. These clusters are likely to be for a population of 30,000 to 50,000, but could be higher. In contrast, Primary care 'Localities' will be between 100-150,000 population.

services that meet the specific needs of their local populations. Instead of a 'one size fits all' model, practices will work together to determine the best solution based on local need and circumstances.

- Multi-disciplinary primary care teams - increasingly General Practice teams - will be supported by specialist nurses, mental health workers, pharmacists, physicians' associates, healthcare assistants and other healthcare professionals. Building on the tradition of hosting services such as the diabetic retinal screening and mental health services, these teams will be capable of offering more services locally to better meet the needs of their local populations – such as DVT services, for example.
- A greater level of collaborative and integrated working between General Practice teams and the wider community and social services system.
- Address public concerns over the availability and resilience of primary care services in the town centre, especially in the context of existing need and likely future population growth.
- GP leadership for the rest of the community system to enable the provision of higher acuity services in the community and allow the sector to 'punch its weight' with the acute sector by keeping people in, or quickly returning them, to their normal place of residence.
- Where it can be demonstrated that funding will be freed up, and it will deliver safe and quality care more efficiently, appropriate work and resources could shift from the acute hospital to the community – for example, certain services that are currently provided in an acute hospital setting could be more appropriately provided in a primary care led Community Hub, or other community setting.
- The implementation of the BNSSG GP Primary Care Strategy will provide the framework to support the required changes, and in addition a General Practice Sustainability Plan will be developed in line with the detail contained in the national GP Forward View.

Weston Primary Care Transformation Programme

Within the locality of Weston and Worle, local GPs have been progressing a programme of work over the last few months to address the challenges described above. The Weston Primary Care Transformation Programme has been looking into primary care estate solutions, alternative models of provision for extended access appointments and urgent care appointments as well as looking into the consolidation of back-office systems and processes. It has also been looking at developing new cluster-based clinical models for the improved management of long term conditions, frailty, care homes and mental health in primary care. This work will now be incorporated into the Weston Sustainability Programme as part of the Enabling Primary Care and Integrated Community Services workstreams and will move forward in a more integrated way, working in close collaboration with the delivery of the other elements of the model.

Non-GP Primary Care

Other contractors within primary care have a key role to play in patient's health and wellbeing. Using the principle that patients should be seen by the most appropriately skilled health care professional at the right time; dentists, optometrists and community pharmacists could play a larger part in the proposed integrated system. This will be fully explored as the programme of work develops

Stronger, More Integrated Community Services & 'Care Campus'

Integrated Community Services

Central to the new model of care is the development of excellent integrated community services working in conjunction with local primary care working at scale in clusters and wider localities, to provide a holistic health and care response that is genuinely tailored to the needs of the local population.

Figure 14 below, which is taken from the BNSSG Primary Care Strategy and aligns with the work of the BNSSG STP's Integrated Primary and Community Care (IPCC) workstream, aims to outline the types of services that might be provided across clusters and localities of GP Practices. Work is already underway locally in Weston to deliver this model.

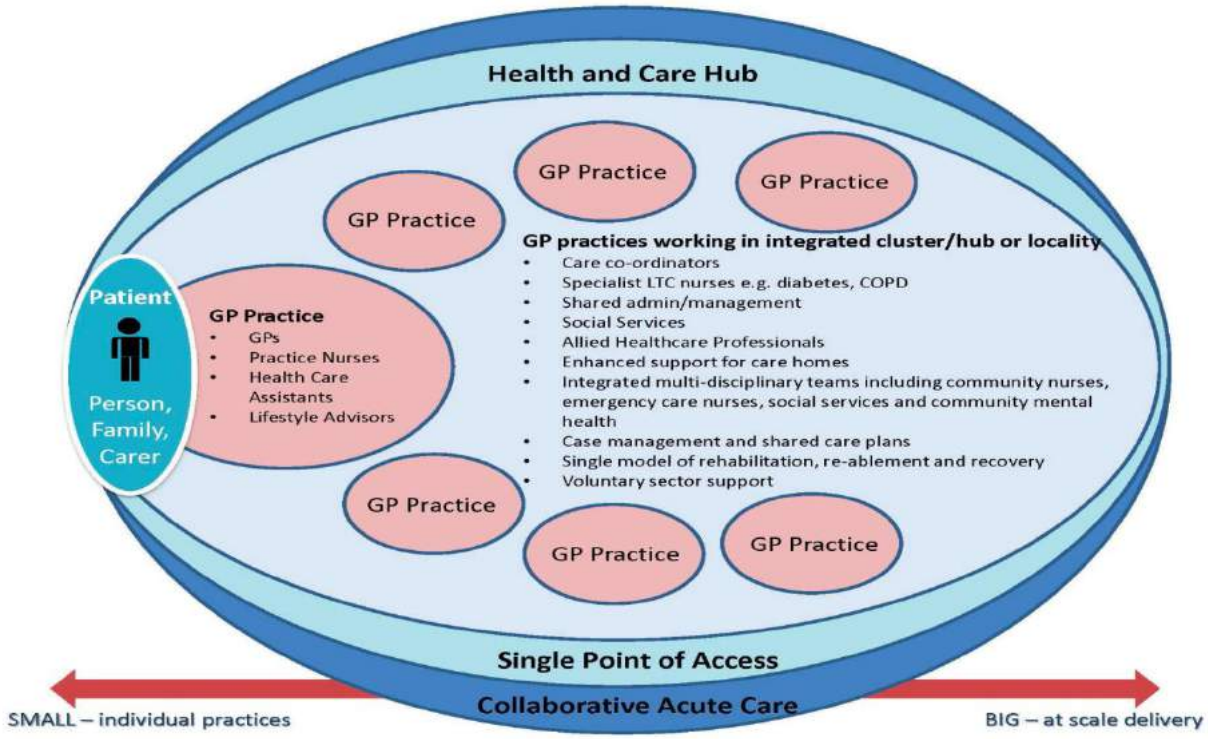


Figure 14: Integrated community services wrapped around GP Practices

'Care Campus' Model

The new model of care also focuses on the creation of a more organised, coordinated and effective community provider environment that is seen as the main conduit for meeting a person's health and care needs. This new community provider environment sees primary care, out-of-hours primary care, community services, mental health, the ambulance service, the local authority and the voluntary sector all working much more collaboratively with each other, and more collaboratively with secondary care, around a single, person centred care plan.

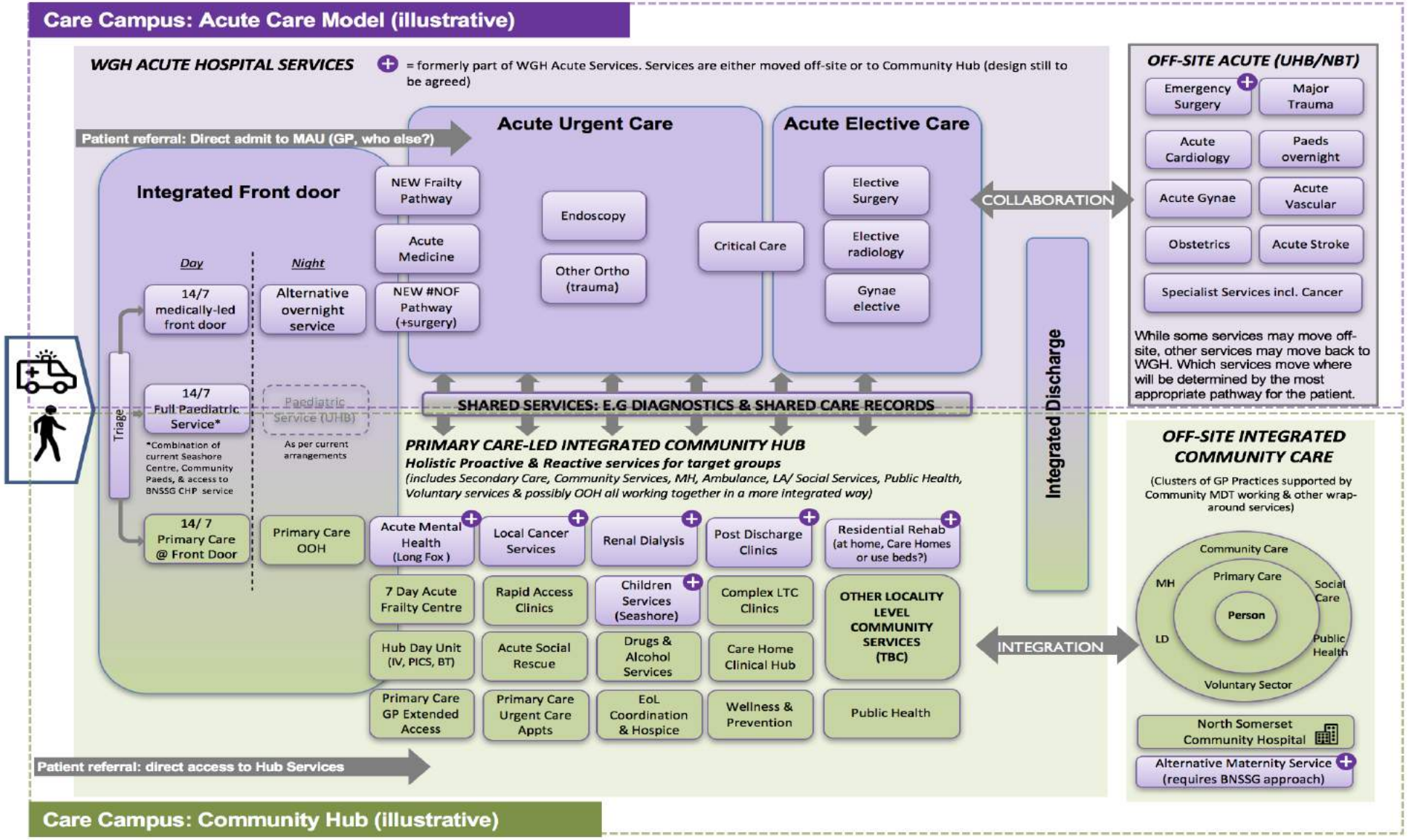


Figure 15: Example of 'Care Campus' Model: WGH providing selected acute services with a co-located Primary Care led Community Hub

Different levels of collaboration will emerge across the system. For example, certain services will be provided at a local GP Practice level, while for other services it will make more sense to provide them at a cluster (30 to 50,000+ population) or locality level (100 to 150,000+ population). A number of key services will need to be provided at a local authority or BNSSG level.

While the exact design of which service is provided where is being taken forward by the STP at a locality level, the direction of travel is clear. For Weston, the emerging consensus amongst local providers and stakeholders is to explore the possibility of turning the WGH site into an integrated 'Care Campus' that can be used by an alliance of providers (supported by strong GP leadership) to provide a wider range of integrated services and become a focal point for the local community system.

Within this 'Care Campus' model, the community provider environment will work with high quality, acute services at WAHT to develop cross-system pathways, build clinical networks and share expertise and advice to the ultimate benefit of the patient. **Figure 15** above gives an illustrative example of the vision for the 'Care Campus' model and it's two central component parts: 1) a co-located primary care led Community Hub that is integrated into the wider 'out of hospital' community system (green elements) and 2) a re-designed Acute Care Model (purple elements). It was shared through the system-wide engagement work to support the development of this document. In response to this Commissioning Context, providers will be expected to work in partnership to develop the design for both parts of the 'Care Campus' model to ensure the two components of the Campus model work together in an integrated and cohesive way. This will include ensuring that the estate – which is owned by WAHT – can have overheads appropriately met.

The following section provides a brief overview of what the Community Hub might provide in terms of example services. It should be noted that the information provided in the following sections is indicative and further work is required to turn this into a workable service model. In addition, the public will play a key role in helping providers to co-design the final solution. Section 0 provides further detail on the Acute Care Model.

Overview of Primary Care led Community Hub

As shown in **Figure 15**, the primary care led Community Hub will be supported by an alliance of providers (including WAHT) all working together to provide a variety of integrated services focused around the needs of key target patient groups. The Community Hub will be co-located at the WGH site and will work in an integrated way with both the wider community based system (referred to in the diagram as Off-site Integrated Primary and Community Services) and a redesigned WGH Acute Care Model.

The 'Care Campus' will have an Integrated Urgent Care Front Door service, with clear triage criteria that will support streaming to re-direct patients to the most appropriate service for their particular needs. This could include the patient's local GP, a particular service in the community, a service in the Community Hub or a service in the hospital. The 'Care Campus' will also provide an Integrated Discharge Service to proactively pull patients through the hospital system and ensure they are well supported on discharge from hospital. Community Hub services will also benefit from access to expert advice and support from on-site secondary care clinicians.

Although the design still needs to be developed, the Community Hub could contain the following types of services:

- **Additional GP urgent care and extended access appointments** to improve 7 day access to GP appointments to cope with current and forecast increases in demand.
- **A 7 Day Frailty Centre** providing proactive and reactive services to a clearly defined group of patients to keep them well and at home. If an individual is appropriately admitted to a hospital bed, the system will react quickly to pull them through the system and will provide excellent rehabilitation and support services to help them get home as soon as possible.
- **A Day Unit** providing services such as intravenous (IV) therapy in the community, management of peripherally inserted central catheters (PICC lines) and blood transfusions in a more comfortable environment so patients don't have to be admitted to hospital.
- **Rapid access to diagnostics** to provide access to a range of diagnostic tests for those patients whose symptoms are non-specific, but are concerning, and who need a diagnosis so that a treatment plan can be put in place. The service could offer patients further investigation of symptoms they may have discussed with their GP through additional tests. These could include: imaging tests such as MRIs, CT scans, endoscopy or other tests such as blood gases. The expectation is that this would be a shared service with the hospital, thereby driving economies of scale through increased activity volumes.
- **Multi-specialty Long Term Conditions Clinics** for high acuity patients, focused on key priority conditions such as CHD, Stroke, hypertension, COPD, and Diabetes etc. Given the integrated nature of the services in the Community Hub, these clinics could be multi-specialty allowing patients to be seen for multiple conditions at the same time thereby avoiding repeat visits, multiple appointments and repeating the same information multiple times.
- **Rapid Access Clinics –** for example for COPD and chest pain.
- **Acute Mental Health services** supported by clinicians from AWP's Long Fox unit which is co-located at WGH. This will help to better manage patients with both mental and physical health needs. Services could include in-patient or crisis teams, IAPT and community mental health.
- **Rapid access to Social Services** to cope with patients attending with complex social issues requiring rapid intervention to avoid admission to hospital. The Community Hub would also use well established trusted assessor models to avoid duplication.
- **Integrated children's services** including combining the current Seashore centre, community paediatrics and BNSSG Community Health Partnership services into an integrated service.
- **Local cancer services** so more patients can be treated closer to home and don't have to travel to Bristol for treatment.

- **A care home support service / integrated care home delivery model** to better support local GPs and community providers in managing patients in local care homes to avoid admission – could also include an AWP specialist mental health care home liaison resource and improved medicines management.
- **Rehabilitation / reablement –** the definition and provision of a clear and robust model for rehabilitation and reablement to better support people on discharge from hospital.

Other examples of the types of services the Hub could provide include:

- **Other clinical services** - drug and alcohol services, end of life and hospice coordination, renal dialysis, post discharge clinics.
- **Other types of services** - wellness and prevention services, public health services, voluntary sector services, social prescribing, care navigation, signposting, crisis café, dementia café.
- **Support services:** Consolidation of back-office functions and process for local primary care.

Local clinicians have developed and tested a number of simple but common scenarios, comparing patient journeys in the current model to the potential benefits of the new integrated system. For example, this early work has identified a range of opportunities to help prevent unplanned admissions. Four examples are provided below.

Scenario: Frail older adult requiring rapid access to diagnostics

- Ann is 82 and lives with her husband, who has arthritis.
- He is more dependent on her than the other way around, but she doesn't consider herself his 'carer'.
- Over 3 days Ann has a couple of unsteady episodes and becomes a bit confused.
- Her husband calls the GP concerned and requests a visit.
- GP visits and Ann has a NEWS score of 2 - slightly raised pulse and slightly low saturations.
- GP is worried about pneumonia, or an infection elsewhere, or that she has a metabolic disturbance and needs more investigations.
- GP ideally wants bloods to ensure that she hasn't got low sodium or raised calcium, and a chest x-ray
- GP also wants her to have some Intravenous fluid (IV) fluids as she seems a little dehydrated.

What is the preferred outcome for this patient?	
Today	• GP arranges for Ann to be admitted to Weston Hospital under 'medical expected'.
Future	• GP calls the Community Hub's frailty service to coordinate the response and investigations. • Ann attends the Community Hub for bloods, a chest x-ray and IV fluids. • The Hub has access to Ann's medical records in EMIS. • Ann is given a comprehensive assessment and is sent home – updates to her care record are shared with her GP. • GP follows up with Ann. • The Hub follows up in a few days to check-up on Ann and her husband.

Scenario: Combination of mental & physical health

- Trevor is 64 and had a psychotic episode 25 years ago.
- He is not really on any meds other than a statin and a BP med.
- Trevor's partner calls GP and describes him as acting strangely over the last week and becoming increasingly agitated and paranoid.
- GP is uncertain as to whether this is a psychotic episode again or a physical cause.
- GP identifies that Trevor needs both a physical work up and a psychiatric review to get to a better understanding of the diagnosis – it's unclear who completes which stage.
- GP refers Trevor to Weston General Hospital.

What is the preferred outcome for this patient?

Today	• Trevor attends Weston Hospital's emergency department. • Given his psychiatric history and that he's a bit unwell - it's unclear whether he should be admitted under 'psychiatry' or 'medicine'. • There's a 50:50 chance that he'll end up being admitted for his physical condition - which is not ideal.
Future	• GP calls the Community Hub for a holistic approach to get to the answer quickly. • Trevor is assessed by an appropriately skilled Urgent Care practitioner and an Acute Mental Health professional.

Scenario: Carer falls ill, but spouse has dementia

- Tomacz is 73 and has type 2 diabetes.
- He has high a blood glucose level, is dehydrated and has a high temperature - possible infection.
- He calls an ambulance.
- Ambulance brings Tomacz and his wife Gloria to Weston Hospital.
- Gloria has dementia and Tomacz is her main carer (no cover).
- There is no safe place for Gloria to go while Tomacz remains in hospital.

What is the preferred outcome for this patient?

Today	• Tomacz and Gloria are both seen in the hospital's emergency department. • Tomacz is admitted into hospital through acute medicine. • Gloria is admitted to a hospital medical bed until alternative arrangements can be made with social services (depending on demand, this may take some time)

Future	• Tomacz and Gloria attend through the 'Care Campus'' Integrated Urgent Care Front Door service. • Tomacz is streamed and admitted into hospital through acute medicine. • Gloria is streamed to the Community Hub where she is attended to by the onsite social services team and dementia team. • The Community Hub rapidly assesses Gloria's needs and arranges for an appropriate care package to get her back home as soon as possible.

Scenario: Care home resident

- Colin is 83 and lives in a residential care home.
- He has a fall at 10am and bangs his head.
- His carers are worried.
- He doesn't have DNAR or a TEP, or much advanced planning in general.

What is the preferred outcome for this patient?	
Today	• Colin's carers call the GP. • GP visits Colin at 3pm and decides to admit him to hospital as they feel he needs a CT scan. • Colin is admitted to Weston Hospital. • Given the time of day, Colin stays overnight and is discharged the next day.
Future	• Colin's carers call a central line and are taken through a set of questions to triage the call. • Rapid Response is dispatched to the home. • Rapid Response liaise with the Community Hub who has visibility of Colin's medical record in EMIS. • Rapid Response and the Community Hub both agree that Colin needs a CT scan. • Colin attends the Community Hub and has the scan. • CT scan is normal and he's back at home by 7pm. • Community Hub follows up with the care home to discuss/help with advanced planning.

Key Design Principles for Integrated Community Services

The delivery of more integrated community services to realise this ambitious model of care will take place in line with a number of underlying design principles:

- Integrated working i.e. breaking down the boundaries and organisational silos that exist between primary, community, and secondary care, mental health, and the local authority to build strong day-to-day working relationships across teams and GP Practices.

- Development of integrated multi-disciplinary teams from a variety of providers organised around clusters of GP Practices to work directly with primary care professionals on a day-to-day basis.

- The inclusion of memory services and dementia enhanced support teams working alongside primary and community care to reduce admissions.
- Robust care coordination and the use of named staff to coordinate seamless and timely access to different parts of the community system.
- A stronger role for the voluntary sector to support care coordination, sign-posting, social prescribing and provision of services.
- A much higher level of generalist skill across community nursing, including high quality self-management support, capable of managing multiple co-morbidities rather than an overreliance on specialist teams to manage a single condition.
- A single point of access for referral (SPA) and telephone contact; shared information management and telephony (IM&T) systems and information governance processes.
- Interoperability with primary care IT systems and streamlined, efficient methods of referral and information sharing; particularly important is the ability to provide direct interoperability with the prevailing clinical systems i.e. EMIS for both primary care and community care (note that NSCP already use EMIS) and inter-operability with secondary care and social care systems.
- Work with primary care, WAHT and other providers to explore the development and financial feasibility of creating a 'Care Campus' and primary care led Community Hub at the WGH site working closely with WAHT on the design of both the Community Hub and Acute Care Models.

It is through the delivery of these design principles and this overall vision for a new way of integrated working across the community provider environment that we will provide the highest standard of service to the people of Weston.

Through this work the CCG also wants to explore whether the Community Hospital at Clevedon is being put to best use in the context of the wider community model. We want to explore the potential use of other sites that are available, most notably Mill Cross in Clevedon. Again, this is the sort of opportunity that could potentially be relevant to the One Public Estate initiative. The CCG will work with the Council to explore such options as part of the implementation of this Commissioning Context across the rest of BNSSG.

A Stronger, Focused Acute Trust & Acute Care Model at Weston Hospital

Redefining the role of Weston General Hospital

As commissioners, we support the view of Weston Area Health Trust's Board that WAHT needs to redefine its role and the role of Weston General Hospital (WGH) both within the place of Weston and across the wider BNSSG system. WGH is, and will remain, a vital part of the service infrastructure, but for a number of years the hospital has found it harder and harder to preserve the full range of services that a small District General Hospital (DGH) of its type might have provided in the past.

The CCG is working closely with WAHT, who have been long term champions of the 'Care Campus' model, to ensure we can bring to the hospital site a wider range of services that will continue to benefit the local population. This will allow us to move towards a more optimal, and less duplicative, model of service provision by coordinating services with those provided by UHB and NBT as part of a wider BNSSG Acute Services Plan.

This new and unique potential role for WGH opens up a range of exciting opportunities to put the hospital at the heart of an integrated and more responsive local system. For example, the potential exists for Weston to become a recognised regional centre for innovative and effective support of frail and older adults, at scale provision of great routine elective care, and the strengthening of local cancer outpatient treatment options.

Increasingly with modern medicine, more complex and specialist services are centralised into larger regional or sub-regional centres as the evidence demonstrates that this is better for patient outcomes. Clinicians are clear that the evidence for the treatment of many life-threatening emergencies is that it's the level of specialist knowledge and skills at the receiving hospital, rather than ambulance journey times, which drive improved outcomes. There are a growing number of examples around England where the role and scope of small DGHs is being re-evaluated, with a stronger emphasis on routine, planned care and the rarer, more complex and life threating conditions being treated at larger local centres.

The CCG's view therefore is that WAHT needs to redefine the role of WGH within the BNNSG landscape and we must collectively take this opportunity to address long-standing issues of clinical and financial sustainability for a number of different services. From the range of different benchmarking indicators included in the financial analysis section (Section 4) of this document it is clear that North Somerset CCG spends a disproportionate amount of funding per head on acute services when compared to its peers. This Commissioning Context does not set out in detail a final model, preferred option or target configuration state for WGH. Based on the information in this Commissioning Context, and the design principles laid out below, the CCG will work with WAHT, UHB and NBT to develop and appraise the possible options for service delivery and define where the balance should lie between "local" vs "at scale" services.

As a system, we must be honest with the public and ensure that we present options that are realistic, rather than implying that any combination of services is possible. Where there are clinical, workforce or financial limitations that make certain options unsustainable or

unrealistic, we need to be open about this. However, the emphasis should be on the positives, setting out clearly what new opportunities for improved and more coordinated care this new approach will bring, rather than focussing exclusively on what services may need to be provided elsewhere in order to make the new system work.

In addition, the CCG's assessment is that WAHT and WGH would be able to operate much more effectively and sustainably if it was part of a larger organisation. This would improve the prospects of attracting both activity and staff. The CCG's expectation is that Acute Trusts will work together across BNSSG to organise services more efficiently for the effective delivery of both urgent and planned care, thereby optimising capacity and affordability for the whole system.

The transformation of services at WGH, to develop a new acute care model will take place in line with a number of underlying design principles:

Key design principles for a new Acute Care Model

- Quality is the overriding consideration for the new model that we are developing, including the ability to routinely and sustainably meet relevant national safety, staffing and clinical standards.
- The WGH site operating as a clinically and financially sustainable 'Care Campus' model (refer to **Figure 15** above showing those elements highlighted in purple) that brings together in one place the best of the Acute Trust with the best of primary care, community services, mental health, social services, the ambulance service, the local authority and the voluntary sector to support the creation of an integrated primary care led Community Hub working in close alignment with a new Acute Care Model.
- An Integrated Urgent Care Front Door service to effectively meet the urgent and emergency care needs of the local and visitor populations, acknowledging that more complex and life threatening conditions may be better treated elsewhere in the system.
- An Integrated Community and Acute Children's Paediatric service, that works closely with the new urgent care service model. Consider partnership options with other children's healthcare providers to improve service resilience and the potential to recruit scare specialist staff.
- WGH operating as a recognised 'centre of excellence' for the effective treatment of frailty, including the development of new pathways - for example a specific integrated acute and community frailty pathway.
- Integrated working with primary and community care services to help proactively manage frail and older patients and help them stay healthy and out-of-hospital for as long as possible. Frail and older patients who do need to be admitted to an acute hospital bed are enabled to go home as soon as possible and that patients' experience of rehabilitation services both in and out of hospital is as seamless as possible.
- WGH operating as a recognised regional centre for NHS elective care, with a coordinated strategy to encourage more local people to choose it for their routine and non-complex elective care.
- Integrated services for patients by working jointly with local primary care and community colleagues, for example through joint LTC clinics in the community and/or the

Community Hub, telemedicine / advice, and encouraging community services to routinely walk wards to "pull" patients through to discharge.

- The ability to use IT to appropriately share patient data and records, thereby improving coordination and efficiency of patient care.
- Integrated working with mental health services, including substance and alcohol misuse services, to ensure a joined-up service for vulnerable groups.
- Greater collaboration across Acute Trusts – working under the guidance of the Acute Care Collaboration workstream of the STP and further enabled by greater partnership working between UHB and WAHT and collaboration with NBT.

The CCG has identified below specific elements of WAHT's current acute service model that need further review. Any proposed changes to these elements need to be considered alongside a broader review of acute service provision that optimises the balance of local services across the three centres of acute provision in BNSSG.

Areas requiring detailed review

- A sustainable Acute Trust that is 'right sized', and doing the work that only it can do by moving services amenable to community care into a suitable community setting (e.g. elements of LTC management including diabetes care, COPD care, rehabilitation, cancer treatments, renal dialysis etc.).
- Fewer and fewer local mothers are choosing to have their babies in the Midwife led unit (MLU) at WGH, and this has long-term implications on the quality and safety of the service. Only around 170 births take place every year at the MLU (~10% of all births in North Somerset). The recommended number of births for a MLU is 500 to give a critical mass of activity to maintain appropriate clinical expertise. In order to reach 500 births, there would have to be a circa 200% increase in the number of people choosing to give birth at the MLU. With the population growing on average at about 1% per year in North Somerset as a whole and around 2% in Weston, relying on demographic growth to close the shortfall of around 300 births per year will not correct this issue. Therefore, it is the CCG's view that alternative options need to be explored as part of a wider review of maternity services across BNSSG.
- A CQC report recently precipitated the temporary closure of the A&E during the hours of 10pm and 8am due to concerns regarding safe and sustainable staffing levels throughout the night. The system has coped well and patients continue to receive safe care. The CCG will review the evidence of the impact that the unplanned closure has had on the wider system and will set this against the range of entrenched clinical and financial challenges that WGH's ED has faced for a number of years. Given these constraints, we need to identify what model of urgent and emergency care can best meet the needs of the population across the whole 24 hour period.
- With the move to focus more on prevention and planned care, this work will review whether emergency general surgery would be better provided at other larger acute hospitals in BNSSG. We think there are sound clinical and financial reasons for locating these services off-site[11], which in turn would free up capacity at WGH to concentrate on becoming a recognised regional centre for non-complex elective care.

[11] http://www.swsenate.org.uk/wp/wp-content/uploads/2013/12/Weston-Review-FINAL.pdf

- In light of the other possible changes outlined above, the options for critical care (i.e. intensive care unit or 'ICU') should also be reviewed. Any possible changes would take place in the context of a strengthened 'Hospital at Night' Team.
- There are other factors that may affect further lines of service provision, for example concentration of acute stroke services and rationalisation of pathology services. Any such changes will need to be understood and factored into the final service delivery model.

A continued focus on prevention & self-care

Prevention is a key aspect of the NHS 5 year forward view and a key aspect of the new model of care. Efforts to prevent ill-health and promote positive health and well-being should consider all three levels of prevention i.e. primary prevention (preventing disease or injury before it occurs), secondary prevention (detecting and treating diseases early to halt or slow progression e.g. improving uptake of cancer screening and early identification of circulatory disease or hypertension) and tertiary prevention (reducing the impact of ill-health or injury on quality of life through initiatives such as patient education programmes, social support for people with long term conditions and ensuring services and communities are "dementia friendly").

The temporary closure of the A&E department on patient safety grounds has understandably focussed public attention on overnight emergency care. However, focusing all of our attention and resource on emergency care is not going to address the significant local health inequalities in Weston, or provide improved provision for primary and community services. While 24/7 urgent and emergency care will always be provided to the people of North Somerset, we want this work to be a catalyst for reframing the conversation with the public, focussing much more on prevention and self-care, the things that we know have a potentially very large impact on enabling people in the Weston area to live longer and more healthy lives.

How will these changes meet the identified priorities?

In Appendices 4 and 5 there is a summary of the priority population and speciality groups that this work has identified and an outline description of how this new integrated model of care will be able to respond to the challenges that have been identified.

Recognising and responding to the public's views

At the beginning of this document we listed a set of key themes that local people and staff have identified as being important to them and would like to be addressed as part of reforming the local heathcare system. Appendix 6 summarises how we think the work described in this document can meet these requirements.

Key Enablers for our New Approach

There are a number of key enablers to support the development of this new model of care:

- **Workforce:** The key enabler to success cited by providers, and summarised in the supply side analysis (Section 3 and Appendix 3), is meeting the challenge of attracting and retaining the right workforce – including greater use of a range of healthcare practitioner roles including Physicians Assistants, Paramedics, and Clinical Pharmacists. We think that the integrated 'Care Campus' model being proposed will benefit:
    - Patients - by providing a more joined-up person centred experience of care.
    - Front-line staff - by offering a more diverse and exciting model of working, not bound by organisational boundaries and targeting those most in need of support to keep them well and out of secondary care.
    - Provider agencies - by reducing the problems caused by the poaching of in-demand and scarce skills/ staff.
    - The wider community - for example by using innovative community resource models such as Health Coaches (as per model at Yeovil Vanguard).

- **Diagnostics:** We need to ensure the diagnostic resource in Weston is shared across the whole system, with fewer unnecessary tests borne out of not knowing the patient and their history and more use of the previous resource to reactively spot and address health problems in their early stages.

- **Medicines Optimisation:** We already do medicines optimisation very well in North Somerset. However, we need to make sure that as this new model of service provision is developed, this important work continues to play a key part in improving efficiency and outcomes for patients.

- **IT:** There is no debate that IT could be better used in the local system. For this programme to be effective, there needs to be far greater integration and communication between local service providers. Although we have had some important gains recently (for example North Somerset Community Partnership and all primary care providers are now using a single clinical system called EMIS) there are further opportunities to improve the interoperability of systems across providers, for example by leveraging and emulating the work of the Digital Global Exemplar sites at both UHB and TSFT and also telemedicine opportunities.

- **Estate:** The estate plan that underlines this work will be a key enabler to its success. There are estates challenges in Central Weston for primary care whereas the WGH site affords opportunities to use a prime piece of estate more holistically and effectively. Work is already underway with local GP Practices in Weston and Worle as part of a successful bid for NHS England ETTF funding to conduct an options appraisal and develop a business case to address the local estate challenges in Central Weston and identify a suitable solution for the provision of primary care in Weston Villages. Further

opportunities for use of the ‘One Public Estate’ approach are being actively explored with North Somerset Council when considering potential sites in the town centre of Weston.

PART 3: DELIVERING THE CHANGE

This work is all about delivering a step change in service provision at a local level in Weston. As a system, we need to be ambitious and challenging in the timescales that we set ourselves to see real and material change in the way we commission and deliver services, supported by the knowledge that all of the things we have proposed in this document have been thought through, described and endorsed by the STP's work and/ or have been tested elsewhere nationally.

As mentioned previously, several attempts in the past have been made to address the sustainability of Weston Hospital. We are now at a time when the ingredients to enable real change are starting to come together, such as: a clear direction from the 5 Year Forward View and proven new models of care; local commissioners and providers working collaboratively to tackle the sustainability and transformation of the local health and care system; clinical leadership for the change; active patient and public dialogue.

In addition, with the bringing together of the three BNSSG CCG commissioning teams, the stronger commissioning organisation is looking at bold ways to support the local system in achieving the local vision.

Since starting the work, we have added a further underpinning principle that the approach we are taking in Weston will create a framework which can be rolled out across the other areas of BNSSG to support the implementation of the BNSSG wide objective of developing and strengthening community based integrated care. The methodology and supporting principles used in this work will be applied systematically across BNSSG, although the specific configuration of services may look different in other places due to local circumstances such as population need, the strength of existing provision and local workforce and estate challenges.

The following two sections focus on the critical building blocks for delivery, the proposed commercial model and key next steps.

Critical Building blocks for Delivery

As set out in the preceding sections of the Commissioning Context, the key building blocks for the delivery of our new care model include:-

Enabling Primary Care to deliver at scale and providing system leadership
We need to ensure that there is a resilient and robust primary care service to provide the platform and leadership to enable our community service model to thrive. As previously mentioned, BNSSG CCGs are already working with NHS England to ensure the GP Forward View (GPFV) funding is being used to support this model.

Delivery of integrated community services & 'Care Campus' model at the WGH site
The CCG's hypothesis is that we already have all the services we need. However, by providing more joined up care across settings, and reducing duplication, we can optimise resources and deliver better care for our patients. This includes being able to manage a higher level of acuity of care in the community which will relieve pressure on the acute

sector. We want to encourage and enable providers to work together in a provider alliance, underpinned by a formal agreement (e.g. a memorandum of understanding or 'MoU'). This is initially about encouraging service delivery, but the CCG may progress to a shared contract mechanism with relevant risk and reward sharing (but probably not in Year 1).

Delivery of an Integrated Acute Care Model (Acute Care Collaboration)
The work done by the North Somerset Sustainability Board over the past 12-18 months has led to the consensus that there is no "stand-alone" solution for WAHT and for WGH. The successful delivery of the vision and aspiration set out in this document is not only enabled by the greater integration of community services, as described above, but is also delivered by close and active collaboration across local Acute Trusts. For example NBT, as well as WAHT and UHB, will be closely involved in helping design the new service models so new ways of doing things will work for the whole system. The Partnership Agreement that was announced jointly by UHB and WAHT in February 2017 has the potential to be an important enabler to support the successful delivery of this work. We also expect T&SFT to be actively and fully involved in the Healthy Weston programme where appropriate.

Whole System collaboration
All partners working together in a coordinated and systematic way will be key to ensuring this new model of care is successfully implemented. This of course applies to the providers who enter into an alliance arrangement, but it applies equally to other services in the system as these bold new ways of organising care for the people of Weston will only work if there is buy-in and cooperation from all parties.

Proposed Commercial Model

The CCG's ambition is to move to local integrated care models that wrap around natural 'placed-based' communities. These may range from a high level agreement between providers, all the way to the development of an Accountable Care System. However organised, we wish to incentivise the development of provider alliances which over time may move to capitated payment models. We think that this is the best way to allow providers to do things in a truly different way that puts the patient at the centre of the way services are designed, organised and delivered.

The CCG will carefully review the lessons learned from other places that have implemented this type of innovation. There will be a phased approach; we will test as we go and we will develop the model in partnership with providers. This will take place against the background of a shared understanding that we can only spend the resources we have and that we need to provide the best possible health and care for our whole population. The NHS England New Care Models Team has agreed to support the CCG in this work to benefit from their latest thinking and experience from other areas.

The phased approach will allow the staged introduction of the new model and there is also the potential for a risk share agreement in the early stages. Further, we may offer an extended contracting period to give stability, surety and the space to develop and evolve services. We would like to continue the conversation with partners over the next few months on the detail and possible options. We may also decide to have a mixed model in terms of

acute provision, for example to retain the competitive incentives embodied by “Payment by Results” to pull in a bigger share of non-complex, high volume surgery (work done to date within the Weston Sustainability Programme to indicates a sizeable financial opportunity if more local people were to choose Weston Hospital as their place of elective care).

Section 4 (Finance) sets out the CCG’s initial thinking on how a capitated budget could be identified for the place of Weston. We know that today we spend more money than we have on providing health and care services across the system. Our collective challenge is to think laterally as well as pragmatically about what needs to change in the way we deliver services to enable all parties to live within their means.

The CCG recognises that further work is required with local providers to agree the precise details of a final commercial model. However, there are a number of known service redesign requirements that can be progressed while these details are being finalised. The CCG will support providers to continue at pace with the redesign of services to improve delivery and patient outcomes wherever possible, rather than waiting for a final commissioning model to emerge.

In summary, the CCG’s commissioning approach aims to deliver three key objectives:

1. Services that better meet the needs of the population, improve patient experience and keep people independent well and healthy at home for as long as possible.

2. Enable health and care providers to be more resilient by sharing resources, eliminating duplication and breaking down organisational barriers.

3. Deliver affordable services and better respond to a rate of growth in funds that will not match the growing, and more importantly, changing demand unless we do something radically different.

Next Steps

This document is designed to test and consolidate the progress made so far in developing a broad consensus for both a vision of future services in Weston and the process by which we, as a system, will work towards implementing the necessary changes.

The section below outlines some of the key next steps that will be taken to design the new model of care and the underpinning services in more detail, and then start to implement them.

Further work is required over the coming months to ensure the right governance and programme structure is in place to enable delivery. Ongoing and robust staff engagement through-out the process will also be vital to the successful delivery of this work.

Some of the key next steps include:

Whole System event

A ‘whole system’ stakeholder event on the 18th October to describe the Commissioning Context to stakeholders. This will lay the ground for a process of public dialogue on the vision and proposed direction of travel. Attendees will include patient and public

representatives, local provider clinicians and staff, representatives from other partner organisations, and key stakeholders.

A re-structured and re-launched Weston Sustainability Programme

The CCG is in the process of re-structuring the existing Weston Sustainability Programme (to be known externally as 'Healthy Weston') to ensure it is fit for purpose in order to deliver the proposed vision and model of care. **Figure 16** below provides an overview of the programme's key workstreams and what each one will be focused on delivering. Each workstream will have its own 'working group' consisting of a designated Chair, a Managerial Lead, admin support and will include representation from local providers, partners and stakeholders. Workstreams 1 to 3 and 5 will be chaired by the CCG, workstream 4 will be chaired by WAHT and workstream 6 will be jointly chaired by WAHT and UHB. In particular, workstream 4 will also include representatives from the whole system, with input from NBT and SWASFT being especially important.

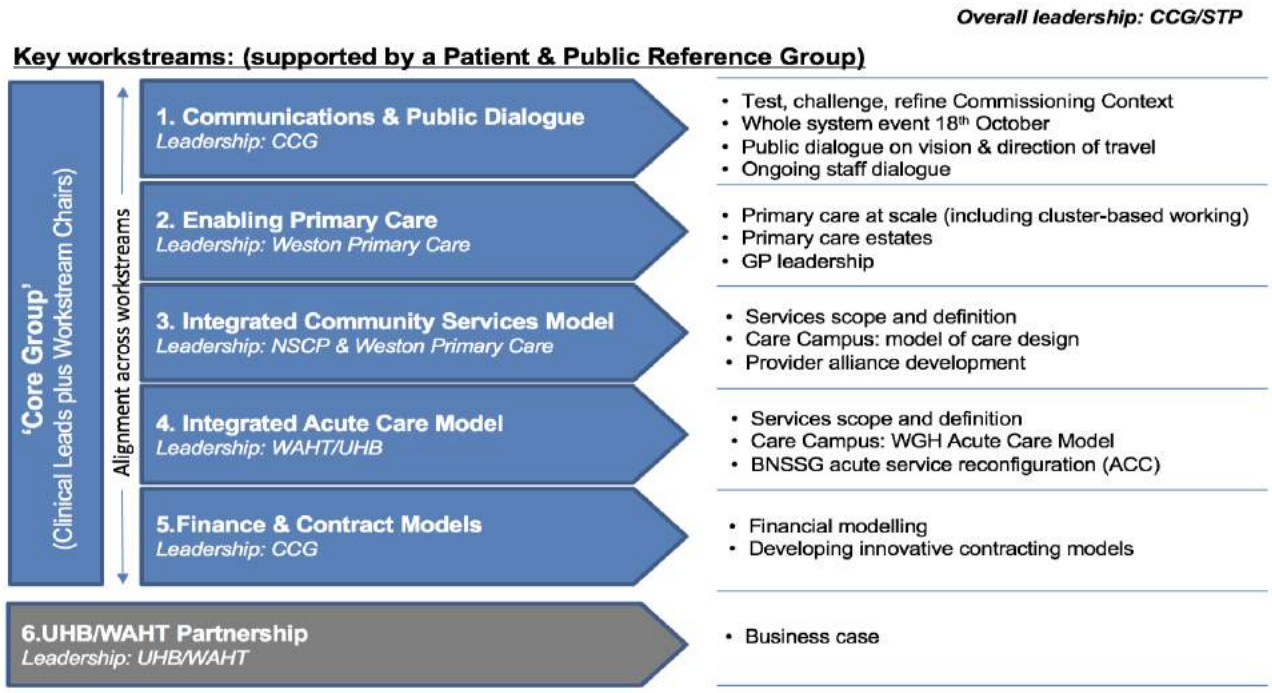


Figure 16: Weston Sustainability Programme - workstreams

Each workstream will develop a clear mandate setting out its key objectives, deliverables, dependencies and timelines. Each workstream will also report on a monthly basis to the North Somerset Sustainability Board which in-turn will report to the STP Sponsoring Board.

This structure will be supported by two additional groups: a 'Core Group' including the Chairs from the various programme workstreams that will provide alignment and act as the 'custodians' of the overall design, and a Patient and Public Reference Group (PPRG) that will provide a sounding board for public and patient related activities. The PPRG group was set up as part of the engagement process held earlier this year. Its membership is being reviewed, but the currently invited organisations include:

- Healthwatch North Somerset
- North Somerset VANS

- Patient Participation Group – Graham Rd Practice
- Senior Community Link
- Older People Champions' Group
- 1 in 4 People
- Vision North Somerset
- LGBT Forum
- Supportive Parents
- Multicultural Friendship Association

The following provides a brief overview of each workstream and what each working group will be focused on delivering:

- *Workstream 1 Communications & Public Dialogue:* This workstream will oversee the development and delivery of a comprehensive Communications and Public Dialogue Plan. As part of the delivery of this plan, they will facilitate a period of public dialogue (see below) that will help to test, challenge and refine the Commissioning Context. They will also help to run a process of co-design whereby patients will be able to get involved in the design of key aspects of the new model of care. Finally, they will develop a standard set of communications materials.

- *Workstream 2 Enabling Primary Care:* This workstream, which will incorporate key elements of the current Weston Primary Care Transformation Programme, will be focused on the development of 'primary care at scale' through cluster/locality based collaborative working arrangements supported by a new BNSSG locality leadership model and locality transformation scheme. As part of this, it will oversee the local implementation of improved access to primary care services (including urgent GP appointments), the delivery of the key objectives of the BNSSG GP Primary Care Strategy (which is based on the national GPFV) and the delivery of the Cluster Resilience Plans. It will also be tasked with addressing the various primary care estate issues across the local area (such as the town centre and provision for Weston villages).

- *Workstream 3 Integrated Community Services Model:* With strong GP leadership and support, this workstream will focus on the design of a new integrated community service model, including the design of the Care Campus at the WGH site and associated primary care led Community Hub. This will incorporate the work of the BNSSG STP's Integrated Primary and Community Care (IPCC) workstream and specifically the work of the multi-disciplinary cluster-based working programme which has already developed a high-level design and supporting infrastructure and is looking to develop a pilot in the Weston area. Working in close collaboration with primary and community providers, this workstream will also deliver new clinical models to better support the three target population groups including frail and older people and people in care homes, children, young people and pregnant women and vulnerable groups.

- *Workstream 4 Integrated Acute Care Model:* This workstream will focus on the development of an integrated Acute Care Model for Weston General Hospital as part of a wider BNSSG Acute Services Plan. A great deal of work has already been done by senior local clinicians in scoping out the options for reform of key acute services at WGH. A key task for this group will now be to finalise and describe the best and most realistic set of options for delivering sustainable services, both in the context of the new Weston 'Care Campus' model but also as part of the wider BNSSG acute provider landscape.

- *Workstream Finance and Contract Models:* As a system, BNSSG needs to move from a focus on what is spent to a focus on what is allocated to us and how this resource is best

used to meet the needs of our population. This group will be charged with ensuring that the financial and activity modelling developed as part of this system redesign work is clear, recognised and owned by all parties. In addition, this group will explore the development of possible options for a new capitated funding / outcome-based contracting model, working closely with an alliance of providers to ensure buy-in and support. This model will focus on affordability and will be benchmarked against the existing PbR system for comparison. A key objective in designing a new contracting approach will be to enable money to follow the patient and reduce the perverse incentives that are a feature of multiple individual contracts. We will learn from best practice elsewhere and ensure that a robust work plan and governance structure is set up to support this process.

- *Workstream 6 UHB/WAHT partnership working:* The partnership between UHB and WAHT is an important enabler of the work described in this document. A joint Partnership Board was set up following the two Trusts' announcement regarding the partnership agreement in February 2017. Representatives from this Board will provide status/progress updates to the North Somerset Sustainability on a regular basis to ensure alignment across the other streams of work.

Public and Staff Dialogue

Subject to Governing Body approval and regulator assurance, the CCG is committed to a 12-week period of public dialogue on the content and objectives of the Commissioning Context, to share the latest thinking and to test our collective ideas.

Learning from the Healthwatch North Somerset report, we will use this period to engage more widely with the local population, building on the momentum created by the specific work on WGH that took place earlier this year. We want to focus on the positive messages around looking to secure the future of the WGH site by developing a 'Care Campus' model and our objectives of improving health outcomes for the population as a whole through a strong and proactive community provider system that is focused on preventive care.

Throughout this process, it is particularly important that each partner organisation ensures that its staff are kept fully informed and feel involved. The CCG will ensure that going forward, we build in regular and formal mechanisms to ensure that clinical commissioners have direct contact with staff, particularly WAHT staff, for the duration of this process.

As described above, Workstream 1 will develop a Communications and Public Dialogue Plan to support this work with input from the PPRG. This plan will focus on four key areas:

1. **Quantitative data collection:** through the period of public dialogue, we want to systematically gather the views and priorities of patients, carers and the public regarding our vision and proposed model of care.

2. **Public meetings and events:** through a combination of bespoke events and attending existing community and patient groups, we plan to ensure there is a wide ranging conversation with the local population.

3. **Service and pathway co-design:** The CCG is commissioning external expert advice to ensure that we can work with patients and 'experts by experience' to work on an

equal basis with local clinicians to develop our new care models in a way that are clinically effective and built around the experience and needs of the patient and their family.

4. **Staff communication and input:** Throughout the lifetime of this programme of work, we will ensure that staff are both kept informed of developments and are fully represented and involved in the design of our new care model.

Design phase (including patient co-design)

Each workstream will undertake a period of design work to build out the core elements of the vision into a more detailed set of tangible design proposals. Specific elements of the design will require input from patients and a process of co-design will be put in place to support this. In addition, certain aspects of the work – such as operational improvements, or pre-requisite system changes will continue to be delivered in parallel during this phase. Note that the more complex elements of the design e.g the Care Campus and associated Acute Care Model may require additional time to complete, but this can only be determined once the workstreams are fully mobilised.

Implementation planning

In parallel with the design phase, an implementation plan will be developed that will set out the key timelines and deliverables across the various programme workstreams. This plan will develop over time and will become more granular as the design work progresses.

Checkpoint

A formal checkpoint will be held at the end of the design phase to assess the design proposals and agree next steps.

Delivery phase

The details of the delivery phase are dependent upon the outcome of the design phase and the checkpoint described above. It is not possible at this stage to accurately predict the phasing, or how long any transitional period to the new model will take. However, when we arrive at this stage we will continue to involve our partners in this work and will keep the public fully informed. The timing of this phase will depend on any requirements for formal public consultation.

High-level timeline

The table below provides indicative timeframes for each of the key next steps as described above.

#	Next step	Draft Time Frame
1	**Approval by Governing Body and regulator assurance**	Early October 2017
2	**Commissioning Context published**	11th October 2017

3	**Whole System event**	18th October 2017
4	**Mobilise Healthy Weston Programme**	October to December 2017
5	**Period of public dialogue** (14 weeks in total)	October to January (TBC)
6	**Staff dialogue**	Ongoing
7	**Design phase** *(including patient co-design)*	Late October to March 2018
8	**Implementation planning**	November to March 2018
9	**Checkpoint**	End March 2018
10	**Delivery phase**	TBC

Figure 17: Next steps high-level timeline

To conclude; this piece of work is about delivering real change to improve the services for our local population; both now and into the future. While the design of the model of care being proposed in this document is still emerging, it is very much aligned to current policy and is similar in concept to other models of integrated care already being delivered elsewhere in the country.

Over the past few years, a lot of work has been done in analysing possible options for service change and more recently this has been supported by the work of the BNSSG STP. Therefore, we believe we have the basis for a sound, and evidence based approach, to deliver effective system reform.

Clearly, this document marks the start of a significant period of system transformation. Coordinated and supported by the North Somerset Sustainability Board, the programme workstream groups described above - along with strong patient, public and staff involvement - will be charged with identifying the best possible combination of services to meet the needs of Weston's population. We want to have an honest and positive conversation with the public about the options that we have at our disposal and how we might make the best overall choices on behalf of the population we serve.

APPENDICES

APPENDIX 1: Note on Population Figures

Note on population and demographics from Public Health.

There are different sources of data to assess the population of North Somerset: the Office for National Statistics (ONS) based on the census (referred to as the 'resident' population) and the population registered with a local GP which includes people who are not resident in the area (referred to as the 'GP registered' population). The ONS figure is based on the census (last completed in 2011) with an annual adjustment made for the number of births and deaths and a figure estimated for net migration.

The latest figures from Public Health for the total population are 211,681 (ONS) and 216,364 (GP registered). A difference of 4,683. This is due to some people being registered, but not resident in North Somerset and an underestimate of population in the census. The total GP registered population based on figures from local GP Practices in July 2017 is ~219,000.

The ONS figure is available as a projection to estimate likely future population growth and is used as the source of planning (e.g. for housing numbers). ONS produce mid-year population estimates which are a recognised source of population figures. Smaller geography analysis based on the census allows for lower geographies such as middle and lower super output areas (LSOA and MSOA) but these may not correspond with the GP Practice groupings commonly used. For example, the area known as Weston-super-Mare may contain the area of Worle and corresponding GP Practices in some population information, whereas these areas may be considered separately in others.

Population projections at such lower geographies are not routinely available and are calculated as bespoke analyses. An example of such a service is offered by Hampshire Council's small area population forecast service. This service was commissioned to provide information on the projected Weston-super-Mare population change over a 10-year period (from 2014-2024) and the data is available using the following link: http://www3.hants.gov.uk/factsandfigures/population-statistics/pop-estimates/small-area-pop-stats.htm

It is therefore common to find a range of values for both population size and predicted growth, depending on the source data used, timeframe considered and (if projecting) the method used. If smaller geographies are applied, there is the additional variable of the boundary used.

APPENDIX 2: Population and Needs Analysis

Current population breakdown & future growth projections

In February 2016, North Somerset Public Health published an overview of the population health of North Somerset and North Sedgemoor.[12] **Figure 18** below, which is taken from this overview, clearly shows that there are more people aged over 65 and over (23%) in North Somerset and North Sedgemoor than the England (17.5%) and South West averages (21%).

	North Somerset & North Sedgemoor		North Somerset		England		South West	
Age range	***No.***	***%***	***No.***	***%***	***No.***	***%***	***No.***	***%***
0-14	41,732	17.0	35,366	17.0	9,676,377	17.8	888,456	16.4
15-24	24,483	10.0	20,748	10.0	6,837,371	12.6	662,309	12.2
25-64	123,009	50.1	104,245	50.1	28,265,162	52.0	2,726,738	50.3
65-74	30,377	12.4	25,743	12.4	5,162,873	9.5	614,926	11.3
75-84	17,904	7.3	15,173	7.3	3,099,319	5.7	367,112	6.8
85+	8,117	3.3	6,879	3.3	1,275,516	2.3	163,762	3.0
All ages	**245,622**	**-**	**208,154**	**-**	**54,316,618**	**-**	**5,423,303**	**-**

Figure 18: Age breakdown in North Somerset & North Sedgemoor, England and the South West, 2015 (Source ONS 2015)

Population change is effected by three factors: the number of babies being born, the number of deaths and the number of people moving into the area:

- **Babies being born** - There are ~2,500 babies born per year with the majority born at St Michael's Hospital and Southmead Hospital in Bristol with an average of only ~170 deliveries at the midwife led unit (MLU) at Weston General Hospital (WGH) and ~25 home deliveries. The recommended number of births for a MLU is 500 to give a critical mass of activity to maintain appropriate clinical expertise. In order to reach 500 births, there would have to be a ~200% increase in the number of people choosing to give birth at the MLU[13].
- **Standard Mortality Ratio (SMR)** - The SMR for North Somerset is 94.2% (versus 100% for England) indicating a lower number of deaths than expected overall. However, the SMR ranges from 57% in Clevedon Yeo to 161% in central WsM which highlights the significant health inequalities that exist across our local population.
- **People moving into the area** – the majority of future growth is currently expected to be focused in Weston and Worle. The area is being redeveloped with key new build housing sites at Winterstoke Village and Parklands Village and Central Weston totalling approximately 6,500 new homes by 2026, many of which will be for younger families, with implications for local primary care, maternity and children's services. This equates

[12] North Somerset Public Health team report: An overview of the population health of North Somerset (2016). Available from www.n-somerset.gov.uk/my-council/statistics-data/jsna/overall-findings/

[13] North Somerset Joint Strategic Needs Assessment (JSNA): Population chapter. Available from www.n-somerset.gov.uk/my-council/statistics-data/jsna/joint-strategic-needs-assessment/

to a total of ~15,000 people, although not all of these will be from outside the county. The emerging West of England Joint Spatial Plan has also identified potential developments of up to 3,600 in Nailsea and Backwell and there is also a large population expansion planned between Long Ashton and Bristol. It should also be recognised that there is also a net importing of older people moving into North Somerset – both in terms of normal housing, but also sheltered flats and care homes.

Given the above, the longer-term projections based on ONS data suggest the population of North Somerset and North Sedgemoor will increase at an annual rate of 1% across all age groups, reaching an estimated combined population of 300,000 by 2030.

It should be noted that the ONS based estimate of a ~1% per year net population growth is assumed to take into account any new housing developments and are the same figures used by North Somerset Council's Planning Department. As many of the people occupying these new houses as they become available over the next decade will already be resident in North Somerset, expert advice from the Public Health team is to plan on the basis of the existing official ONS projections. This is to avoid double-counting, using guesswork and having multiple figures circulating.

Figure 19 below looks at the projected population increase over the next 10 years based on 2014 ONS projection. The largest increase is set to be in the 75-84 age group (50% vs. 36% in England) followed by the over 85s (~46% vs. 42%). In respect to the younger age groups, the population is projected to rise in the 0-14 age group by ~12% (vs. ~8% in England), which equates to an additional 4,000 children in total in the next 10 years. Both the 15-24 and the 25-34 age groups are also increasing faster that the England average.

	North Somerset & North Sedgemoor			North Somerset					
Age	**2015**	**2020**	**2025**	**2015**	**2020**	**2025**	**% change 2015-25 North Somerset & North Sedgemoor**	**% change 2015-25 North Somerset**	**% change 2015-25 England**
0-14	42,362	45,666	47,318	35,900	38,700	40,100	11.7%	11.7%	7.6%
15-24	24,308	23,482	24,662	20,600	19,900	20,900	1.5%	1.5%	-1.8%
25-64	123,782	127,794	130,508	104,900	108,300	110,600	5.4%	5.4%	4.0%
65-74	31,034	32,214	31,624	26,300	27,300	26,800	1.9%	1.9%	7.3%
75-84	18,172	21,830	27,258	15,400	18,500	23,100	50.0%	50.0%	35.9%
85+	8,496	10,148	12,390	7,200	8,600	10,500	45.8%	45.8%	42.1%
All ages	**248,154**	**261,134**	**273,760**	**210,300**	**221,300**	**232,000**	**10.3%**	**10.3%**	**7.0%**

Figure 19: 2012-based sub-national population projections for North Somerset and North Sedgemoor combined and percentage change, England, 2015-2025 Source: ONS, 2014 (assume trends 2008-2012 continue)

Specific population growth in Weston-super-Mare (WsM)

Estimates obtained from Hampshire Council's small area population forecast service which takes into account housing development suggests growth in WsM in the 10-year period from 2014-2024 will be 22%, compared to background growth across the whole of North Somerset of 13% (in the same time frame 2014-2024, current estimate 10% from 2015-2025). This area includes Worle, St. Georges, Kewstoke, Uphill, Locking and Hutton. Based

on the 2014 population figure for that area (88,220) the 22% increase to 2024 will result in a population of 107,635 in WsM.

Life expectancy & health inequalities

Life expectancy is the average number of years a person is expected to live based on a range of factors. Healthy life expectancy is an estimate of the years of life that will be spent in good health. Across North Somerset and North Sedgemoor, life expectancy at birth is ~80 years for males and ~84 for females. These figures are similar to the South West average and slightly higher than England overall. However, these figures mask significant health inequalities across our local population. Health inequalities are the differences between people or groups due to social, geographical, biological or other factors. These differences have a huge impact because they result in people who are worst off experiencing poorer health and shorter lives. The Joseph Rowntree Foundation estimates that poverty costs the NHS £29bn per year (equivalent to 25% of the entire NHS budget in England).

As commissioners, our approach to addressing health inequalities is to ensure health services are equitable and address the specific needs of our most deprived communities. Evidence shows that people in lower socio-economic groups are more likely to have a greater prevalence of severe and enduring mental and physical health problems. The impact is greatest on children living in poverty. The national rate of children living in poverty, after housing costs, in England is 25% with the average for North Somerset being 19%. However, in WsM Central Ward it is 36% and WsM South Ward is 38%. More than one in five children starting primary school in England are overweight or obese and obesity leads to serious increased risk of lifelong health problems including type 2 diabetes, heart disease and cancer. The figures in North Somerset are similar to the England average, but likely to be higher in Weston.

Life expectancy varies considerably across North Somerset. WsM Central Ward has the lowest life expectancy, where the respective figures are 67.5 years for males and 76 years for females. Conversely Clevedon Yeo has the highest life expectancy for both males and females, at ~86 years and 92.5 years respectively. This creates a gap in male life expectancy between these Wards of ~18.5 years for men and 16.5 years for women.

The main causes of the gap in life expectancy for men are circulatory diseases – such as coronary heart disease (CHD) and stroke (28.3%), cancers (17.6%) and external causes including injury, suicide and poisoning (17.8%). For women, the main causes were circulatory diseases (25.8%), respiratory – such as COPD (15.1%) and cancer (14.8%).

Although CHD has reduced significantly in recent years, it remains a leading contributor to the gap in life expectancy accounting for 15% of the gap in males and 12% of the gap in females. Other circulatory diseases are also important contributors to life expectancy inequalities. Stroke is an increasing contributor in female life expectancy and other circulatory diseases contributed relatively more to the gap in male life expectancy.

Other important contributors to the gap in life expectancy are cancer, pneumonia and COPD, with a notable increase in the contribution of COPD to the female life expectancy inequalities. Suicide and other external causes contribute more to the male life expectancy gap than the female gap whereas mental and behavioural disorders (including dementia) contribute relatively more to the female than male life expectancy inequalities.

Using data from Public Health England it is estimated that 46% of male deaths and 36% of female deaths in the most deprived areas were considered 'excess'; i.e. these deaths would not have occurred if all areas in North Somerset had the same mortality profile as the least deprived areas[14].

Causes of death, premature death, and morbidity

The leading causes of death across all ages in North Somerset are CHD, Stroke, influenza and pneumonia, dementia and Alzheimer's, and cancer. There are differences by gender with a number of females dying from dementia and Alzheimer's disease and the higher proportion of males dying from CHD. North Sedgemoor is similar with the main causes of death being circulatory diseases, cancers and respiratory diseases.

Although numbers vary from year to year, the overall number of deaths is generally decreasing with the exception of deaths from pneumonia and influenza which are stable and deaths from dementia and Alzheimer's which are increasing. This is to be expected given the increases in life expectancy and ageing population.

Premature deaths are deaths that occur before a person reaches an expected age (set at age 75). **Figure 20** below shows the leading causes of premature death in North Somerset.

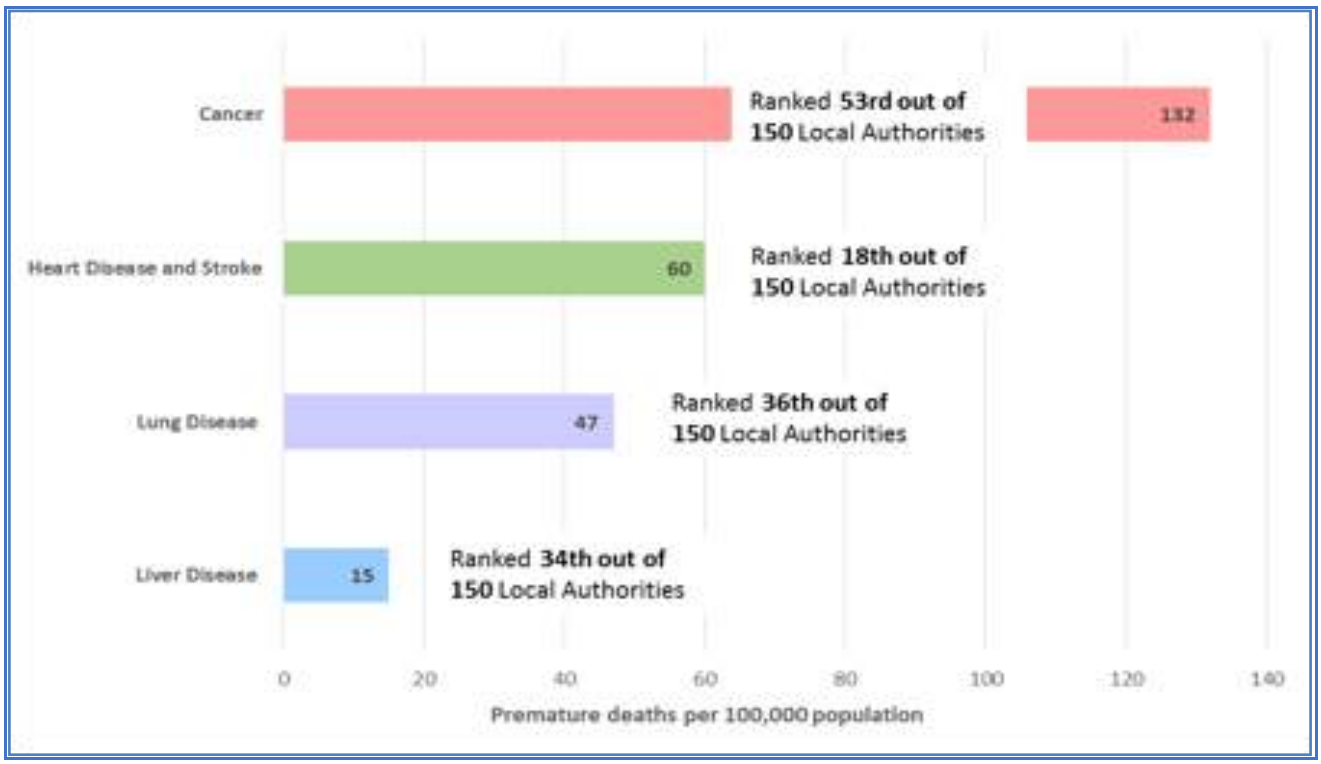


Figure 20: The leading causes of premature death in North Somerset and rankings compared to other local authorities in England, 2013-2015[15]

North Somerset ranks 45th out of 150 local authorities with 305 premature deaths per 100,000 population (note: the leading local authority would rank 1st). This is statistically

[14] Public Health England: Longer Lives data tool: Available from http://healthierlives.phe.org.uk/topic/mortality
[15] Source: Public Health England - Longer Lives Mortality Rankings, 2013-2015

significantly lower than the premature death rate across England. However, when compared to 14 other comparable local authorities with similar levels of deprivation, North Somerset ranks 10th out of 15 and worse than average within the group. The rates for premature deaths from cancer and liver disease are higher than the group average.

WsM Central and South Wards have the highest premature death rates from all causes of death, cancer and circulatory diseases. Almost one in ten residents in these Wards describe their health as 'bad' or 'very bad' and between 25- 30% of residents report having a limiting long-term condition or disability.

Years of Life Lost (YLL) is a measure of the average number of years people would have lived had they not died prematurely. Overall YLL from causes considered amenable to healthcare in North Somerset have shown a decreasing trend since 2001-2003, however there is variation between disease groups. The potential years of life lost from amenable cancers (including breast, colorectal and skin cancer) in North Somerset have been increasing and are above national figures. Amenable cancers are now the primary cause of years of life lost from treatment amenable causes in North Somerset, representing more than a third of total years of life lost.

In the North Sedgemoor locality, the leading contributors to years of life lost before the age of 75 are cancer, circulatory diseases, respiratory diseases and diseases of the digestive system; the biggest cause in the latter category being chronic liver disease. Accidents, including land accidents are also a significant cause of years of life lost in North Sedgemoor.

DALYs take into account the number of years of a person's life are lost but also the amount of time spent with a disability, hence they capture the impacts of chronic conditions and those associated with pain and morbidity. In North Somerset the leading causes of DALYs lost are cancer (neoplasms), mental health and behavioural disorders, musculoskeletal conditions and cardiovascular disease; in particular low back and neck pain (6,249), ischaemic heart disease (4,887), chronic obstructive pulmonary disease (2,377) and cerebrovascular disease (2,233).[16]

Prevention

Using the 3-4-50 model[17] can help to identify where initiatives on prevention can have the most impact. As stated above, the four leading causes of premature mortality locally are cancer, circulatory diseases, respiratory diseases and liver disease. Overall these account for over 50% of all premature deaths in North Somerset. Primary risk factors for these diseases include smoking, substance misuse, poor diet and low physical activity.

- Smoking prevalence in North Somerset is approximately 15%. However, this varies by Ward with 25% of residents in more deprived areas estimated to be smokers. North Sedgemoor locality is estimated to have a lower prevalence than the national rate (13% & 18% respectively).

[16] http://www.n-somerset.gov.uk/my-council/statistics-data/jsna/overall-findings/

[17] 3-4-50 Model - The 3-4-50 model was developed in Oxford but utilised in San Diego and published in 2010. It represents a useful framework for considering the major population health issues in a local area.

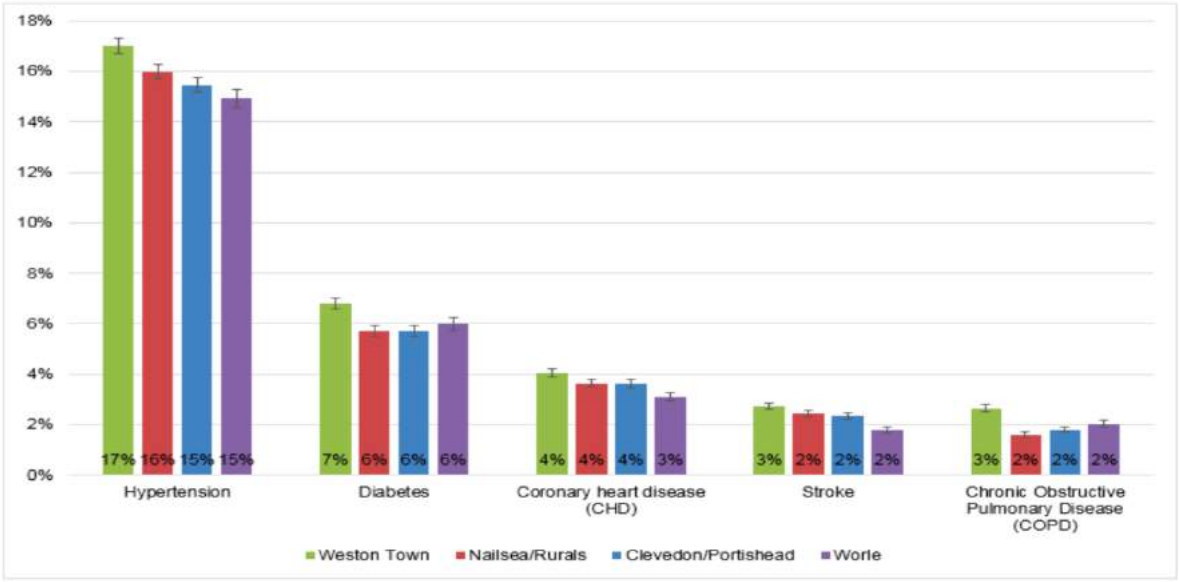
- The pattern of alcohol consumption varies by deprivation within North Somerset. People living in more affluent areas tend to drink more frequently than those in less affluent areas. However, heavy or binge drinking is more common among residents of less affluent areas. In North Sedgemoor, alcohol-related admissions for the locality are lower than those seen nationally.
- National data suggests a fall in the number of people reporting taking illicit/ psychoactive drugs. However, in North Somerset there has been a 15% increase in the number of new presentations to structured treatment in 2015/16 compared with 2014/15.
- Physical activity levels in North Somerset are similar to regional and national averages (57%, 58% and 56% respectively), while the prevalence of childhood obesity in North Somerset and the North Sedgemoor locality is similar to that seen nationally with around a fifth of 4- 5year olds classed as obese or overweight.

The above risk factors in part contribute to the following average numbers of premature deaths (i.e. under 75 years of age) per year in North Somerset (total 617).[18]

- Cancer: 271
- Lung disease: 55
- Other causes: 139
- Circulatory disease: 122
- Liver Disease: 30

Current & future disease prevalence summary (North Somerset only)

Figure 21 below provides details of the disease prevalence across the following areas: Weston Town, Worle, Nailsea/Rurals, Clevedon/Portishead (also referred to as 'Gordano').



[18] Based on 2013-2015 figures from the Public Health England outcomes framework. Available from www.phoutcomes.info/

Figure 21: QOF disease prevalence 2015/16 for North Somerset

The health status of people registered with practices living in and around Weston Town is poor compared to North Somerset overall and the other locality areas. Nearly two thirds (64%) of those registered with Weston Town practices reported having a long term health condition, compared to 51% in Worle and 57% in the North Somerset area. More than one in five people in Weston Town (23%) and Worle (21%) reported a long-term health problem or disability that limits their day-to-day activities compared to 17% in both the Clevedon and Portishead and Nailsea and Rurals localities.

As would be expected from the above figures, disease prevalence figures are highest in the Weston Town where 17% of people are recorded as having hypertension, 7% suffer from diabetes, 4% from coronary heart disease (CHD) and 3% from stroke.

The growing, ageing population of North Somerset is leading to a shift in the pattern of local health needs and an increase in demand on health and care services. More people are living with long term conditions, and many will live with more than one health condition, be it affecting physical or mental health. Managing these conditions in a holistic and proactive way is a significant challenge as local services and staff have historically focused on managing specific conditions rather than being integrated around the needs of the patient.

The pattern of risk factors within the local population will affect health needs and outcomes and preventative action, such as reducing tobacco and alcohol use, improving diets and increasing physical activity, will help to mitigate against some of the increases in demand for healthcare.

Modelling disease prevalence rates against predicted changes in the North Somerset population shows the number of people living with cardiovascular disease (including hypertension), respiratory disease (COPD), diabetes and dementia is likely to increase over the next 10-20 years. It is estimated that by 2030 there will be; over 1,700 more people living with CHD and around 750 more people having had a stroke compared to 2015; over 10,000 more individuals living with hypertension compared to 2015; and around 6,000 people living with COPD.

Estimates also indicate there will be around 20,500 people living with Diabetes by 2030, an increase of around 6,000 people. This is dependent on the prevalence of obesity within North Somerset and assumes the current increasing trend continues. Finally, the ageing population means the numbers of people living with dementia are predicted to increase to almost 6,000 people by 2030, an increase of almost 2,500.

In order to address current and future health needs effectively, and within the available resources, healthcare services not only need to develop new models of care to better manage illness and injuries out of hospital in the community and closer to home, but also be promoting healthier lifestyles and choices. Health professionals should encourage patients to engage in healthier lifestyles, both through “making every contact count” and signposting to community and voluntary services which support behaviour change, such as Health Trainers / Health Coaches.

Weston Villages Profile

The following information is based on a Public Health Report (July 2017) that specifically looked at the likely impact of significant new housing developments in the Weston Villages.

Weston Villages

The Weston Villages are the main strategic growth area for North Somerset and are forecast to deliver up to 6,500 new homes and 10,000 new jobs. The population is likely to be generally younger than the North Somerset average and in better health with less disease prevalence.

The overall population figure is 14,880 based on the building of 6,500 homes with an average of approximately 2.3 persons per household. The current trajectory of housing development plan is shown below with blue representing completed dwellings and green planned developments. As at July 2017, approaching 1,000 of the homes are built and occupied.

Figure 22: Weston Villages completions & trajectory

(Total between 2011/12-16/17= 835, total between 2017/18-2025/26=5,668)

Population profile

Previously the overall census profile for North Somerset was applied to this population number to give an illustrative example of what the population would be like if it mirrored the overall North Somerset profile. However, it is likely that new build housing will attract a different demographic profile and based on advice from North Somerset Council's Research and Monitoring Officer, it was agreed the closest population match would be that of the Locking Castle area, which has seen similar new build development and has now established a resident population.

Therefore, the 2011 census data for four lower layer super output areas (LSOA) in Locking Castle was used to model the population age structure, ethnicity and long term health problems for the new population of Weston villages. The disease prevalence is based on data for the Stafford Medical Group, a practice with two branches; a small branch in Stafford Road in Central Weston and a larger branch in the Locking Castle area. It should be noted

that the numbers used to create this profile are fairly small and therefore it should be interpreted with caution.

Age profile & ethnicity

The age profile is likely to be much younger than North Somerset with a high proportion of 0-14 and 25-44 year olds. Estimates for the BME population suggest that the proportion in Weston Villages (3%) is fairly similar to North Somerset (2.7%).

Life expectancy and fertility rates

Life expectancy for both males (82.6) and females (87.4) is higher than the North Somerset average (79.8 and 83.5 respectively). The fertility rate in Weston Villages (86 per 1,000 females aged 15-44) is likely to be the highest in North Somerset and is much higher than the average rate (66). In the Weston Villages area, the dependency ratio (i.e. the ratio of the number of dependents to working age people) is 52.5%, which is lower than the North Somerset average (60.7%).

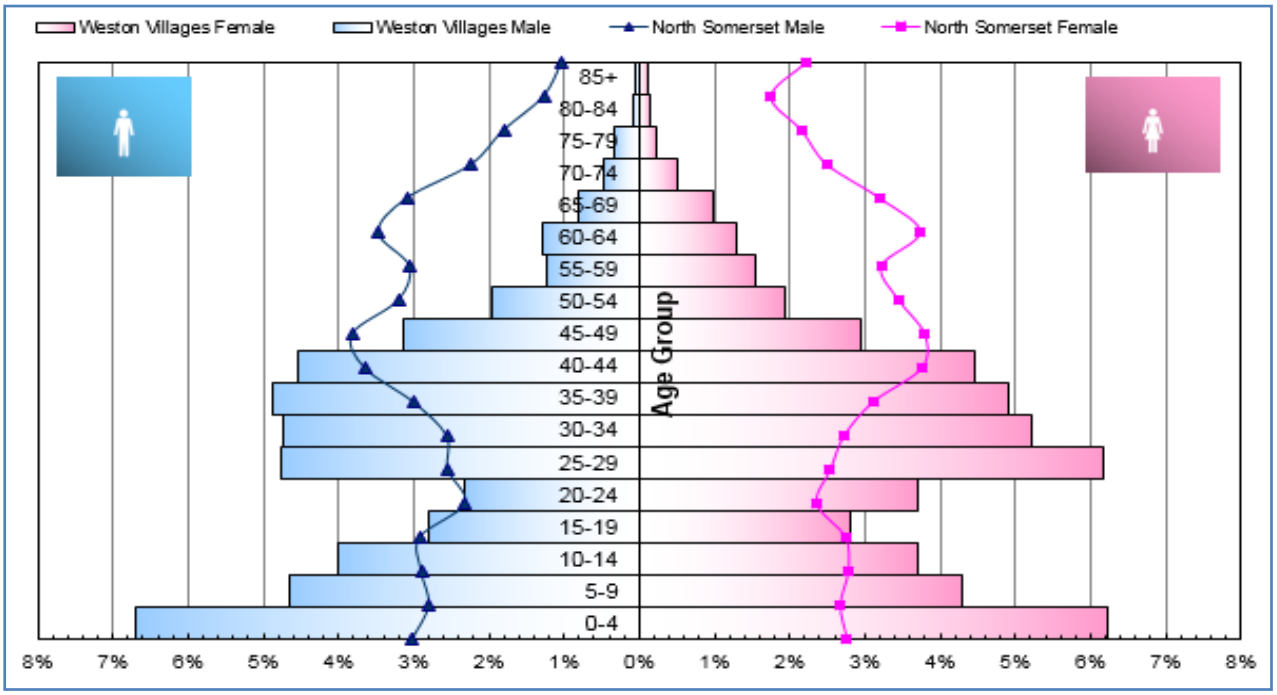


Figure 23: Population profile of Weston Villages

Indicators of health

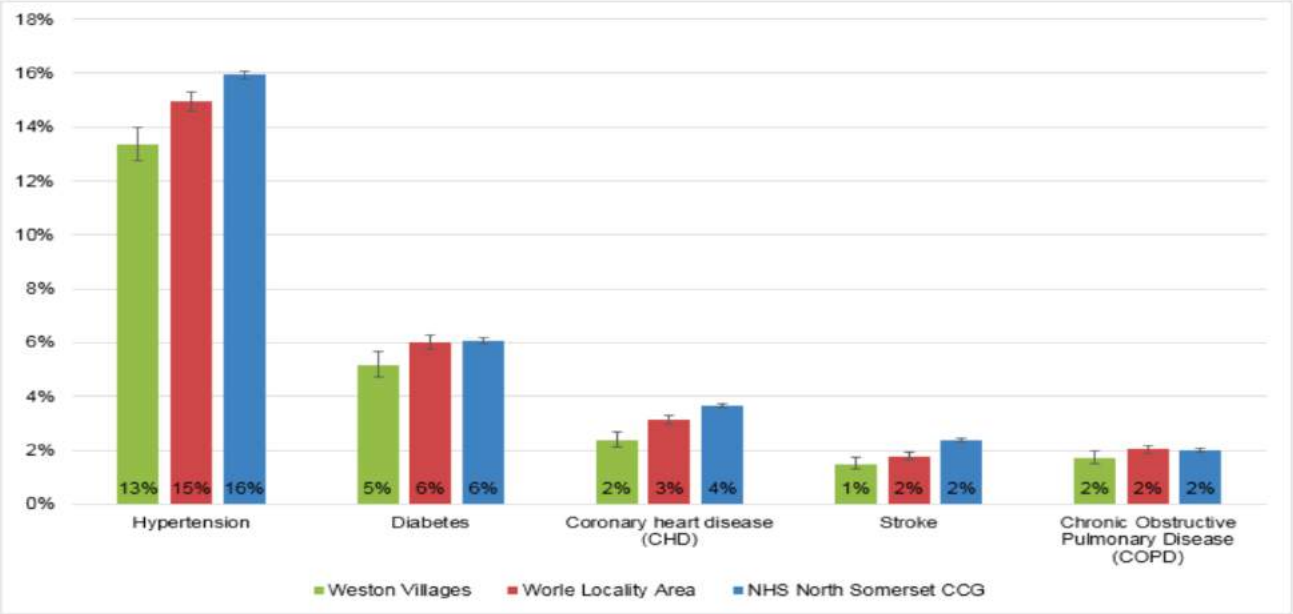


Figure 24: QOF disease prevalence for Weston Villages, 2015/16

Less than one in ten people in Weston Villages are likely to have a long term health problem or disability that limits their day-to-day activities compared to 19% in North Somerset. Levels of bad and very bad health (2.3%) were also lower than the North Somerset average (5.3%). There are fewer carers in Weston Villages (6.1%) than in North Somerset (11%).

As would be expected from the above figures, disease prevalence rates are lower in the Weston Villages area compared to both Worle and North Somerset as a whole. One in eight people are recorded as having hypertension (13%), 7% suffer from diabetes, 4% from CHD and 3% from stroke and COPD. This is shown in Figure QOF disease prevalence, 2015/16.

APPENDIX 3: Supply Side Analysis

Acute Hospital Services (WAHT, UHB, NBT)

Service provision

In North Somerset, 60% of secondary care acute services (excluding specialised services) are delivered by Weston Area Health Trust (WAHT), with the great majority of the remaining acute capacity provided by North Bristol Trust (NBT) and University Hospitals Bristol (UHB) in Bristol and Taunton & Somerset NHS Foundation Trust (TSFT) in Somerset. WAHT, which employs ~1,800 staff and has an annual turnover of circa £100m, delivers clinical services from three sites as described below.

The first site from which WAHT provides services is Weston General Hospital (WGH), which is one of the smallest district general hospitals (DGHs) in the country. It is has ~265 beds and is located in the town of WsM providing acute emergency services for adults including a 24/7 emergency department (ED), critical care (a 5 bed intensive care unit or 'ICU'), medicine (including a medical assessment unit or 'MAU' and clinical decisions unit or 'CDU') and a surgical assessment unit or 'SAU', together with supporting diagnostic services. There is also a midwife led unit (MLU) for maternity services and a range of planned or 'elective' treatments including general surgery, urology, orthopaedics, and other services such as endoscopy, haematology and some cancer care.

WAHT also provides children's and young people's community health services, including child and adolescent mental health services (CAMHS), from two children's centres located at Drove Road in WsM and The Barn in Clevedon. It also provides some community services including physiotherapy, speech and language therapy (SALT) and occupational therapies (OT).

WAHT not only provides acute health services to the population of North Somerset, but also provides acute services to the population of the North Sedgemoor area of Somerset. Around 20% of the Trust's activity is made up of patients resident in North Sedgemoor accounting for around 2% of Somerset CCG's total population. The total catchment population of WAHT is estimated to be between 160,000 and 180,000 people. This is comparable to other small coastal hospitals such as North Devon Trust, which is similarly struggling with service sustainability issues.

Such small coastal hospitals consequently find it difficult attract sufficient market share to generate sufficient economies of scale and WGH is no different. In WGH's case, to the west is the sea, and to the east is an arc of three much larger, higher profile acute service providers as described above. This is particularly the case with urgent and emergency care as little – if anything at all – by way of urgent care activity is likely to pass the larger hospitals in preference for treatment at WAHT.

Within BNSSG, there are also two large tertiary acute providers: UHB and NBT. These hospitals, which are 24 and 26 miles away from WsM respectively, are used far more extensively by residents who live in the northern half of North Somerset while in the southern part, 25 miles from WsM, patients also attend Musgrove Park Hospital (part of TSFT) where Somerset CCG acts as that provider's coordinating commissioner.

WAHT has established joint working and network arrangements with its neighbouring acute providers (sometimes referred to as 'acute care collaboration'). This allows WAHT to deliver a range of additional services at WGH and support local consultants in maintaining their clinical skills. In February 2017 UHB and WAHT announced a partnership agreement, undertaking to:

- Draw-up a formal partnership agreement, describing how the partnership will help address long-standing issues of clinical and financial sustainability at WGH.
- Develop a joint service strategy, setting out proposed areas for co-operation, which could include a greater range of shared clinical and management services.
- Establish a joint management board to oversee delivery of this work.

The precise detail of how the partnership agreement will work is still being developed between the two providers. The final model of closer working and support between the two hospitals is recognised by the system as being an important component of ensuring a stable and well-functioning local health economy and is welcomed.

Overview of current quality and performance against targets

WAHT: The latest CQC report (June 2017) rated the Trust as 'Requires Improvement' overall. The Caring domain was rated as 'Good' while the domains of Safety; Effective and Well-led rated as 'Requires Improvement'. The Responsive domain was rated as 'Inadequate' which means that at the time of the inspection, there was an insufficient sense of urgency to respond to patients in the emergency department (ED) to promote discharge that would initiate flow through ED to the rest of the hospital. This responsiveness is an important element in reducing overcrowding in the ED.

UHB: The latest CQC report rated the Trust as 'Outstanding' overall. The Effective and Well-led domains were individually rated as 'Outstanding', with Safety and Caring as 'Good' and Responsive as 'Requires Improvement'.

NBT: The latest CQC report rated the Trust as 'Requires Improvement' overall. The Well-led domain was rated as 'Good' while the domains of Safety, Caring and Responsive were rated as 'Requires Improvement'.

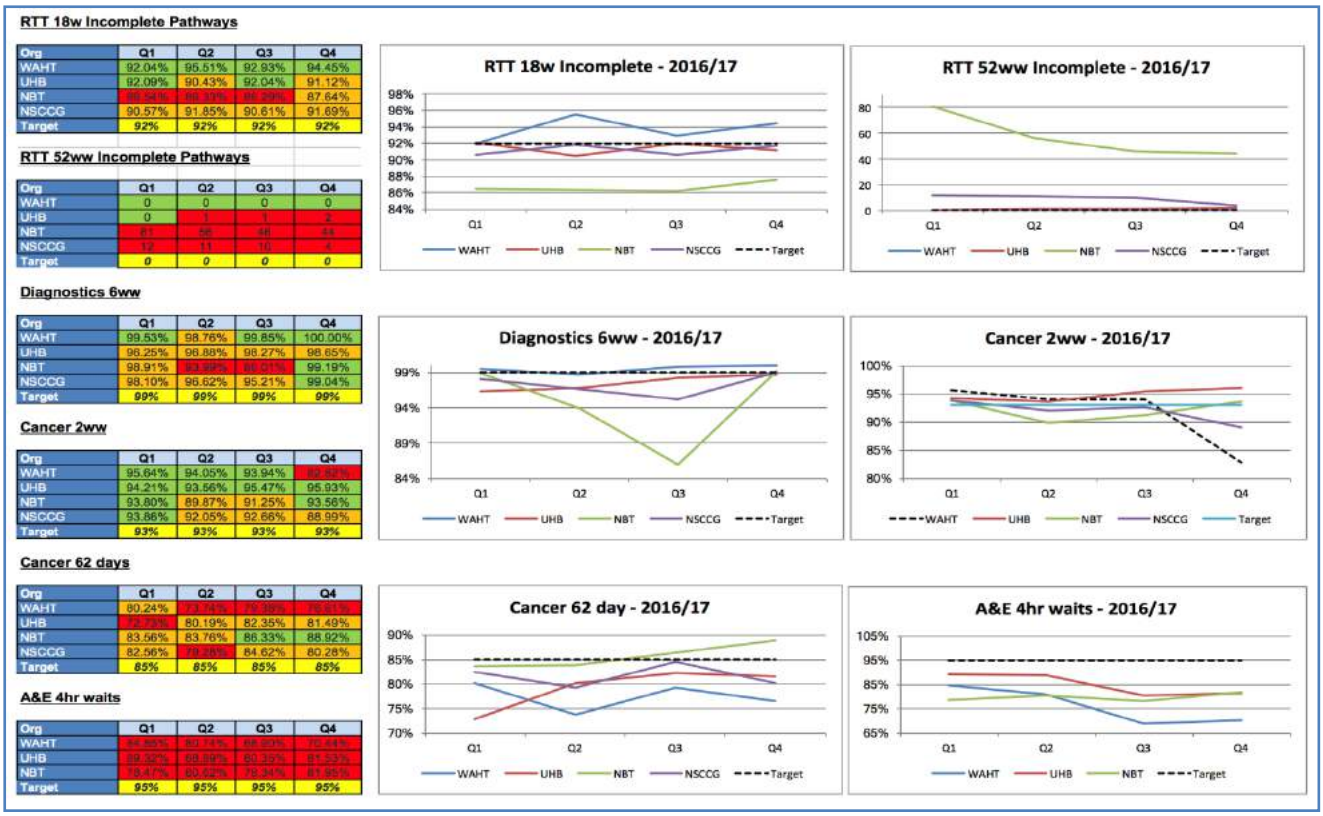


Figure 25: Acute provider performance Q1-Q4, 2016/17

Figure 25 above summarises the performance data for the four quarters of 2016/17 for key acute performance targets. Please note that these numbers are in relation to all Trust activity, not just North Somerset residents. The average for North Somerset CCG is shown as 'NSCCG' and most of the targets are rated as 'amber' with challenges around the 2 week wait and 62 day treatment targets for cancer.

Service delivery challenges (including workforce & capacity constraints)

WAHT: A pressing constraint for WAHT is an inability to attract and retain sufficient numbers of emergency department (ED) specialist doctors – both consultants and middle grades. Although the ED is busy, 50-55,000 attendances per annum, these numbers may not be sufficient to generate the critical mass required for a financially self-sustaining service under standard NHS contracting rules. Coupled with this, the long-standing uncertainty about the future of services at the hospital and the more varied options on offer at other local providers has made it doubly difficult to recruit ED specialists – a group for which there is already a national shortage. This results in the CCG needing to pay premiums for a number of services, in particular A&E and critical care services) to keep the services running which impacts the funding available to invest in other services.

This situation was compounded by the withdrawal in 2015 of FY2 trainee doctors from overnight ED shifts due to a lack of appropriate supervision. This meant the Trust has relied very heavily on agency and locum doctors to fill shifts, which ultimately has culminated in the temporary closure of the ED overnight on the grounds of patient safety.

The Trust also has recruitment challenges in other areas such as acute medicine, gynaecology, CAMHS and community paediatrics and requirements to change service models/staffing on the back of a number of Royal College reports.

Training of junior doctors at WAHT overall has been under enhanced monitoring since 2015 as a result of coming bottom nationally in the Junior Doctor GMC survey. FY2 overnight doctors were removed from the ED overnight at the same time. The Trust improved to 7th lowest nationally in the 2016 survey of all Trusts in England, but returned to last place in England in the 2017 survey. A follow-up inspection has been scheduled for November 2017.

UHB: The key issues for UHB are clinical recruitment and retention in some specific areas and meeting a number of constitutional standards as shown in **Figure 25**.

NBT: NBT has recently come out of financial special measures, although the provider continues to run a very significant deficit. The key issues for NBT are as follows: significant imbalance in demand and capacity for planned/elective surgery leading to a heavy reliance on outsourcing to the Independent Sector and meeting a number of constitutional standards as shown in **Figure 25**.

Summary Hospital-level Mortality Indicator (SHMI)

The SHMI reports on mortality at trust level across the NHS in England using a standard and transparent methodology. It is produced and published quarterly as a National Statistic by NHS Digital. The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there[19]. A ratio of 100 equates to 'as expected'.

For the main acute providers serving North Somerset, the SHMI for Jan 2016 – Dec 2016 is set out below. Please note that this information relates to all patients at each Trust, rather than specifically residents of North Somerset:

- Weston Area Health Trust: 111.06
- University Hospitals Bristol: 99.30
- North Bristol Trust: 96.67

Out of Area Acute Hospital Services (TSFT)

TSFT is commissioned by Somerset CCG and was rated 'Good' overall in its last CQC inspection. The organisation has one main location at Musgrove Park Hospital; a large acute hospital providing a wide range of acute services. Musgrove Park does take patients from parts of North Somerset. For example, in the recent modelling prior to the temporary overnight closure of the ED at WGH, it was assumed that Musgrove Park would take around 12% of the displaced activity. At the four week stage after closure, Musgrove Park has seen more walk-ins, more ambulance arrivals and more emergency admissions than the

[19] http://content.digital.nhs.uk/SHMI

modelling would suggest. Although the proportional differences have been high, the numbers are around 2 more walk-ins per day and 2 more ambulance arrivals per day. Any future provider alliance will need to ensure strong operational and planning links with TSFT.

Non-NHS Acute Provision

Somerset Surgical Services – an independent healthcare provider – also use WGH's theatres. The organisation provides a range of services, many of which are not currently provided by WAHT. Procedures available under this arrangement include Cataract Surgery, Lumbar Spinal Surgery, Non-Cosmetic Plastic Surgery, Specialist Foot and Ankle and Hand and Wrist, Orthopaedic Hip and Knee and Oral-Maxillofacial Services.

Through patient choice, North Somerset residents also access planned care treatment through a range of local providers, including Care UK's facility at Emerson's Green and the Nuffield's facilities in Bristol and Taunton. In 2015/16 BNSSG spent £40m on planned care in non NHS facilities, the largest proportion being on trauma and orthopaedics.

South Western Ambulance Service

Service provision

South Western Ambulance Service Foundation Trust (SWASFT) covers 20% of the landmass of England and has significant travel distances to address in order to achieve response times for clinical delivery. The Trust's primary role is to respond to emergency 999 calls, 24 hours a day, 365 days a year. 999 calls are received in one of two emergency operation centres, where clinical advice is provided and emergency vehicles are dispatched if required. In addition, air ambulance services are provided by charity support and staffed by SWASFT.

Although the traditional view of the ambulance service is one of a transport service responding to calls and conveying patients to the nearest A&E department, this view is outdated and not the position in SWASFT.

Currently, only 46% of patients are conveyed to an A&E department, which is the lowest appropriate patient conveyance rate in the country.

SWASFT's ambition is to safely manage more patients on scene, or in their own homes, using alternate referral pathways and supporting community based services, and only where this is not appropriate, convey them to the most clinically suitable facility (not necessarily the nearest e.g. all major trauma patients have been conveyed to NBT (Southmead) since 2012).

Overview of current quality and performance against targets

The latest CQC report for SWASFT rated the organisation overall as 'Requires Improvement' along with the domains of Safe, Effective and Well-led. The Trust was ranked 'Good' for Responsiveness and 'Outstanding' for Caring.

SWASFT has been participating in a national pilot called the Ambulance Response Programme which measures performance differently from current national standards.

- Response times for Category 1 calls (life threatening injuries or illnesses) for North Somerset was at 71.76% for June 2017 (against a target of 75%), better than the Trust's overall performance. However, some unpredictable spikes in demand remain an issue that SWASFT are working with commissioners to review; these can affect monthly performance.
- Time to call answer – ambulance services are expected to answer 95% of all 999 calls within 5 seconds. SWASFT are currently at 55 seconds. Recent underperformance has been driven by a combination of staff vacancy, sickness and unexpected spikes in demand.
- Hospital handover delays continue to impact on available resource. In June 2017, there were 252 handovers involving North Somerset patients which took longer than 15 minutes, equating to roughly 35 hours of lost time. For WGH specifically, 206 handovers took longer than 15 minutes, equating to over 21 hours lost.
- Number of incidents per head of population for North Somerset is 38.59 per 1000 population, which is average against the other SWASFT areas.

Service delivery challenges (including workforce & capacity constraints)

Workforce is a particular challenge for SWASFT, specifically the recruitment and retention of specialist paramedics, paramedics and clinical hub call takers and clinicians. The training time for paramedics is three years and as a staff group they are in high demand. There are also non-personnel constraints to SWASFT; for example, the lead in time for ordering and taking delivery of new vehicles, if capacity requirements increase, can be 4-6 months.

Primary Care (General Practice)

Service provision

There are currently 18 GP contracts in North Somerset – 14 PMS[20], 3 GMS and 1 APMS. Services are offered to a current GP registered list size of ~219,000 people (as of July 2017) from across 29 sites. Ten of these contracts are for GP services in the Weston & Worle localities with services delivered from 14 sites serving ~100,000 patients.

The number of contracts has declined from 25 since the CCG was formed in 2013. This has predominantly been through mergers. An APMS GP led walk-in and registered GP list service at WDH and the Boulevard Weston were initially changed to a 'front-door' nurse led service at the hospital and a GP practice at the Boulevard and then both services were closed in September 2013 following an unsuccessful tendering process. Two practices have recently applied to NHSE to close branch surgeries – Wrington village (Mendip Vale Medical

[20] PMS contracts –are currently in the second year of a five year process of alignment, to ensure all practices are being bought to the same level of funding to be in line with funding for GMS contract.

Group) and Stafford Place (Stafford Medical Group). These are going through due process and the CCG has been consulted.

Most practices operate hard and soft list boundaries. These are more porous in Weston/Worle where many practices have patients living in or around the town, but outside of the practice boundary. There are no closed lists and no applications for such in progress.

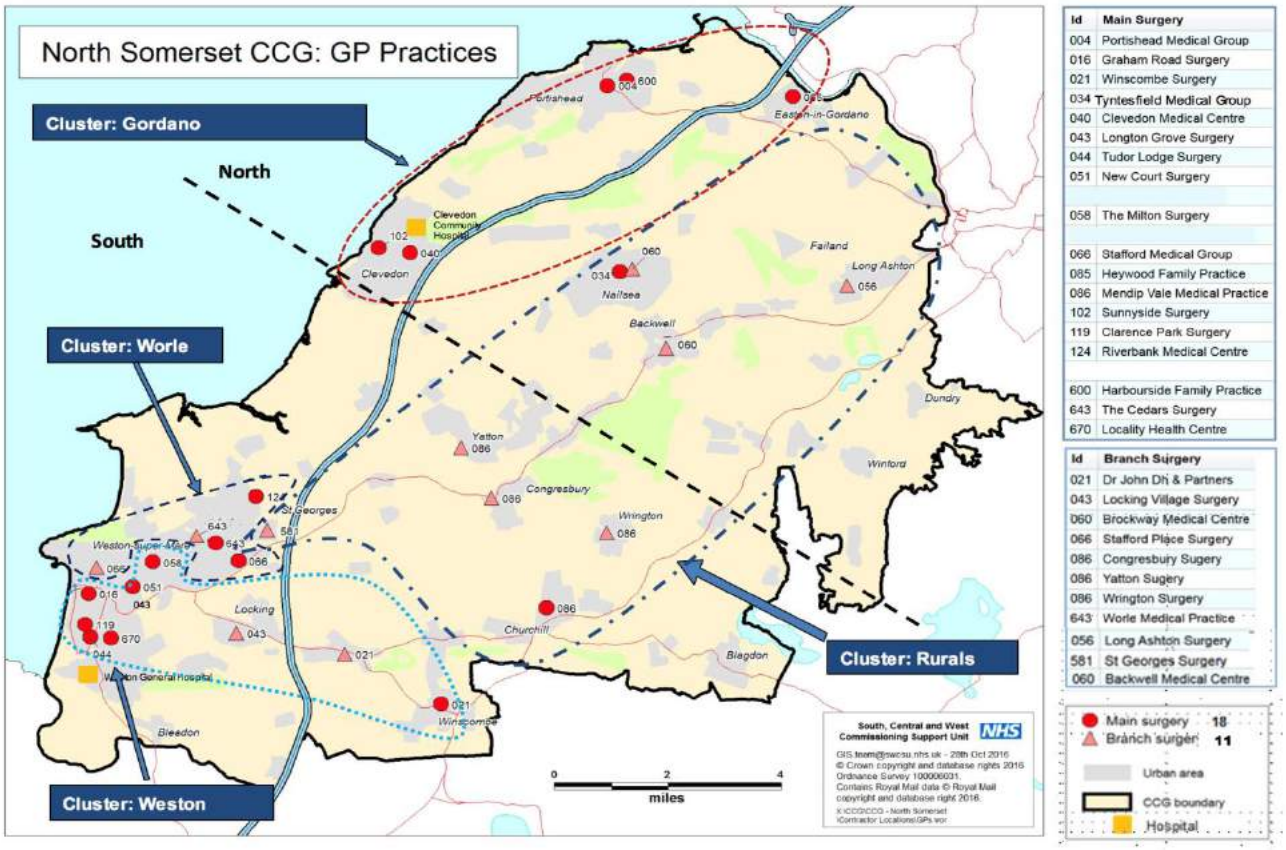


Figure 26: North Somerset CCG GP Practice map (as of July 2017)

Figure 26 above marks out both the main and branch surgery locations for GP Practices across North Somerset. GP Practices are currently split into four groups called 'clusters'[21]: Weston, Worle, Gordano and the Rurals. These clusters are geographically based and closely match the North Somerset Community Partnership's (NSCP) community ward teams. Although formal cluster-based working (also referred to within the CCG as primary care working 'at scale') is still developing, the CCG is working closely with local GP Practices to develop greater resilience to demand pressures by working across clusters of practices to create additional capacity and share services to reduce costs.

The table below provides further detail on which GP Practice is aligned to which cluster as well as current cluster list size as of July 2017. It should be noted that future GP Practice mergers are more than likely which may result in further movement of GP Practices between the various cluster groupings.

Weston	Worle

[21] Defined here as the registered population of a specific group of General Practices based on a geographical location where different services work in an integrated way for the population. These clusters are likely to be for a population of 30,000 to 50,000, but could be higher. In contrast, Primary care 'Localities' will be between 100-150,000 population.

List size as at 1st July 2017: **66,480**	List size as at 1st July 2017: **36,521**
• Clarence Park Surgery • Locality Health Centre • Graham Road Surgery • Longton Grove Surgery • The Milton Surgery • New Court Surgery • Tudor Lodge Surgery • Winscombe & Banwell Family Practice	• Stafford Medical Group • Riverbank Medical Centre • The Cedars Surgery
Gordano	**Rurals**
List size as at 1st July 2017: **58,349**	List size as at 1st July 2017: **57,659**
• Clevedon Medical Practice • Harbourside Family Practice • Heywood Family Practice • Portishead Medical Group • Sunnyside Surgery	• Mendip Vale Medical Practice • Tyntesfield Medical Group

Figure 27: GP Practices by cluster (as of July 2017)

Five practices across eight sites have formed a company (which may become a Community Interest Company) partly in response to the increasing population in the Weston Villages. The original members have agreed to keep their lists open to new Weston Village residents. Discussions are underway with other local practices and more may join in due course.

The Locality Health Centre practice has recently taken over the management of Clarence Park and Graham Road surgeries. A formal merger is not possible at present because Locality is an APMS contract (expiry 31.10.18) but it is expected that the two PMS practices will merge pending a decision on any 2018 procurement for the Locality contract.

Interest in working more collaboratively is more evident and advanced in Weston, Worle and Winscombe, driven in part by the Weston Primary Care Transformation Programme. It is least evident in the Rurals.

Overview of current quality and performance against targets

All but one of the current practices in North Somerset have been inspected and rated by the CQC. The only one that hasn't is Mendip Vale Medical Group, although some of the constituent practices were inspected prior to merger.

All practices were assessed as good except:

- Locality Health Centre — Outstanding
- The Cedars — Requires improvement
- St Georges — Requires improvement (now part of Mendip Vale Medical Group)
- Worle — Requires improvement (now part of The Cedars)

When asked about their overall rating of GP services in North Somerset, patients responded as follows:

- 87% of patients surveyed said their experience is 'very good' or 'fairly good'. This is similar to the satisfaction ratings reported in South Gloucestershire and Bristol. This ranges between 69-98% depending on the GP Practice that the patient is registered with.
- A total of 8 practices in North Somerset are below the CCG average for overall satisfaction.
- Amongst patients aged 65 or over, 94% rate their experience as 'very good' or 'fairly good'.
- Currently 77% of patients are very/fairly satisfied with opening hours. This ranges by GP Practice between 58% and 93%.

Service delivery challenges (including workforce & capacity constraints)

As with all health and social care agencies in North Somerset, GP services are challenged by the higher proportion of frail older patients in the local population, including those living in the high local concentration of residential and nursing homes. The position is compounded in the Weston area by the large socio-economic inequalities with the usual attendant challenges to individual health and wellbeing – both physical and mental. Recruitment presents a similar challenge for BrisDoc, with North Somerset being the most challenging area within BNSSG for recruitment of GPs to work out-of-hours.

Recruitment is a material issue for a number of practices in North Somerset, particularly in the south of the patch. This is complicated by the fact that four practices in the centre of Weston do not meet national standards for premises providing GP services. Practices across the CCG report difficulty in recruiting GPs, particularly at partner level. Training practices generally appear to have less of an issue than non-training practices.

In terms of an ageing workforce, more than 17.5% of BNSSG GPs are over 55 and 4.3% are over 60 years old. In North Somerset, the percentages of GP and nursing staff over the age of 55 are shown in **Figure 28** below.

Cluster	GPs over 55 (%)	Nurses over 55 (%)
Weston	37	45
Worle	40	57
Gordano	16	29
Rurals	17	32
North Somerset average	**27.5**	**41**

Figure 28: % of GPs and Practice Nurses aged over 55 by cluster

Access to primary care services can be more difficult in rural areas especially for patients relying on public transport. Lack of access in the centre of Weston (Central Ward, Weston Hillside and Weston Uphill) is also a cause for concern particularly since the closure of the

Boulevard and the relocation of two practices – Longton Grove and New Court – into a co-located site elsewhere in the town. Recent public engagement has shown that the public, media and elected councillors are concerned over the sustainability and accessibility of local primary care services.

The annual total rental cost for these premises is estimated to be circa £2.2 million, excluding rates, services charges and running costs. The rent charges across practices ranges widely. 71.5% of GP premises were constructed pre-2000, which highlights the need to implement changes in the estate to make it fit for future provision. There are some immediate challenges to a number of surgeries in the Weston area.

Primary Care (Out of Hours)

Service provision

Out of Hours GP services are provided by BrisDoc Healthcare Services which is a co-operative social enterprise working out of two bases in North Somerset: New Court Surgery on Locking Road in WsM and the Community Hospital in Clevedon. In a typical weekend BrisDoc will have more patient contacts that the emergency departments of WAHT, NBT and UHB combined.

Location	Opening hours
Newcourt Surgery, Locking Road, Weston	19.30–8am Monday to Friday 24 hours Sat, Sunday, Bank Holidays
North Somerset Community Hospital (Clevedon)	19.00–23.00 Monday to Friday 09.00–21.00 Sat, Sunday, Bank Holidays

Figure 29: BrisDoc services and opening hours

In 2016/17:

- 4,694 North Somerset patients were referred via BrisDoc's professional line, which provides senior clinical support to SWASFT, acute EDs, nursing homes and other community providers.
- BrisDoc work closely with NHS111 and are the primary recipient of onward referrals.
- 80% of calls from paramedics on the scene are closed by the out-of-hours service, or referred to the patient's own GP.
- Referral to 999 or emergency admission is <8%.
- BrisDoc has a workforce including a varied and effective skill mix – 36% of the clinical rota is filled by Advanced Nurse Practitioner (ANP) prescribers, Telephone Advice Nurses, Emergency Care Practitioners (ECP) and Pharmacists.

Overview of current quality and performance against targets

1 In 2016/17:

- 110,737 patients were cared for by the service across BNSSG – 26,082 from North Somerset.

- 10,297 North Somerset patients received a clinical advice call (12,000 + calls in total including those who were subsequently converted to a Home visit or face to face appointment).
- 11,575 North Somerset patients had a face to face appointment.
- 4,209 North Somerset patients received a home visit.
- 96.6% of urgent patients have an appointment booked and are in a base within two hours of referral by 111.

Service delivery challenges (including workforce & capacity constraints)

The clinical workforce model for the out-of-hours GP service relies on sessional (i.e. self-employed) GPs for approximately 60% of the rota fill. GP availability is a constraint nationally and locally, with engagement from GPs willing to work sessions out-of-hours being limited and GP willingness to work Weston shifts is challenging in the summer months due to the traffic congestion en-route.

2 GPs working out-of-hours sessions face increased indemnity costs approximately double that of those seen in daytime care – this can disincentivise GPs to work shifts, and fixed indemnity cover may limit the number of shifts a GP can work per annum. Fluctuations in daytime GP availability have a large impact on Out of Hours demand, and although capacity is flexible, it cannot be flexed indefinitely. A 1% fall in daytime capacity leads to a potential 40% increase in out-of-hours demand.
It is important to optimise the location of a base in North Somerset – Clevedon is often underutilised by North Somerset patients and patients are sent from south and central Bristol. Traffic routes and public access are important, as well as footfall and patient demand.

NHS 111 (Urgent Care by phone)

NHS 111 is a free-to-call single non-emergency medical helpline and has replaced the telephone triage and advice services provided by NHS Direct, NHS24 and local GP out-of-hours. The service is available 24 hours a day, every day of the year and is intended for urgent but not life-threatening health issues.

Service provision

Care UK provides NHS 111 services for the BNSSG CCGs. For 2017/18, the total contractual value (excluding any financial adjustments for performance) is £2.8m and the financial split across the three commissioners is Bristol 49%, North Somerset 26% and South Gloucestershire 25%.

Overview of current quality and performance against targets

In 2016/17, the 111 service received 326,143 calls for BNSSG patients, against contractual levels of 295,455 – 10.4% more activity. Activity above contract has been common across the lifespan of the contract.

Figure 30 below includes latest performance against some of the key national metrics:

Metric	Performance – May 2017	Standard	Commentary
Calls answered in 60 seconds	93.0%	≥95%	Strong performance in past 6 months
Call abandonment	0.9%	≤5%	Consistently achieves target
Combined clinical contact (warm transfers plus call backs in 10)	79.2%	≥70%	Generally strong performer
Referrals to Emergency Departments	7.9%	≤5%	Target has never been achieved. Causal factors include staffing pressures
Referrals to the ambulance service	9.9%	≤10%	Mixed performance traditionally, but generally performs in line with the national average

Figure 30: 111 Performance against target for May 2017

Service delivery challenges (including workforce & capacity constraints)

Care UK has challenges with recruitment and retention for both clinical and non-clinical staffing; this is an issue common to 111 across the country. At the present time, there is a clinical vacancy rate of circa 25% and a Health Advisor vacancy rate of about 13%. The provider is able to flex its existing, predominantly part-time, workforce to manage demand as well as accessing the network as described above, although it is clear that more resilient staffing would be likely to result in improved service delivery - (e.g. a reduction in referrals to ambulance services and hospital emergency departments).

Community Services

Service provision

North Somerset Community Partnership (NSCP) is a Community Interest Company (CIC) that provides healthcare services on behalf of the CCG to the people of North Somerset. The organisation is staff owned and was founded in 2011, employing over 750 staff. The contract value is in excess of £28.5m per year.

The majority of services that NSCP provide are adult community focused and are usually delivered in the patient's usual place of residence, with a number of clinics based across the area. These services include district nursing, rapid response, therapies and a range of specialist services. NSCP run the minor injuries unit (MIU) at North Somerset Community Hospital in Clevedon, and also provide a number of children's services including school nursing and health visitors.

Overview of current quality and performance against targets

The latest CQC inspection for NSCP rated the organisation as 'Good' overall, and 'Good' in all individual domains for all services, except for Safety for community health services for adults and community health services for children, young people and families, which were both rated as 'Requiring Improvement'.

Service delivery challenges (including workforce & capacity constraints)

NSCP are managing an ever-increasing number of frail and complex patients in the community. The high number of care home beds in North Somerset, and the imperative of admission avoidance for this cohort of patients, adds to the service pressures. The

availability of home care and other packages of care also puts further demand on the service.

There are workforce recruitment and retention challenges particularly with regard to community nursing roles in specific localities and some specialist clinical roles such as community matrons.

Historically, there have been a high level of Delayed Transfers of Care (DTOC) at WGH (although more recent figures show a significant improvement) and challenges of maintaining patient flow across the three BNSSG Acute Trusts. Also, multiple assessment procedures across organisations mean the processes to enable discharge from local acute hospitals are different and therefore complicate efforts to ensure patients can always be discharged as soon as it is appropriate to do so. A new integrated discharge service has recently started at WGH to address some of these issues.

The current model of rehabilitation in North Somerset includes a 24-bedded unit operating out of WGH, plus Discharge to Assess capacity. The community in-patient ward at North Somerset Community Hospital in Clevedon (which NSCP manage) has been closed for an extended period due to building works but is due to reopen this winter.

Mental Health Services

Service provision

Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) is a significant provider of mental health services commissioned by a number of CCGs in a catchment area covering Bath and North-East Somerset (B&NES), Bristol, North Somerset, South Gloucestershire (BNSSG), Swindon and Wiltshire. The North Somerset contract with AWP is in excess of £16m per year.

AWP provides a range of mental health services for the adult population of North Somerset. Figure 31 below summarises the range of services provided and their key locations:

Inpatient services	
Juniper Ward, Long Fox Unit, (Weston General Hospital)	Adult Mental Health Inpatient Beds x 18
Cove and Dune Wards, Long Fox Unit, (Weston General Hospital)	Later Life Mental Health Inpatient Beds x 25 (Cove =15 & Dune =10)
Elmham Way, Worle	Community-based in-patient rehab beds x 7
Community services	
The Coast Resource Centre	Recovery Team Early Intervention in Psychosis IAPT / Positive Step Psychological Therapies Service Assessment Team (incorporating ex- PCLS functions)
Long Fox Unit, Weston General Hospital.	Intensive Team NSC AMHP Service A&E Hospital Liaison

Windmill House	Complex Interventions Team DEST Memory Team Later Life Therapies
Weston Super Mare Town Hall	Mental Health Triage Service (incorporating ex- PCLS functions)
Other LDU Services	
Portishead Police HQ	MH Control Room and Street Triage Service
Carlton Centre, Weston.	Vocational Services

Figure 31: AWP services in North Somerset

Overview of current quality and performance against targets

AWP awaits the publication of their CQC Report following the recent inspection. The Trust was rated as 'Good' for the Effective, Caring and Responsive domains and 'Requires Improvement' for the domains of Safety and Well-led.

Service delivery challenges (including workforce & capacity constraints)

There are significant staffing challenges in some parts of AWP – particularly in the east of the footprint. Recruitment has been challenging particularly with regards to staffing on acute mental health in-patient wards.

Local Authority Services

North Somerset Council (NSC) commission and provide a wide range of services that are extremely relevant to the issues that this document seeks to address. Services managed by NSC include:

- Dementia
- Learning disabilities
- Mental health conditions
- Personal care
- Physical disabilities
- Sensory impairments
- Substance misuse problems
- Caring for adults <65 years
- Caring for adults >65 years
- Children's services
- Safeguarding adults & children

Home care capacity & service delivery challenges:

The CCG commissions home care provision via NSC. Between 2015 and 2017, the CCG has supported the NSC with its recommissioning of home care into single locality providers. The completed process sees the three main providers Alliance, Brunel Care, and Notaro taking the lead provider roles across the county. These three providers are expected to meet the need for the majority of home care provision in North Somerset. The challenges these providers face are largely in recruiting sufficient care staff to meet demand. Recruitment

challenges are seen most acutely across the rural areas of North Somerset, and also the more affluent urban/commuter areas such as Portishead, Clevedon, Nailsea and Backwell, where better paid employment is available either locally, or by commuting to Bristol.

Care home capacity & service delivery challenges:

North Somerset is currently served by 110 care homes (69 residential and 41 nursing). The 2013 Market Position Statement (MPS) identified that the 83% of care homes in North Somerset are small (1-20 places) and medium (20-40 places) in size, with the remaining 17% being larger (over 40 places) in size. At the time of the MPS publication 61% of homes were in WsM and Uphill; 13% were in Clevedon; 5% in Nailsea and Backwell; 4% in Worle and Kewstoke; 4% in Portishead; 4% in Congresbury and Yatton; and the others are dotted around in smaller communities. These figures highlight part of the challenge to commissioners in attempting to support patient and family choice with a care home placement near to home, particularly where those choices are for care in the northern parts of North Somerset and the rural areas.

There were 3,202 care home beds in 2011, which has reduced to 3,051 as of August 2017, with that figure likely to fall by an estimated 100 beds by the end of the financial year due to further home closures. The CCG requires an estimated 220-300 beds at any one time in order to meet the needs of individuals that are heath funded via Continuing Healthcare or Section 117 aftercare. Further reductions in the available capacity is likely to affect the CCG and local authority's ability to control the fees paid for care home beds, which has historically been more effective than Bristol and South Gloucestershire. Based on a total population of approximately 50,000 aged over 65, this equates to a ratio in North Somerset of 1 bed for every 16 people over 65. The ratio in Bristol is 1:21 and in South Gloucestershire it is 1:26.

Voluntary Sector

There is a plurality of service provision commissioned from the voluntary and community sector in North Somerset. The two largest contracts are with the British Red Cross and 1 in 4 (a local mental health charity). Voluntary Action North Somerset (VANS) represents, develops and empowers the voluntary, community and social enterprise sector in North Somerset to be at the forefront of positive social change and development. It will be very important in the provider service model that is developed from this work that we maximise the use and contribution of local community and voluntary sector resources.

APPENDIX 4: Additional Finance Information

The table below shows the original forecast deficit figures submitted to NHS England as part of the BNSSG STP October submission. The table shows that every provider and every CCG across the BNSSG STP footprint is forecast to be in significant deficit by 2020/21, assuming no action is taken to address the situation. The table clearly demonstrates that there are no easy solutions to the problems we face. To achieve an affordable and sustainable service model for the North Somerset population, it will necessitate a radical transformation of the way in which health and care services are provided for local people.

		"Do Something" Solutions				
Surplus / (Deficit)	**"Do Nothing" 2020/21 Positon**	**STF Funding**	**Identified Savings**	**Unidentified Savings**	**Weston Sustainability**	**Total BNSSG STP**
Providers	**£'m**	**£'m**	**£'m**	**£'m**	**£'m**	**£'m**
University Hospitals Bristol NHS FT (UHB)	(47.6)	13.3	36.1	4.4		6.2
North Bristol NHS Trust (NBT)	(80.6)	14.0	65.0	1.6		(0.0)
Weston Area Healthcare NHS Trust (WAHT)	(20.6)	3.1	10.1	0.0	7.4	(0.0)
Avon & Wiltshire Mental Health Partnership (AWP)	(17.3)	0.7	4.6	12.0		(0.0)
South Western Ambulance Service (SWAST)	(3.2)	1.5	1.6	0.1		0.0
Community Interest Companies (CiCs)	(15.0)			15.0		0.0
Sub-total Providers	**(184.3)**	**32.6**	**117.4**	**33.1**	**7.4**	**6.2**
Commissioners						
Bristol CCG	(60.9)		8.0	52.9		0.0
North Somerset CCG	(30.3)		3.7	26.6		0.0
South Gloucestershire CCG	(30.0)		9.8	20.3		0.0
Sub-total Commissioners	**(121.2)**	**0.0**	**21.5**	**99.8**	**0.0**	**0.0**
System Wide		28.4		(28.4)		0.0
Total Organisational Financial Plans	**(305.5)**	**61.0**	**138.9**	**104.4**	**7.4**	**6.2**

Figure 32: BNSSG STP financial position (October 2016 submission)

CCG Benchmarking Data

Figure 33 below compares CCG programme spend with programme spend at national level taken from the "NHS 5 Year Forward View Review: Recap briefing for the Health Select Committee on technical modelling and scenarios" (May 2016). In 2014/15 North Somerset is spending some £11-£12m more on acute services than the national average would indicate

	Programme Expenditure 2014/15					
	National		*North Somerset*		*North Somerset based on National Profile*	*North Somerset v National Profile*
	£bn	***%***	***£m***	***%***	***£m***	***£m***
Acute	35.5	52.9%	151.3	57.3%	139.67	11.6
Mental Health	6.7	10%	23.4	9%	26.36	(3.0)
Primary Care	9.3	14%	35.8	14%	36.59	(0.8)
Community Provision	7.8	12%	24.0	9%	30.69	(6.7)
Continuing Healthcare	4	6%	14.8	6%	15.74	(0.9)
Other Programmes	2.1	3%	9.5	4%	8.26	1.2
CCG Reserves/Contingency	0.4	1%	-	0%	1.57	(1.6)
Running Costs	1.3	2%	5.2	2%	5.11	0.1
Total	**67.1**	100%	**264**	100%	**264.00**	**0.0**

Figure 33: CCG programme spend vs national level 2014/15

Figure 34 below compares North Somerset programme spend per weighted capital with peers. Absolute peer comparisons across programmes are difficult because of differences in reporting and classification of spend but a high level review of 2016/17 spend across main programme heads indicates higher spend on acute services in North Somerset in the order of £9.7-£13.4m.

	Spend per Wtd Capita £ 2016/17			Potential (Saving)/Cost(£m)	
	North Somerset	***C4V Peer Avge (10)***	***C4V Peer Avge (5)***	***@ 10 Peer Avge***	***@ 5 Peer Avge***
Acute	716	673	657	(9.7)	(13.4)
Non Acute	318	291	286	(6.0)	(7.1)
Continuing Care	70	88	94	3.9	5.3
Prescribing	154	163	168	2.0	3.3
1% Reserve	12	13	13	0.2	0.2
Total	**1,271**	**1,228**	**1,219**	**(9.7)**	**(11.8)**

Figure 34: Comparison of spend with Commissioning for value peers (C4V)

The national RightCare Programme focuses on the value for money of hospital admissions. The comparison with peer CCGs is limited to admissions covered by the national Payment by Results tariff, but it indicates higher levels of acute spend in North Somerset as summarised by disease group in **Figure 35** below. The potential reduction in acute spend if North Somerset matched peer performance is £9.9m.

Disease Area	Planned	Urgent	Total
	£m	***£m***	***£m***
Cancers and Tumours	1.3		1.3
Circulation (CVD)	0.3	1.1	1.3
Endocrine, Metabolism & Nutrition	0.1	0.1	0.3
Gastrointestinal	0.5	0.7	1.2
Genitourinary	0.3	0.5	0.8
MSK	2.3	0.3	2.6
Neurological	0.1	0.8	0.9
Respiratory	0.2	0.3	0.5
Trauma and Injuries	0.2	0.8	1.0
Total	**5.2**	**4.7**	**9.9**

Figure 35: RightCare Potential Savings

MSK is the biggest single opportunity identified from RightCare and there is a BNSSG wide programme of work in progress to realise these potential savings.

APPENDIX 5: Key Priority Population Groups

Frail and Older People

Frail older people are the most significant patient group in terms of complexity, growing demand and potential for improved care pathways. The JSNA uses the definition of frail older people to be *"people over 75 with a significant level of physical or mental impairment which may interfere with the ability to undertake daily living and requires support from either formal or in-formal care services."* However, it's not just the over 75s who can be described as 'frail'. People living in the most deprived areas of WsM can also be described as frail even if they are only in their 40s due to mental health issues or alcohol and substance abuse.

Given the current pressures on the urgent care system, frail older people are more at risk of having a poor experience of care, worse clinical and social outcomes, and more rapid deterioration than would be expected in our particular population. Because care is fragmented, thresholds for admission are often lower than medical necessity criteria would indicate and lengths-of-stay (LOS) exceed the need for the delivery of true acute inpatient care, resulting in poorer outcomes for patients.

The Five Year Forward View (5YFV), NHS England's 'Frail Older People, Safe Compassionate Care' and the British Geriatric Society's 'Fit for Frailty' all identify a strong evidence base to support a holistic approach to meeting the needs of people living with frailty: *"Care needs to be just as important as treatment. Older people should be properly valued and listened to, and treated with compassion, dignity and respect at all times. They need to be cared for by skilled staff who are engaged, understand the particular needs of older people and have time to care."*

'Hard Truths, the Journey to Putting Patients First', is the government's response to the Francis Report, and was published in November 2013. It states: *"There are two building blocks. Firstly, what we already know works for older people in crisis, but needs to be deployed more universally. Secondly, a newly-emerging preventative approach that offers the real possibility of living better with frailty and of a reduction in the unscheduled primary and secondary care contacts that characterise our current response. If frail older people are supported in living independently and understanding their long-term conditions, and educated to manage them effectively, they are less likely to reach crisis, require urgent care support and experience harm."*

Key statistics:

- The rate of hospital admission increases significantly with age so that in North Somerset, 1 in 3 people aged over 85 were admitted to hospital as an emergency in 2016/17 compared with 1 in 13 aged 65-74.
- Across BNSSG, the over 85s account for 13.5% of all emergency hospital admissions with an average acute LOS of 12 days. The over 65s account for 42.6% with an average acute LOS of 9.2 days. The average cost of an emergency admission for a frail older person is £4,856.
- In North Somerset, 22,000 residents are aged over 75 of which 6,500 are aged over 85. The over 75 population currently accounts for 30% of all admissions, 60% of beds and

40% of admitted patient costs. The number of over 75s is predicted to rise to 37,000 in 2030; a 68% increase.

- The impact of projected growth in the older population for North Somerset is illustrated in Section 4: The Financial Challenge (Figure 10). Overall this represents an additional 20 hospital beds based on current lengths of stay with an estimated £2m increase in cost related to emergency admissions alone. If this is projected into the future an additional 65 beds would be required over the next 10 years.

- NHS RightCare (2016) analysis has identified relatively high spend on emergency care for complex co-morbidities due to falls/fractures, UTI/urology, pneumonia /respiratory conditions which typically relate to frail older people.

- 83% of the beds in WGH for non-elective admissions are occupied by people who are 65 or over.

- In North Somerset, 63% of the total admissions of people over 85 are admitted to WGH (59% for over 75s).

- 1 in 3 over 85s were admitted more than once in a year for an unplanned admission and 1 in 6 of over 75s.

- 75% of the total bed capacity in North Somerset is in Care Homes. There are 110 care homes (69 residential & 41 nursing), and 3000 beds in North Somerset, of which 38% are in Weston town. The care home population will increase by 88% by 2030.

We need to do more in supporting our older population in keeping healthy and out of hospital. When people in this group do need to go into hospital, services need to work together more effectively to support them to return to their place of residence much more quickly.

Children & Young People (including complex needs and young people mental health)

In summary, the provider landscape for children and young people services is fragmented with services provided across a number of different providers including WAHT, NSCP and CCHP (Community Children's Health Partnership) which is part of the North Bristol Trust. There are also capacity problems in WAHT community paediatric services (which includes OT, Physio & SALT services) meaning that in some cases, patients are waiting a long time to be seen.

Key statistics:

- The child population (those aged under 14) is projected to rise by ~12% (an extra 4,000 children) in the next 10 years.

- In some areas, demand for children's community services is rising and complexity is increasing:

- Paediatric referrals were 659 in 2015/16 and had risen to 784 in 2016/17, a 16% increase
- Physiotherapy referrals were 355 in 2015/16 and had risen to 326 in 2016/17, a 9% decrease
- Speech and Language referrals were 581 in 2015/16 and had fallen to 564 in 2016/17, a 3% decrease
- Occupational Therapy referrals were 222 in 2015/16 and had risen to 308 in 2016/17, a 39% increase
- Number of Children requiring Continuing Health Care (CHC) has risen dramatically since 2012/13 (from 3 to 11 as of Sept 2017) and is expected to rise even further.

- The increase in referrals has increased pressure on access and waiting times. There are also challenges due to the impact of seasonal spikes on demand and the ability of the community provider (WAHT) to cope.

- Services have been historically underfunded, e.g. mental health average is £40 per child in North Somerset compared to £46 in Somerset

- 1 in 10 children aged 5 to 16 will have a diagnosable mental health need, with 50% of all mental health conditions emerging before the age of 14. 75% of all mental health conditions emerge before the age of 25.

- North Somerset has a higher than average (England & regional averages) number of:
  - Children and young people admitted to hospital due to self-harm
  - Children and young people with a conduct disorder (estimated through proxy measures)
  - Children and young people in care who are in the 'borderline' or 'cause for concern' mental health categories (as measured by the Strengths and Difficulties Questionnaire)

- Specialist CAMHS referrals are up 10% in the last year. Of these referrals, an average of only 54% are accepted which may indicate a lack of awareness of thresholds, a lack of early help services, or particular issues relating to holding cases in the community.

- The WAHT specialist CAMHS team is small, not resilient and has experienced problems with recruitment.

- For specialist CAMHS, 35% of children and young people have to wait more than 18 weeks to be seen. Waiting times for the autistic spectrum pathway are approximately 56 weeks.

- Specialist CAMHS in-patient beds – children and young people often have to travel to a different part of the country to access a bed. Recently for example a young person in crisis was placed in Bury, Lancashire.

- The national rate of children living in poverty, after housing costs, in England is 25% with the average for North Somerset being 19%. However, in WsM Central Ward it is 36% and WsM South Ward it is 38%.

Pregnant Women:

- The local Midwife led maternity service at Weston is not chosen by enough women to make it clinically or financially viable in its current form.

- The number of deliveries at the midwife led unit (MLU) at Weston General Hospital is currently at around 170 per year; the minimum level for a clinically appropriate unit of this type is considered to be ~ 500.

Vulnerable Groups for example people with mental health needs, learning difficulties and those who struggle with drug and alcohol addiction.

There are areas in North Somerset, particularly in Weston, with concentrated numbers of people living with mental health issues, learning disabilities and those struggling with drug and alcohol addiction. People with these issues tend to have much poorer physical health and a lower life expectancy.

Key statistics:

- In North Somerset, mental health is one of the top four causes of Disability Adjusted Life Years (DALY) lost.

- North Somerset has a higher prevalence of depression than the England average, but rates of serious mental health problems recorded in GP Practices are similar to the England average and are higher in more deprived areas.

- Suicide rates are a third higher than the national average, but have improved more recently. The rate of self-harm hospital stays is 222 per 100,000, worse than the England average

- Nationally the number of adults with learning difficulties (LD) is increasing and is predicted to increase by 1% each year for the next 15 years. GP Practice prevalence of LD (0.48%) is higher than the average for England (0.45%) and has increased over the last few years. LD prevalence is higher in more deprived areas.

- By 2020, 75% of all people with LD over the age of 14 should receive an annual health check and receive a health action plan. In North Somerset, the current rate is just 53%; however there is significant variation between practices.

- The rate of alcohol related hospital admissions per 100,000 population has increased year on year and is higher than the national rate. Annually there are around 2,700 hospital admission of problem drinkers in the North Somerset population.

- Alcohol harm related hospital admissions in North Somerset are estimated to cost the NHS more than £3m in healthcare costs each year.

- 63% of males and 48% of females engaged with the local drug treatment service also have a current diagnosed mental health issue.

- Weston has a high number of alcohol and drug rehabilitation beds and people living in the locality are four times more likely to be admitted to hospital for alcohol specific conditions.
- Years of life lost to potentially amenable conditions such as HIV, Hepatitis C and TB are increasing in North Somerset, whereas the national trajectory is decreasing

The local system has also identified a number of key specialities that have been highlighted as priorities. The following section provides a number of the key statistics as to why these have been chosen.

APPENDIX 6: Key Priority Speciality Groups

Urgent & Emergency Care (including Emergency Surgery)

Key statistics:

- The Weston General Hospital (WGH) A&E – referred to by clinicians as the 'emergency department' (ED) is currently closed temporarily overnight for safety reasons (CQC 2017).
- There have been unsuccessful efforts to recruit sufficient numbers of key clinical posts to reliably and safely staff the ED. The removal in 2015 of FY2 trainees in department overnight has caused further pressure in this area. This situation has contributed to a comparatively large amount of spend on agency staff to help fill gaps in this service, amongst a range of others across the Trust. In 2016-17 WAHT spent £11.7m on agency staff, more than double its cap set by NHS Improvement of £4.68m.
- WGH sees 50,000 to 55,000 A&E attendances per annum (~141 per day): 80% are minors, 29% arrive by ambulance, 58% walk-in, and the remainder are mainly GP referrals.

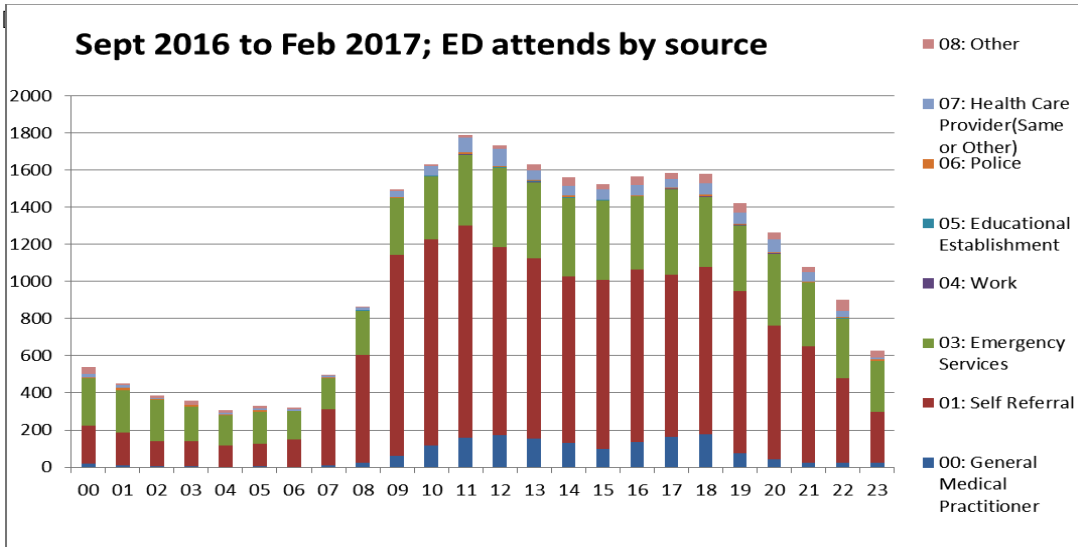


Figure 36: Weston ED demand across 24hr period

- The ED has a 23% conversion rate of attendances to admissions and 80% of activity occurs between 8am and 10pm.
- The number of attendances at the ED are generally flat, and the conversion rate of attendance to admission (around 23%) is comparable to WAHT's peers.

- During quarter 4 of 2016-2017, WAHT reported the highest bed occupancy rate of any acute provider in England (reported level of 100% general & acute beds occupied). This contributes to the challenges of achieving effective patient flow within the hospital.

Arrival			Disposal Method	
Arrival Source	% of Arrivals	No of Arrivals	Admitted	Discharged
00: General Medical Practitioner	6.47%	9.1	47.72%	52.28%
01: Self-Referral	57.72%	81.4	7.69%	92.31%
03: Emergency Services	29.07%	41.0	50.00%	50.00%
04: Work	0.17%	0.2	2.38%	97.62%
05: Educational Establishment	0.14%	0.2	22.22%	77.78%
06: Police	0.44%	0.6	15.18%	84.82%
07: Health Care Provider (Same or Other)	3.54%	5.0	24.53%	75.47%
08: Other	2.42%	3.4	12.54%	87.46%
TOTAL	100%	141.0	23.34%	76.66%

Figure 37: Pattern of demand during a 24 hr period, by referral source

Critical Care

- 350 patients were treated in the critical care unit in the year 2016 – 2017. (That is the report run from ICNARC which only calculates the statistics on patients within the 4 walls of the ITU).
- In addition to the above, the unit managed another 50 patients for a total of 1050hrs in the recovery area in escalation.
- Bed occupancy (within the critical care unit, not including recovery) is 84.3%.
- A total of 164 patients were admitted under general medicine, with the remaining 186 being a mixture of general surgery, orthopaedics, urology, breast surgery, colorectal surgery.
- 47% (144 patients) of the unit's admissions for the year, were at Level 3 status, meaning they required advanced respiratory support (level 3 status).
- Of the 164 general medical patients requiring admission to ITU, 92 required invasive ventilation.
- 55 patients required haemofiltration.

Planned Care

- WAHT has an overall market share of 31% for elective inpatients and day cases in North Somerset. This share rises as high as 55% in some GP practices closest to the hospital, but is significantly lower in others.

- WGH has 4 theatres of which three are laminar flow. Elective sessions include: x8 Colorectal, x2 UGI, x4 Breast, x2 General surgery, x3 CEPOD (which is done in main theatres). Elective and CEPOD lists are done in the day time.

- The day surgery unit has two theatres. There are 8 male and 8 female beds on the unit. Increased use of OP surgery rather than day-case for hysteroscopies. (Source: Finnamores report 2016)

- During 2016/17, WAHT completed: 1,442 elective in-patient procedures, 14,267 day case procedures and 105,036 out-patient attendances. (Source: WAHT annual report 16-17)

Mental Health

- Refer to Appendix 5: Vulnerable Groups.

Cancer

- Cancer is the second most common cause of death in North Somerset after cardiovascular disease.

- Based on Public Health England Cancer Dashboard for North Somerset, the all type incidence rate (in 2014 per 100,000 population) for cancer was 679.98 vs. an England average of 608.3 (higher incidence seen for breast, colorectal and prostate cancers).

- Overall, the most common cancer diagnosis is non-melanoma skin cancer. If non-melanoma skin cancer is excluded, the most common cancer in females is breast (195 deaths per year on average) and in men prostate (175 deaths per year on average).In North Somerset the second most common cancer diagnosis for both men and women is colorectal (bowel).

- Deaths from cancer are the leading cause of premature death in North Somerset. Between 2013 and 2015 the average number of deaths per year in people under 75 from cancer was 271, accounting for 44% of all early deaths.

- A large proportion of early deaths are from cancers with modifiable risk factors such as smoking, alcohol consumption, poor diet and physical inactivity and around 10 lives could be saved each year in people under 75 from cancers such as colorectal and lung.

- There are also a number of years of life lost from cancers that are considered treatment amenable cancers (including breast, colorectal and skin cancer). These account for a third of total years of life lost in North Somerset and are where early detection and treatment increase survival.

- Based on RightCare data (Jan 2017) there are opportunities to reduce emergency presentations for lung, breast and colorectal cancer – implying the need for earlier

detection and diagnosis. There are also opportunities to increase the number of women attending breast and cervical screening and increase the % of 60-69 year olds screened for bowel cancer. The % of patients with cancer who have had a review 6 months after diagnosis is 61% which significantly lower than the England average of 80%. This equates to 621 patients.

- There are currently on-going challenges in meeting 2 week wait (particularly for WAHT) and delivering the 62 day treatment target across BNSSG (refer to Figure 25 for performance data).
- BNSSG in line with The Cancer Alliance are prioritising improvements in early diagnosis of cancer through improved access to diagnostics and reducing emergency presentations.

Circulatory Disease

- An estimated 71% of all over 75s have high blood pressure, which given the associated diseases of having hypertension, indicates this as an area of concern.
- According to disease prevalence models, cardiovascular disease is set to increase at a rate of 1.05% annually for people aged 16 and over.
- By 2030, a predicted 25,897 people will have circulatory disease.
- The over 75 age group will have the fastest growth rate at 4.4% annually, reaching 14,525 over 75s with the disease by 2030. This is nearly 40% of all people in North Somerset over the age of 75 years.
- Outcomes are slightly above average for North Somerset, but circulatory disease is the biggest single cause of life expectancy inequalities for both men (28.3%) and women (25.8%).

Stroke

- There are 30+ more deaths from stroke than the national average (RightCare 2016), with variation in practice, referrals & outcomes for patients at high risk of stroke or following stroke across BNSSG.
- Only 28% of high risk patients are being seen within 24 hours. Alternative models are achieving 90%, which equates to 23 strokes prevented each year.
- Sentinel Stroke National Audit Programme reports overall acute scores of C/D (on a scale of A-E).
- Stroke services cost BNSSG CCGs £24m per annum.

Respiratory (COPD)

- Respiratory disease is the third leading cause of premature death (i.e. aged under 75) in North Somerset. It claims around 90 deaths per year in total across North Somerset.
- The prevalence of COPD has a clear gradient of increasing prevalence with increasing deprivation. In North Somerset there are twice as many people with COPD in the most deprived areas than the most affluent.
- In 2015, approximately 4,352 people were diagnosed with COPD and almost 1,000 were estimated to be undiagnosed.
- There is a limited community based respiratory service and a very limited specialist service in Weston General Hospital. North Somerset does not meet NICE guidance or GOLD standards regarding admission avoidance or early supported discharge.
- Length of stay may be unnecessarily extended due to early supported discharge support not being available. This can lead to patients becoming deconditioned, in greater need for social care on discharge.
- There is a large non-elective opportunity to reduce respiratory admissions due to pneumonia HRG (DZ11A, B and C) against peer group average. Spells are particularly high compared to peers for Pneumonia with major complications (HRG DZ11A). There were 860 excess bed days for DZ11A in 8 months for North Somerset CCG. This may be partly due to the age profile of the patients admitted for pneumonia as the case mix variances are in age groups 75 to 84 years and 85+ years.
- Weston are £296,016 over reference costs (mostly for 'non-admitted face-to-face attendance follow up' (£179,668) & 'non-admitted face-to-face attendance 1st appointment (£32,046).
- There is a key in-balance in skills and resources in North Somerset as compared with Bristol and South Gloucestershire in relation to community and secondary care specialist respiratory staff.

Liver Disease

- Liver disease is amongst the top four causes of premature mortality in North Somerset.
- Early deaths from liver disease are twice as high for men as for women; causes being alcohol, obesity and Hepatitis C.
- Estimates suggest 1,300 injecting drug users in North Somerset of which 40% have the Hepatitis C virus. Although proportionally this is not high for this population[22], it does indicate a potentially significant demand on treatment services.

[22]http://www.emcdda.europa.eu/system/files/publications/2953/TDXD16002ENN_final_web.pdf

- For further alcohol related statistics, refer to Appendix 5: Vulnerable Groups.

Frailty as a specialty

- Refer to Appendix 5: Frail and Older People.

Musculo-skeletal conditions (MSK)

- The term “musculoskeletal conditions” encompasses well over 200 disorders affecting bones, muscles and soft tissue and also includes musculoskeletal injuries due to sports and in the workplace, and trauma related to external causes such as falls and road traffic accidents.

- In North Somerset, MSK conditions are one of the top 4 causes of Disability Adjusted Life Years (DALYs) lost. For example, low back and neck pain account for 6,249 DALYs per year in North Somerset.

- Based on RightCare analysis, non-elective spend in North Somerset is above average for total MSK spend. This is also the case for is spend on emergency admissions for back, neck and musculoskeletal pain. Locally there is a higher than average non-elective spend for osteoporosis and rheumatoid arthritis which is likely due to a higher prevalence due to an older demographic footprint. North Somerset also has a slightly higher spend on hip fractures in people aged 65-79.

- MSK and trauma and orthopaedic programmes appear in the top ten areas of spend for North Somerset and it has two outcomes defined as a 'worse outlier' (Hip fracture: collaborative orthogeriatric care and Hip fracture: multifactorial risk assessment).

Diabetes

- Prevalence is predicted to increase by 42% from 14,437 in 2015 to 20,483 in 2030 – a rise of ~6,000 people (APHO, 2011) coupled with an ageing population.[23]

- North Somerset patients have poorer blood glucose control than the England average (National Diabetes Audit 15/16).

- There are significant difficulties within North Somerset recruiting to podiatry posts and the diabetic foot clinic does not have 'Hot Foot' status in North Somerset; patients with emergency ‘hot foot’ problems go to NBT.

- Outcomes are lower than the England average. The National Diabetes Audit (2015-16) shows that 14.2% of people with type 1 diabetes met all 3 treatment targets (versus an England average 18.3%) while 35% of people with type 2 diabetes met all 3 treatment targets (versus an England average of 40.4%). There are also 4 more major amputations every year compared with the average rate in England.

[23] http://webarchive.nationalarchives.gov.uk/20170106081135/http://www.apho.org.uk/DISEASEPREVALENCEMODELS

- The growing elderly population, and increasing diabetes prevalence due to rising obesity levels/poor diet will place a greater strain on specialist nurses.
- Numbers of patients attending structured diabetes education have been reported as being very low. All patients diagnosed with type 2 diabetes should be offered structured education to enable them to help themselves delay disease progression.
- Tackling obesity, promoting exercise, and helping patients with non-diabetic hyperglycaemia delays the onset of diabetes.

Dementia

- Dementia and Alzheimer's is one of the three biggest causes of death in North Somerset.
- In North Somerset, it is estimated that 1.79% of people are living with dementia.
- In 2015, 3,634 people were diagnosed with dementia, and it is estimated that by 2035 this will increase to 7,012 people.
- Whilst most causes show a declining death rate the rate from dementia and Alzheimer's appears to be increasing.
- RightCare data identifies North Somerset as having upwards of 15% more short stay emergency admissions for people aged 65+ with dementia than our 10 comparator sites. The best comparator site achieved 111 fewer admissions and 72 fewer short stay admissions.

End of Life

- An estimated 2,400 people die per year in North Somerset.
- North Somerset performs well against national benchmarks in terms of managing end of life (EOL) deaths within the community. 2015 data shows 54% of deaths took place in a person's usual place of residence, compared with a national figure of 46%.
- North Somerset has a higher rate of deaths within care homes: 34.4% in North Somerset versus 22.6% nationally and 27.2% across the south west. It also has a higher rate of deaths in hospice: 6.3% in North Somerset versus 5.6% nationally and 4.9% across the south west.
- Limited EOL community nurse capacity has resulted in an increased reliance on hospice nurses.
- There is scope to improve the way residential homes manage EOL patients. There are pockets of good practice in North Somerset currently, but plenty of potential to further reduce the number of people who die in hospital. This is likely to require increased training for residential homes to achieve this.

Maternity

- Refer to Appendix 5: Pregnant Women.

APPENDIX 7: How Will These Changes Meet the Identified Priorities?

The table below sets out the CCG's view as to how the proposed model of care will better meet the needs of the population and the identified priority groups and specialities.

Priority	Way forward
Frail and Older adults *(Including Care Homes)*	The opportunity to develop a more effective, joined up and efficient service for our Frail Older and Care Home population is clear. We want this work to result in a more resilient and integrated primary and community care system, with wrap around support from other key community partners, and the Acute Trust, to deliver a more holistic and patient centred service to better meet the needs of the Frail Older and Care Home population. This service will include a 7-day Frailty Centre based in a primary care led Community Hub co-located on the Weston 'Care Campus' that will provide an integrated suite of both proactive and reactive services to a clearly defined cohort of patients to keep them well and at home and if they are appropriately admitted to a hospital bed and provide excellent rehabilitation and support services to help them get home as soon as possible. This service could include a Specialist Mental Health Care Home liaison service.
Children, Young People & Pregnant Women *(including complex needs and young people's mental health)*	The option to pool staffing resource and expertise across community and acute paediatric services and co-locate them in the Weston 'Care Campus' presents an opportunity to provide a more joined up model of care for an important and growing section of our population. This opportunity includes the possibility of strengthening the urgent care offer if a seven day service model can be developed. In terms of maternity, we need to find the right location and configuration of birthing services to ensure numbers are sufficient to maintain clinical expertise, exploring a range of clearly defined options that best meets the needs of the local population. A solution needs to be found for maternity services across the whole of BNSSG.
Vulnerable Groups *For example people with mental health needs, learning difficulties and those who struggle with drug and alcohol addiction.*	Conditions such as poor mental health and substance misuse can in themselves create a type of frailty that requires a joined up and comprehensive response. GPs with a special interest may be able to serve a much larger population than their own practice list for some specific conditions, supported by specialist community services. By coalescing these services in a primary care led Community Hub co-located on the Weston 'Care Campus', integrated care pathways can be developed that bridge the traditional divide of 'in versus out of hospital' to better manage these patients in a more holistic, proactive way. The voluntary sector, mental health and public health will all play a critical role in helping to develop these pathways and provide services in the Hub.

Urgent & Emergency Care *(including Emergency Surgery)*	Developing the right "front door" model for urgent and emergency care at Weston General Hospital (WGH) is a crucial part of this work, and the design will need to be considered in the context of its proposed role as an integrated 'Care Campus'. The unplanned temporary overnight closure of WGH's emergency department provides an opportunity to learn from a real life situation as to how we can best provide services for our local population out-of-hours. We also need to take this opportunity to see how the flow through the whole hospital can be improved through better joined up working. An integrated rehabilitation offer should help to reduce length of stay for example, and should help flow, which we know from the recent CQC report, has been a major issue at WGH.
Critical Care	There is a clear consensus that although the service as presently configured was rated as 'Good' recently by the CQC, the current model of critical care offered on the Weston Hospital site (5 Level 3 beds) is sub-optimal due to size and scale. The model of critical care is dependent upon the model of care of other services in the hospital. However, the Critical Care Clinical Expert Group has said that there are two broad options of either expanding the unit or contracting it. Regardless of the service model that is finally agreed, there needs to be a 24/7 on site resuscitation team if the site is to continue to have acute inpatient wards. There is also a recognised need to ensure that the 'Hospital at Night' Team is sufficiently robust, although this is a business as usual requirement rather than something that is linked to a transformational change agenda.
Planned Care	Moving certain services (e.g. emergency surgery) off site would afford the potential to develop the provision of high volume non-complex elective surgery on the Weston site. This would take advantage of WGH's refurbished theatres and ability to attract and retain (for example) a strong orthopaedic team.
Mental Health	Refer to Vulnerable Groups section above.
Cancer	Cancer is a major priority for our system. A significant number of deaths from "treatment amenable" conditions are from cancers such as skin and breast. We want this new model to deliver better early diagnosis, supported by a coordinated screening and diagnostic programme. We would like to explore the possibility of using the Weston 'Care Campus' and the primary care led Community Hub for community based treatments for cancer wherever possible so local residents don't need to travel to Bristol for treatment.
Circulatory Disease	In North Somerset the over 75's have the fastest growing rate of circulatory disease and this must present a major risk for unplanned admission if not managed in a proactive way. The Weston 'Care Campus' provide opportunities for improved long term conditions (LTC) management through the availability of rapid access to diagnostics, multi-speciality LTC clinics, integrated multi-disciplinary teams and expert support and advice from acute clinicians.

Stroke	We know that as the number of older adults grows, the higher the number of strokes that are likely to occur. Across BNSSG we need to review the best place to treat patients who have suffered a stroke, using evidence based models such as Hyper Acute and Acute Stroke Units. The Weston 'Care Campus' could also potentially play a vital role in this process by focussing on stroke rehabilitation and reablement. However, the best outcome of course is to prevent the stroke in the first place. As the risk of stroke increases with age, the local primary care and integrated Community Hub services have an opportunity - by monitoring and treating high blood pressure for example - to help offer a more comprehensive preventive service.
Respiratory (COPD)	The Weston 'Care Campus' / Community Hub model will provide improved integrated primary and community care working to prevent admission through the provision of: closer pathway integration with secondary care, integrated community /acute respiratory teams, including early supported discharge, improved mentoring across primary, community and secondary care, specialist respiratory support to Practice Nurses and GPs, improved access to diagnostics, hot clinics and a single point of access (SPA) for referrals, enhanced LTC management and multi-speciality clinics (to include, for example, heart failure).
Liver Disease	Liver disease contributes disproportionately to poor outcomes in North Somerset. We want to reduce unnecessary Liver Function Tests and unnecessary referrals to secondary care in order to free up capacity to focus on effective treatment of those in need. The Weston Campus model will allow for better shared care of patients who often (if their liver disease is for example related to substance misuse, alcohol or obesity) may have multifaceted needs
Frailty as a specialty	Refer to Frail and Older adults above.
Musculo-skeletal conditions (MSK)	Our new service model is designed to support older patients at risk of non-elective admissions, particularly for falls and fractured neck of femur. Also a more resilient, federated primary care service would have the opportunity to support people living with MSK problems and ensure they have timely access to community physiotherapy and improved support to self-manage their condition. For those patients who do need surgery for MSK, WGH represents an excellent choice for many of the most common conditions and there should be an assumption throughout the system that choosing Weston is a good option for many common MSK conditions.

Diabetes	The Weston 'Care Campus' and Community Hub service provides an opportunity to improve the management of patients with LTCs such as Diabetes by moving the provision of general diabetes care into the community. This will involve providing rapid access to diagnostics, improved access to rapid access clinics and hot foot clinics, improved access to Diabetes Specialist Nursing teams, and swift access to secondary support.
Dementia	Dementia that is not diagnosed and/or supported is a major risk for unnecessary acute admissions of frail older patients who then may suffer the deconditioning associated with an in-patient environment. We want Weston to be known as a centre of excellence for frailty and as such services will need to become highly effective in identifying and managing dementia working collaboratively within well-defined and rehearsed pathways and operating models. This could also involve improved access to Mental Health Liaison services and to the Dementia Support Team to avoid admissions and help maintain individuals with dementia in their own homes and in residential / nursing homes.
End of Life	The best place for patients to die is often at home. This doesn't always happen for a variety of reasons. The integration of services that are commonly involved in the care of a person on an end of life pathway affords us the opportunity to improve the choices and overall care of these patients meaning more people will be able to live out their days in their place of residence.
Maternity	Refer to Children, Young People & Pregnant Women above.

APPENDIX 8: Recognising and Responding to Public & Staff Views

Theme	Response
Core services should be provided as locally as possible (care closer to home) and provided in a more integrated and joined-up way	The work to improve the resilience and coverage of local primary care services, through a federated 'at scale' approach, is a core element of this work. Another core element is the development of more integrated community services wrapped around GP practices and a more effective interface with local acute services.
The need to focus more resources on improving access to General Practice, and at Primary and Community Services more broadly to reflect the increased demand from an ageing and growing population.	We have set out clearly in this document as to the projected growth in the population over the course of the next decade, which will average about 1% per year. Within this estimate the new housing stock has been factored in although clearly the rate of growth in particular parts of North Somerset, and particularly around Weston, will vary. The challenge is not so much about volume, but age as we will see proportionally large increases at both ends of the lifespan. This is why two of our three priority population groups are frail/older adults and children/young people Although there is rising pressure on GP services – in common with the system as a whole – the centralisation of specific services for key population groups is intended to enable a more resilient and responsive set of services, making best use of the system's human and building resources.
The need for a clear and sustainable future for Weston General Hospital and to Ensure other larger acute hospitals support WAHT to deliver sustainable services	The proposals to turn the Weston General Hospital site into a 'Care Campus' model with a primary care led, integrated Community Hub is a great step forward in ensuring the sustainability of the site. Of course, acute services will also continue to operate from WGH, in close cooperation with primary and community services – supported by the UHB Partnership Agreement.
Ensure other larger acute hospitals support WAHT to deliver sustainable services	We agree that the ultimate outcome of the Partnership Agreement between UHB and WAHT is a key part of the solution for the local health economy. Stronger collaboration between UHB, WAHT and NBT are also very important and are being coordinated through the BNSSG STP.
Provision of 24/7 urgent and emergency services, including sufficient resources for South Western Ambulance Service.	We know that a clear and sustainable future model for emergency services must be an output of this collective work. We need to be clear about how the whole system can work together (given for example how many of the serious and life threatening cases already bypass Weston and go to larger, specialist hospitals). If sustaining a specific model of care is likely to take up a disproportionate amount of time, energy and funds we need to have an honest conversation as to what that means in terms of other services that cannot be provided if we choose to spend our resources in this way. Any long term changes to the urgent care model in Weston would need to include a detailed analysis of the any additional capacity

	requirements for the ambulance service. SWASFT are closely involved with this work and therefore we are confident that any final set of proposals will ensure the right level of ambulance support will be factored in.
People being treated in hospital for conditions that could be managed in a community setting. If a person is admitted, they should be better supported to come home as soon as possible.	For frail older patients we know that the evidence is undeniable that if they stay in hospital longer than is medically necessary then this is likely to do long term harm to their health as it can affect – for example - mobility, confidence and muscle mass. The whole idea of the integrated out of hospital model and the aspiration to turn Weston in to a centre of excellence for frailty revolves around the desire to help people keep well and out of hospital, but equally enabling them to return to their normal place of residence as soon as possible though strong rehabilitation and coordinated care.
Collaborating more effectively to optimise support and services provided by our voluntary, community and social enterprise sector.	A key feature of the new model of care is an increased role for our local voluntary, community and social enterprise sector.
The need to create interesting and satisfying jobs and roles to address the gaps in the workforce and create interesting and exciting opportunities for provider staff to work across organisational boundaries.	The ability to work with the patient holistically, rather than seeing them for one isolated part of their care is something that we hope will appeal to staff across all organisations. The idea of redefining WGH as a centre of excellence for certain specific areas of care is also intended to ensure that Weston becomes a more attractive and exciting place to work.
Travel times are an important consideration for patients, particularly for those from deprived and/ or rural populations	We need to ensure that core services are available locally wherever possible to meet this concern, with more complex and specialised services potentially being provided elsewhere to enable this and where clinically appropriate to do so. Travelling long distances is particularly challenging for frail older people – hence the need to provide services more locally and in the community where possible.
The need to reduce variation in service pathways by adopting best practice from across BNSSG	By bringing together best practice from BNSSG (and beyond) we intend to ensure that unnecessary clinical variation and inefficient service pathways can be identified and clinicians and services supported to improve the effectiveness and efficiency of the care offered to patients.

Professionals and organisations should be better at sharing information (supported by integrated IT systems and shared medical records).	We want this work to break down organisational boundaries and enable providers to think of themselves as part of a system rather than individual contractors doing specific task paid for by commissioners.
Address patient need holistically rather than a set of individual conditions to avoid repeating the same information to multiple professionals (i.e. say something once) and having needs re-assessed multiple times.	Patients regularly tell us that having to tell their story over and over again can be a major source of frustration and in some cases leads to delays in progressing smoothly and quickly through the system. Integrating services both physically, and through the better use of IT, affords us great potential to reduce unnecessary duplication of effort.
Help to understand and navigate the 'system' and be kept informed about what's happening	Every patient should be kept fully informed and involved in their care. Sometimes the reasons they are not is actually to do with poor communication channels between the different agencies involved in their care. By enabling providers to come together we expect that patients will experience a more joined up and seamless service.
Before any significant decisions are made, local people must be fully involved	The Communications and Public Dialogue Plan sets out how we will involve local people in this work to get their views and support our co-design model of service development through a three month period covering October to January. Local staff will also be involved.

APPENDIX 9: Developing the Commissioning Context

The following section describes the approach taken in developing this Commissioning Context and provides details of the organisations, clinicians and people who provided their time and expertise.

Approach

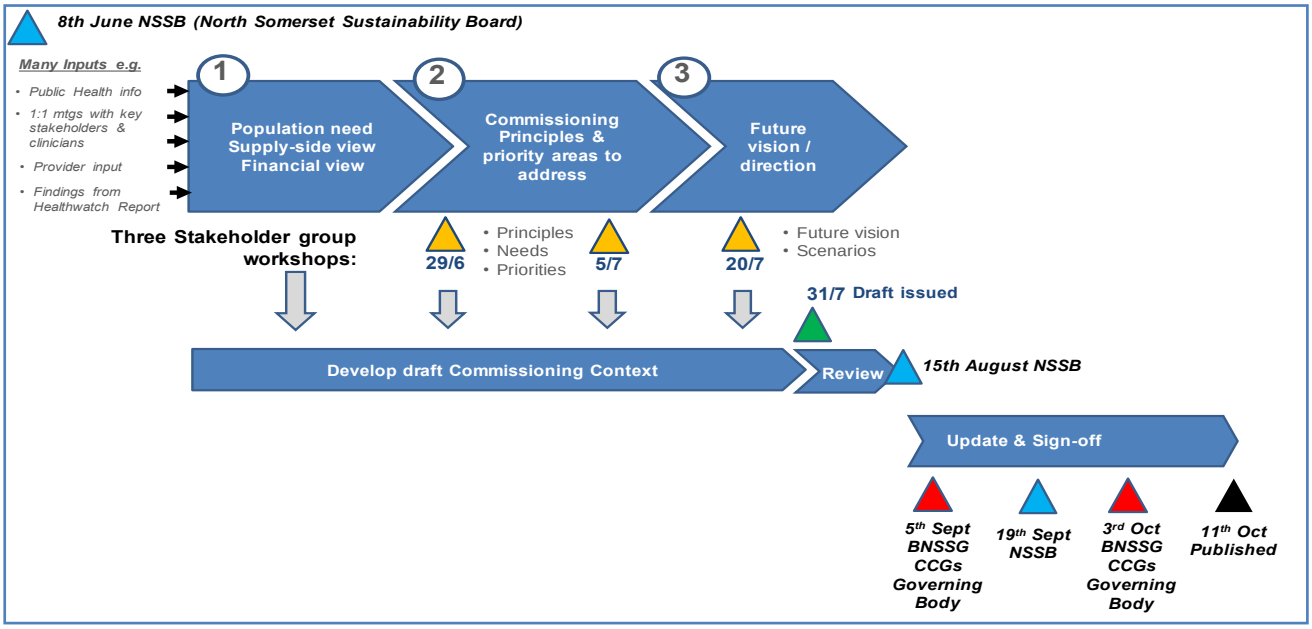


Figure 38: Approach to developing the Commissioning Context

The work to develop the Commissioning Context was initiated at the North Somerset Sustainability Board (NSSB) on the 8th June 2017 and the approach taken is summarised in the figure above. The NSSB is Chaired by Mike Jackson, Chief Executive of North Somerset Council, and includes senior representation from across the local health economy (refer to the following section for further details on membership). The approach consisted of three key phases as outlined below:

Phase 1: Population Need, Supply-side and Financial View

- The first phase involved gathering a significant amount of information from a wide variety of sources to build a comprehensive view of population need including local demographics, population trends and future projections and local health and care need information sourced from various joint strategic needs assessment (JSNA) reports and data from public health, as well as more detailed information from local commissioners. This information was supplemented by a series of 1-2-1 meetings with key stakeholders and clinicians.
- To develop the supply-side view of the provider landscape, information was provided by local providers and partners, including current service provision and key service delivery challenges.
- The financial section, and supporting narrative, was developed by the CCG and then subsequently shared with local providers for feedback and comment. The information in

this section aligns with the CCG's Financial Recovery Plan for 2017/18, the CCG's two year Operating Plan for 2017/18 and 18/19, and the provider financial figures provided in the BNSSG STP.

- Finally, the recommendations highlighted in the recent Healthwatch report were also taken into account.

Phase 2: Commissioning Principles & Priority Areas

Through a series of workshops with a core group of key local clinicians and stakeholders, the CCG defined the following:

- A set of Commissioning Principles (refer to Section 0) to set out a clear set of commissioning parameters or 'guard rails' against which the Commissioning Context and the future vision for local services could be developed.

- An agreed set of Priority Areas of Focus (refer to Section 0) based on a comprehensive review of the local population need that looked at the data both through a population 'lens', and a clinical speciality 'lens', to identify those areas most in need of system transformation.

Phase 3: Future Vision & Direction

The future vision for local services was shared, discussed and developed in a half-day workshop on the 20th July. Using a series of common real-life patient scenarios to bring the session to life, key local stakeholders compared and discussed how patient need is managed currently in comparison with how it could be managed in a more integrated way. Various 'Care Campus' examples were explored along a spectrum of possible options that brought together acute, community and social care services into a single integrated model of care co-located at the Weston General Hospital site.

An initial draft of the Commissioning Context was issued for review at the end of July and the future direction of travel to deliver the vision and model of care was then discussed and agreed at the North Somerset Sustainability Board on the 15th August, along with specific points of feedback on the draft report. The report was subsequently updated based on the feedback submitted along with further clarification discussions on specific topics to ensure alignment and agreement. The document was then submitted for BNSSG CCG Governing Body review on the 5th September and review by the North Somerset Sustainability Board on the 19th September. A final version was then submitted for BNSSG CCG Governing Body approval on the 3rd October and the final version published on the 11th October 2017.

Organisations and People

The CCG developed this Commissioning Context in close collaboration with key local partners and with the involvement of a significant number of senior stakeholders from across the local health and care economy.

The organisations involved included:

The people involved from these organisations included:

Workshop 1 (26/6):

- Mary Backhouse (GP)
- Colin Bradbury (CCG)
- Judith Brown (NSCP)
- Debbie Campbell (CCG)
- Peter Collins (WAHT)
- Eva Dietrich (AWP)
- Deborah Greenfield (LA)
- John Heather (GP)
- Andy Hollowood (UHB)
- Mike Jenkins (GP)
- Alison Moon (CCG)
- Julia Ross (CCG)
- Kathy Ryan (Brisdoc)

Workshop 2 (5/7):

- Colin Bradbury (CCG)
- Judith Brown (NSCP)
- Debbie Campbell (CCG)
- Peter Collins (WAHT)
- Eva Dietrich (AWP)
- John Dyer (SWAST)
- Deborah Greenfield (LA)
- Mike Jenkins (GP)
- Alison Moon (CCG)
- Anne Morris (CCG)
- Julia Ross (CCG)
- Kathy Ryan (Brisdoc)

Workshop 3 (20/7):

- Miriam Ainsworth (GP)
- Mary Backhouse (GP)
- Georgie Bigg (Healthwatch)
- Colin Bradbury (CCG)
- Judith Brown (NSCP)
- Debbie Campbell (CCG)
- Paula Clarke (UHB)
- Peter Collins (WAHT)
- Eva Dietrich (AWP)
- John Dyer (SWAST)
- Mark Graham (Weston Primary Care)
- Deborah Greenfield (LA)
- John Heather (GP/OneCare)
- Andy Hollowood (UHB)
- Mike Jenkins (GP)
- Mary Lewis (NSCP)
- Ray Montague (Brisdoc)
- Anne Morris (CCG)
- Laura Nicholas (STP)
- James Rimmer (WAHT)
- Julia Ross (CCG)
- Mike Vaughton (CCG)
- Eve Wilson (Protect our NHS)
- Andrea Young (NBT)

The table below provides the full list of people who were either involved in the workshops to develop the Commissioning Context, or who provided feedback on the document:

Name	Position	Sustainability Board?
Miriam Ainsworth	Clinical Lead for Community Services & LTCs, North Somerset CCG	N
Mary Backhouse	Clinical Chair, North Somerset CCG	**Y**
Georgie Bigg	Chair, Healthwatch North Somerset	**Y**
Colin Bradbury	Area Director for North Somerset, BNSSG CCGs	**Y**
Judith Brown	Chief Executive, NSCP	**Y**
Debbie Campbell	Programme Director, Weston Primary Care Transformation Programme, North Somerset CCG	**Y**
Paula Clarke	Executive Director of Strategy & Transformation, UHB	N
Peter Collins	Medical Director, WAHT	**Y**
Eva Dietrich	Clinical Director, AWP	N
John Dyer	Head of Operations, SWASFT	**Y**
Paul Goodwin	Deputy Chief Officer & Director of Commissioning & Governance - Somerset CCG	**Y**
Mark Graham	CEO, For All Healthy Living Centre - Weston Primary Care	N
Deborah Greenfield	Acting Service Leader Adults' Support & Safeguarding, North Somerset County Council	N
John Heather	GP at New Court Surgery, Chair of OneCare	**Y**
Maria Heard	Transformation Programme Director, NHS England	**Y**
Andy Hollowood	Clinical Strategy Lead, UHB	N
Suzanne Howell	Managing Director, AWP	**Y**
Mike Jackson	Chief Executive, North Somerset County Council	**Chair**
Mike Jenkins	GP at Riverbank Medical Centre & Mental Health Clinical Lead for North Somerset CCG	N

Victoria Keilthy	Head of Delivery and Development	**Y**
Mary Lewis	Director of Nursing, NSCP	N
Cara MacMahon	CEO, Voluntary Action North Somerset	**Y**
Ray Montague	Chairman, BrisDoc	N
Alison Moon	Director of Transition, BNSSG CCGs	N
Anne Morris	Director of Nursing and Quality, BNSSG CCGs	N
Laura Nicholas	BNSSG STP Programme Director	**Y**
James Rimmer	Chief Executive, WAHT	**Y**
Julia Ross	Chief Executive, BNSSG CCGs	**Y**
Derek Sprague	Local Director - South West, Health Education England	N
Mike Vaughton	CFO, North Somerset CCG	N
Eve Wilson	Local Protect our NHS Representative	N
Andrea Young	Chief Executive, NBT	**Y**

APPENDIX 10: 'You said… and your views have influenced the CCG to…'

This section links public and staff feedback gathered as part of the earlier engagement process for the Weston Sustainability Programme with the content of this Commissioning Context document. It shows where feedback has influenced the CCG's vision and the direction of travel for a new model for health and care in the 'place' of Weston.

The feedback presented below came from a mixture of public and staff contributors and from a range of different sources: e.g. on-line survey, community and public meetings, staff engagement, correspondence and social media. The direct quotes (italicised) are illustrative of many of the 6600 items of feedback data received. Other 'You said …' entries are summaries of commonly occurring themes.

Healthwatch North Somerset collated all of the feedback received through the engagement into an independent report: Healthwatch North Somerset - Weston General Hospital at the Heart of the Community - Public and Staff Engagement - 30 June 2017.[24]

You said…	Your views have influenced the CCG to …
Q1. Do our reasons for change make sense to you? Responses: = 391 Yes: 63% No: 37%	
Your reasons for needing services to change made sense to most of us: ***"To make better use of resources in the current climate and opportunity to improve efficiency"*** ***"Opportunity to redesign for improved efficiency".***	Build on this foundation. The Commissioning Context document provides much more detail about why "doing nothing" is not an option for the future.
Additional service areas are just as	Widen the scope of the Weston Sustainability

[24] https://www.northsomersetccg.nhs.uk/media/medialibrary/2017/07/Engagement_Report_Weston_General_Hospital_at_the_Heart_of_the_Community.pdf

You said…	Your views have influenced the CCG to …
important as the services expressed as the four main ideas for the engagement. Including Primary Care, Mental Health, Children and Young People's Services, and especially Child & Adolescent Mental Health Services (CAMHS).	Programme to look at a whole system approach to improving services for the population of the 'place of Weston'. This includes Primary Care, Community Care, Mental Health Services as well as Acute Hospital Services. It also includes services across all life stages.
"I am concerned for older very ill people". ***"Invest in acute frailty services e.g. older people's advice and liaison services, or integrated acute frailty teams".***	Plan to better meet the needs of older people and people with frailty. They are one of three priority groups identified for service re-design. The Care Campus model includes an Acute Frailty service.
"Challenge is to centralise in the hospital those things needed on site and take other things out to GP surgeries and home, which technology now allows to be done safely there".	Develop a new model for health and care offering holistic care that will make the most of scarce resources and place the right service in the right place, to meet the needs of patients, services users and staff.
"But there is a hidden reason - lack of money. This country can and must spend more on its health and community services. You should be open about this".	Set out and explain the financial challenge in detail. Being transparent about affordability is a main principle underpinning our public dialogue and co-design process.
Q2. Do you think we need to change? If not why not? Responses = 391 Yes: 208 (83%) No: 44 (17%) (139 no response)	
83% of respondents said … *'we need to change'.* ***"I understand they need to save money, but after receiving treatment at Weston General I wouldn't want them to change. I would hate to be taken to another hospital if taken ill at night".***	Offer a 12 week public dialogue phase and a process of co-design that will enable people to explore together how we can make the most of our scarce emergency care workforce and change current services to provide an affordable, good, safe and appropriate 24/7 urgent and emergency care service.
"It does make sense, but it looks like short term plans".	Set out some key ambitions for the developing new model for health and care, in that it will be both affordable and sustainable. The focus is on providing solutions to current challenges into a long term future.
"I fully understand the need to recruit staff and to save money, but I am finding it hard to reconcile this with the fact that Weston has a growing population and in summer months this increases considerably. Surely there is a need for better facilities to meet this demand". ***"Staff allocated to achieve maximum support to patients within budget and bed turnover".***	Set out in detail the challenges around a growing and ageing population and the impact of tourism. The impetus for change starts from how we will best address the health needs of the population. We also look at how the workforce will need to develop to meet those needs. The new model of health and care focuses on better facilities to meet the specific 'place of Weston' population need within the finances available.

You said…	Your views have influenced the CCG to …
No your ideas don't make sense – what about: • **[the]Increasing population** • **Hospital needs to be bigger and better funded** • **Impact of journey times to other hospital** • **Insufficient information to make comment** • **A&E is needed 24/7** • **Transport** • **Risks to patients in being transferred** • **Ambulance provision** • **Ability of other hospitals to cope with extra patients**	Widen the scope of the Weston Sustainability Programme to include these additional factors and provide sufficient information to ensure people can continue to contribute to developing the proposed new model of health and care. Ensure that a key principle of the new model of health and care is to provide services as close to where people live as possible and as appropriate for the best patient outcomes. Consider the impact of patients travelling to other hospitals for certain treatments and procedures. Factor in the interdependencies between services and organisations by working at a health system level.

Q. 3 Have we represented our ideas clearly? If not what further information would be helpful?
Responses = 221
Yes: 154 (70%) No: 67 (30%)

"I would clarify your proposals for extended day and 7 day working. I hope your elective care plans are for 12 hour operating across at least 6, ideally 7 days to maximise capacity. Also, what about outpatients and rehab/re-enablement?"	Offer an opportunity through public dialogue and co-design to work on the detail of how services will operate within the proposed new health and care model including services offering 7 day working. Implementation will be informed by staff views and the views of public contributors. Co-design groups will work together to see how best specific service changes can be implemented.
"Enabling strategy of community working is too non-specific. The challenges of NS Local Authority are well known locally, but your relationship with primary care and the VCS are important too".	Provide much more detail about how primary care; community care; social care; mental health care and acute hospital care can work within a more joined up way supported by services from the Voluntary, Community and Social Enterprise Sector within the proposed new model for health and care for the 'place of Weston'.
"Ideas are presented clearly but sound too simple. I expect anyone who works in healthcare will have a different opinion and a feeling of helplessness that the plan is already made. The legality states that this process has to happen but the deal is done which will be revealed in 3 months. I really would love to think that my opinion would	Provide assurance within the Commissioning Context document that the 'deal is not done' and that public and staff contributions are vital to develop the new model of health and care proposed. The public dialogue and co-design process will aim to draw as many contributors into the planning and shaping of the new model as wish to participate.

You said…	Your views have influenced the CCG to …
actually count!!!"	
"You are hiding the ultimate goal which is to close the hospital".	Provide assurance that the 'ultimate goal' is to have affordable, appropriate and sustainable acute hospital, community, and mental health and primary care services to meet the health needs of the population. In particular, the Care Campus model is proposed to be created within the Weston General Hospital estate.
"The ideas presented are more of a fait accompli than an options proposal, the option to close or scale down is not considered".	Provide assurance that no decisions about long term service configuration and re-design have been made. The public dialogue and co-design process offers opportunities for staff and public contributors to participate by working alongside clinicians and health planners to develop the new model of health and care.
"I don't understand why you clarify that non-seriously ill patients recover quicker closer to home. Does this not apply to seriously ill patients as well?"	Clarify further, to explain that patients with very serious illness or major trauma have better outcomes when they are treated by specialist teams with access to all of the right equipment to manage their condition. Not every hospital provides the full range of teams and equipment needed to treat every possible serious illness or major trauma. For example, in our area North Bristol Trust treats major trauma and University Hospitals Bristol treats serious heart conditions. We do acknowledge the difficulties arising for visitors who need to travel further to visit loved ones but the priority is for patient safety and ensuring the best patient outcomes.
You said that you would have liked further information on: • **Costs** • **Population** • **Impact assessments of each idea** • **Statistics on the numbers affected by the ideas**	Provide much more detail on most of these factors within the Commissioning Context Document. Further work will be undertaken as the Weston Sustainability Programme of work progresses. Any significant service re-design proposal/s will require impact assessments for equality and quality.
"More information about why these proposals have been made would be helpful".	Provide more detailed information in the Commissioning Context Document about the various challenges to the system and why 'doing nothing' is not an option.

You said…	Your views have influenced the CCG to …
"Very jargony in your articles in the Mercury. Nobody knows what you're trying to say. Be Clear".	Provide a detailed Commissioning Context Document to meet the need for openness and transparency acknowledging that the document is not written specifically for a public audience and uses by necessity some professional and technical language. To support greater accessibility to key information, and to promote a shared understanding of the challenges and potential solutions, a range of more accessible materials are being prepared. These will include presentations, Easy Read versions of key topic areas and will be supported by community meetings where the information can be discussed and clarified. We aim to keep jargon to a minimum and to respond to any enquiries clearly and promptly.
"I think your ideas are very vague and misleading, the titles don't reflect exactly what you're trying to say, for example increasing the number of ITU beds then saying you are going to take the intensive care part of it away and send the patients to larger hospitals leaving Weston to only deal with HDU patients. I think your explanations needed to be more in depth".	Provide much more detail in the Commissioning Context Document. This will be strengthened through the period of public dialogue and co-design.
Q4. What issues do these ideas (any or all of them) raise for you, that you would want us to explore before any decisions are made? Responses: 391, 261 comments received	
"You should consolidate public's views and publish the frequently occurring and best suggestions. The public can then be asked to comment further".	Publish the independent Healthwatch North Somerset report which details all of the feedback received through the public engagement period from February to April 2017. For the Public Dialogue and Co-design period we plan to publish the outputs of place based meetings and co-design groups as we progress through the process. We will also publicise ways to become involved.
"I recognise the value of utilising planned surgery - particularly in view of a new theatre and a lot of surgeons sat around	Provide a public dialogue and co-design process that will include staff currently delivering services, and who understand some

You said…	Your views have influenced the CCG to …
kicking their heels when electives are cancelled. However, my concern would be having a significant drive towards more planned surgeries whilst the situation in ED is not solved. My worry is that there will be a significant promotion of WGH's ability to do more non-complex elective surgeries but that the hospital will still cancel these when in Opel 4 thereby reducing public confidence in the hospital to meet the needs of the community".	of the challenges on the 'frontline'. Provide a whole system approach to problem solving through the new model of health and care set out in the Commissioning Context document that considers in detail the interdependencies between services and pre-empts unintended consequences associated with any service change.
Q5. Are there any other ideas for change that we should be exploring which would make services more viable (better quality, more affordable)? Responses: 391, 232 comments received	
"For years now health professionals have been the victims of negligence claims to the extent that as soon as anyone presents at an A&E dept. The doctors and nurses seem to err far too much on the side of caution. Whilst thoroughness is a virtue it can sometimes assume the status of the proverbial "Jobs Worth award" and thus take up a lot of time with its attendant expense".	Provide a proposal for a new model of health and care that will ensure that people who enter the health system will be seen by the right health professional, in the right place at the right time. This will help to ensure that the health professional treating the patient will be able to manage their condition appropriately and effectively. Self-care and prevention of illness is seen as a core part of the model, with health education being incorporated within the services offered by the Care Campus. Overall this approach should increase patient satisfaction with their experience and so help to reduce claims and complaints.
"We need to make better use of IT and this will cost money and investment but it could take treatments into people's homes - there needs to be a real understanding that investment this way can save money in the end - keeping people out of hospital and healthy is cost effective. However, the movement of money out of Trusts does affect how they can deliver their services so Trusts must be part of designing these pathways and it must be a conversation with clinical teams not just managers who have never been clinicians making decisions when they don't really understand the barriers to the "good idea".	Consider within the new model of health and care and the Care Campus model in particular, how IT can improve the patient and workforce experience. With appropriate consent, sharing electronic patient records across organisational boundaries is an example of this.
Idea 1: Change the Urgent and Emergency Care Service Model Overnight from 10pm – 8am. Responses: 391 187 comments received, 70 stated 'do not close' A&E	

You said…	Your views have influenced the CCG to …
"Shutting A&E 2200-0800hrs to ambulances is utter madness. It will risk patient health".	Provide a further opportunity to review long term solutions for emergency and urgent care services at Weston General Hospital. These services are set out within the Commissioning Context Document for public dialogue and co-design. Since the earlier engagement; due to the Care Quality Commission report and for issues of safety, the Emergency Department at Weston General Hospital is now closed between 22:00hrs and 08:00hrs. The Weston Sustainability Programme Team is gathering data to accurately measure the impact of this situation on patient flow and patient care. Findings from this analysis will be fed into discussions about future services.
"Over a quarter of our emergencies seen at Weston General are between the hours of 10pm and 8am. 28% is a lot of poorly people. Anyone presenting at 2am is probably poorly enough for a doctor".	
"Closing the emergency department, what happens when you can't get a GP appointment for 3 weeks and become so ill that you have to attend A and E to get help. Only to find the department has no doctors. What happens then, I have no car, and buses don't run that time of night so I phone an ambulance to take me to another hospital that if they're not already waiting outside the other hospital due to lack of hospital beds".	
Idea 2 Bring day to day Non-Complex Planned Operations Back to Weston General Hospital Responses: 391 (HWNS report states 'smaller response to this idea')	
"Weston General Hospital is already very good at providing surgery when beds allow, so to imagine this will improve is fantasy".	Provide more detail in the Commissioning Context document about how planned surgery could be provided at Weston General Hospital by developing the concept for a stronger, focused Acute Trust and Acute Care Model. The Acute Care Model includes consideration of the need for further discussion concerning critical care beds; both as Intensive Care beds and/or High Dependency beds.
"If more operations at Weston General Hospital are being considered then occasionally things don't go quite as planned and patients need some major aftercare. It seems therefore unwise to consider not providing some limited ITU capability".	
"I know you've said there would be High Dependency beds, but I would be worried about having surgery in a hospital that didn't have an intensive care unit. If something went wrong, I would not want to travel 20 miles, or more by ambulance to another hospital".	
Idea 3: Transfer Some Emergency Surgery to Other Hospitals Responses:391 'HWNS report states 'very few direct answers to idea 3'.	
"Transfer emergency surgery - no one will want to work for the Trust and recruitment	Provide a proposal for a new model of health and care set out in the Commissioning Context

You said…	Your views have influenced the CCG to …
will be difficult, meaning more locums and higher cost".	document that considers recruitment and retention issues.
"Stopping emergency surgery at Weston Area Health Trust - this work helps attract staff into posts".	By developing the new model of health and care and the especially the Care Campus model it is hoped that this will offer a new and exciting opportunities for clinical and non-clinical staff as well as new roles for voluntary sector providers and for volunteers.
Idea 4: Increase the Number of Beds in the Critical Care Unit on the Weston General Hospital Site. Responses: 391 114 comments – HWNS state 'that the staff and pubic focus was on possible closure of ITU'	
"Cutting back on ITU, why would you do that, if anything it should be increased, from personal experience I can tell you having a loved one far away from Weston, i.e. Bristol, puts untold strain on the family and can result in more casualties, driving whilst upset, or trying to make it to the hospital before they pass away is unexplainable, you don't think about others, wrong as that is, your mind is taken over by your grief". ***"Increasing the size of the ITU. Too expensive".*** ***"No, definitely should concentrate on HDU beds, and option to take ITU to other specialist units".***	Providing clearer information within the Commissioning Context document will help to explain the interdependencies between services and how we need to ensure that patients are treated in the right place to achieve the best and safest patient outcomes. One of the key principles embedded within the new model for health and care for Weston is that it has to be both affordable and sustainable into the future. By starting from a perspective of meeting the health needs of the population we can design services together to meet these particular needs rather than keep a narrow focus on changes to one element or service within the whole system.
Q6. Are there any of these ideas that we simply should not be considering and why? Responses: 391 187 comments received 37 stated 'no' or 'N/A'	
Shutting A&E because of the distances to travel to other hospitals and risks to patient safety.	Provide a further opportunity to review long term solutions for emergency and urgent care services at Weston General Hospital. These services are set out within the Commissioning Context Document for public dialogue and co-design. Since the earlier engagement; due to the Care Quality Commission report and for issues of safety, the Emergency Department at Weston General Hospital is now closed between 22:00hrs and 08:00hrs. The Weston Sustainability Programme Team is gathering data to accurately measure the impact of this situation on patient flow and patient care.

You said…	Your views have influenced the CCG to …
	Findings from this analysis will be fed into discussions about future services.
Q7. Is there anything else important that you think we have missed?	
"Narrow the gap with community services and discharges. Have one clear admission prevention team and one clear integrated discharge team. Make the patient flow co-ordinator part of these two teams so that everything is co-ordinated for the patients as soon as they arise".	The Commissioning Context document proposes a Care Campus concept that is based on clear integration between primary and community care and mental health and acute care services.
"At the earliest possible stage, it is important to have clarity as to who will be making the crucial decisions, the question regarding staffing and workload and how these plans will not burden other Trusts, who also have similar pressures regarding bed occupancy".	Will make decision making committees and processes and committees clearly identified within our Public Dialogue and Communication processes. The North Somerset Sustainability Board and the Bristol, North Somerset and South Gloucestershire CCGs Governing Body (meeting in common) are decision making groups for the Weston Sustainability Programme.
"No, pretty well covered all aspects that I'm aware of".	
"Not sure what is happening to CAMHS? Under-resourced vital team for children of North Somerset".	Children and Young people's services and mental health services will be included in the new model of health and care set out within the Commissioning Context document.
"Not that I can think of, although the ITU does also need to be refurbished as it is so dated compared to the rest of the hospital!!"	Noted!
Q8. Do you have further ideas, comments or views that you would like to have included with the feedback? Responses: 391 152 comments	
"Are there any services that could be moved to Burnham-on-Sea hospital or Clevedon hospital instead of Weston so we would have more space in Weston as the hospital is much too small even now?"	Continue to work closely with Somerset CCG to see how we can redesign services that work for the population.
"What assurances are there that the CCG (having been rated as inadequate, and being put into special measures) has the means and ability to deliver on these proposals and programme of work?"	Reorganise our commissioning organisation to optimise and strengthen our leverage (power to make things happen). North Somerset CCG is in a process of transition with an intention towards merger with Bristol and South Gloucestershire (BNSSG) CCGs. Working from a stronger basis and as part of the BNSSG Sustainability and Transformation Partnership will help us to ensure we have both the means and ability to deliver this programme of work.
"Very poor, virtually non-existent	

You said…	Your views have influenced the CCG to …
notification of this consultation in the community with Somerset....it looks as if you don't want to know what 20 percent of Weston's patients think. I think it could well be challenged..."	Ensure better publicity for the population in Somerset of our Public Dialogue process and opportunities to become involved in co-design work as the programme of work progresses.

END

Healthier Together

Improving health and care in Bristol,
North Somerset and South Gloucestershire

HEALTHY WESTON

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Appendix 9 Best Practice Pathways

2nd November 2018

Common enablers to all models

- Standardized care pathways
- Common approaches (integration) across whole system
- Easy access to senior decision makers – on site or remotely
- Remote advice to specialist opinion
- Mental health crisis teams available, ideally in ED/UTC
- Stabilisation and rapid transfer for patients needing escalation
- Transfer back from specialist centres to local units
- Easy step-down or transfer to community / social settings
- Greater use of hot clinics
- Enhanced use of IT and technology
- Staff rotations

Potential clinical service models for A&E (1/2)

Additional models for major trauma centre and major emergency hospital (with higher consultant presence) are not shown

	Model A A&E + UTC (24/7)	Model A A&E + UTC (Restricted hours)	Model B A&E + UTC ("Medical")
Staffing	▪ ED consultant available 24/7[1] ▪ Additional complement of Tier 1 and 2 practitioners (incl. Mental Health) ▪ Diagnosticians ▪ Multidisciplinary team to support frailty unit	▪ ED consultant in person until 2 hours after A&E closes ▪ Junior doctor cover until 2-4 hours after close of A&E ▪ Complement of Tier 1 and 2 practitioners (incl. Mental Health) during opening hours ▪ Multidisciplinary team to support frailty unit	▪ ED/acute medicine consultant on site until 2 hours post ED closure ▪ Stabilise & transfer team (anaesthetist + critical care nurse) on site during opening hours ▪ Mental Health practitioner available ▪ Multidisciplinary team to support frailty unit ▪ Remote access to A&E consultant
Other service requirements	▪ Level 3 critical care ▪ NCEPOD staffed theatre 24x7 ▪ 24x7 interventional radiology and endoscopy available ▪ Ambulatory unit and clinical decisions unit ▪ Frailty unit ▪ Primary care front door	▪ Level 3 critical care ▪ NCEPOD staffed theatre 24x7 ▪ Interventional radiology and endoscopy available ▪ Ambulatory unit and clinical decisions unit ▪ Frailty unit ▪ Primary care front door	▪ Level 2 or 3 critical care ▪ Transfer for services not on site including interventional support ▪ MAU and frailty unit on site ▪ Primary care front door
Conditions covered	▪ All A&E attendances and GP referrals ▪ GP out of hours services at UTC	▪ All A&E attendances and GP referrals during opening hours ▪ GP out of hours services at UTC	▪ Medical ED attendances, minor illnesses and injuries, GP referrals ▪ Stabilise and transfer others ▪ GP out of hours services at UTC
Conditions not covered	▪ Major complex conditions needing treatment at specialist centres (e.g. polytrauma, hyperacute stroke) ▪ Stabilise and transfer patients needing tertiary (specialist) care	▪ Major complex conditions needing treatment at specialist centres (e.g. polytrauma, hyperacute stroke) ▪ Stabilise and transfer patients needing tertiary (specialist) care	▪ Surgical ED attendances e.g. patients requiring laparotomy ▪ Other complex needs (any life or limb threatening conditions); conditions requiring critical care

1 For small DGH the assumption is that this would require 8- 10 WTE consultants

Potential clinical service models for A&E (2/2)

	Model C A&E (Urgent treatment centre)	Minor injury
Staffing	▪ GPs ▪ Advanced Nurse Practitioner (ANP) support ▪ HCAs ▪ Multidisciplinary team of GPs, geriatricians, ANPs to support frailty unit ▪ Mental Health practitioner available ▪ Remote access to A&E consultant	▪ ENPs ▪ HCAs
Other service requirements	▪ Capacity to stabilize and transfer ▪ Possibly ambulatory care observation and assessment ▪ Possibly frailty unit	▪ Capacity to stabilize and transfer
Conditions covered	▪ All minor illnesses and injury ▪ Stabilise and transfer others ▪ GP out of hours services	▪ Minor injuries e.g. lacerations
Conditions not covered	▪ Suspected complex fractures; other complex needs (any life or limb threatening conditions); conditions requiring critical care	▪ All patients needing medical input

Potential clinical service models for Acute Medicine (1/2)

	24/7 acute medical take (with a Medical Assessment Unit)	Selective acute take (with a Medical Assessment Unit)	Medical Assessment Unit (MAU) only
Staffing	▪ Acute medicine consultant on site during opening hours of 'front door' ▪ 24 x 7 medical reg on site	▪ Acute medicine consultant on site during opening hours of "front door" ▪ 24 x 7 medical reg on site	▪ Acute medicine consultant on site during opening hours of "front door" ▪ Medical registrar on call
Other service requirements	▪ Level 3 critical care ▪ Interventional radiology and acute bleed service available ▪ Frailty unit and AAU ▪ Diagnostics ▪ Standardized care pathways with GP admits direct to AAU/frailty unit	▪ Level 1 or 2 critical care (with ability to step up to transfer) ▪ Acute assessment unit ▪ Frailty unit ▪ Diagnostics ▪ Standardized care pathways with GP admits direct to AAU/frailty unit	▪ Level 1 or 2 critical care (with ability to step up to transfer) ▪ Acute assessment unit ▪ Frailty unit ▪ Diagnostics ▪ Standardized care pathways with GP admits direct to AAU/frailty unit
Conditions covered	▪ All acute medical admissions except for hyper-acute stroke and cardiac care	▪ All non- high acuity	▪ Non-high acuity patients requiring up to 48-72 hours stay
Conditions not covered	▪ Hyper acute stroke patients requiring thrombectomy ▪ Hyper acute cardiac care ▪ Hepatology	▪ Stroke patients, hyper acute cardiac care, subset of patients requiring level 3 critical care ▪ Acute bleeds ▪ Hepatology	▪ High acuity patients ▪ Patients needing longer inpatient care

Potential clinical service models for Acute Medicine (2/2)

	Ambulatory Care Unit with no beds	Step up / step down or discharge to assess (D2A) beds but no medical take
Staffing	▪ Acute medicine consultant or registrar on site during opening hours of "front door“	▪ Multi disciplinary team with GPs, care of the elderly consultants, ANPs, AHPs, social care
Other service requirements	▪ Frailty unit ▪ Diagnostics ▪ Standardized care pathways with GP admits direct to ACU/frailty unit	▪ Access to specialist opinion ▪ Access to hot clinics ▪ Diagnostics ▪ Capacity to stabilize and transfer ▪ Standardized care pathways
Conditions covered	▪ Patients requiring short term observation and assessment within 24 hours	▪ Patients needing short term assessment
Conditions not covered	▪ Patients needing inpatient care	▪ Acutely unwell patients who warrant care in a more specialist centre

Potential clinical service models for Emergency Surgery

	24 / 7 emergency general surgery	On-call general surgery with no registrar OOH	Ambulatory emergency surgery	Surgery hot clinics (SAU + recovery beds)	Minor injury only
Staffing	▪ 24 / 7 gen. surg. consultant for emergency surgery cover ▪ Surgical registrar OOH and consultant on-call ▪ Anesthetists available ▪ Stabilise & transfer team (anesthetist + critical care nurse) on call	▪ 12 / 7 “in hours" general surgery consultant cover ▪ Consultant surgeon at night (emergencies only) on call ▪ Stabilise & transfer team (anesthetist + critical care nurse) on call	▪ Surgical consultant cover on standby to offer opinion ▪ No on-call rota	▪ Daytime consultant cover for hot clinic ▪ No emergency surgery on-call rota OOH	▪ No "in hours" cover from general surgery team (all care provided by elective surgery teams) ▪ No emergency surgery on-call rota OOH
Other service requirements	▪ Level 3 critical care ▪ NCEPOD staffed theatre 24x7 ▪ Interventional radiology available	▪ Level 3 critical care ▪ NCEPOD staffed theatre 12x7 ▪ Interventional radiology available	▪ Capacity to stabilize and transfer	▪ Capacity to stabilize and transfer	▪ Capacity to stabilize and transfer
Conditions covered	▪ All emergency procedures for patients up to ASA 4 ▪ All #NOF patients admitted directly from SWASFTs as well as those coming through A&E requiring shared care with medics as well as surgeons	▪ All emergency procedures for patients up to ASA 4 ▪ All #NOF patients admitted directly from SWASFT as well as those coming through A&E requiring shared care with medics as well as surgeons	▪ Ambulatory surgical activity e.g., abscess drainage, gall bladders, piles (add to DC lists) ▪ All emergency pro-cedures not required within 12 hours ▪ Well #NOF patients	▪ No emergency surgery ▪ Hot clinic outreach (GP direct access) ▪ All emergency procedures not required within 12 hours ▪ Well #NOF patients	▪ Minor injury e.g. laceration
Conditions not covered	▪ Specialist surgical procedures that require transfer to a specialist centre (e.g., vascular, head injury)	▪ All high risk patients and high complexity procedures	▪ All high risk patients and high complexity procedures ▪ Emerg. laparotomy + all non-medical abdominal pain ▪ Comorbid #NOF patients	▪ All high risk patients and high complexity procedures ▪ Emerg. laparotomy + all non-medical abdominal pain ▪ Comorbid #NOF patients	▪ All patients needing medical input ▪ All #NOF patients, including otherwise well #NOF patients

Potential service models for critical care

	Critical care L3, shared rota +/- eICU*	Critical care L2 +/- eICU*	L1 Ward based care	No enhanced care
Staffing	▪ 24x7 Critical care consultant cover ▪ If eICU - consultant 14x7 / on-call OOH, eConsultant 24x7 ▪ 1:1 RN	▪ 24/7 acute medicine **or** anaesthetic consultant cover ▪ Transfer team for step up and stabilize if required ▪ 1:2 RN	▪ More intensive monitoring, e.g., cardiac monitoring supported by transfer team ▪ Transfer team for step up and stabilize if required ▪ 1:4 RN	▪ No transfer team or support for intensive monitoring
Conditions covered	▪ Level 3 patients - requiring two or more organ support (or needing mechanical ventilation alone)	▪ Level 2 patients - single organ support (excluding mechanical ventilation) such as ionotropes and invasive BP monitoring	▪ Level 1 patients only – no organ support required ▪ CPAP	▪ Normal ward care
Conditions not covered	▪ None	▪ Patients requiring multiple organ support	▪ Patients requiring organ support (including vasopressor support)	▪ Patients requiring organ support or intensive monitoring

***eICU refers to an electronic intensive care unit platform which intensive care consultants can access remotely**

Potential clinical service models for Elective Care

	All elective surgery w/ emergency theatre	Non-complex elective surgery w/ enhanced day care unit (ASA 3 or less)	Non-complex elective surgery with enhanced day care unit (ASA 2 or less)	Day cases only (stand alone or satellite)
Staffing	▪ Full surgical team + 24 / 7 emergency surgical team ▪ OOH cover provided by surgical specialities; on-call anaesthetic consultant ▪ Specialist level in-hours + OOH cover at junior level ▪ Local consultant, local consultant OOH cover	▪ Junior team (specialist level) in-hours, resident anaesthetist, access to medical opinion ▪ Surgery reg or equivalent OOH (specialist level) ▪ Consultant workforce from larger centre or multiple site cover at consultant level	▪ RMO with remote consultant cover ▪ Rotating theatre staff, radiographers; Consultant delivered intervention (extended hours?) & anaesthesia ▪ ECPs for day time care with extended hours	▪ Full surgical team present during (and beyond) opening hours of day surgery unit ▪ Consultant delivered ▪ Radiology + access to radiology ▪ No junior staff
Other service requirements	▪ Level 3 critical care ▪ NCEPOD staffed theatre 24x7 ▪ 24x7 interventional radiology ▪ All elective medicine	▪ Level 2 critical care ▪ NCEPOD staffed theatre 12x7 ▪ 12x7 interventional radiology ▪ All elective medicine	▪ Capacity to stabilize and transfer ▪ All elective medicine	▪ Capacity to stabilize and transfer ▪ All elective medicine
Conditions covered	▪ All complexity general surgical procedures ▪ Elective non-complex T&O day cases ▪ Elective non-complex paediatric surgical cases ▪ Up to & including ASA 4 ▪ Emergency surgery ▪ Interventional Radiology	▪ All mid and low complexity general surgical procedures for medium risk patients ▪ Elective non-complex T&O day cases ▪ Elective non-complex paediatric surgical cases ▪ Up to & including ASA 3 ▪ Endoscopy, Interventional Radiology + other procedures	▪ ASA 2 or less : LOS 1-5 days for IP, day cases (including elective non-complex T&O and paediatric surgical procedures) ▪ Endoscopy + some procedures ▪ Protocols for escalation available	▪ All LA work ▪ Day Case GA ASA 2 or less (including elective non-complex T&O and paediatric surgical procedures)
Conditions not covered	▪ Supra-specialist surgical procedures performed in national centres (e.g., neuro-surgery, oncoplastic recon-struction, vascular surgery)	▪ High complexity and / or high risk patients ▪ ASA 4 + conditions in column 1	▪ Interventional Radiology ▪ No enhanced care ▪ ASA 3 + conditions not covered in other models	▪ No enhanced care

Potential clinical service models for Paediatrics

	Inpatient paediatrics	SSPAU + ambulatory care	SSPAU + ambulatory care (limited hours)	MDT led care at front door (no paediatrician)	Minor injury unit
Staffing	▪ 10 WTE consultant paediatricians to cover 24 / 7 rota	▪ Consultant paediatrician on site when ED is open ▪ Shared staff with A&E with paediatric expert / GPwSI in paeds covering OOH ▪ Facilities for children available 7 days through SSPAU and ED/UTC	▪ Consultant paediatrician on site for limited hours when SSPAU is open ▪ OOH cross cover from A&E consultants (trained in paediatric Early Warning Score Assessment), GPs, senior paediatric nurse practitioner	▪ Paediatric expertise at the "front door" provided by MDT including A&E consultants, GPs, senior paediatric nurse practitioner +/ paediatric doctors	▪ No paediatrics expertise at the “front door”
Conditions covered	▪ All acute general paediatric illnesses requiring admission ▪ Common care pathways across patch	▪ Minor acute illnesses, minor trauma, burns and infections, IV antibiotics ▪ Acutely unwell children transferred ▪ Repatriate cases from Bristol ED if appropriate ▪ Common care pathways across patch ▪ Scheduled care provision	▪ Minor acute illnesses, minor trauma, burns and infections, IV antibiotics ▪ Acutely unwell children transferred ▪ Common care pathways across patch ▪ Repatriate cases from major ED if appropriate ▪ Scheduled care provision	▪ Minor acute illnesses ▪ Acutely unwell children transferred	▪ Minor injury only
Conditions not covered	▪ Tertiary (specialist) paediatric care	▪ Illness requiring >8 hours observation ▪ Children requiring admissions ▪ Neonates requiring NICU	▪ Illness requiring >8 hours observation ▪ Children requiring admissions ▪ Neonates requiring NICU	▪ Children with more serious conditions who need consultant paediatric care	▪ All children needing medical or surgical input

Potential clinical service models for Maternity

	Full obstetric service	Lower risk obstetric service with Level 1 neonates	24 / 7 midwife-led unit
Staffing	▪ 24 / 7 consultant obstetrician on labour unit – possible some cover could be provided by shared rota with nearby trusts ▪ 24 / 7 paediatric cover	▪ 12x7 consultant presence on labour unit ▪ SCBU staffed with registrar paediatrician and / or nurse practitioner (no NICU)	▪ 24 / 7 midwife available on site or on call ▪ Support staff ▪ Primary care hubs for midwife clinics
Other service requirements	▪ Level 3 critical care ▪ Emergency surgery	▪ Level 2 critical care	▪ Capacity to stabilize and transfer
Conditions covered	▪ All births ▪ Emergency gynaecology ▪ Antenatal care / in day assessment unit or in community ▪ Postnatal care in hospital if complex or community (short stay in-unit after birth)	▪ Moderate risk births, may require aesthetic and paediatric support ▪ Births which may require SCBU ▪ Antenatal care / in day assessment unit or in community ▪ Postnatal care in hospital if moderate risk or community (short stay in-unit after birth)	▪ Low risk births, 37 - 42 weeks of gestation ▪ Antenatal care / in day assessment unit or in community ▪ Postnatal care in community (short stay in-unit after birth)
Conditions not covered		▪ Births at risk of requiring NICU ▪ Births under 34 weeks ▪ Women with more complex co-morbidities	▪ Women requiring obstetric care, high-risk pregnancies, maternal-fetal medicine, epidurals, C-sections

Details of proposed service model for frailty/LTCs

	Frailty Unit in front door (no beds)	Frailty Hub	Locality frailty teams	Locality teams for people with different LTCs
Staffing	▪ Emergency medicine / Acute medicine / Frailty consultant ▪ GPs ▪ Specialist nurses ▪ Therapists ▪ Social care ▪ Medicines Management ▪ Wellness navigators	▪ GPs ▪ Specialist nurses ▪ Therapists ▪ Social care ▪ Mental Health Pract. ▪ Medicines Management ▪ Wellness navigators	▪ GPs ▪ Specialist nurses ▪ Therapists ▪ Social care ▪ Mental Health Pract. ▪ Medicines Management ▪ Wellness navigators	▪ GPs ▪ Specialist consultant input ▪ Specialist nurses ▪ Therapists ▪ Social care ▪ Medicines Management ▪ Wellness navigators
Other service requirements	▪ Diagnostics – X ray, U/S, MRI, CT, phlebotomy and (ideally) a lab	▪ X-ray, Phlebotomy	▪ Phlebotomy	▪ Phlebotomy
Conditions covered	▪ Acute medical admissions ▪ Anyone with a care plan for them to be treated/care for locally	▪ Anyone with a care plan for them to be treated/care for locally ▪ Rapid assessment	▪ All older people to be assessed for frailty/wider health needs	▪ All people with a long term condition
Conditions not covered	▪ Highly complex medical or surgical conditions for treatment as per national guidance (e.g. hyper acute stroke)	▪ Acutely unwell patients	▪ Any patient needing rapid assessment/rapid response care which cannot be managed locally	▪ Patients requiring inpatient care specialist input

Urgent and Emergency Care Pathway: 'minor' patients

	Triage and first contact with healthcare professional	Investigations	Treatment	Follow-up
Minor Injuries (e.g., laceration requiring stitches)	▪ Patients can publicly access information rapidly to guide them to the appropriate level of care based on the severity of their injury (e.g. 111, pharmacies) ▪ Patients are able to access a convenient location nearby where they can be seen relatively quickly / are clearly communicated what timing will be	▪ Low level diagnostics (incl. X-rays) as required - only relevant tests completed ▪ Simple, quick, focused investigation, where the results are explained quickly and easily understandable ▪ Onsite or remote support, including reporting as required ▪ Clear and easy route to escalate into major injury category if indicated by investigation or examination	▪ Timely, appropriate care in a single encounter ▪ Good communication that gives patient understanding of the problem, including potential complications ▪ Patient is discharged as quickly as possible	▪ Patients given understanding of follow up required (best case: no follow-up) ▪ Follow-up (when required) is easy to schedule and conveniently located for patient ▪ If complications arise, patients have clear pathway and can follow it easily and quickly
Minor illness (e.g., urinary symp-toms)	▪ Patients can access information rapidly to guide them to the appropriate level of care based on the severity of their illness ▪ Interaction with overlapping pathways (e.g. frailty and mental health) to guide patients to most appropriate care ▪ Patients have easy access (local, short travel, easy parking, etc.); Wait times are reasonable and communicated accurately ▪ Should be able to have easy access in extended hours	▪ Investigation given right away at point of contact or same day, as close to 1st contact as possible (e.g. one-stop ambulatory care if possible) ▪ Real time tests are used to help inform decision ▪ Minimum amount of investigations at appropriate time required to provide an accurate diagnosis ▪ Onsite or remote support, including reporting as required ▪ Consistent investigations with same standards in all locations ▪ Focus on completing diagnosis to rule out major illness/injury vs minor problems ▪ Clear and easy route to escalation if indicated by investigation or examination	▪ Timely, appropriate care ▪ Good communication that gives patient understanding of the problem, including potential complications ▪ Patient is discharged as quickly as possible	▪ Patients given good advice and simple explanations of next steps for recovery ▪ Any follow-up is as convenient as possible for the patient (e.g., virtual/remote, local) ▪ If complications arise, patients have clear pathway and can follow it easily and quickly

Source: Health Weston Clinical Service Design & Deliver Group - July 26 and August 9, 2018 Workshop

Urgent and Emergency Care Pathway: 'major' patients

	First contact with healthcare professional	Investigations	Treatment	Follow-up
Moderate trauma (e.g. #NOF)	▪ Patient seen in appropriate centre as local as possible ▪ Support from relevant specialty available within acceptable timeframe at the location or remotely where appropriate	▪ Support services available as required ▪ Additional assessments given as required (X rays, CT, etc.) ▪ Diagnosis made quickly on one site or remotely and communicated clearly, with treatment options provided / explained	▪ On site 24/7 care available ▪ Treatment in line with national standards e.g. for #NOF ▪ Clinicians with relevant training available ▪ Enhanced recovery + rehab (e.g. PT / OT) given as required ▪ Discharged as quickly as possible ▪ Clear and speedy escalation pathway if necessary	▪ Follow up with member of patient treatment team as local as possible ▪ Patients able to recover as close to home as possible / at home if possible ▪ Re-entry into appropriate pathways supported should issues arise
Standard/ major Illness (e.g., chest pain and fever)	▪ Patient has immediate access to assessment at correct place of treatment, the appropriate clinician (e.g. correct skills) is available to provide an accurate diagnosis ▪ Assessment by (consultant) within 12 hours ▪ Explanations are simple, advice is clear, next steps are described, easy access for patients to ask questions	▪ Sufficient diagnostic facilities to allow initial triage for >90% of patients to correct transfer location ▪ Full range of assessments available as required, quickly ▪ Rapid access to specialist opinion within appropriate timescale	▪ On site 24/7 care available ▪ Care given in one place, as quickly as necessary ▪ Care provided by specialist where appropriate ▪ All types of assessments required given (e.g., scans, blood, etc.), as regularly as required ▪ Access to ICU if required ▪ Access to medical or surgical opinion and surgery if necessary	▪ Discharged as soon as possible ▪ Follow up is provided to patients with part of their care team or another specialist, as conveniently as possible for the patient ▪ Re-entry into appropriate pathways supported should issues arise
Major complex condition or Trauma (e.g., major RTA)	▪ Patient is taken to agreed major trauma centre to ensure quality of care ▪ Support available immediately at the location ▪ Treatment ideally given at only one place	▪ Full range of complex support services available as required ▪ Additional assessments given as required (X rays, CT, etc.) ▪ Diagnosis made quickly on one site and communicated clearly, with treatment options provided / explained ▪ Specialists available within appropriate timeframe	▪ On site 24/7 care available ▪ Clinicians with adequate relevant training in issue available ▪ Enhanced recovery and access to other specialists given as required ▪ Access to ICU if required ▪ Discharged as quickly as possible	▪ Follow up available with member of patient treatment team as local as possible ▪ Patients able to recover as close to home as possible / at home if possible ▪ Re-entry into appropriate pathways supported should issues arise

Source: Health Weston Clinical Service Design & Deliver Group - July 26 and August 9, 2018 Workshop

Urgent and Emergency Care Pathway: Clinical standards and best practice evidence

	First contact with healthcare professional	Investigations	Treatment	Follow-up
'Minor' patients	▪ Integrated primary care to reduce avoidable emergency admissions (GMS Contract 2014/15) ▪ Every emergency department should have a co-located primary care out-of-hours facility *(Acute and emergency care: prescribing the remedy (2014))* ▪ Treatment at scene (or transfer to primary/community care) where appropriate *(Transforming NHS Ambulance Services, NAO, 2011)* ▪ Each emergency department and acute admissions unit has an IT infrastructure that effectively integrates clinical and safeguarding information across all parts of the urgent and emergency care system *(Seven Day Clinical Standards, NHS England, 2014)* ▪ Community and social care must be coordinated effectively and delivered 7 days a week to support urgent and emergency care services *(Acute and emergency care: prescribing the remedy (2014))*			
Standard/ major Illness (e.g., chest pain and fever)	▪ All emergency admissions to be seen and assessed by a relevant consultant within 12 hours of the decision to admit or within 14 hours of the time of arrival at the hospital *(Keogh (2015) Transforming urgent and emergency care services in England)* ▪ Prompt screening of all complex needs inpatients should take place by a multi-professional team which has access to pharmacy, psychiatric liaison services and therapy services (including physiotherapy and occupational therapy, 7 days a week with an overnight rota for respiratory physiotherapy) (*NHS England (2015) Commissioning Standards Integrated Urgent care)*	▪ All hospitals admitting medical and surgical emergencies should have access to all key diagnostic services (e.g., diagnostic imaging, interventional radiology, interventional endoscopy, bronchoscopy, pathology) in a timely manner 24 hours a day, 7 days a week, to support decision making *(The Royal College of Emergency Medicine (2015) Emergency Department Capacity Management Guidance)* ▪ Critical Care Unit should have dedicated medical cover present in the facility 24 hours per day, 7 days per week (*Keogh (2013) NHS Services, Seven Days a week)*	▪ Triage, treatment and discharge or admission within 4 hours *(national standard)* ▪ Senior decision-makers at the front door of the hospital, and in surgical, medical or paediatric assessment units, should be normal practice, not the exception *(CEM, Workforce Recommendations, 2010, and The Way Ahead 2008-2012, 2008)* ▪ Ensuring that care is delivered by consultant anaesthetists and consultant surgeons for high risk emergency laparotomy patients 24 hours per day, seven days per week (NELA Patient Audit 2017) ▪ Any surgery conducted at night should meet NCEPOD requirements and be under the direct supervision of a consultant surgeon *(NHS London (2011) Adult emergency services: Acute medicine and emergency general surgery commissioning standards)* ▪ Provide consultant-delivered emergency general surgery in each trust *(GIRFT general surgery report 2017)* ▪ Acute medicine inpatients should be reviewed daily be a relevant consultant (*Keogh (2015) Transforming urgent and emergency care services in England)* ▪ When on-take for emergency / acute medicine and surgery, a consultant and their team are to be completely freed from any other clinical duties / elective commitments that would prevent them from being immediately available *(Keogh (2015) Transforming urgent and emergency care services)*	

Elective Care Pathway – Low Complexity

Majority of planned care occurs in primary care

Primary care

- Access is standardized across populations
- Wait times are less than 7 days
- Local referral protocols standardised & followed
- Consistent, standardised advice and guidance process (on things like local policy) using up to date technology to ensure one seamless pathway
- One clinical information system for use
- Clear communication to patient on what is being provided
- Direct access to intervention through multiple providers (e.g., physio)
- Direct access to investigation

First acute contact with healthcare professional

- Access is standardized across populations, with minimal delays and referrals prioritised based on patient problems. Patients are triaged as required depending on urgency of condition
- Wait times are in line with or better than national targets including for 2 week rule referrals and patients suspected of cancer
- Clear to patients who they should be seeing and why (e.g., referral from GP)
- Openness and clear communication to patient on what is being provided
- High quality advice and guidance provided to inform patients of choice and next steps
- Technology leveraged to facilitate process (e.g., electronic communication) with rapid communication back to referrer
- One clinical information system for use
- Completed as locally as possible
- Care is provided across specialties as much as possible with provision of elective outpatient care aligned with need for specialist presence in acute hospital to cover urgent and emergency care
- No patient is not provided access

Investigations

- Initial investigations done at point of first contact or as quickly as possible / close to patient as possible
- All investigations required are provided quickly and closely (e.g., PATH / imaging/ endoscopy)
- One clinical information system for use
- Early communication of results & immediate referral of urgent problems (as per protocol)

Interventions

- Day surgery when possible
- No cancellations
- Openness and clear communication to patient on what is being provided
- All appropriate equipment available for the procedure
- Continued provision of an appropriate training environment
- One clinical information system
- Clear patient ownership during inpatient stay
- Appropriate level of in hours cover
- All pre-op assessment standardised, carried out at initial decision to treat and carried out locally
- Early decision confirming patient suitable for local treatment
- Procedures to be provided locally
- Surgeons and teams are provided adequate volumes & avoid duplication of services
- Seamless package of care
- High calibre out of hours cover
- Robust rescue plan and escalation policy for the deteriorating patient including access to HDU or ICU either locally or within network
- Delivery of upper quartile outcomes standardised mortality
- Services ensure quality patient experience & satisfaction

Follow-up

- Full use of processes to enable early discharge
- All to be provided locally including out of hospital
- Clear protocols for post operative management
- Follow ups minimized and only as required
- High quality electronic discharge summary

Source: Health Weston Clinical Service Design & Deliver Group - July 26, 2018 Workshop

Elective Care Pathway – High Complexity

Majority of planned care occurs in primary care

Primary care

- Access is standardized across populations
- Wait times are less than 7 days
- Local referral protocols standardised & followed
- Consistent, standardised advice and guidance process (on things like local policy) using up to date technology to ensure one seamless pathway
- One clinical information system for use
- Clear communication to patient on what is being provided
- Direct access to intervention through multiple providers (e.g., physio)
- Direct access to investigation

First acute contact with healthcare professional

- Access is standardized across populations, with minimal delays and referrals prioritised based on patient problems. Patients are triaged as required depending on urgency of condition
- Wait times are in line with or better than national targets including for 2week rule referrals and patients suspected of cancer
- Clear to patients who they should be seeing and why (e.g., referral from GP)
- Openness and clear communication to patient on what is being provided
- High quality advice and guidance provided to inform patients of choice and next steps
- Technology leveraged to facilitate process (e.g., electronic communication) with rapid communication back to referrer
- One clinical information system for use
- Completed as locally as possible
- Care is provided across specialties as much as possible with provision of elective outpatient care aligned with need for specialist presence in acute hospital to cover urgent and emergency care
- No patient is not provided access

Investigations

- *As in Low Complexity*
- Interventional treatment done locally when possible but may need to be referred to specialist centre for low volume complex procedures in high risk patients

Interventions

- *As in Low Complexity*
- All preop assessment standardized, carried out at initial decision to treat and carried out locally wherever possible
- Early decision confirming if patient suitable for local treatment or if patient unsuitable for local treatment and has to be transferred to another centre
- As many procedures as possible to be provided locally
- Surgeons and teams are provided adequate volumes
- Robust out of hours cover aligned with the complexity of the procedure and the comorbidities of the patient
- Robust rescue plan and escalation policy for the deteriorating patient including access to HDU or ICU either locally or within network
- Seamless package of care irrespective of location of that care
- Minimum length of stay if patient transferred to another centre for treatment with consideration of transfer back to local centre for post operative care if appropriate

Follow-up

- Full use of processes to enable early discharge both locally and when care provided in other centres
- As much as possible to be provided locally irrespective of location of surgery
- Clear protocols for post operative management
- Follow ups minimized and only as required
- High quality electronic discharge summary with clear guidelines for the management of complications

Source: Health Weston Clinical Service Design & Deliver Group - July 26, 2018 Workshop

Elective Care Pathway: Clinical standards and best practice evidence

Primary care	First acute contact with healthcare professional	Investigations	Admission for surgery	Follow-up
	▪ Radiology, laboratory and other tests are performed as expeditiously as possible, necessitating a minimum number of hospital visits for the patient. Hospital outpatient clinics should be coordinated where possible *(RCSI Model of Care for Elective Surgery, 2013)* ▪ Ensure all units are operating within a hub and spoke network model, as defined by the national service specification, emulating the most advanced hub and spoke models that exist currently. This in turn should deliver improved early decision-making capability and access to diagnostics, allowing early treatment, prioritised by degree of urgency (*GIRFT Vascular Surgery report 2018)*	▪ Require reversible risk factors to be addressed prior to non-urgent procedures, using a patient-centred approach utilizing shared decision-making *(GIRFT general surgery report 2017)*	▪ Patients should be admitted in ring fenced beds, on the day of surgery where possible *(RCSI Model of Care for Elective Surgery, 2013)* ▪ Enhanced recovery and discharge planning should begin at the outset of the patient's elective surgical journey *(RCSI Model of Care for Elective Surgery, 2013)* ▪ Time from presentation to surgery for all patients in need of CEA should be no longer than seven days *(GIRFT Vascular Surgery report 2018)* ▪ Ensure that every patient is reviewed by a consultant pre- and post-operatively, seven days a week (*GIRFT Cardiothoracic Surgery report 2018*) ▪ Minimize the numbers of complex surgical procedures that are carried out in small volume centres, using networks as they develop (*GIRFT Urology report 2018*) ▪ Ensure that diagnostic and therapeutic interventions can be undertaken in the right setting including one-stop outpatient facilities (*GIRFT Cranial Neurosurgery report 2018*) ▪ Community rehabilitation services should be adequately resourced to provide early, intense and frequent rehabilitation to all hip fracture patients (*British Orthopaedic Association, A national review of adult elective orthopaedic services in England, 2015*)	

Source: Health Weston Clinical Service Design & Deliver Group - July 26, 2018 Workshop

Paediatrics: best practice care for acutely unwell child

	Triage and first contact	Immediate assessment and treatment	Treatment	Follow-up	Treatment	Follow-up
Unwell child	▪ Easy access to information to support parental decision making – on phone/online/ applications ▪ Parental education through health visitors and other parental groups ▪ Parents have easy access (local, short travel, easy parking, etc.); Wait times are reasonable and communicated accurately ▪ Should be able to have easy access – same day and extended hours	▪ Standardised screening tests and protocol ▪ Parent able to obtain same day appointment in out of hospital setting ▪ Suitably qualified staff e.g. GP/nurse with experience in paediatrics ▪ Access to paediatric expertise in person (e.g. MDT or specialist clinics in primary care) or over the phone/online (e.g. specialist number, via e-referral system) to allow speedy and appropriate escalation ▪ Treatment as per protocols ▪ Shared records with parents and inpatient/referral unit	▪ Direct referral to hospital as per standardized protocols ▪ Paediatric expertise (nurse, consultants, middle grade, ANP) available on site during opening hours ▪ If <1 year, child should be seen by consultant paediatrician ▪ Safeguarding expertise available if required	▪ If admitting: ▪ Direct transport to IP unit, with barrier free transfer ▪ Quick referral systems, uninterrupted, no ability to refuse or delay a referral ▪ Shared staffing with ED ▪ Shared records through online secure system ▪ If observing: Observing unit should have 1: xx ratio ▪ Wards should have extended opening hours ▪ If discharging: Follow up phone call next day for those discharged from SSAU	▪ Shortest stay possible in IP unit ▪ Early discharge with monitoring in community ▪ 7 day community services to enable early discharge ▪ 1:4 nursing ▪ Consultant presence 24x7 (10 WTE paediatric consultants)	▪ Follow up done in community with access to specialists in clinic next day as required (SSAU or community access) ▪ Consultant to follow up if needed or community nurses or GP to be done in home, hospital, or GP practice ▪ Assessment unit (CIU) has ambulatory care and follow ups

Community paediatrics, social care for children with learning disabilities/physical disabilities, children's mental health and paediatric surgery considered separately

Source: Health Weston Clinical Service Design & Deliver Group - July 26, 2018 Workshop

Paediatrics: Clinical standards and best practice evidence for care of the acutely unwell child

	Triage and first contact	Immediate assessment and treatment	Treatment	Follow-up	Treatment
Unwell child: Clinical standards and best practice evidence	▪ Whole pathway commissioning for children's services that includes ED attendance or hospital admission avoidance by easy availability of GP urgent appointments and consultant led provision of rapid access paediatric clinics (Joint Statement by RCGP, RCN, RCPCH and CEM on the urgent & emergency care of children and young people, 2011) ▪ Hours of operation for Short Stay Paediatric Assessment Units (SSPAU) should match times of population demand (RCPCH, Standards for SSPAU 2017)	▪ Alternatives to full hospital admission by provision of SSPAUs (with the same role as Clinical Decision Units for adults) run in partnership with Emergency Departments, as well as early discharge enablement by community nursing and SSPAUs (Joint Statement by RCGP, RCN, RCPCH and CEM on the urgent & emergency care of children and young people, 2011) ▪ Every child or young person on the SSPAU with an acute medical problem is seen by appropriate tier-two specialist within 4 hours and consultant* within 14 hours (RCPCH, Standards for SSPAU 2017) ▪ Contracted staffing levels and competencies for children trained clinicians (including safeguarding) must reflect the standards set by RCPCH, RCN, CEM ▪ Health professionals should have access to the child's shared record (RCPCH, Standards for SSPAU 2017) ▪ Effective safeguarding systems are child centred (Working Together to Safeguard Children, 2013)	▪ Evidence-based guidelines are used for the management of conditions with which infants, children and young people may be admitted to the SSPAU (RCPCH, Standards for SSPAU 2017) ▪ A consultant paediatrician* is readily available on the hospital site at times of peak activity of the SSPAU and is able to attend at all times within 30 minutes. Throughout all the hours they are open, SSPAUs have access to the opinion of a consultant paediatrician* via telephone (RCPCH, Standards for SSPAU 2017)	▪ All paediatric inpatient units adopt an "attending consultant" system ▪ All general acute paediatric consultant rotas are made up of ≥10 EWTD-compliant WTEs ▪ There should be a minimum of two registered children's nurses at all times in all inpatient and day care areas ▪ Specialist paediatricians are available for immediate telephone advice for acute problems for all specialties and paediatricians ▪ (RCPCH (2015) Facing the Future)	▪ Before they are discharged, every child referred for a paediatric opinion is seen by, or has their case discussed with: a consultant paediatrician, a middle grade paediatrician, or an advanced children's nurse practitioner (RCPCH – Standards for Paediatric Services (2015)) ▪ Children and young people and their parents and carers are provided, at the time of their discharge, with both verbal and written discharge and safety netting information, in a form that is accessible and that they understand (RCPCH, 2017, Standards for SSPAU)

Community paediatrics, social care for children with learning disabilities/physical disabilities, children's mental health and paediatric surgery yet to be discussed

* Or equivalent

Maternity pathway: Best practice summary

Pre-conception (in community)

- Implement integrated programme of women's health (including smoking cessation), sex education and contraception through primary care, community and schools (supported by council)
- Provide pre-conception advice and counselling for prospective parents on complicating factors in pregnancy
- Primary care ensures at risk women (social and clinical) are offered pre pregnancy advice e.g. for women with epilepsy or diabetes

Antenatal care

- Booking referral by midwife by 10 weeks (National guidance)
- Rigorous ongoing risk assessment
  - Stratify patients by risk
  - Midwifery groups responsibility for identifying high risk women and targeting services at them
- Adopt NICE guidance
  - 7-10 antenatal appointments
  - 2 ultrasounds in low risk pregnancy
  - Include all national screening programmes in routine care
- Adopt midwife led care model (case loading), with direct access to midwives; access to OUs as needed
- Concentrate services in easy-access local community centres to facilitate registry and productivity
- Leverage IT-enabled solutions to increase sharing of records and improve productivity in community-based care
- Use MSWs to improve midwife productivity

Birth

- Ensure choice of location for birth, based on risk profile:
  - Provide high quality information e.g. risk profile of different units
  - Default option midwife led
  - Ensure clear transfer protocols for rapid transfer
- Ensure appropriate site staffing based on risk:
  - Low risk: Midwives
  - Medium/High risk: Midwifery, obstetric & medical consultants, anaesthetics, ICU, neonatal ICU
  - Supra-specialist: Level 3 critical care, maternal and neonatal ICU care, anaesthetics, surgery, ICU, neonatal ICU
  - 60-98hrs per week of consultant presence on labour ward rising to 168hrs in future
- Interdependencies include:
  - Medium risk: anaesthesia (1 duty, 1 available on call); NICU level 1 (could be level 2 depending on the number of deliveries), blood transfusion on-site, HDU
  - High risk: Complex ultrasound, endocrinology, surgery, interventional radiology, critical care, 24/7 anaesthesia, NICU level 2, blood transfusion services
  - Supra-specialist: Complex surgery, medical specialists, interventional radiology, critical care, 24/7 anaesthesia, NICU level 3
- Ensure clear transfer protocols for rapid transfer
- Continuity of carer throughout antenatal, birth and post natal but esp. 1:1 care during established labour through increased midwife productivity (Better Births – National Maternity Review)
- Provide high quality, safe maternity services
  - Increase percentage of normal births in low risk settings
  - Provide formal clinical networks
  - Handle complexity through specialisation

Post-natal & neonatal care

- Provide high-quality, routine post-natal care focused on people who need it based on social risk and clinical need
  - Contact with Health Visitor within 10-14 days post-birth
  - Health visitors targeted at most needy families; consider appointments in local community centres/GP practices instead of home
- Leverage IT-enabled solutions to increase sharing of records and improve productivity in community-based care – also using MSWs
- Midwife and Health visitor (post 10 days) proactively support breastfeeding to increase initiation/rates at 3/6 months
- Provide accessible, targeted specialist post-natal care if needed
- Dedicated neonatal care – separate rota from paeds
- Implement level 1/2/3 neonatal care

People with LTCs and frailty: best practice care

Prevention	Early Diagnosis	Ongoing Care & Management	Access to Specialist Care	End of Life Care / Palliative Care
▪ Focus on whole population ▪ Attention to health behaviours across all groups ▪ Involvement of wider range of healthcare professionals e.g. pharmacists to provide health messages	▪ Early identification of people at risk of LTCs and preventative advice given/planned ▪ Early identification of frailty (use of frailty index included) ▪ Diagnosis and screening available locally (not required to be hospital) with diagnostic tools available for all healthcare professionals ▪ Same day access to urgent tests as required (e.g., X Ray, MRI, blood) ▪ Plans in place for all patients with a diagnosed LTC - are clear and access to services is easy ▪ Directory of services available in local systems accessible by patients for reference ▪ Mental health considered from early stage ▪ Secondary prevention in place e.g. falls service	▪ Conditions managed proactively, with mental wellbeing considered at all levels of care ▪ Clear plans in place for all patients with a diagnosed LTC and/or frailty - are clear and access to services is straightforward ▪ Care provided/managed by multidisciplinary support team (e.g., trained teams of specialists from acute, primary care, and community) – regular meetings in person and via video/virtual MDT meetings ▪ Individual/team responsible for each patient and ongoing review of care/adherence to plan ▪ Continuity of care maintained as much as possible ▪ Records are shared between all organisations - including ambulance, social care - and shared with patient and carers ▪ Emphasis on long-term self-care owned by patients; technology, public campaigns, social support, and community sessions used to educate patients ▪ Practitioners have easy access to experts to inform support without having patient escalated ▪ Remote access to information for patient and carer available ▪ Patients given advice on self management to prevent escalation of condition ▪ Extensive use of social prescribing	▪ Patients able to quickly obtain specialist opinion in most appropriate way possible - as close to home with minimum skill level required (from non-consultant to specialist) ▪ System linked throughout (GP and Community and Ambulance) ▪ Alternatives to hospital access available (e.g., intensive care teams, hospitals at home, day hospital, local acute care units, access to specialist primary care nurses) ▪ Patients clear on treatment escalation plans and have quick access to treatment if required ▪ Easy access to care plans and care records for family and carers	▪ Care provided in the most appropriate setting with emphasis on allowing patient to remain at home or as local as possible (e.g., community beds) ▪ Advanced care planning done in timely manner

Source: Health Weston Clinical Service Design & Deliver Group - July 26, 2018 Workshop

Healthy Weston PCBC

Appendix 10: Examples of models from other hospitals

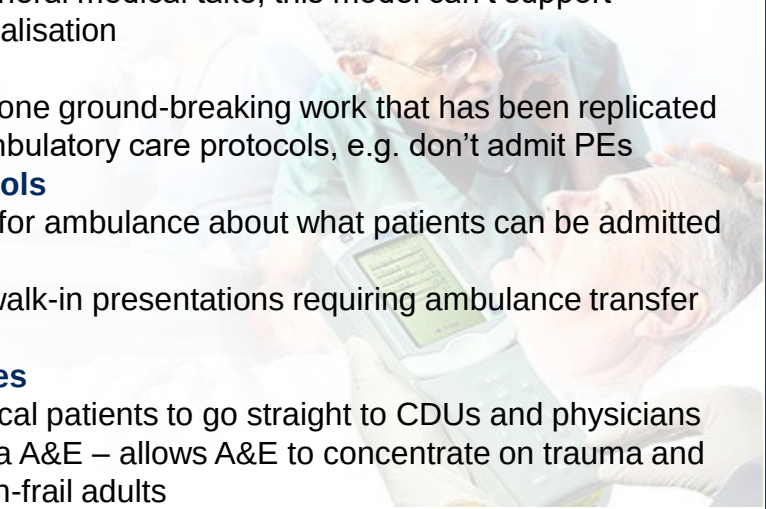
East Kent Hospitals (1/2) similar to 9a but are hoping to progress to further stages

Context

- **Background**
  - **Catchment**: 750,000 (broadly 3 geographies of 250,000 each)
  - **Hospitals**: 5
    - Kent and Canterbury, Canterbury
    - Queen Elizabeth the Queen Mother, Margate
    - William Harvey, Ashford
    - Royal Victoria, Folkestone
    - Buckland Income of £480,000 mill
  - 5 site Trust formed in 1999
  - Become an FT in 2009
  - 3 of 5 hospitals with unselected medical takes
    - A&E departments at Margate and Ashford
    - Kent and Canterbury hospital has an Emergency Care Centre staffed by emergency physicians
  - Paeds and consultant led obs located at 2 sites
    - Midwifery led units and ambulatory paediatrics at other sites

How it works in practice

- **Multidisciplinary team**
  - The site without general surgery has an Emergency Care Centre instead of a traditional A&E. There are two factors key to it working effectively
    - **It is staffed by senior physicians** "at the front door" from chest, gastrenterology and cardiology. An outstanding geriatric service is also critical to good patient flow.
    - **Rapid access diagnostics** both for GPs and ECC staff; diagnose then decide whether or not to admit, rather than admit in order to diagnose. This allows for the timely identification of surgical emergencies, e.g. scanning for suspected appendicitis
- The Trust insists that all newly appointed Consultant Physicians participate in the general medical take; this model can't support extensive sub-specialisation
- **Triage protocols**
  - The Trust has done ground-breaking work that has been replicated nationally on ambulatory care protocols, e.g. don't admit PEs
- **Ambulance protocols**
  - Clear guidance for ambulance about what patients can be admitted at which site
  - Agreement on walk-in presentations requiring ambulance transfer between sites
- **Capacity challenges**
  - Aim to get medical patients to go straight to CDUs and physicians without going via A&E – allows A&E to concentrate on trauma and children and non-frail adults



SOURCE: East Kent Hospitals University NHS Foundation Trust, Dr. Neil Martin

East Kent Hospitals (2/2)

Key implementation challenges

- **Biggest challenges**
  - A&E Consultant recruitment is impossible (4/10 FTEs in post at the moment) and has helped to drive the push towards physicians staffing the hospital entry point, which has proved to be much more effective at reducing admissions and improving LOS
- **Resolutions**
  - Need for surgical opinions reduced by having experienced physicians leading the medical service including the ECC: aim to get medical patients to go straight to CDUs and physicians as new model – so A&E deals with trauma and children/young adults
  - At QEQM, paeditatricians manage patients without involving surgeons even though they're on site –the key is that the Trust paediatricians have good diagnostics access, can resuscitate, stabilise and transport
  - Frail elderly are cared for pre- and post- surgically by geriatricians, not surgeons. Geriatricians over time have developed more surgical skills and will continue to do so
- **Ongoing concerns**
  - Two general surgical hubs planned to merge into one over so further hybrid models will be necessary. Current thinking is that this will be based on an "RMO" model i.e. someone with FRCS but not CCST
  - This consolidation of general surgery from 2 to 1 site will challenge the surgical services that are already centralised

- **East Kent shows it is possible to**
  - **Cut bed numbers by around a third:** East Kent has cut down 200-300 bed days p.a. through senior decision making at the right points in care pathways, resulting in reduced LOS; they have reduced from 1300 to 1100 beds so far and aiming towards 800 beds
  - **Use telemedicine to support services working collaboratively and safely across sites.** The Trust uses telemedicine to support its stroke services. (The distances mean that a London model isn't appropriate as would risk 60mins thrombolysis). They have 7 day stroke clinics supported by 7 day diagnostics 8-8pm at all 3 sites. The neurologist can see the CT scan results and also benefits from images taken with a standard video camera. East Kent has highest radiology use in the Atlas of Variation and they attribute some of their productivity and low LOS to this
  - **Use diagnostics to reduce the number** of people who come under the care of surgeons ("the surgical take")

SOURCE: East Kent Hospitals University NHS Foundation Trust, Dr. Neil Martin

Trafford model for selective take is similar to the model 12a/27b

Trafford General was a sub-scale DGH. It is being remodelled as an elective centre with urgent care 16/24, and a focus on elderly and integrated care, orthopaedics and day surgery

Key features of new service model:

- Nurse-led Urgent Care Centre 8:00-20:00
- Medical admissions unit
- High dependency unit
- 18 intermediate care beds – 27 more planned in 2017
- OP, diagnostic and day surgery services
- Specialist orthopaedic centre
- Rehabilitation and elderly care
- Hub site for 24/7 nurse-led community enhanced care service – established in 2014

Service delivery - prior to implementation of new service model

- Catchment population of 100,000 people
- 112,000 outpatient attendances per year
- 14,000 elective day cases per year
- 5,000 elective inpatients per year
- 8,000 emergency admissions per year – but as few as 1 emergency surgical operation per day
- 58,000 A&E attendances/year – one of the smallest Type 1 A&E departments in the country
- 93 ICU patient spells/year – below the minimum threshold of 200/year

Impact

- Nurse-led multi-disciplinary[1] model of community urgent care available 24/7
- GPs can refer to service as alternative to A&E
- Service provides response within 6 hours following GP or Ambulance Paramedic referral and provides enhanced care including social services for 72 hours – usually provided in patient's own home
- Service can also provide enhanced care post-discharge
- In first 9 months:
  - 760 admissions and 1,500 A&E attendances avoided
  - £1.3m in estimated savings

1 MDT includes community matrons and nurses, IV therapy team, heart failure nurse, dementia nurse, occupational and physiotherapy, medicines management, rehab and social care

At Rochdale an advanced EUCC with step-up was developed, covering 80% of previous A&E volumes (1/2) – similar to 27

Care Model: Rochdale 'EUTC' onsite MAU

Patients/conditions treated

- Minor nose bleeds (not on Warfarin)
- Minor cuts, bites and stings
- Burns and scalds
- Infections (including abscesses)
- Foreign bodies in wounds, ears and noses
- Muscular sprains and strains to shoulders, arms and legs
- Fractures to shoulders, arms, legs & ribs
- Dislocations of fingers, thumbs and toes
- Minor eye conditions including conjunctivitis and foreign bodies
- Minor chest, neck and back injuries
- Minor head injuries with no loss of consciousness or alcohol-related
- Minor allergic reactions
- Minor ailments such as coughs, colds, flu symptoms, sore throat, earache, urinary tract infections and sinusitis
- Diarrhoea / Constipation
- Emergency contraception

Conditions not treated

- Extensive trauma
- Extensive burns
- Patients requiring resuscitation
- Suspected acute heart attack
- Suspected acute stroke
- High risk gastrointestinal haemorrhage
- Sick children (cardiac arrest/peri-arrest, head injuries)

Support services provided

- Basic Laboratory services
- X-ray diagnostics 08:00 – 24:00, 7 days a week
- Ante-Natal Ultrasound 08:00 – 17:00, Monday – Friday
- CT when coverage is available, 09-17, Monday – Friday
- MRI 08:00 – 20:00 Monday - Friday
- Step-up/ Resuscitation room
- Pharmacy support 7 days a week

Key goals and achievements

- Patients discharged within 4 hrs
- Retains 80% of old A&E activity and growing
- Patients assessed within 20 minutes of arriving
- Patients will be seen by a Clinical Decision Maker within an hour of presenting
- Children and the elderly will be cared for along the above guidelines

SOURCE: Rochdale EUCC Operational Policy 2012

The Rochdale EUCC is consultant led but with flexibility to ensure appropriate clinical input at all times (2/2)

Clinician type	Number /shift	Coverage	Rationale
Specialist Consultant	0	As needed	There is an understanding that when necessary the OP Consultants will provide support
A&E Consultant	0-1	1 session Mon-Fri, 1 on weekend days[1]	Additional support provided from Fairfield DGH during OOH; Staffing takes place when possible
Staff-grade Physician	0-1	8am-10pm 7 days a week	Available to cover for an A&E consultant and to support other Clinical Decision Makers (CDM)
General Practitioner	1	1-3CDM on early shift, 2-3CDM on late shift, 2CDM on night shift[2]	CDMs provide the majority of the care with Consultant and Staff Grade input when necessary (CDM = consultant, GP staff-grade physician or ENP)
Emergency Nurse Practitioner	1		
Practice Nurse	1	1 on early and late shifts	Provide support to the Clinical Decision Makers
Triage Nurse	1	24/7	Generally a Senior ER practice nurse/Triage nurse to swiftly identify needed escalation
Healthcare Assistant	1	24/7	Provide support to the Clinical Decision Makers

1 A&E consultant 6 days a week is the goal but is not always feasible due to availability, covered by Staff Physicians
2 Includes 1 GP 24/7

SOURCE: Rochdale UCC Operational Policy 2012

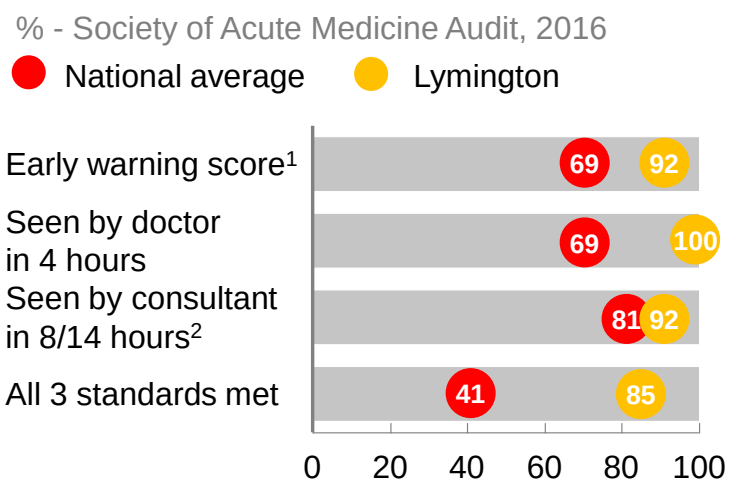
Lymington Hospital: Medical Assessment Unit – seven day consultant-led services similar to 27

Model of care in MAU

- Consultant presence in MAU 12/7 and out-of-hours consultant phone line for guidance/advice, same day rapid assessment and admissions
- 2 x daily consultant reviews in MAU
- Daily reviews as required and daily ward rounds 7/7 for all inpatients
- 4 new consultants recruited to support 7 day consultant-led acute assessment:
  - 1 Acute Medicine/Gastro-enterology
  - 1 Cardiology
  - 2 Respiratory

Lymington Hospital Acute Assessment Unit

Impact on clinical standards



Impact in other areas

Operational

- 15.3% increase in same day assessment and diagnostics
- 19.3% increase in admissions
- ≥10% admissions avoided due to availability of consultant advice/guidance and liaison with community/OPD
- Reduction in admissions at adjacent/referral hospitals at Southampton and Bournemouth

Clinical quality

- >45% of suspected sepsis patients treated with antibiotics <1 hour, compared to <10% previously (Sepsis Audit)

Patient/staff experience and satisfaction

- High patient and staff satisfaction and improve communication with relatives and carers

1 Nurse assessment within 30 minutes

2 14 hours out-of-hours

Source: Trust presentation and website; press

Abingdon Hospital Emergency Multidisciplinary Unit (1/2) similar to model 27

Context

Case for change

- 40% increase in emergency admissions of patients >65years
- Patients over 65 years have:
  - Longer lengths of stay,
  - Higher cost per case,
  - High risk of hospital-related illness
- Unsustainable model of care with recognition to treat frail elderly closer to and in their own homes, without compromising quality

Initiative

- An Emergency Multidisciplinary Unit setup to provide emergency care for patients seen:
  - in primary care, or
  - by ambulance service
- Services 140,000 population, spanning 11 GP practices, over South West Oxfordshire
- 5 short-term beds (<72hrs) for patients not suitable for remain in own homes
- 8am-8pm Mon-Fri, 10am-4pm Sat and Sun

Key enablers

Multidisciplinary team

- GPs, geriatricians, nurses, physiotherapists, occupational therapists and social care
- Co-location within the same building, hosting other services for quicker rehabilitation

Clear pathway for delivering care

- Acutely unwell individual seen by paramedic
- Dedicated EMU ambulance driver
- If any indication that may need tertiary care, taken directly e.g. HASU, PCI or #NOF
- Clear surgical cases taken to another A&E
- Vast majority of elderly either do not need treatment at mild stages of acute illness, or are not fit for surgery
- Access to large selection of IV therapies

Risk stratification

- Develop clinician skill to manage unwell frail patients
- Identify and appropriately manage patients suitable for ambulatory (non-bed-based care)

Rapid Point of Care diagnostics – within 2 mins

- Bloods – tests include U&Es, calcium, blood gases, glucose, Hb, INR and troponin
- Imaging – chest and abdominal XR availability
- Identifies patients too unwell for ambulatory care

SOURCE: Oxford Health NHS Foundation Trust: Community Hospitals in Oxfordshire.

Abingdon Hospital Emergency Multidisciplinary Unit (2/2)

Impact

- 20 cases/day seen by the Emergency Multidisciplinary Unit
- Running cost estimated at £1m per year, excluding Fixed Costs
- 30% reduction in over 80s admissions in the area over last 2yrs
- Easier access for patients
  - Closer to home
  - Reduced travel times
  - Median time to assessment, after referral is 1hr
- Flexibility to add modular components to change volume and scope of activity e.g. low-risk maternity services
- Medical staff provided by OUHT as part of a rotation, allowing sufficient volume and training to maintain skillsets

Stakeholder feedback

- Abingdon EMU team were proud winners of prestigious **Guardian Healthcare Innovation Awards** in the category of **Best Service Delivery Innovation**
- “This award underlines that working in partnership can lead to new, improved services for patients closer to where they live,” said Pete McGrane, Clinical Director of Community Services Division at Oxford Health NHS FT.
- "When expert teams assess patients promptly and tailor care to individual needs, the results are great quality of care and best value for money. The EMU 'emergency team' approach does exactly that, and is being rolled out county-wide,” said Dr James Price, Clinical Director at Oxford University Hospitals NHS Trust said.

NHS Choices feedback:

- “I was referred to Abingdon EMU for a short notice health checkup by my doctor. On arrival I was brought straight through to the ward without waiting. The doctor spoke immediately with me to explain the process, then nurses efficiently and professionally performed the up-front tests. Everything was kept calm and unstressed despite being busy and they managed to avoid any long wait on my part.”
- “I was seen very promptly by helpful and courteous staff, and was pleasantly surprised to have even had my x-rays reviewed by the time I'd walked the length of the corridor! In total I spent no more than an hour being seen including the time I spent with my GP. I really can't fault this at all.”

SOURCE: http://www.phc.ox.ac.uk/news/guardian-healthcare-innovation-award-winners; NHS Choices: Abingdon Community Hospital Director, Out of Hospital Care Network, Oxford AHSN

Queen Mary's hospital sees over 130,000 patients a year and offers more than 60 services – some similarities to model 27

Key Facts

- Part of St George's University Hospitals FT, a large teaching hospital
- Amputee rehabilitation unit is an international centre of excellent
- 139 bed capacity
- 61% of staff would recommend this organisation as a place to be treated

The hospital is famous for its specialised seating service which casts and makes wheelchairs for people who cannot use a standard wheelchair and its prosthetic limb-fitting service

Key Services

Minor Injuries Unit

- Sees ~16,500 people per year
- Unit interacts well with the other services at Queen Mary's Hospital.
- However the CQC reported evidence of poor interaction with the main A&E service at St George's Hospital due to the location
- Nurse led

Day Surgery Unit

- Offers diagnostic service for endoscopy and urology.
- Procedures are carried out under sedation; general anaesthetics are not used in the day surgery unit.

Outpatient services

- For children, young people and adults
- Approximately 3,000 patients a week are seen in OP department
- Services include urology, ophthalmology, podiatry, orthopaedic, cardiovascular, prosthetic, orthotic, wheelchair and sexual health, treatment & burn dressing, rapid diagnostic facilities
- CQC reported effective multidisciplinary working at Queen Mary's Hospital in the outpatients departments

Community inpatient services

- Queen Mary's has 20 beds in the rehabilitation centre, 69 mental healthcare beds and 50 elderly and intermediate care beds.
- 3 inpatient wards
- Multidisciplinary teams with support from social workers who were based on the hospital site
- Some concern over lack of medical cover during night

SOURCE: Queen Mary's Hospital Quality Report, April 2014 ; https://www.stgeorges.nhs.uk/about/history/qmh/

Whitstable: Encompass group's community health operating centres (1/2) similar to model 27

Current services

LTC pathways
- Diabetes
- Cardiology
- COPD
- Dementia

Urgent care
- Level 3 MIU
- Fracture clinic
- DVT service
- Co-located ambulance response base

Diagnostics
- Echocardiography
- Ultrasound
- Digital x-Ray
- Mobile MRI

Consultant-led OP clinics
- Cardiology
- Gynaecology
- Dermatology
- Hand/wrist/forearm
- 17 specialties (delivered by local FT)

Screening
- AAA
- Genetics
- Retinal photography
- Diabetes

Day surgery
- Dermatology
- Cataract

MSK
- Acupuncture
- Chiropractice
- Physiotherapy

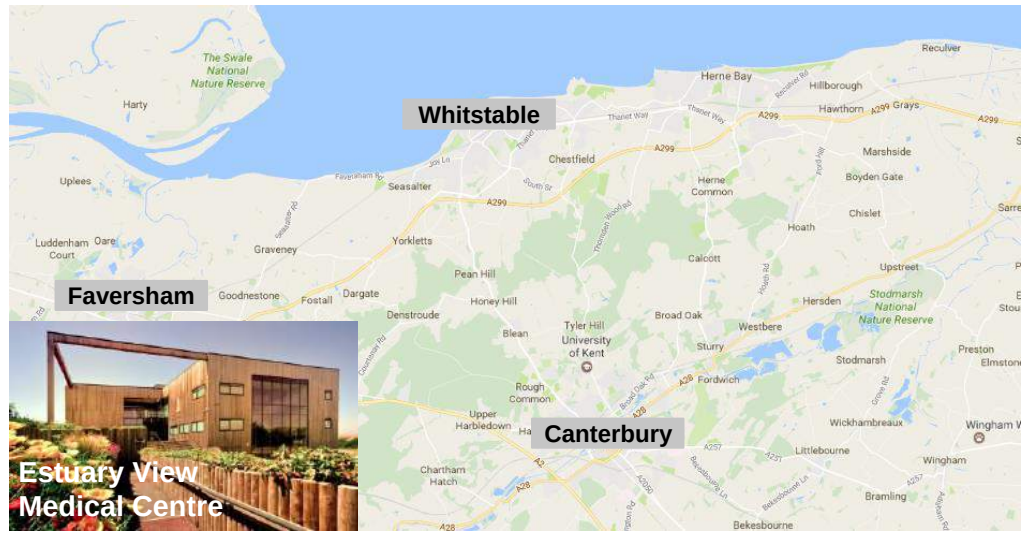
GPwSI clinics
- Insulin initiation
- Prostate
- Warfarin
- Cardiology
- Dermatology
- Epilepsy
- Cardiac rehab/HF
- Primary care surgery
- Steroid Injection
- Hearing aids
- Opthalmology screening
- Glaucoma
- ENT

Services planned for 2017

Enhanced rehab and intermediate care:
- Teaching nursing home
- New community hospital
- Extra care sheltered accommodation and day centre

Footprint

- 16 GP practices across Whitstable, Faversham and Canterbury
- 5 Community Health Operating Centres (advanced care hubs) – e.g. Estuary View Medical Centre
- 169,000 population served



SOURCE: Encompass

Whitstable multi-community partnership (2/2) - ENCOMPASS

Type of model: Multispecialty community providers

Local context and objectives

- Whitstable multi-community partnership encompasses 16 GP practices situated across Whitstable, Canterbury and Faversham
- 169,000 population – with aging demographic profile and increasing proportion of patents with multiple long term condition and complex needs

Main elements of care model

- The partnership provides **14/7 access to extended primary care and urgent care**, and a range of diagnostic services
- 5 **community hub operating centres** providing a wider range of services – e.g. wound and catheter centres of excellence with tele-links to hospital-based specialist. Over time, these centres will include community beds, nursing home beds and extra care facilities
- 700 patients with most complex needs receive **high-intensity integrated case management**
- **Shared training** in integrated care for care workers and specialists, with the aim of enabling care workers to access better specialist input

Key success factors

- **Scale**: size of the partnership allows for significant investment in transforming services
- **Workforce redesign** including training and new roles: e.g. 2 **social prescribers** recruited, **community paramedic** practitioners1 piloted
- IT infrastructure to allow system-wide **data sharing**
- **Digital tools** – e.g. waitless App for urgent care

Evidence of impact

- Improved access to wider range of services
- Expected reduction in admissions and ALOS
- 5% shift of activity from A&E to MIU (through waitless app)
- 30% reduction in catheter-related hospital attendances (£150k savings in 2017/18)

1 GPs can request a Community Paramedic to visit a patient at home – replacing the GP home visit with a swifter and more appropriate response (leading to a 6% reduction in ambulance conveyances during pilot)

Source: Encompass website; press search

Healthy Weston Pre-Consultation Business Case

Appendix 11:

Healthy Weston Listening and Engagement Events and Feedback

Table 1: Option Decision Route

Date 2018	Event	Attendees	Objectives	Outcome
19th April	Stakeholder co-design event	Representatives from charities, homeless groups, housing, Rehab organisations, disability groups, patient representatives, members of public (150 invited in total – Appendix 9 for full list)	To update stakeholders on feedback from co-design phase and inform them of next steps	Updated stakeholders on future development of long list of models
26th June	Newly formed Clinical Service Design and Delivery Group	Clinicians from UHB, WAHT, CCG, AWP, NBT, NSCP, Primary Care	To agree the transition from Co-Design Phase to Pre-Consultation Business Case and role of CSDDG	Establishment of Clinical Service Design and Development Group (CSDDG)
9th & 29th August	Healthy Weston Clinical Workshops	Clinicians from AWP, NBT, NSCP, Primary Care, SWASFT, UHB, WAHT. Representatives from McKinsey (McK), CCG and STP (54 attendees in total - Appendix 9 for full list of attendees)	Agree best practice pathways and potential clinical models for future modelling	500 models to 37 generic models "Long List" agreed
6th Sept	Clinical Services Design and Delivery Group	Clinicians from UHB, WAHT, NSCP, Primary Care, SWASFT Representatives from McK, CCG, Hood and Woolf (H&W)	Review long list against service line and rationalise	Agreed to recommend 6 (including base case) potential clinical models to Steering Group: 3a, 9a, 12, 27b and 37b

Date 2018	Event	Attendees	Objectives	Outcome
20th Sept	Steering Group	CEO's of BNSSG CCG, WAHT, NSCP and UHB. Medical Directors of NBT and WAHT, Chair of CSSDG. Representatives from CCG, NSC, McK, and H&W.	To consider recommendation from CSDDG regarding potential options – with option 12 being refined into 12a and 12b – difference is critical care	Agreed 7 options in line with CSDDG recommendations to be progressed for more detailed modelling
1st Oct	Steering Group	CEOs frrom BNSSG CCG, WAHT and UHB. Chair CSDDG, Medical Director WAHT, Representatives from McK H&W	To consider the evaluation criteria recommended from CSDDG	Agreed evaluation criteria
9th Oct	Extended Clinical Services Design and Delivery Group Workshop	Clinicians from UHB, WAHT, NSCP, Primary Care, SWASFT Representatives from McK, CCG, H&W plus other clinicians	Evaluation of options against agreed evaluation criteria to shortlist	Recommend 3a, 9a, 12a, 12b, and 27b as viable options, with 1a and 37b not supported
12th Oct	Finance and Enabling Group	DoFs of all Acute Trusts	Evaluation of options against agreed financial criteria	Recommend 9a, 12a, 12b and 27b as viable options (1a, 3a, 37b not supported)
18th Oct	Steering Group	CEOs from BNSSG CCG, NSCP, UHB, NBT. NSC Public Health Director, Chair of CSDDG and GP Weston Locality Lead, Medical Director WAHT,	To consider the evaluations from CSDDG and FEG to make decision	Agreed Options 3a, 9a, 12a and 27b (with 3a for light touch). Option 12b removed as no material advantages over 12a or 27b). Requested further review of remaining

Date 2018	Event	Attendees	Objectives	Outcome
		SWASFT, Somerset CCG. Representatives from CCG, STP, McK, H&W	on options to go forward	options by CSDDG and FEG
24th Oct	Clinical Services Design and Delivery Group	Clinicians from WAHT, NBT, NSCP, UHB, SWASFT. Representatives from CCG and McK.	To consider issues raised by SG and review assessment to enable clearer differentiation with focus on options 3a, 9a, 12a, 27b	Moderation of activity shift for model 27b. Recommendation to SG that options 9a, 12a and 27b be considered for consultation (with 3a as base)
26th Oct	Finance and Enabling Group	DoFs from Acute Trusts	Remodel with revised shift of activity for 27b. Bottom up validation of activity and financial modelling for 9a, 12a and 27b	To confirm support for 9a and 12a, with concerns around 27b due to levels of capital required
1st Nov	Steering Group	CEOs from BNSSG CCG, UHB, NBT and NSCP. Medical Director from WAHT, NSC Public Health, SWASFT, Chair CSDDG and GP Lead Weston & Worle Locality. Representatives from CCG, McK and H&W	To consider the further evaluation from CSDDG and FEG to inform decision on options for PCBC	Recommended 9a, 12a and 27b be tested through consultation. Recognised that 27b represented potential long term direction of travel which may require phased approach. Agreed to explore whether phasing needed 2 steps 9a, 12a or one step (blended model between 9a and 12a)
20th Nov	Clinical Senate	Representatives from Steering Group,	Clinical Senate review of	Senate strongly supported no change is not

Date 2018	Event	Attendees	Objectives	Outcome
	Review	CSDDG and NHSE England	PCBC and emerging options (9a, 12a and 27b)	an option, supported model 9a for immediate implementation to address quality and safety issues, and move to 27b. did not support option 12a and was concerned that it could, in fact, introduce more risk
29th Nov	NHS E Stage 2 Assurance Meeting	Clinicians from WAHT, NBT, NSCP, UHB, SWAFST Representatives from CCG, McK	To respond to Clinical Senate feedback and describe 27b more fully and transition steps to get there	Steering group received report from CSDDG and clarification on what was included in 27b and agreed to be preferred option with 9a as first step towards it
19th Dec	NHS E Stage 2 Assurance Meeting	NHS E Assurance Panel, BNSSG CCG Executives	To seek assurance from NHS E on preferred option with 2 phases – 1st phase 9a and longer term 2nd Phase towards 27b	NHS E confirmed that they felt that Phase 1 should be framed as a fixed point, and Phase 2 as a direction of travel, rather than as a second fixed point. NHS E confirmed that they would approve going to consultation for Phase 1 (9a).
19th Dec	Steering Group	Teleconference with CEOs from BNSSG CCG, UHB, NBT, WAHT, NSCP and nominated representative for CEO T&SFT. Medical Directors from WAHT, NSC Public Health, T&SFT, Chair CSDDG and GP Lead Weston & Worle Locality. Representatives from	Update Steering Group on NHS E assurance and agree next steps to determine preferred option for consultation	PCBC to be redrafted to reflect NHS E recommendations with 9a being the option to be consulted upon within a described 5 year vision /direction of travel Clinical Assumptions around critical care and emergency surgery in 9a to be tested

Date 2018	Event	Attendees	Objectives	Outcome
		CCG and H&W		in CSDDG
4th Jan 2019	Joint DoFs and Clinical Directors meeting	DoFs from BNSSG CCG, NBT, UHB and STP with Clinical Directors from WAHT & NBT, Directors of Transformation UHB and WAHT Executive Director for Healthy Weston	To agree clinical assumptions about movement of patients under 9a and identify activity and bed implications	DoFs understood the broad assumptions that had resulted in remodeling and reduction in beds but tasked CSDDG to explore at HRG actual shift for 9a and would accept the outcome of this for PCBC. They agreed that the limited number of beds would be able to be repatriated/repurposed
9th Jan 2019	Clinical Service Design and Delivery Group	Clinicians from WAHT, NBT, UHB and NSCP, Business and Financial Analysts from CCG, Representatives from CCG	To agree HRGs for patients who will be impacted under 9a around critical care and emergency surgery who will move to neighbouring hospitals to remodel with actual LOS	Actual shift of patients by HRG (by neighbouring trust) identified To revise activity and financial modelling to reflect this to be included in PCBC for 9a
15th Jan 2019	Steering Group	CEOs from BNSSG CCG, UHB, NBT and NSCP. Medical Director, NSCP Public Health, SWAFST, Chair CSDDG and GP Lead Weston & Worle Locality. Representatives from CCG, McK and H&W	Sign-off the key messages and approach as set out in the draft Consultation Document and Pre Consultation Business Case	Agreement of key messages, ensuring that the separation of immediate changes and a potential long term future which needs more co-design work was made clear

Table 2: Healthy Weston Engagement Timetable August 2017 – December 2018

	Healthy Weston Governance Groups	Clinical Engagement	Healthwatch	Staff Engagement	HOSP/HOSC	MPs/Cllrs	Public Meetings and Patient Engagement	Hard to Reach	Somerset CCG
August 2017							22/08/17 PPRG Meeting		
September 2017			10/10/17 North Somerset Healthwatch meeting						
October 2017			10/10/17 North Somerset Healthwatch Board meeting	30/10/17 WAHT Staff Briefing	26/10/17 North Somerset HOSP meeting		26/10/17 WAHT Patients Council		
November 2017	08/11/17 Comms & Dialogue Meeting			14/11/17 WAHT Staff Briefing 28/11/17 Healthy Weston All Staff Event		02/11/17 Weston Labour Party Meeting 21/11/17 Weston Town Council Meeting	14/11/17 Weston Public Meeting 21/11/18 Healthy Weston Public Meeting, Worle 29/11/17 Shipham Public Meeting		
December 2017							05/12/17 Healthy Weston Public Event	07/12/18 Victoria's Kitchen (Homeless community)	
January 2018		08/01/18 Vulnerable Communities Pathway Workshop and Feedback 11/01/18 Children and Young Peoples' Pathway Workshop 18/01/18 Frail Older Peoples' Clinical Workshops 25/01/18 Care Homes Workshop – Weston Town Hall		23/01/18 Staff meeting at Weston Football Club			05/01/18 Cheddar Public Meeting 10/01/18 Yatton Public Meeting 11/01/18 Cheddar Public Meeting – Co-Design section 16/01/18 Healthy Weston Public Event, Worle 19/01/18 North Somerset PPG Chairs Meeting	03/01/18 Community Outreach at Tisley House Nursing Home 07/01/18 Rough Sleepers' Community Outreach Meeting 12/01/18 Alzheimer's Team 13/01/18 Children's Emotional and Wellbeing Partnership 31/01/18 Fibromyalgia Support Group 31/01/18 Future in Mind	
February 2018		01/02/18 Care Campus Service Redesign Workshop 05/02/18 Frail Older People's Clinical Workshop					12/02/18 Learning Disability Parent Group 14/02/18 Learning Disability Speaking Up Group 19/02/18 Young Persons' Learning Disability Group @ Weston College 24/02/18 Domestic Abuse Co-ordinator 28/02/18 Somewhere To Go outreach		
March 2018				30/03/18 Healthier Together newsletter					
April 2018				09/04/18 Healthier Together newsletter x 4 (09/04/18, 13/04/18, 20/04/18, 30/04/18)			19/04/18 Healthy Weston Update Event		

	Healthy Weston Governance Groups	Clinical Engagement	Healthwatch	Staff Engagement	HOSP/HOSC	MPs/Cllrs	Public Meetings	Hard to Reach	Somerset CCG
May 2018				17/05/18 Meeting with Somerset Surgical Services 25/05/18 Healthier Together newsletter			29/05/18 PPRG Meeting		
June 2018	19/06/18 HW Steering Group 26/06/18 Comms & Engagement Group	07/06/18 North Somerset Clinical Leaders meeting 26/06/18 CSDDG	26/06/18 Comms & Engagement Group	Healthier Together Newsletter (08/06/18, 15/06/18)	07/06/18 North Somerset HOSP			27/06/18 Meeting with CEO Vision North Somerset 29/06/18 Meeting with VANS Leadership Group	
July 2018	17/07/18 HW Steering Group	26/07/18 Clinical Workshop	11/07/18 Meeting with Healthwatch CEO	20/07/18 Healthier Together newsletter	23/07/18 Weston Town Council Meeting	02/07/18 Meeting with Cllr Nigel Taylor			
August 2018	23/08/18 HW Steering Group 29/08/18 Comms & Engagement Group	15/08/18 Clinical Workshop 29/08/18 Urgent Care Workshop	29/08/18 Comms & Engagement Group	Healthier Together newsletter x 5 (03/08/18, 10/08/18, 17/08/18, 24/08/18, 31/08/18) 09/08/18 Update letter and onward cascade briefing circulated to staff	30/08/18 Meeting with North Somerset HOSP Chair	09/08/18 Healthy Weston update letter	15/08/18 Healthy Weston Update Letter 24/08/18 PPRG Evaluation Criteria Call 28/08/18 PPRG Evaluation Criteria Call		
September 2018	07/09/18 HW Steering Group 12/09/18 Comms & Engagement Planning Meeting 20/09/18 HW Steering Group 27/09/18 Comms & Engagement Group	06/09/18 CSDDG 25/09/18 CSDDG 26/09/18 CSDDG	06/09/18 Meeting with Healthwatch CEO 12/09/18 Comms & Engagement Group 18/09/18 Healthwatch North Somerset Meeting 27/09/18 Comms & Engagement Group	Healthier Together newsletter x 4 (07/09/18, 14/09/18, 21/09/18, 28/09/18) 28/09/18 Update letter and onward cascade briefing circulated to staff	17/09/18 Boundary/Neighbouring HOSCs – Correspondence 20/09/18 North Somerset HOSP – Informal Briefing 26/09/18 North Somerset HOSP 26/09/19 BNSSG JHOSC Meeting	18/09/18 Meeting with Nigel Ashton 28/09/18 Healthy Weston update letter	18/09/18 North Somerset PPG – Chairs 18/09/18 BNSSG PPIF Meeting 25/09/18 PPRG Meeting	24/09/18 Voluntary Action North Somerset (VANS) AGM 26/09/18 Old People Champions Group – September HW Update 27/09/18 VCSE Sector/Representatives Meeting	20/09/18 Somerset CCG Governing Body Meeting
October 2018	01/10/18 HW Steering Group 18/10/18 HW Steering Group 25/10/18 Comms & Engagement Group	03/10/18 Healthy Weston – Wider Clinical Event 05/10/18 Meeting with UHB Medical Director 08/10/18 Clinical Engagement Event 08/10/18 Healthy Weston – Wider Clinical Event 09/10/18 CSDDG 24/10/18 CSDDG	25/10/18 Comms & Engagement Group	Healthier Together newsletter x 4 (05/10/18, 12/10/18, 19/10/18, 26/10/18) 08/10/18 WAHT Staff Listening Event x 3 10/10/18 Weston Staff Event 11/10/18 Weston Staff Event	18/10/18 Somerset HOSC – HW Presentation	05/10/18 Call with John Penrose MP	10/10/18 Healthy Weston Public Event 10/10/18 Stakeholder Event 16/10/18 North Somerset PPG Chairs Meeting 17/10/18 North Somerset PPRG 23/10/18 Tyntesfield PPG 30/10/18 Case for Change published	08/10/18 'Somewhere To Go' Meeting 08/10/18 North Somerset Homeless Services 24/10/18 Request to drop in at Greenfield Way Site (Traveller community) 25/10/18 NS Locality Leadership Groups & System Partners (VCSE, local authority)	

	Healthy Weston Governance Groups	Clinical Engagement	Healthwatch	Staff Engagement	HOSP/HOSC	MPs/Cllrs	Public Meetings	Hard to Reach	Somerset CCG
November 2018	29/11/18 HW Steering Group 29/11/18 Comms & Engagement Group	20/11/18 Clinical Senate 29/11/18 CSDDG		Healthier Together newsletter x 4 (02/11/18, 09/11/18, 16/11/18, 23/11/18) 28/11/18 Weston Staff Engagement Event	07/11/18 Somerset HOSC – HW Presentation	05/10/18 Call with John Penrose MP	23/11/18 Case for Change Roadshow (Sovereign Centre) 27/11/18 PPRG Meeting 30/11/18 Case for Change Roadshow (Healthy Living Centre) 30/11/18 Healthy Weston Public Event	01/11/18 North Somerset Citizens' Advice AGM 13/11/18 LGBT+ Healthy Weston Drop-In Session 15/11/18 Deaf Community – Communication Café 23/11/18 Addaction meeting 26/11/18 Learning Disability Network Meeting	29/11/18 HW Steering Group
December 2018	19/12/18 HW Steering Group 20/12/18 Comms & Engagement Group	20/12/18 CSDDG		05/12/18 Weston Staff Engagement Event 07/12/18 Healthier Together newsletter	05/12/18 Somerset HOSC 11/12/18 North Somerset HOSP	07/12/18 Meeting with John Penrose MP and Marc Aplin	03/12/18 Public Listening Event 03/12/18 Stakeholder Event 07/12/18 Case for Change Roadshow (Tesco) 14/12/18 Case for Change Roadshow (Healthy Living Centre)		19/12/18 HW Steering Group
January 2019	04/01/19 STP DoFs and Clinical Directors meeting 15/01/19 HW Steering Group 17/01/19 Comms & Engagement Group	09/01/19 CSDDG 09/01/19 GP Forum 14/01/19 Meeting with T&SFT CEO and Medical Director 17/01/19 CSDDG 17/01/19 GP Consultation following PLANET	17/01/19 Comms and Engagement Group	22/01/18, 24/01/18 Meetings with Weston General Hospital Consultant Committee (HMAC)	31/01/19 North Somerset HOSP	21/01/19 Mendip District Council Meeting 21/01/19 Presentation to Weston Town Council	24/01/19 WAHT Patient Council		21/01/19 Somerset Engagement Advisory Group

Table 3: Healthy Weston Engagement Log

DRAFT Healthy Weston Engagement Log			
Governance	VIP Stakeholders	Hard to Reach	Other
Date	**Name**	**Type**	**Code**
26/10/2017	North Somerset HOSP	Meeting	
07/11/2017	WAHT Board Meeting	Meeting	
20/11/2017	People and Communities Board	Meeting	
21/11/2017	W-s-M Town Council Meeting	E-mail	
01/05/2018	Report to Comm Exec	Meeting	
02/05/2018	CCG / WAHT - Formal meeting between Exec teams	Meeting	
05/06/2018	BNSSG Governing Body Seminar	Other	
07/06/2018	North Somerset Clinical Leaders' Meeting	Meeting	
07/06/2018	North Somerset HOSP	Meeting	
27/06/2018	Meeting with WAHT Chair	Meeting	
03/07/2018	BNSSG AGM	Meeting	
18/07/2018	BNSSG Clinical Cabinet	Meeting	
30/08/2018	Meeting with NS HOSP Chair	Meeting	
04/09/2018	BNSSG Governing Body Seminar	Meeting	
06/09/2018	Meeting with Healthwatch CEO	Meeting	
12/09/2018	Weston Area Health Trust AGM	Meeting	
17/09/2018	Boundary/Neighbouring HOSCs - Correspondence	Meeting	
20/09/2018	North Somerset HOSP - Informal Briefing	Meeting	
20/09/2018	North Somerset HOSP	Meeting	
25/09/2018	PCCC Meeting	Meeting	
26/09/2018	NS Health Overview Scrutiny Panel (HOSP) Meeting	Meeting	
26/09/2018	BNSSG JHOSC Meeting	Meeting	
26/09/2018	Meeting/Update - JL, JR, DJ	Meeting	
02/10/2018	Trust Board Meeting - WAHT, UHB, NBT	Meeting	
02/10/2018	BNSSG CCG Governing Body Meeting	Meeting	
17/10/2018	NS Executive Committee Meeting (People and Communities Board)	Meeting	
18/10/2018	Somerset HOSC HW Presentation	Meeting	
19/10/2018	BNSSG Governing Body Meeting	Meeting	
06/11/2018	Trust Board Meeting - WAHT, UHB, NBT	Meeting	
06/11/2018	BNSSG CCG Governing Body Meeting	Meeting	
29/11/2018	HW Steering Group Meeting	Meeting	
04/12/2018	Trust Board Meeting - WAHT, UHB, NBT	Meeting	
04/12/2018	BNSSG CCG Governing Body Meeting	Meeting	
11/12/2018	NHSE Assurance - Provisional	Meeting	
13/12/2018	NHSE Assurance Stage 2 - Provisional	Meeting	
14/12/2018	HW Stage 2 Assurance	Other	
19/12/2018	NHSE Assurance Stage 2 - Provisional	Meeting	

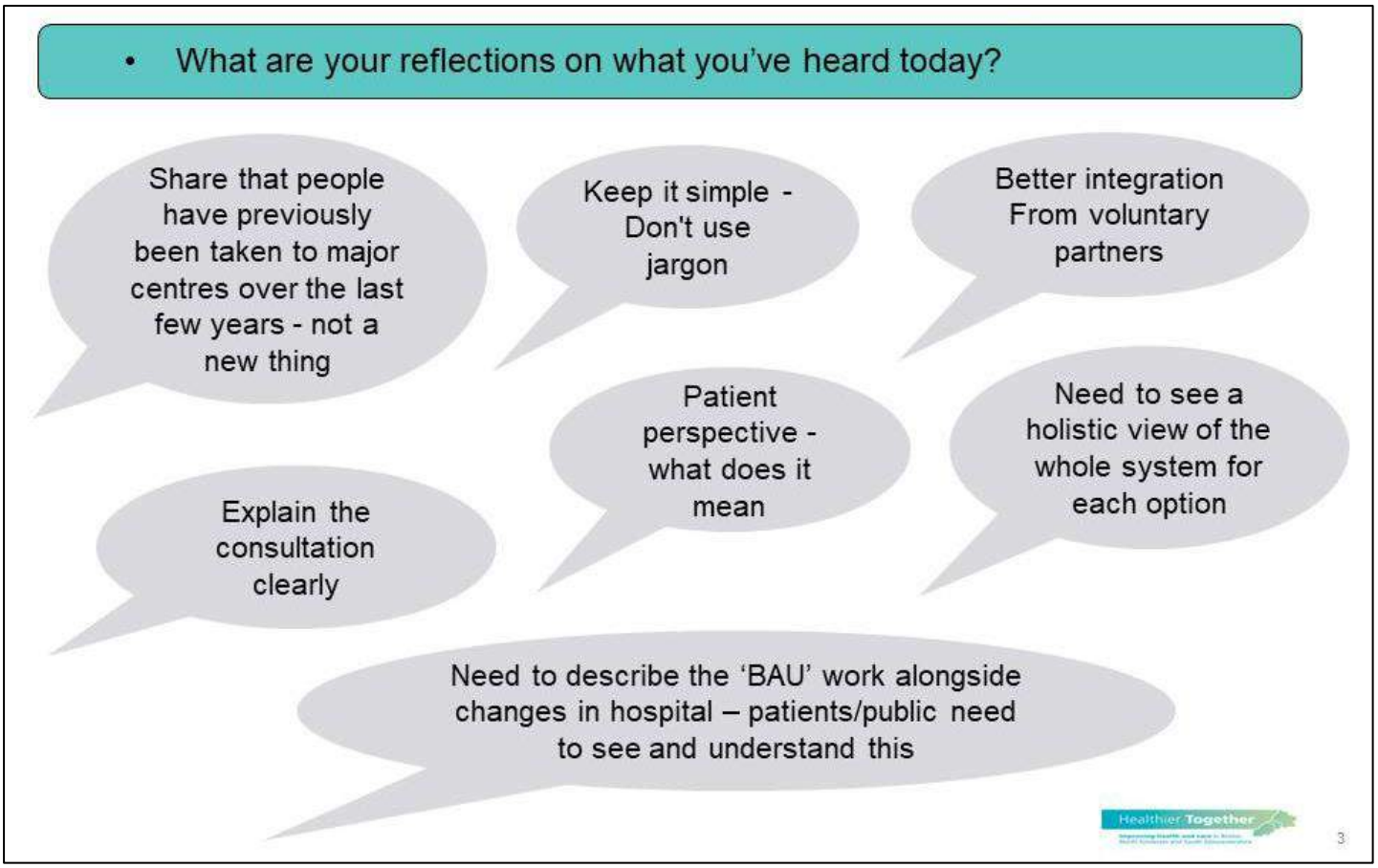
19/12/2018	HW Steering Group Meeting	Meeting	
20/12/2018	CSDDG Meeting	Meeting	
04/01/2019	Joint DoFs and Clinical Directors Meeting	Meeting	
09/01/2019	CSDDG Meeting	Meeting	
09/01/2019	North Somerset GP Forum	Meeting	
02/07/2018	Meeting with Cllr Nigel Taylor	Meeting	
11/07/2018	Meeting with John Whitlow	Meeting	
11/07/2018	Meeting with NS Healthwatch CEO	Meeting	
24/07/2018	Call with Sheila Smith	Telephone	
29/08/2018	Informal meeting with Rachel Morris	Meeting	
10/09/2018	Meeting with Dr A Burnett	Meeting	
25/09/2018	Jeremy Spearing Update	Meeting	
05/10/2018	Call - John Penrose MP	Telephone	
09/10/2018	HW Meeting - Katie Norton and Andrew Burnett	Email	
07/12/2017	Victoria's Kitchen (Homeless community)	Other	
03/01/2018	Community outreach at Tilsley House Nursing Home	Other	
07/01/2018	Rough Sleepers' Community Outreach Meeting	Other	
08/01/2018	Vulnerable Communities Pathway Workshop	Other	
08/01/2018	Vulnerable Groups Feedback	Other	
12/01/2018	Alzheimer's Team - Village Church Hall	Other	
13/01/2018	Children's Emotional and Wellbeing Partnership	Meeting	
18/01/2018	Frail Older Peoples' Clinical Workshops	Other	
25/01/2018	Care Homes Workshop Weston Town Hall	Other	
31/01/2018	Fibromyalgia Support Group	Meeting	
31/01/2018	Future in Mind	Meeting	
05/02/2018	Frail Older Peoples' Clinical Workshop	Other	
12/02/2018	Learning Disability Parent Group	Other	
13/02/2018	Fibromyalgia Support Group	Meeting	
14/02/2018	Learning Disability Speaking Up Group	Other	
19/02/2018	Young Persons' Learning Disability Group @ Weston College	Meeting	
24/02/2018	Domestic Abuse Co-Ordinator	Meeting	
28/02/2018	Outreach visit to 'Somewhere To Go'	Other	
27/06/2018	Meeting with CEO - Vision North Somerset	Meeting	
29/06/2018	Meeting with VANS Leadership Group	Meeting	
24/09/2018	Voluntary Action North Somerset (VANS) AGM	Meeting	
26/09/2018	Older People Champions Group - September HW Update	Meeting	
27/09/2018	VCSE Sector / Representatives Meeting	Meeting	
08/10/2018	'Somewhere To Go' Meeting	Meeting	
08/10/2018	North Somerset Homeless Services	Meeting	
24/10/2018	Request to 'drop in' at Greenfield Way Site - Traveller Community	Email	
25/10/2018	NS Locality Leadership Groups and System Partners (VCSE, local authority)	Meeting	
01/11/2018	North Somerset Citizen's Advice - AGM	Meeting	
13/11/2018	LGBT+ Healthy Weston Drop-In Session	Other	
15/11/2018	Deaf Community - Communication Cafe	Meeting	

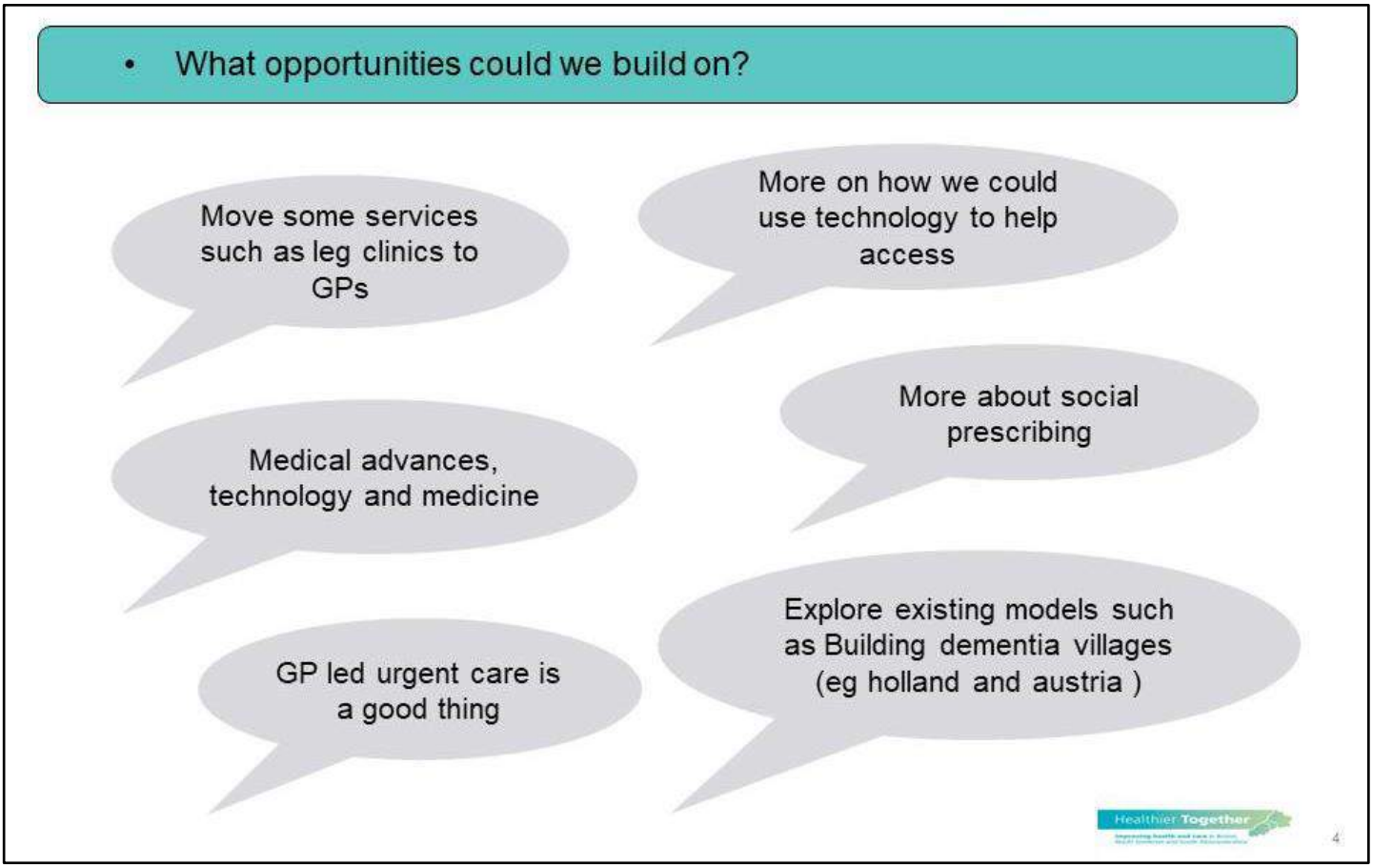
23/11/2018	Addaction Meeting (Substance and Alcohol Misuse)	Meeting	
26/11/2018	Learning Disability Network Meeting	Meeting	
22/08/2017	PPRG Meeting	Meeting	
17/09/2017	NS Healthwatch Meeting	Meeting	
10/10/2017	NS Healthwatch Board Meeting	Meeting	
26/10/2017	WAHT Patients Council	Meeting	
30/10/2017	WAHT Staff Briefing	Meeting	
02/11/2017	Weston Labour Party Meeting	Meeting	
08/11/2017	Comms and Dialogue Meeting	Meeting	
14/11/2017	WAHT Staff Briefing	Meeting	
14/11/2017	HW Public Meeting, Weston	Other	
21/11/2017	HW Public Meeting, Worle	Meeting	
28/11/2017	WAHT Staff Engagement	Other	
28/11/2017	Healthy Weston All Staff Event	Other	
29/11/2017	Shipham Public Meeting	Other	
05/12/2017	HW Public Event	Other	
05/01/2018	Cheddar Public Meeting	Other	
10/01/2018	Yatton Public Meeting	Other	
11/01/2018	Cheddar Public Meeting - co-design section	Other	
11/01/2018	Children and Young People's Pathway Workshop	Other	
16/01/2018	HW - Worle Public Event	Other	
16/01/2018	Workshop at the Campus (Weston)	Other	
19/01/2018	North Somerset PPG Chairs Meeting	Meeting	
23/01/2018	Staff Meeting @ Weston Football Club	Meeting	
01/02/2018	Care Campus Service Redesign Workshop	Other	
01/02/2018	Social Media Feedback received	E-mail	
08/02/2018	Maternity Feedback Workshop	Other	
15/02/2018	Probus	Other	
18/02/2018	Personal Reflection on the Co-Design Process	E-mail	
22/02/2018	Maternity Services Feedback	Other	
22/02/2018	Children and Young Peoples' Design Ideas	Other	
19/04/2018	Healthy Weston Update Event	Other	
16/05/2018	BNSSG STP Social Enterprise Forum	Meeting	
17/05/2018	Meeting with Somerset Surgical Services	Meeting	
29/05/2018	PPRG Meeting	Meeting	
04/06/2018	Post Stage 1 DCO Meeting	Meeting	
07/06/2018	Briefing for T&S	Other	
19/06/2018	HW Steering Group Meeting	Meeting	
21/06/2018	STP Conference	Meeting	
26/06/2018	Comms and Engagement Meeting	Meeting	
26/06/2018	CSDDG Meeting	Meeting	
17/07/2018	Steering Group Meeting	Meeting	
23/07/2018	Weston Town Council Meeting	Meeting	
26/07/2018	Clinical Workshop	Meeting	

09/08/2018	Clinical Workshop	Meeting	
15/08/2018	Healthy Weston Update Letter	Email	
15/08/2018	Pre-Stage II DCO Meeting	Meeting	
23/08/2018	Steering Group Meeting	Meeting	
24/08/2018	PPRG Evaluation Criteria Call	Telephone	
28/08/2018	PPRG Evaluation Criteria Call	Meeting	
29/08/2018	Urgent Care Workshop	Meeting	
29/08/2018	Comms and Engagement Group Meeting	Meeting	
06/09/2018	CSDDG Meeting	Meeting	
07/09/2018	HW Steering Group	Meeting	
11/09/2018	Social Partnership Forum	Other	
11/09/2018	HW Delivery Team Meeting	Meeting	
12/09/2018	Communications and Engagement Planning Meeting	Meeting	
17/09/2018	HW Core Team Weekly Check-In	Meeting	
17/09/2018	Healthier Together SRO Delivery Lead Group	Meeting	
18/09/2018	BNSSG PPIF Meeting	Meeting	
18/09/2018	Leadership Meeting - JR and HB	Meeting	
18/09/2018	Healthwatch NS - Meeting	Meeting	
18/09/2018	HW Delivery Team Meeting	Meeting	
19/09/2018	Frailty Team Meeting	Meeting	
20/09/2018	Somerset CCG Governing Body Meeting	Meeting	
20/09/2018	HW Steering Group Meeting	Meeting	
24/09/2018	HW Core Team Weekly Check-In	Meeting	
24/09/2018	Frailty Steering Group Meeting	Meeting	
25/09/2018	CSDDG Meeting	Meeting	
25/09/2018	PPRG Meeting	Meeting	
25/09/2018	HW Delivery Team Meeting	Email	
26/09/2018	CSDDG Meeting	Meeting	
27/09/2018	Comms and Engagement Meeting	Meeting	
28/09/2018	Call with AWP	Telephone	
01/10/2018	HW Core Team Weekly Check In	Meeting	
01/10/2018	HW Steering Group	Meeting	
02/10/2018	HW Delivery Team Meeting	Meeting	
03/10/2018	HW - Wider Clinical Event	Other	
05/10/2018	Meeting with UHB Medical Director	Other	
08/10/2018	HW Core Team Weekly Check In	Meeting	
08/10/2018	Clinical Engagement Event	Other	
08/10/2018	HW - Wider Clinical Event	Other	
08/10/2018	WAHT Staff Listening Event x3	Other	
09/10/2018	CSDDG Meeting	Meeting	
09/10/2018	HW Delivery Team Meeting	Meeting	
10/10/2018	Stakeholder Event	Other	
10/10/2018	HW Public Event	Email	
10/10/2018	Weston Staff Event	Other	

11/10/2018	Weston Staff Event	Other	
15/10/2018	HW Core Team Weekly Check In	Meeting	
16/10/2018	NS PPG Chairs Meeting	Email	
16/10/2018	HW Delivery Team Meeting	Meeting	
17/10/2018	North Somerset PPRG	Meeting	
18/10/2018	HW Steering Group	Meeting	
23/10/2018	HW Delivery Team Meeting	Meeting	
23/10/20218	Tyntesfield PPG	Meeting	
24/10/2018	Stakeholder Event - Provisional	Other	
24/10/2018	CSDDG Meeting	Meeting	
25/10/2018	Communications and Engagement Meeting	Meeting	
30/10/2018	HW Delivery Team Meeting	Meeting	
30/10/2018	Case for Change - published	Other	
31/10/2018	Stakeholder Event - Provisional	Other	
02/11/2018	Healthier Together bulletin - Healthy Weston	Email	
06/11/2018	HW Delivery Team Meeting	Meeting	
07/11/2018	Somerset HOSC - HW Presentation	Meeting	
13/11/2018	HW Delivery Team Meeting	Meeting	
20/11/2018	Clinical Senate	Other	
20/11/2018	HW Delivery Team Meeting	Meeting	
23/11/2018	Case for Change Roadshow (Sovreign Shopping Centre)	Other	
27/11/2018	PPRG Meeting	Meeting	
27/11/2018	HW Delivery Team Meeting	Meeting	
29/11/2018	Communications and Engagement Meeting	Email	
29/11/2018	CSDDG Meeting	Meeting	
30/11/2018	HW Public Event	Other	
30/11/2018	Case for Change Roadshow (Healthy Living Centre)	Other	
03/12/2018	Public Listening Event	Other	
03/12/2018	Social Partnership Forum	Other	
04/12/2018	NS Executive Committee Meeting	Meeting	
04/12/2018	HW Delivery Team Meeting	Meeting	
07/12/2018	Case for Change Roadshow (Tesco WsM)	Other	
11/12/2018	HW Delivery Team Meeting	Meeting	
14/12/2018	Case for Change Roadshow (Healthy Living Centre)	Other	
18/12/2018	HW Delivery Team Meeting	Meeting	
14/01/2019	Taunton and Somerset Trust HW Update	Meeting	
15/01/2019	HW Steering Group Meeting	Meeting	
17/01/2019	Update given to GP at PLANET	Meeting	

Fig. 1: Summary headline themes and feedback from Healthy Weston October 2018 Stakeholder Event





- What concerns do you have? And how can we address them?

Closure of A&E - this doesn't answer that specific question. This matters to people and language needs to be clear on this

Integration is key but it isn't happening – primary care/social care/wider system not working together. Sceptical that this will change

Too much duplication out there – e.g. on social prescribing. How to join up more efficiently?

Concerns around public transport - big issue for rural areas

not clear enough yet about what models will mean

Will what we are designing do what we think it will?

Healthier Together

- How can we ensure we deliver a meaningful public consultation on our final proposals for change early next year?

Use all networks in the community to reach all groups e.g. LGBT, BME

Need much more detail – everything too vague at the moment

Simple messaging key

Explain how everything fits together

Put info into libraries, in local paper, citizens advice bureau, benefits offices

Please include lay members as part of the clinical debate

Use patient journeys to describe

Use social media

Play info on TVs at GP surgeries

Healthier Together

- What are your reflections on what you've heard today?

Continuity of care is key to quality clinical work

Our views slanted by our own health needs/experience

Like the idea of 'one door' with more specialists there and patient telling their story just once

Need to support grass roots staff – too top heavy in organisations

Keep doing what you are doing

People taking responsibility for own health - care with language - can be patronising

Distance from services - night time especially being sent to taunton/bristol - how do we get home

- What opportunities could we build on?

Orthapaedic regional centre

Longer term funding for voluntary sector. See them the professional they are

Improve electronic communication

Doing what is required - progression in thinking - chance of successful change

Use our active voluntary and community sector

You need to take people with you

Build on excellent local GP practices

Cataract surgery - income generation

- How can we ensure we deliver a meaningful public consultation on our final proposals for change early next year?

multiple ways of communicating

Better publicity needed

More pictures - especially for benefit of learning disabilities

Make it more appealing

How to get to young people? Can't forget them

At least a month notice for meetings

Use real examples of patients – answer the 'what does it mean for me

- What concerns do you have? And how can we address them?

Heard it all before- cynical about this working

GPs not reactive enough in what they do. Public has to push for everything. Frustrating

Too much to take in

Course for anxiety and depression

Process and systems needed to free up resources

Mental health – will the support and money actually go to mental health services? Don't believe it

Want more detail about hospital care and community care

None of the models will work unless workforce numbers increase

Table 4: North Somerset HOSP Meetings & Healthy Weston Programme attendance

Meeting	**North Somerset HOSP**	**North Somerset HOSP**	**North Somerset HOSP**	**North Somerset HOSP**	**North Somerset HOSP**
Date	**26/10/2017**	**22/02/2018**	**07/06/2018**	**20/09/2018**	**11/12/2018**
Representatives from CCG	Colin Bradbury, Area Director (BNSSG CCG)	Colin Bradbury, Area Director, BNSSG CCG	Colin Bradbury, Area Director	Colin Bradbury, Area Director	Colin Bradbury, Area Director
Update/ Discussion/ Decision/ Action	**Update**: CB presented a report outlining the Healthy Weston Programme **Discussion**: Discussion of the report, Q&A **Decision**: The panel decided to consider submitting a formal response to the Healthy Weston Commissioning Context.	**Update**: CB gave a presentation on Healthy Weston and other CCG priorities for North Somerset. James Rimmer (WAHT) presented a report on the progress since the overnight closure of the Weston General A&E.	**Update**: CB gave a presentation updating the panel on Healthy Weston progress and next steps, co-design and engagement, and the Healthier Together (STP) progress. **Decision**: The panel requested further update on KOIs for the January HOSP meeting.	**Update**: CB presented an update to the panel, answered questions and listened to concerns. **Decision**: It was agreed that the Chief Executive of the BNSSG CCG would arrange a future date to meet with the panel.	
Evidence	Minutes of the meeting 26th October 2017	Minutes of the meeting 22nd February 2018	Minutes of the meeting 7th June 2018	Minutes of the meeting 20th September 2018	Healthy Weston presentation slides 11/12/18
	Healthy Weston Programme update 26/10/18	CCG Update 22/02/18	CCG Update 07/06/18	Healthy Weston presentation 20/09/18	Healthy Weston update report 11/12/18

Table 5: JHOSC Meetings and Healthy Weston attendance

Meeting	**Joint Health and Overview Scrutiny Committee**	**Joint Health and Overview Scrutiny Committee**	**Joint Health and Overview Scrutiny Committee**
Date	**23/10/2017**	**27/02/2018**	**27/09/2018**
Attendees	Julia Ross, Chief Executive, BNSSG CCG	Julia Ross, Chief Executive, BNSSG CCG Rebecca Balloch, Comms & Engagement Lead	Julia Ross, Chief Executive, BNSSG CCG
Update/ Discussion/ Decision/ Action	**Update:** JR presented the Comms & Engagement plan. **Action**: JR to discuss the plan and KPIs for the programme at the next meetings. **Action**: CCG to note feedback to test public documents with lay people of all ages before publishing.	**Update:** Update given on Healthier Together and the Healthy Weston programme	**Update**: JR gave an update on the progress of the community services reprocurement.
Evidence	Healthy Weston Programme update report 23/10/17	Healthier Together narrative report 27/02/18	Healthy Weston presentation slides 26/09/18
	STP Plan 23/10/17	Healthy Weston presentation slide deck 27/02/18	Healthy Weston evaluation criteria 26/09/18
	JHOSC minutes 23/10/17	Healthier Together covering report 27/02/18	JHOSC Draft minutes 27/09/18
		JHOSC minutes 27/02/18	

Table 6: Somerset Scrutiny Panel meetings and Healthy Weston attendance

Meeting	**Somerset Scrutiny Panel**	**Somerset Scrutiny Panel**	**Somerset Scrutiny Panel**	**Somerset Scrutiny Panel**
Date	**07/11/2018**	**05/12/2018**	**30/01/2019**	**13/03/2019**
Attendees	N/A	Glyn Howells, Director, Glyn Howells Associates		
Update/ Discussion/ Decision/ Action	A Healthy Weston programme update report was sent to the Scrutiny Committee, but the item was deferred until the next meeting.	**Update**: GH gave a presentation on the Healthy Weston programme progress.		
Evidence	Healthy Weston programme update report	Healthy Weston Programme update report		
	Healthy Weston presentation	Healthy Weston presentation		
	Scrutiny Summary of Outcomes	Scrutiny Summary of Outcomes		

Table 7: Patient & Public Reference Group, Patient & Public Involvement Forums, and Healthy Weston engagement

Meeting	**PPRG**	**PPRG Evaluation Criteria Conference Call**	**PPRG Evaluation Criteria Conference Call**	**North Somerset PPIF**	**Corporate PPIF**	**PPRG**	**North Somerset PPIF**
Date	**29/05/2018**	**24/08/18**	**28/08/2018**	**17/10/2018**	**18/09/2018**	**25/09/2018**	**11/12/2018**
Attendees from CCG	Katie Norton, Programme Director for Healthy Weston	Katie Norton, Programme Director	Katie Norton, Programme Director Colin Bradbury, Area Director – North Somerset	Mary Adams, Patient and Public Engagement Manager	Katie Norton, Programme Director	Katie Norton, Programme Director Mary Adams	Colin Bradbury, Area Director – North Somerset
Update/ Discussion/ Decision/ Action	**Update:** KN was introduced as the Programme Director for Healthy Weston and described briefly the next steps for the programme.	**Other attendees:** Alan Rice (Chair), Alex Gutsall (Alliance), Alun Davies (NSC), Barbara Seaton (Senior Community Link), Eileen Jacques (Healthwatch), Maggie Blackmore (Chair, Patient Council), Nigel Briers (NS LGBT Forum), Rachel Ballin (NSC), Triliria Newbury (MFA)	**Other invitees:** Alan Rice (Chair), Alex Gutsell (Alliance), Alun Davies (NSC), Barbara Seaton (Senior Community Link), Celia Henshall (Vision North Somerset), Doreen Smith (VANS), Maggie Blackmore (Chair, Patient Council), Nigel Briers (LGBT Forum), Rachel Ballin (NSC) Rachel Gibbons (NSCP),	**Update**: KN presented a powerpoint on Healthy Weston, a discussion took place **Action:** Members of the group were asked to feedback to KN.		**Update:** Update from KN, discussion of HW Engagement plan presented by Penny Turner, discussion of draft Case for Change document	
Evidence	PPRG Minutes 29/05/2018			NS PPIF Minutes 17/10/2018		PPRG Minutes 25/09/2018	

Table 8: Healthier Together Social Partnership Forum and Healthy Weston Programme

Meeting	**Healthier Together Social Partnership Forum**	**Healthier Together Social Partnership Forum**	**Healthier Together Social Partnership Forum**
Date	**18/01/2018**	**16/05/2018**	**11/09/2018**
Attendees from CCG	Colin Bradbury, Area Director – North Somerset	Katie Norton, Programme Director for Healthy Weston	Katie Norton, Programme Director for Healthy Weston
Update/Discussion/Decision/Action	**Update**: CB gave a verbal update on the Healthy Weston Programme and invited attendees to email him with queries or comments.	**Update**: KN gave an update on the Healthy Weston Programme. **Discussion**: There was a discussion around the housing plans for Weston, and engagement event attendance to date.	**Update**: KN provided an update on Healthy Weston work **Action**: KN to forward the presentation for the JHOSC meeting on 27/09/18 to the SPF members.
Evidence	Minutes of the meeting held 18th January 2018	Minutes of the meeting held 16th May 2018	Minutes of the meeting held 11th September 2018

Table 9: October 2017 Healthy Weston Launch Event Invitees

Role / Title	Organisation
General Practitioner	Primary Care Provider
Management Team	Weston Area Healthcare Trust
Clinical Chair	BNSSG
Commercial and Business Development Manager	CURO
Nursing AHP	Weston Area Healthcare Trust
Medical Specialty	Weston Area Healthcare Trust
Councillor	North Somerset Council
Gastroenterologist	Weston Area Healthcare Trust
Strategy and Policy Development Officer	North Somerset Council
Chair	Healthwatch North Somerset
Patients Council - Weston Area Health Trust	Patient and Public Reference Group
Nursing AHP	Weston Area Healthcare Trust
Area Director	BNSSG
Senior Communications and Engagement Manager	NHS England
Chair, Lesbian - Gay, Bisexual and Transgender Forum	Patient and Public Reference Group
Medical Director	BNSSG
Chief Executive	North Somerset Community Partnership
Nursing AHP	Weston Area Healthcare Trust
Head of Medicines Management	BNSSG
Divisional Lead, South	North Somerset Community Partnership
Director of Finance	NHS England
Nursing AHP	Weston Area Healthcare Trust
Turnaround Delivery Programme Director	BNSSG
Director of Strategy	Avon & Wiltshire Mental Health Partnership
Director of Strategy & Transformation	University Hospitals Bristol
Chief Executive	Bristol Community Health
Medical Director	Weston Area Healthcare Trust
Healthwatch Volunteer	Healthwatch Somerset
Clinical Senate Manager	NHS England
Health Partnership Development Manager	Weston College
Patient Participation Group Member	New Court Surgery
Director of Strategy	Weston Area Healthcare Trust
Nursing AHP	Weston Area Healthcare Trust
Management Team	Weston Area Healthcare Trust
Nursing AHP	Weston Area Healthcare Trust
Patient Participation Group Chair	Riverbank Medical Centre
Patient Participation Group Member	Clarence Park Surgery
Nursing AHP	Weston Area Healthcare Trust
Director of Corporate Services	BNSSG
Medical Specialty	Weston Area Healthcare Trust
Director of Commissioning Reform	Somerset CCG

Chief Executive	Primary Care Provider
Deputy Chief Operating Officer	University Hospitals Bristol
General Practitioner	Primary Care Provider
Director of Operations	North Somerset Community Partnership
Interim Director of Commissioning	BNSSG
Public Health Services Lead	Public Health England
Lay Member - BNSSG CCG	Patient and Public Reference Group
General Practitioner	Primary Care Provider
Vision North Somerset	Patient and Public Reference Group
Nursing AHP	Weston Area Healthcare Trust
Consultant Surgeon	University Hospitals Bristol
Consultant - Community Paediatrician	Weston Area Healthcare Trust
Councillor	North Somerset Council
Chief Executive	North Somerset Council
Chief Officer	Healthwatch North Somerset
Assistant Primary Care Manager	BNSSG
Clinical Senate Manager	NHS England
Health Partnership Development Manager	Weston College
Patient Participation Group Member	New Court Surgery
Director of Strategy	Weston Area Healthcare Trust
Nursing AHP	Weston Area Healthcare Trust
Management Team	Weston Area Healthcare Trust
Nursing AHP	Weston Area Healthcare Trust
Patient Participation Group Chair	Riverbank Medical Centre
Patient Participation Group Member	Clarence Park Surgery
Nursing AHP	Weston Area Healthcare Trust
Director of Corporate Services	BNSSG
Medical Specialty	Weston Area Healthcare Trust
Director of Commissioning Reform	Somerset CCG
Chief Executive	Primary Care Provider
Deputy Chief Operating Officer	University Hospitals Bristol
General Practitioner	Primary Care Provider
Director of Operations	North Somerset Community Partnership
Interim Director of Commissioning	BNSSG
Public Health Services Lead	Public Health England
Lay Member - BNSSG CCG	Patient and Public Reference Group
General Practitioner	Primary Care Provider
Vision North Somerset	Patient and Public Reference Group
Nursing AHP	Weston Area Healthcare Trust
Consultant Surgeon	University Hospitals Bristol
Consultant - Community Paediatrician	Weston Area Healthcare Trust
Councillor	North Somerset Council
Chief Executive	North Somerset Council
Chief Officer	Healthwatch North Somerset
Assistant Primary Care Manager	BNSSG
Area Director	BNSSG
A&E Consultant	University Hospitals Bristol
General Practitioner	Primary Care Provider

Clinical Chair	BNSSG
Nursing AHP	Weston Area Healthcare Trust
Volunteer	Citizens Advice
Management Team	Weston Area Healthcare Trust
Deputy Regional Manager	NHS Improvement
Associate Director of Transformation	BNSSG
Patient Participation Group Member	Highbridge MC
General Practitioner	Primary Care Provider
Deputy Director of Community Commissioning	BNSSG
Medical Director	One Care
Public Health Services Lead	Public Health
Nursing AHP	Weston Area Healthcare Trust
Mayor of Weston super Mare	North Somerset Council
Clinical lead for Weston	Somerset CCG
Regional External Relations Officer	MS Society South West Region
Director of Transition	BNSSG
Director of Nursing	BNSSG
Frailty Lead	Weston Area Healthcare Trust
Representative	Addaction
Deputy Director of Strategy	University Hospitals Bristol
Acting Director Workforce & OD	University Hospitals Bristol
Chair - Multicultural Friendship Association	Patient and Public Reference Group
Programme Director	STP PMO
Medical Director	Brisdoc
Orthopaedic Surgeon	Weston Area Healthcare Trust
Councillor	North Somerset Council
Councillor	North Somerset Council
Head of primary care	NHS England
Operations and Delivery	NHS England
Patient Participation Group Chair	Winscombe and Banwell Family Practice
Orthopaedic Surgeon	Weston Area Healthcare Trust
Head of Comms	Weston Area Healthcare Trust
Patient Participation Group Chair, Graham Road Surgery	Patient and Public Reference Group
Director of Nursing	Weston Area Healthcare Trust
Chief Executive	Weston Area Healthcare Trust
Public Health Services Lead	Public Health
Chief Executive	BNSSG
Interim Head of Assurance and Delivery	NHS England
Nursing AHP	Weston Area Healthcare Trust
Nursing AHP	Weston Area Healthcare Trust
Patient Participation Group Chair	Sunnyside Practice
Medical Specialty	Weston Area Healthcare Trust
Director - People & Communities	North Somerset Council
Advanced Nurse Practitioner (homeless & substance misuse)	North Somerset Community Partnership
Head of Communications	North Somerset Community Partnership
Management Team	Weston Area Healthcare Trust

Chief Executive - Voluntary Action North Somerset	Patient and Public Reference Group
Nursing AHP	Weston Area Healthcare Trust
Consultant Psychiatrist - CAMHS	Weston Area Healthcare Trust
Practice Manager	Primary Care Provider
Paediatric Consultant	University Hospitals Bristol
Patients Council	Weston Area Healthcare Trust
Patients Council	Weston Area Healthcare Trust
Multicultural Friendship Association	Patient and Public Reference Group
Nursing AHP	Weston Area Healthcare Trust
ITU Consultant	Weston Area Healthcare Trust
Patient Participation Group Chair	Cedars Surgery
Delivery Director	BNSSG
Chief Finance Officer	BNSSG
Assistant Director, Adults' Support and Safeguarding	North Somerset Council
Director of Operations	Weston Area Healthcare Trust
Nursing AHP	Weston Area Healthcare Trust
Head of Service Improvement	BNSSG
Consultant	Weston Area Healthcare Trust
Consultant, General Surgery	North Bristol NHS Trust
Medical Specialty	Weston Area Healthcare Trust
Councillor/ HOSP Chair	North Somerset Council
Head of Midwifery	University Hospitals Bristol
Executive Director of Nursing	South Western Ambulance Service
Chief Executive	University Hospitals Bristol
Primary Care Workeforce Lead	BNSSG
Deputy Head of Nursing - Out of Hours	Brisdoc

Table 10: April 2018 Healthy Weston Update Event Invitation List

Organisation	Attendees
Access Your Care	2
Addaction	1
Alliance Living Support	2
Alzheimers Society	3
Avon & Somerset Constabulary	1
Avon & Wiltshire Mental Health Partnership	7
BNSSG Clinical Commissioning Group	37
BNSSG STP	1
Brisdoc	1
Bristol Community Health	1
Citizens Advice Bureau	1
Communications Specialist, BNSSG CCG	1
For All Healthy Living Centre, GP Practice	1
Hanover Housing	1
Healthwatch North Somerset	1
Healthwatch Somerset	2
Lesbian, Gay, Bisexual and Transgender Forum	2
MS Society South West Region	1
NHS England	2
NHS Leadership Academy	2
North Somerset Community Partnership	15
North Somerset Council	10
Patient and Public Reference Group Member	1
Patient Participation Group Member	1
Patients Council, Weston Area Health Trust	1
Protect Our NHS	3
Public Contributor	17
Public Health	3
Somerset Clinical Commissioning Group	2
South West Ambulance Service	2
University Hospital Bristol	4
Vision North Somerset	1
Voluntary Action North Somerset	1
Weston Area Health Trust	17
Weston Area Health Trust/United Hospital Bristol	1
Weston College	1

Table 11: Co-Design Register of Agreed Participants – 26th June 2018

Organisation	Expressed an Interest In	Clinical Work-Stream	Attendees
A&S Police	Vulnerable communities		1
Access Your Care Ltd			1
Alliance Housing			1
Alliance Living (Housing)	Vulnerable		1
Alzheimers Society			4
AWP/Clinical Psychologist	Care Campus		1
Bridging the Gap Together			1
Chair PPG		Frail	1
Chairman of WAHT	Topic workshop		1
Change makers			1
Citizen's Advice North Somerset	Community Hub - information and advice (benefits +)/ Vulnerable groups		1
Clevedon Osteopathic Practice	Overall interest		1
Consultant Rheumatologist - WAHT	Housing/Frail/Vulnerable		1
Creative Design/Art Therapy	Frail/older/care homes		1
Curo			2
Deliberative	Emergency & Critical Care		1
District Councillor		Integrated Community	1
District Councillor	topic workshops		1
District Councillor/Older Peoples Champions GroupChair	Care homes		1
Faith Leader	codesign workshop		1
Graduate Sports Therapist	Overall interest		1
Graham Rd PPG & homeless charity	Frail	Primary Care	1
Hanover (Housing)		Vulnerable	1
Health and Care Faculty - Weston College	Children & YP and Vulnerable Groups		1
Healthwatch NS Chair			1
Involvement Coordinator – North Somerset (AWP)	Mental Health - Community Hub/Vulnerable		1
Macmillan			1
Mayor of Weston s Mare	Clinical pathways - Children & YP	interested in all	1
Member of public			1
Member of public			1
Member of public	Children & YP		1
Member of public	Vulnerable Groups/MH		1
Member of public	Vulnerable Groups/MH		1

Member of public			1
Member of public	Overall interest		1
Member of public	Overall interest		1
Member of public	Care homes		1
Member of public	Maternity topic workshop		1
Member of public	codesign workshop		1
Member of Public			1
Member of Public			1
Member of public	Frail & Older People/ topic workshops		1
Member of public / Former governor UHB	codesign workshop		1
Member of public			1
Mental health	Mental Health - Community Hub/Vulnerable		1
North Sedgemoor residents			2
NS Council	Vulnerable people and Children / Young People		1
NSC - Adult Social Care & Care Homes	Residential Care	Vulnerable	1
Patient Leader/PPG	Primary Care/community		1
Patients Council, WAHT			1
Service User	Mental Health		1
Shades of Humanity	Vulnerable		1
Somewhere To Go	Topics - disadvantaged communities		1
Voluntary Action North Somerset	all groups		1
Wedmore Parish Council			1
Western Counselling rehab	Vulnerable		1
Weston Hospital Staff member	Codesign workshop for Emergency & Critical Care		1
Wrington PPG	Frail	Primary Care	1
YMCA	Vulnerable		1

Table 12: Clinical Design Event Invitation List – 9th August 2018, 29th August 2018

Role	Organisation	Number of Invitees
Clinician	North Somerset Community Partnership (NSCP)	3
Clinician	Paul White	
Clinician	South West Ambulance Service NHS Foundation Trust (SWASFT)	1
Consultant	Weston Area Health Trust (WAHT)	21
Consultant	University Hospitals Bristol (UHB)	1
Consultant	UHB	2
Consultant	North Bristol NHS Trust	1
Consultant	Avon and Wiltshire Mental Health Partnership (AWP)	1
GP	Weston-Super-Mare surgery	1
gp	BNSSG CCG	1
gp	BNSSG CCG	1
gp	Weston-super-Mare surgery	1
GP	Weston-super-Mare surgery	1
GP	Bristol surgery	1
Gp	BNSSG CCG	1
Manager	WAHT	2
Manager	BNSSG CCG	14
Manager	NSCP	1
Manager	McKinsey	1
Manager	Hood & Woolf	1

Healthy Weston Pre-Consultation Business Case

Appendix 12: Public Dialogue and Codesign Themes

HEALTHY WESTON

PUBLIC DIALOGUE & CODESIGN THEMES

INDEPENDENT SUMMARY

OCTOBER 2017 – MARCH 2018

THE Evidence Centre

Key messages

Healthy Weston: Joining up services for better care in the Weston area set out a vision for more joined up health and care services for Weston-super-Mare, Worle, Winscombe and the surrounding areas. Between 18 October 2017 and 2 March 2018, the *Healthy Weston* programme invited people to be part of a public dialogue and codesign process to help plan services. In total, 1,627 pieces of feedback representing 2,518 people were received including notes from workshops, survey forms, emails, letters and social media posts. An independent team compiled themes from feedback.

Healthy Weston vision

The overall vision set out in *Healthy Weston* described services working in a more joined up manner, with strengthened and streamlined care inside and outside hospital. Amongst the 1,311 pieces of feedback that commented about this, 89% supported the vision in principle. People from different parts of the local area, men and women and those from all age and ethnic groups were equally likely to support or challenge the vision. Those that raised challenges were concerned about whether it would be feasible to implement the vision and whether the approach was a way to save money.

Key things to consider

Healthy Weston described possible ways to improve how general practices work together, offer a hub of community services on the site of Weston General Hospital and develop a stronger more focused hospital. There were some overarching factors that people wanted taken into account, no matter what the topic. These included:

- the characteristics of the **local population** including the growing number of residents and tourists, increasing elderly and the needs of vulnerable groups
- **staffing issues**, including the need to recruit, retain and train staff to support better working across organisations and services
- the need to consider Weston in the context of other services and how services could be better **interlinked**
- issues with **transport**, including the limited availability and cost of public transport, difficulties driving to other areas and limited and costly parking
- issues with resources and **infrastructure** including adequate funding, buildings and information technology
- the **implementation approach**, including providing more details about potential developments and ongoing ways of being involved in planning

Care outside hospital

The *Healthy Weston* survey asked about people's highest priorities for care outside hospital, including general practice and care in the community. Priorities included:

- GP clinics, community services and hospital services **working closely** together
- getting a healthcare appointment on the **same day**
- health services helping people to **look after themselves** and stay well

Community hub at Weston General Hospital

Healthy Weston proposed offering a range of services in a hub on the site of Weston General Hospital, potentially including diagnostic tests, chemotherapy, services for children, services for the frail and elderly, mental health services and clinics for people with long-term conditions. 76% of feedback that commented about this supported this idea. Challenges and things people wanted taken into account included:

- worries about accessibility, including issues with **public transport** and parking
- concern that this approach would result in **less quality or quantity** of services
- perception that services need to be **specialised**, not all 'lumped together'
- the need to **separate** some groups from others, for instance older people or those with mental health needs could be seen separately from children

Stronger, more focused hospital

The Accident and Emergency (A&E) Department at Weston General Hospital is temporarily closed between 10pm and 8am due to long-standing difficulties recruiting enough permanent doctors to run the service safely overnight. *Healthy Weston* suggested that some people who needed emergency care may be able to be **admitted directly to hospital wards** rather than being admitted through A&E. 33% of feedback that commented about this supported this approach. Concerns included how decisions about admission would be made, whether there would be enough staff available to support admissions to wards and the impact that this could have on other services including wards and ambulance teams.

75% of all feedback received raised concerns about the provision of A&E more generally. People believed that Weston General Hospital should have a 24 hour A&E service due to the large and growing local population, concerns about the perceived safety, cost and inconvenience of travelling elsewhere in an emergency, pressure on ambulance services, and the limited capacity of other A&E Departments to cope.

Healthy Weston stated that the **midwife-led unit** at Weston General Hospital had a relatively low number of births. 22% of feedback that commented about this supported asking families who wanted to use a midwife-led unit to have their babies at Bristol, with care before and after birth in Weston. 46% did not support this and 32% did not mind either way. Challenges raised included difficulties, cost and perceived safety issues travelling whilst in labour, reduction in choice and wanting to sustain existing good quality local services. An alternative proposed was to rotate midwives through both Bristol and Weston, so midwives could keep their skills up to date.

Planning next steps

People who took part in workshops were reportedly positive about the *Healthy Weston* approach to involving people and wanted to continue being involved. In the *Healthy Weston* survey, people were asked about criteria that the NHS should take into account when weighing up different possibilities. The criteria prioritised were:

- population numbers and needs (48% of survey responses)
- time to travel to services when it is an emergency (48%)
- number and type of staff available to run the service safely (41%)
- ways the NHS could be more efficient (23%)

The NHS has committed to consider all feedback when planning next steps.

Contents

This document was prepared by The Evidence Centre, an independent organisation helping teams use information for improvement. The document sets out feedback provided by people from Weston, Worle and surrounding areas. The feedback represents people's opinions, rather than objective facts. Views from a wide range of people are included and not every person who provided feedback will agree with all of the points raised. The opinions expressed do not represent an official view from the NHS, partner organisations or The Evidence Centre.

5 March 2018

Healthy Weston

Healthy Weston: Joining up services for better care in the Weston area set out the NHS' vision for more joined up health and care services for Weston-super-Mare, Worle, Winscombe and the surrounding areas. The stated aims were to:[1]

- support local people to stay well
- look after people at home or in the community, keeping them out of hospital
- help those who go to hospital get home faster, with support if needed
- develop stronger general practice services alongside community services
- join up health and social care services to support people more effectively
- reduce the gap between levels of health for poorer and wealthier people
- deliver better health and social services to the people who need them most such as frail people, children, pregnant women and vulnerable people including those with mental health needs, learning difficulties or drug or alcohol issues
- secure a strong and vibrant future for Weston General Hospital

The *Healthy Weston* programme is part of the Bristol, North Somerset and South Gloucestershire Sustainability and Transformation Partnership, which is made up of 15 local health and care organisations. NHS North Somerset Clinical Commissioning Group is facilitating the programme.

Between 18 October 2017 and 2 March 2018, the *Healthy Weston* programme invited individuals and organisations to be part of a public dialogue and codesign process to consider improving services in Weston. This built on feedback previously received from local people, which reportedly helped to shape *Healthy Weston*. The dialogue process involved gathering feedback from:

- an event for organisations across health and social care
- eight meetings open to the public
- six workshops about children's services, maternity care, vulnerable groups, older people, care homes and services at the site of Weston General Hospital
- five meetings open to staff from healthcare organisations
- visits to 27 committees, community groups and voluntary sector organisations
- an online survey
- Facebook posts and tweets posted on the Clinical Commissioning Group's pages, in response to advertised posts or mentioning 'Healthy Weston'/'HealthyWeston' or 'Weston General Hospital'
- emails, letters or telephone feedback submitted to the programme

Local people and organisations provided feedback about *Healthy Weston* and suggested factors that the NHS should take into account when planning next steps. This document summarises themes from the feedback, highlighting where people were positive about the proposed direction of travel and areas of challenge. The summary was compiled by an independent team, outside the NHS.

1 Wording drawn from *Healthy Weston: Joining up services for better care in the Weston area* released by the NHS in October 2017.

Independent summary

Process used to compile feedback

The *Healthy Weston* programme reportedly reviewed all of the feedback received during the public dialogue period and used it when refining the vision and considering next steps. In addition to examining suggestions internally in detail, the programme wanted a straightforward summary of the most commonly recurring themes across all of the types of feedback.

The programme shared survey responses, copies of correspondence and notes from dialogue events with an independent team. The independent team read every piece of feedback, numerically coded each comment within the feedback and drew out recurring themes using qualitative and quantitative methods. The themes summary was provided to the NHS within one working day of the conclusion of the dialogue period. The independent summary of themes did not seek to describe the detail of individual responses and is not a substitute for reviewing individual correspondence, meeting notes or surveys.

Caveats

There are some things to bear in mind when interpreting the themes summary:

- The feedback represents people's **opinions**, rather than objective facts.
- Views from a wide range of people are included and not every person who provided feedback will agree with all of the points raised.
- The themes cannot be generalised to represent the opinions of all people in Weston and the surrounding areas. It summarises what people who took the time to provide feedback contributed.
- The extent to which themes could be compiled was influenced by the level of detail in feedback. For instance, some notes from meetings were not detailed and some survey responses or tweets stated support or challenge for a particular approach without noting the reasons for this view.
- The number of pieces of feedback that mentioned each theme was counted. However caution is needed when interpreting these numbers because **one 'response' or piece of feedback did not necessarily equate to one person**. Pieces of feedback varied in size and scale, with some comprising a short tweet from an individual, others a letter representing an entire organisation and others being notes from meetings with many participants, for example. It would not be appropriate to count a meeting with 30 people as the same as a survey form from one person. Notes from meetings comprised just 3% percent of pieces of feedback, but these meetings included 950 people. The number of pieces of feedback that mentioned each theme was included to illustrate the extent to which themes recurred, but this does not represent the proportion of the population or of all people engaged who may hold a certain view.

Feedback received

Types of responses

Between 18 October 2017 and 2 March 2018, the *Healthy Weston* programme received **1,627 pieces of feedback**, representing comments from at least 2,500 people and organisations. Table 1 lists the types of feedback from which themes were compiled.

Overall, 96% of responses came from people sharing their own views, 1% were from groups or organisations and 3% were notes from meetings or workshops. The groups that provided feedback included voluntary sector organisations, statutory services and a lobby group.

Table 1: Sources of feedback included in the independent summary of themes

Source of feedback	Number of pieces of feedback	Number of people represented
Surveys	1,342	1,334 + 8 groups
Social media posts	224	222 + 2 groups
Notes from meetings and workshops	46	950
Letters and emails	15	10 + 5 groups
Total	**1,627**	**2,518 + 13 groups**

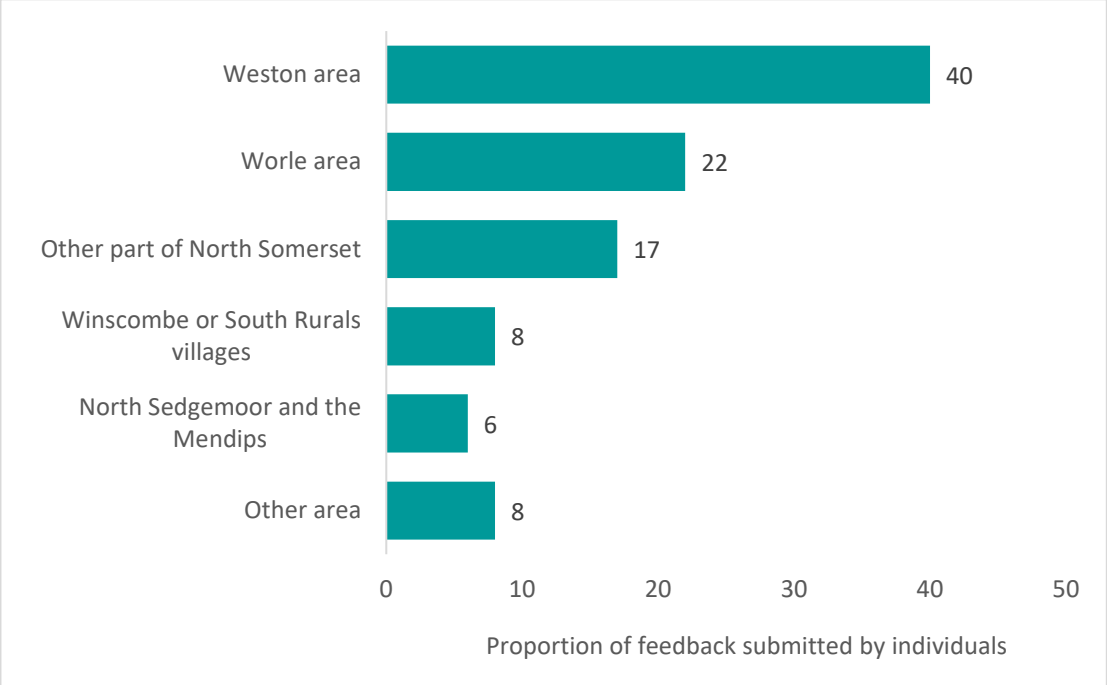
Note: People and groups who provided more than one piece of feedback are counted multiple times in these figures.

Characteristics of people providing feedback

Where people shared their own individual views, where known about two fifths were from Weston (40%) and one fifth were from Worle (22%), with most of the rest from surrounding areas (see Figure 1). Eight out of ten of people who provided feedback said they were people who used services, carers or members of the public (80%) and 13% were workers providing health or care services (see Figure 2).

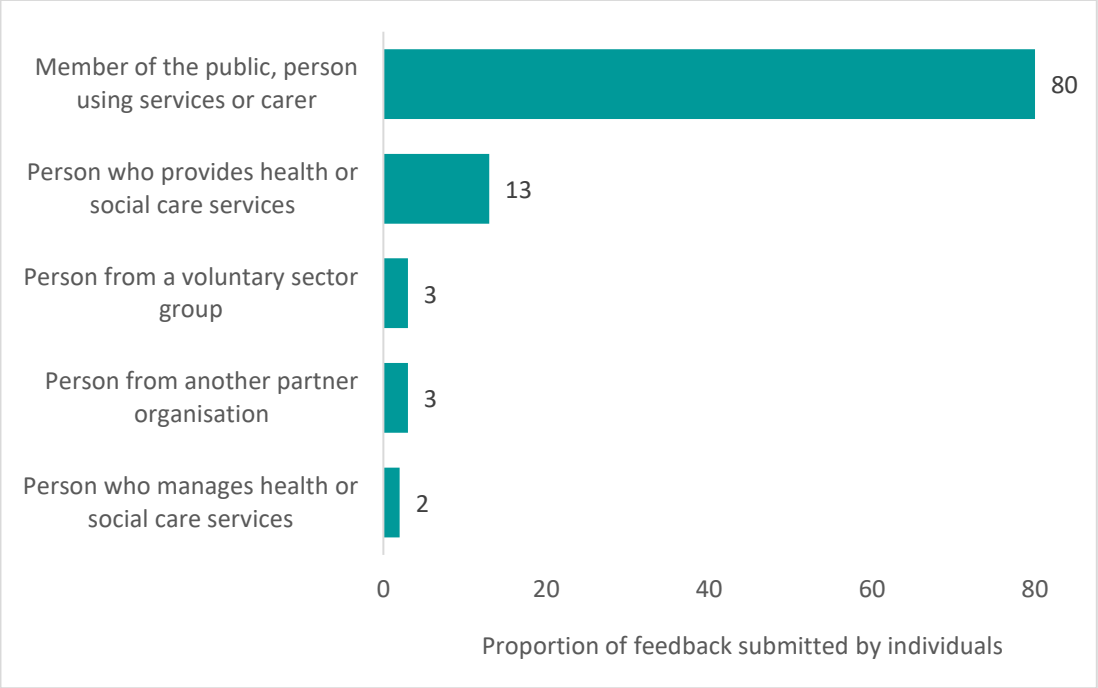
Two thirds of feedback submitted by people sharing their own views was from women (68%) and one third from men (32%). Three people identified their gender as ‘other.’

Figure 1: Place of residence of people who provided feedback



Note: based on 1,305 pieces of feedback from individuals that stated their place of residence.

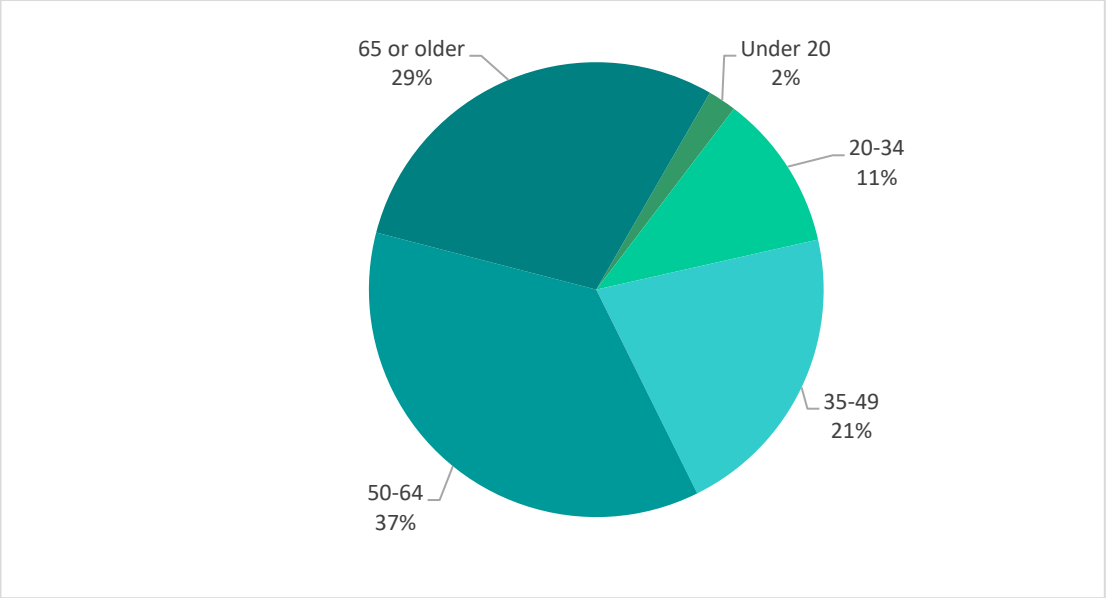
Figure 2: Types of people who shared their views



Note: based on 1,304 pieces of feedback from individuals who stated their ‘main role’.

Only people who completed surveys were asked about their age and ethnic group. This information was collected to help the *Healthy Weston* programme understand whether a wide range of people participated in the dialogue. Two thirds of surveys submitted by people sharing their own views were from those over the age of 50 (66%, see Figure 3). 97% of surveys submitted by individuals were from people who identified as White / White British, 1% were Asian / Asian British, less than 1% were Black / Black British and 2% said they were from other ethnic groups.

Figure 3: Age groups of individuals responding to the Healthy Weston survey



Note: based on 1,315 survey responses from individuals.

The *Healthy Weston* survey also asked about people's health conditions and their use of health services. One quarter of individuals who completed the survey said they had a long-term physical health condition (25%), 8% had a physical disability and 8% said they had a mental health condition. Fourteen percent said they were an unpaid carer of someone with a health condition and 8% a parent of a child aged under five years. The *Healthy Weston* team can use this information to check whether people providing feedback have similar characteristics to the local population. These characteristics can also be used to understand whether some groups of people are more likely to support or challenge aspects of the *Healthy Weston* approach.

Six out of ten people who answered the survey as an individual said that in the past six months they had used general practice services (60%), 7% community health services, 17% the Accident and Emergency Department in Weston and 6% said they had been admitted to hospital in Weston in the past six months. The *Healthy Weston* team can use this information to gauge whether those engaging in the dialogue process were more or less likely than the general population to have used various health services recently.

This type of information was not available from people who provided feedback at meetings, in workshops or via social media or correspondence.

Overall vision

Key points

1,311 pieces of feedback commented about the overall *Healthy Weston* vision (81%).

On average, nine out of every ten pieces of this feedback were positive (89%) and one out of ten raised challenges.

Feedback was particularly positive about encouraging health and care organisations to work together.

Some pieces of feedback wanted more information about how things would work in practice. Others were concerned that the vision outlined in *Healthy Weston* was based on a desire to save money.

Healthy Weston described a vision of health and care services working more cooperatively to address the needs of local people, with the people using services at the heart of decision-making. The emphasis was on enhancing general practice care, integrating community services and creating a stronger, more focused hospital. Feedback that explicitly commented on the *Healthy Weston* vision was generally favourable. For example, **89% of survey responses said they would be happy for health and care organisations to be encouraged to work more closely together**. One percent said they would not be happy with this and 10% said they would not mind either way.

> *"There is a large 'gap' between medical and social services which needs closing quickly. If it is done correctly it should save lives, time and money."* (Survey from member of the public)

> *"There has always been a division between health and social care services. We need more joined up working to provide a more effective service tailored to individual needs."* (Survey from person who provides health or care services)

Men and women and those from different ethnic groups were equally likely to be positive. The older people were, the less likely they were support encouraging health and care organisations to work more closely. Similarly those from North Sedgemoor and the Mendips were slightly less likely than other areas to support this.[2]

2 Throughout this document, any references to differences between groups are based on statistical significance tests at the 95% level of confidence ($p<0.05$). This means that it is unlikely that the differences noted occurred by chance.

Some pieces of feedback suggested the broad vision was positive, but that more information was needed about how ideas would be put into practice and the specifics of how health, social care and the voluntary sector would work together more effectively (17 pieces of feedback).

Features of the *Healthy Weston* vision that were deemed particularly positive included:

- an opportunity for better coordination and patient-centred care (178 pieces of feedback)
- the potential for easier access to services (88 pieces of feedback)
- better use of resources (69 pieces of feedback)
- improved services and support for vulnerable groups, children and the elderly (48 pieces of feedback)
- a welcome focus on prevention and self-care (8 pieces of feedback)
- the perception that plans were based on evidence and what has worked well in other areas (6 pieces of feedback)
- the potential to use information technology to greater effect (6 pieces of feedback)
- the innovative nature of the approach, deemed by some to be exciting and different (4 pieces of feedback)

About one out of every ten pieces of feedback raised challenges about the overall *Healthy Weston* vision. The most common concern was that the vision was an attempt to save money or was a result of not having adequate resources to maintain current services.

> *"This is a laudable statement of intent. However so far as we can ascertain, there is little money to achieve this so it may not happen properly or efficiently, if at all. If it does happen it will rely increasingly on volunteers or families. This is no way to plan for the NHS of the future."* (Email from group)

Two pieces of feedback suggested that *Healthy Weston* appeared to assume that there were enough services available and that the main improvement needed was integration of these services, whereas in this view there were significant gaps in services.

The overall impression was that people and organisations that provided feedback thought that the underpinning vision of *Healthy Weston* was of merit, but questioned the rationale and how such ideas would work in practice. There was a concern that services may be withdrawn or less accessible than currently.

Things to consider

Key points

Whether people were commenting about the overall *Healthy Weston* vision or specific types of services, there were some cross-cutting issues that people thought the NHS should consider. 550 pieces of feedback commented about things that the *Healthy Weston* programme should take into account when planning next steps (41%).

These included:

- characteristics of the **local population**, including growing numbers of residents and new housing developments, increasing numbers of elderly residents, additional demands from tourists and addressing inequality and the needs of vulnerable groups (5% of all pieces of feedback received mentioned this)
- **staffing issues**, including the need to recruit, retain and train staff to support better working across organisations (11% of all pieces of feedback received)
- the need to consider Weston in the context of other services and how services could be better **interlinked** (7% of all pieces of feedback received)
- issues with **transport**, including the limited availability and cost of public transport, difficulties driving to other areas and limited and costly parking (3% of all pieces of feedback received)
- issues with resources and **infrastructure** including adequate funding, buildings and information technology (IT) (7% of all pieces of feedback received)
- the **implementation approach**, including providing more details about potential developments, building the reputation of existing services and continuing to engage with local people during the planning process (4% of all pieces of feedback received)

In total 550 pieces of feedback provided 805 comments about overarching issues relevant to the *Healthy Weston* vision and services covered within it. These were issues that cut across different aspects of care rather than responding to suggestions about specific services (which are described overleaf).

Population characteristics

Eighty pieces of feedback suggested that *Healthy Weston* should take into account the characteristics of the local population when developing plans. People suggested that:

- it is important for services to accommodate the growing population in Weston, Worle and surrounding areas, including influxes due to tourism (45 pieces of feedback)
- there are a growing number of elderly people living in Weston and surrounding areas (11 pieces of feedback)
- services should be developed to take account of particularly vulnerable groups and health and social inequalities (9 pieces of feedback)
- a lot of people from outside the country might be using health services and services may be reliant on international staff (8 pieces of feedback)
- it is important to make sure that services are appropriate for local people (7 pieces of feedback)

Examples of feedback emphasising the need to consider population characteristics included:

> *"Weston and area has a large and growing population with many poverty-stricken people, elderly, single parents, mentally ill etc. Travelling to Bristol or Taunton is stressful, expensive and confusing for many local people."* (Survey from member of the public)

> *"Think about the projected population e.g. new build housing in Weston, increasing number of families requiring health care - what services will they need?"* (Survey from person providing health or social care)

> *"I would support an integrated, well-resourced community service and this should be based on in depth research about the local needs rather than adhering to central government cuts. I strongly believe in the NHS as a service and not a business for profit for shareholders and in my opinion proper research is required about the needs of the local population and the results should then be the driving force before any changes are made."* (Survey from member of the public)

The *Healthy Weston* programme identified some population groups as particularly in need of detailed consideration and hosted workshops to discuss ways to improve services for these groups. The NHS took detailed notes at these workshops and the details are not replicated here. However Boxes 1, 2 and 3 provide brief summaries of some of the suggestions made for supporting children and young people, the frail elderly and vulnerable groups.

Box 1: Examples of suggestions about developing services for children

In January 2018, 25 people took part in a workshop to identify how health and care services could better meet the needs of children and young people. Participants included members of the public, parents, health and care professionals, the voluntary sector, mental health services and others. Recommendations from the group included:

- all aspects of *Healthy Weston* need to include care for children and youth
- it is not just the child, but also their family that needs to be considered
- services such as children's centres need to be retained
- extend the hours during which services are available broader than 9am-5pm
- it would be helpful to have joined up IT systems and shared records
- it would be helpful to have a physical location to provide joined up care
- address gaps in mental health support for children
- consider joint budgets for health and social care
- workforce training and development is needed to support integrated working
- any developments to services need to be evaluated
- the *Healthy Weston* codesign process should be continued and extended

This box does not seek to replicate the detailed notes from the event, but rather to briefly summarise some of the key points to give a flavour of feedback.

Box 2: Examples of suggestions about developing services for frail older people

In January 2018, about 28 people took part in a workshop to consider how health and care services could better meet the needs of frail older people. Participants included members of the public, carers, health professionals, social services, the voluntary sector, mental health services, care homes and others. Suggested priorities included:

- focusing on joining up existing services, streamlining and sharing information
- proactive preventive care to keep people more independent and well
- addressing issues related to public transport and difficulties travelling
- learning what has worked and not worked in other areas, and why
- promoting the community hub widely
- considering a mobile hub, with services that travel to villages
- working with care homes to reduce admissions and do advance care plans
- ensuring that staffing requirements are thought through for all services
- having realistic timeframes and implementation plans for *Healthy Weston*

Support was expressed for clusters of general practices working together and a community hub.

Detailed notes were taken at the event. This box does not seek to replicate that detail, but rather to highlight some of the key points.

Box 3: Examples of suggestions about developing services for vulnerable groups

In January 2018, about 30 people took part in a workshop to identify the needs of groups who may benefit from targeted support, including those with learning disabilities, mental health issues and the homeless. Participants included members of the public, the voluntary sector, health professionals, mental health workers, social care workers and others. Suggestions included:

- using language to describe people and services that is sensitive, not stigmatising
- helping people help themselves, including peer support and school health promotion
- offering more signposting and navigation to existing services
- working closely with the voluntary sector to maintain and expand services
- ensuring transport is available / free to help people get to services
- having multiple community hubs, virtual hubs or ‘crisis cafes’
- offering services outside routine 9am-5pm hours
- offering support for people in crisis, including people to talk to about issues
- multiagency provision of recovery services spanning all sectors
- developing technology and apps that can be recommended across agencies
- sharing records across services
- having a shared care plan across services to help care for the ‘whole person’
- identifying the 100 people who use services most for targeted support

This box does not seek to replicate the detailed notes from the event, but rather to briefly summarise some of the key points to give a flavour of feedback.

Staff issues

Another factor that people wanted the *Healthy Weston* programme to consider was the personnel delivering health and care services. There were 182 pieces of feedback about this. People said:

- more effort should be made to attract staff to Weston, including medical and nursing staff for hospital, mental health and community health services (62 pieces of feedback)
- the number of managerial and administrative staff should be reduced so more funds could be diverted to hiring and retaining frontline staff (55 pieces of feedback)
- changes to services and uncertainty about the future can impact on staff morale and recruitment and retention. Some thought there was a need to focus more on engaging staff in the development process and providing reassurance (22 pieces of feedback)
- there was thought to be undue reliance on agency staff (18 pieces of feedback)
- more focus should be placed on training workers to help provide more joined up services (9 pieces of feedback)
- it is important to upskill teams to better communicate with people about what they are doing and why, including vulnerable groups (9 pieces of feedback)
- rotational posts with other trusts should be considered to allow services to be offered in Weston and to help teams keep up to date with their skills (6 pieces of feedback)
- professionals should work more closely with family members and carers, recognising them as an important member of the team (2 piece of feedbacks)

Examples of the types of comments people provided about issues related to staffing included:

> *"I feel services could be improved by offering permanent members of staff incentives to stay on this type of contract rather than locuming. This could be better pay, the trust offering training to extend their knowledge and career progression. The more we can offer to staff members who are new in post, the more motivation people have towards their jobs and patient care. A lower staff turnover would mean better, safer and a continuous standard of patient care.*" (Survey from person who provides health or care services)

> *"Better staff training and appreciation. You would then rely less on agencies, keeping costs down and keep valuable hardworking staff within the trust if you only put money and services into your own staff who want to develop their roles further and help out in this crisis our amazing lifesaving NHS is facing."* (Survey from person who provides health or care services)

> *"The larger trust should take over Weston as a satellite, and skilled staff from the larger teaching hospitals have rotation in Weston. More money should be put into prevention and self-care and primary care services should work together more closely."* (Survey from person who provides health or care services)

Interlinkages across services

Some people were eager for more work to be undertaken with health, social care and voluntary sector partners and to understand the broader implications of *Healthy Weston*. Ninety-nine pieces of feedback commented about this. People mentioned that:

- mental health should be included in any plans (24 pieces of feedback)
- health and social services should work in a more joined up way and any health plans should be mindful of changes happening in social care (18 pieces of feedback)
- it was important to think about how Weston links with Bristol and other places, rather than viewing Weston in isolation (14 pieces of feedback)
- it was important to improve communication between services (11 pieces of feedback)
- developing services in Weston could reduce pressure on services in Bristol (10 pieces of feedback)
- the NHS should work alongside the voluntary sector (10 pieces of feedback)
- children's services should be included in any plans (8 pieces of feedback)
- there should be more focus on handovers in the system where a person's care transfers from one agency to another (2 pieces of feedback)
- it was important to have parity of provision across neighbouring areas (2 pieces of feedback)

Examples of comments provided about considering context and interlinkages included:

> *"I think third sector organisations such as Citizens Advice Bureau and Addaction (amongst many others) have a role to play in prevention and early identification of problems, especially in the mental health area. NHS funding needs to be shared with these organisations to support the heavy load of mental health problems."* (Survey from person who works in the voluntary sector)

> *"Mental health services need a radical rethink. They are extremely poor, particularly for children. Creative ways of improving services should be looked at. Preventative services should be prioritised. Bureaucracy should be slashed as should the management structure. Commissioning needs totally rethinking. It's not just about money if services can be more effective."* (Survey from member of the public)

Two pieces of feedback wanted to understand how a planned merger of local clinical commissioning groups in April 2018 would affect the *Healthy Weston* programme.

Transport and infrastructure

Responses highlighted that there may be challenges in achieving the *Healthy Weston* vision. A common area of concern was the extent of financing and infrastructure available, with 164 pieces of feedback commenting about this. People said:

- many people in Weston and surrounding areas do not drive and there were perceived to be poor public transport links, making it difficult to travel to other centres. Public transport infrastructure, car parking and travel affordability was deemed to be an essential issue for consideration in planning (54 pieces of feedback)
- there was perceived to be inadequate funding available to implement *Healthy Weston* ideas (70 pieces of feedback). Some felt that a solution to this would be to introduce charges for some services or for non-attendance at appointments or to pay more tax to fund the NHS (17 pieces of feedback)
- better use of information technology could save money and help to share records across services. This included improving computer record systems and using videoconferences, teleconferences and smartphone apps to support better access to care (19 pieces of feedback)
- there was a need to consolidate and improve buildings and facilities (5 pieces of feedback)
- the availability of ambulances would need to increase if *Healthy Weston* plans were to succeed (4 pieces of feedback)

Examples of the types of comments made about travel and infrastructure included:

> *"Cost of travel to distant hospital for frail, sick, disadvantaged and people without family support seems to be an unacknowledged barrier. Bus travel when ill can be impossible. Taxi fares are prohibitive for many. Elderly cancer patients are told there is no transport help available. This is a major issue for old and young alike and must not be overlooked if services are to be distant."* (Survey from member of the public)

> *"Consider disabled/older people who don't drive. If you put services further away ensure transport is provided or accessible. To spend an hour waiting for a bus to get to a hospital is not acceptable."* (Survey from member of the public)

> *"Weston needs to become seriously more efficient - more up to date systems and processes and IT. Every day professionals are slowed by inefficiencies in the tools they work with. Improve these, improve guidelines, and streamline the administrative processes and we can have more time to look after patients."* (Survey from person who provides health or care services)

Implementation approach

Ninety-seven pieces of feedback provided suggestions about how the *Healthy Weston* vision could be implemented or potential challenges with the implementation approach. Comments included:

- self-care and prevention should be included in any plans (27 pieces of feedback)
- it is important to build up the reputation of services so that staff want to work locally and people are confident using local services (10 pieces of feedback)
- more information is needed about potential approaches, the financial model and efficiencies (9 pieces of feedback)
- continuity of care should be considered in any plans (9 pieces of feedback)
- it is essential to have a clear plan and accountability for delivery, positioned as the start of an ongoing process (8 pieces of feedback)
- risk factors and interdependencies need to be acknowledged (7 pieces of feedback)
- the NHS should be run as a service, not a business (7 pieces of feedback)
- strong leadership is needed (6 pieces of feedback)
- records could be analysed to identify who to target for specialised care and self-care support (5 pieces of feedback)
- the programme timescale may be unrealistic, with a lot to be done in a short period (3 pieces of feedback)
- the service usage statistics provided by the programme may not be accurate (3 pieces of feedback)
- avoid terms such as ‘patients; and ‘vulnerable’ as these may be disempowering (2 pieces of feedback)
- it is important to evaluate or audit any changes made (1 piece of feedback)

Examples of the types of comments people and organisations made about planning, implementation and communication issues included:

> *“Delivering prevention needs a robust action plan: This is long overdue – it is time to stop just talking and thinking about prevention and health and wellbeing – we need to make real strides, and quickly. For starters, we have to seriously start to make inroads into reducing the high rate of avoidable complications due to the continued unsatisfactory preventative approaches to chronic disease management.”* (Email from health professional)

> *“One of the big issues is the rate at which staff are leaving NHS and care service providers. To my mind this is an area where, when credible progress is being made, communicating with staff to demonstrate things are improving is essential. If people have hope of a better future and can see change for the better they are less likely to ‘give up’ and leave. This is not a routine staff communication exercise… it is rather full blown marketing exercise to sell the improving NHS as an attractive prospect – giving hope where right now things are not looking so good.”* (Email from member of the public)

Care outside hospital

Key points

41 pieces of feedback commented about suggestions to enhance general practice services (3%).

12% of comments made about this were positive, 57% raised challenges and 31% made suggestions or asked for more information. A single piece of feedback could include both positive points and challenges.

Key concerns were:

- difficulties getting GP appointments (41 pieces of feedback)
- worries about transport and travelling further for general practice care (20 pieces of feedback)
- potential issues with continuity of care (11 pieces of feedback)

Design ideas suggested to enhance general practice included:

- ensuring that general practices take **advance bookings** for appointments, rather than requiring people to telephone at 8am each day to book a slot (20 pieces of feedback)
- offering **out-of-hours** appointments including before and after standard office hours and at weekends (10 pieces of feedback)
- upskilling general practice staff to **signpost** to local services and support self-care (8 pieces of feedback)
- **upskilling** general practice staff to listen to people and speak with them respectfully, including vulnerable groups (5 pieces of feedback)
- GPs or nurses with special skills **visiting local general practices** to run specialist clinics, rather than residents travelling to see specialists (3 pieces of feedback)
- examining how tasks currently undertaken by GPs can be done by others (1 piece of feedback)

In addition, the *Healthy Weston* survey asked people about their highest priorities for care outside hospital, including general practice and care in the community. Priorities included:

- GP clinics, community health services and hospital services working closely together
- being able to get a healthcare appointment on the same day
- health services helping people to look after themselves and stay well

As well as the overarching things that people asked the NHS to consider described in the preceding section, there were some comments about specific components of the *Healthy Weston* vision for care outside hospital.

Care outside hospital includes general practice, community services and other healthcare services that provide ongoing support in local areas on a day-to-day basis. The NHS reported that more than 90% of contact with health services happens through general practices. The *Healthy Weston* vision is for general practices to work more closely with each other, and with other health, community and care services. This might mean that individual general practices pool their resources and expertise and work as clusters. For example, a general practitioner (family doctor) or general practice nurse who has particular skills in caring for people with diabetes might see people with diabetes from across the local area, not solely people registered with their practice. *Healthy Weston* is also considering whether general practice buildings are fit for purpose and how to bring more services together under one roof.[3]

This section describes people's feedback about the *Healthy Weston* vision for care outside hospital.

Enhanced general practice services

Most pieces of feedback did not state whether or not they supported the *Healthy Weston* vision for general practice services. 41 pieces of feedback provided 172 comments about this. More challenging than supportive comments were made.

Suggested enhancements to general practice that feedback was most positive about included:

- the planned use of technology, such as having appointments using telephone or videoconferences (6 pieces of feedback)
- potential benefits for vulnerable groups (5 piece of feedback)
- the possibility of improved access to care (3 pieces of feedback)
- widening the range of professionals providing care, acknowledging that not everyone needs to be seen by a general practitioner (2 pieces of feedback)
- the focus on prevention and self-care (2 pieces of feedback)
- the possibility of social prescribing and signposting via care navigators (2 pieces of feedback)

Examples of comments included:

> *"Grouping GP surgeries together to make one large practice may be a good idea as long as we then don't have to travel out of area to get an urgent same day appointment."* (Survey from member of the public)

> *"If I could get my prescription… over the phone or by Skype, I definitely would. It's hard finding time to attend an appointment when you work full-time, and I'd rather my GP spent time on patients whose needs are more troublesome than mine. I'm also not too fussed about seeing a doctor or the same person - I'd definitely be more bothered about getting an appointment quickly, when/if I needed one."* (Survey from member of the public)

3 Wording drawn from *Healthy Weston: Joining up services for better care in the Weston area* released by the NHS in October 2017.

Ninety-eight pieces of feedback raised challenges about potential new approaches for general practice. The things that people expressed most concern about were:

- difficulties getting appointments, with people concerned about approaches that required them to telephone at 8am to book an appointment rather than being able to book days in advance (41 pieces of feedback)
- worries about transport and travelling further for general practice care (20 pieces of feedback)
- potential issues with continuity of care, especially if moving to clusters of practices (11 pieces of feedback)
- vulnerable groups who rely on primary care finding it difficult to travel further to other general practices (11 pieces of feedback)
- gaps in staff training and an aging general practice workforce nearing retirement (8 pieces of feedback)
- problems sharing records between services (3 pieces of feedback)
- mergers into larger practices or clusters could mean job losses for administrative staff (1 piece of feedback)
- inadequate buildings and facilities (1 piece of feedback)
- concern that those with specialist skills supporting a range of practices would be overburdened (1 piece of feedback)
- a perception that clusters were for the benefit of GPs, not people using services (1 piece of feedback)

A perceived lack of access to general practice appointments was the most common feedback about this topic and people did not feel that changes being considered as part of *Healthy Weston* would alleviate these issues:

> *"Some people in the group fed back about their difficulties in accessing GP services. Appointments hard to get, phone lines being engaged from early in the morning and when finally getting through all appointments having been allocated. Thought the idea of practices working together to share workforce was a very good idea. But worried this might overburden specialist staff even more if they had to work across many practices."* (Notes from meeting)

> *"It would be nice if our own GPs could become a bit more accessible. To be told that there are no available appointments often in a time scale of 6-8 weeks is not really on!!!"* (Survey from member of the public)

People also raised questions about how clusters of general practices would work day to day and whether there would be any benefits for local people:

> *"Don't close / merge GP surgeries! Not everyone can travel easily, My GP surgery is in walking distance and I have always gotten an appointment when needed - I don't want it to change."* (Survey from person providing health or care services)

> *"Ever expanding GP practices are increasingly being operated to the convenience of the doctors and the needs and wants of patients, that used to be the highest priority, are now the last considerations to be made."* (Survey from member of the public)

Other suggestions for general practice care

Some feedback suggested that it was important to consider how services provided for people in care homes could be streamlined (7 pieces of feedback). A workshop was run to develop how general practices could work with care homes. Box 4 provides a brief summary of the key points raised.

Other design ideas suggested to enhance general practice care were:

- ensuring that general practices take **advance bookings** for appointments, rather than requiring people to telephone at 8am each day to book a same-day slot (20 pieces of feedback)
- offering **out-of-hours** appointments, including before and after standard office hours and at weekends (10 pieces of feedback)
- upskilling general practice staff to **signpost** to local services and support self-care (8 pieces of feedback)
- **upskilling** general practice staff to listen to people and speak with them respectfully, including vulnerable groups (5 pieces of feedback)
- GPs or nurses with special skills **visiting local general practices** to run specialist clinics, rather than residents travelling to see specialists (3 pieces of feedback)
- examining how tasks currently undertaken by GPs can be done by others (1 piece of feedback)

Examples of comments made in this regard included:

> *"Services need to be available to meet demand of shift workers and minimise time away from work. I could go to a 7am appointment but there aren't any available and therefore I have to have time off work."* (Survey from member of the public)

> *"An overhaul of the generally unpleasant procedures involved in getting a GP appointment is our biggest gripe - nowhere else in the country refuses to let you book an appointment in advance so you can make sure you can take time off work to attend, rather than insisting you call at 08:30 on the day and hope you can be seen, as you are already going to have to not turn up to work on time."* (Survey from member of the public)

Box 4: Examples of feedback from workshop about supporting care homes

In January 2018, 16 people attended a workshop to consider approaches for improving the way health services work with care homes. Participants included representatives from care homes, general practices and other health services. Residents currently keep their usual GP when they start living at a care home, meaning that many general practices may be serving people in the same care home. Workshop participants were asked for feedback about changing this to have one general practice assigned to each care home, so that all residents in the home were served by the same practice.

Potential positives with this approach were thought to be:

- possibility of developing a relationship between a home and a GP
- possibility of more rapid and streamlined care
- simple model which mirrors other zoning approaches

Suggested challenges with this approach were:

- reducing choice for residents and their families
- lack of continuity of care for residents transferring from their usual GP
- disincentive for residents to move to homes, if they needed to lose contact with their usual GP who they may have known for many years
- concern that the approach is for the benefit of general practices, not taking account of what residents might prefer
- may take some time to embed if residents do not want to switch GPs
- may mean more work and travel for some practices

Questions were raised about how practices would be assigned to care homes.

Care home representatives thought that more could be done to build trust between care homes and health services and to upskill care home teams. It was suggested that there could be more education about how to reduce ambulance callouts by care homes and additional support for nurses in care homes to undertake activities that might currently be completed by GPs.

Participants said they thought the *Healthy Weston* engagement approach was new and valuable and were eager to continue joint planning.

This box does not seek to replicate the detailed notes taken at the workshop, which were reportedly used by the *Healthy Weston* team to shape ongoing planning. Feedback about the model is not generalisable to the views of others, particularly as the sample was small and others were not asked publicly to comment on the suggested approach during the dialogue period.

Important aspects of care

People who completed a *Healthy Weston* survey were asked how important different aspects of care outside hospital were to them. Most survey responses thought that it was important for health services to work closely together (98%), for health services to help people keep themselves well (92%), to be able to get an appointment on the same day (89%), and not to have to travel any more than five miles further than currently for a non-urgent appointment (89%, see Figure 4). Fewer people thought that it was important to be able to have an appointment with a professional without seeing them in person (57%) or to always see a doctor rather than another well-trained health professional (61%).

Women were more likely than men to say it was important to always see the same health professional for non-urgent appointments and to not have to travel any more than two miles further than currently to access healthcare. People from minority ethnic groups were more likely than others to say that it was important to get all services in one place, be able to get appointments on the same day and always see a doctor, rather than another well-trained health professional. The older people were, the more likely they were to say that it was important to always see a doctor. People from Weston were less likely to think this was important than those from other areas.

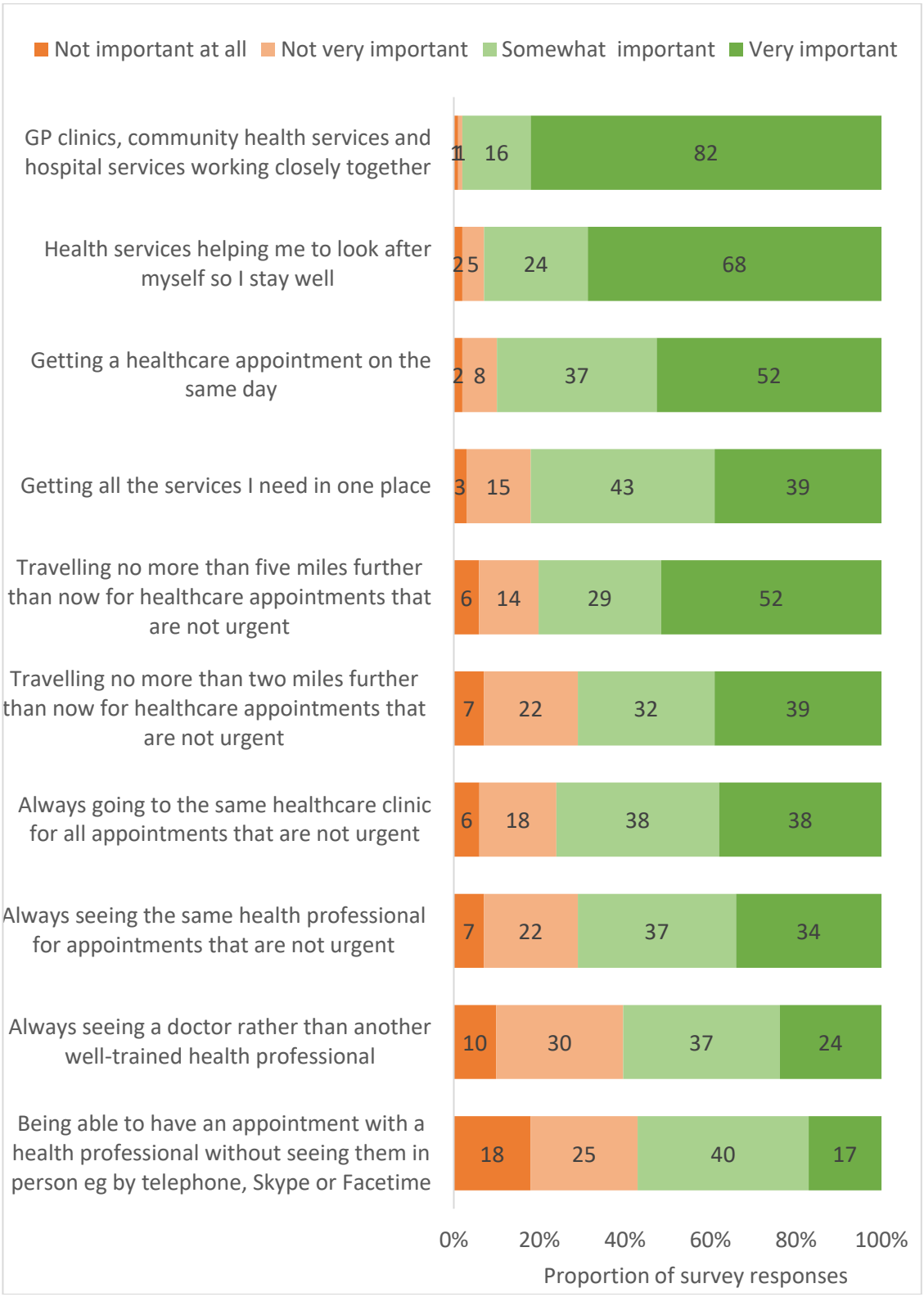
When asked to choose their single highest priority from a list, the most commonly mentioned factors were:

- GP clinics, community health services and hospital services working closely together (30% of survey responses that answered this question)
- getting a healthcare appointment on the same day (18%)
- health services helping people to look after themselves so they stay well (10%)
- always seeing the same health professional for appointments that are not urgent (9%)
- getting all the services needed in one place (9%)

The top priority areas remained the same no matter where people lived, their age, ethnicity or gender, or how frequently they used general practice services.

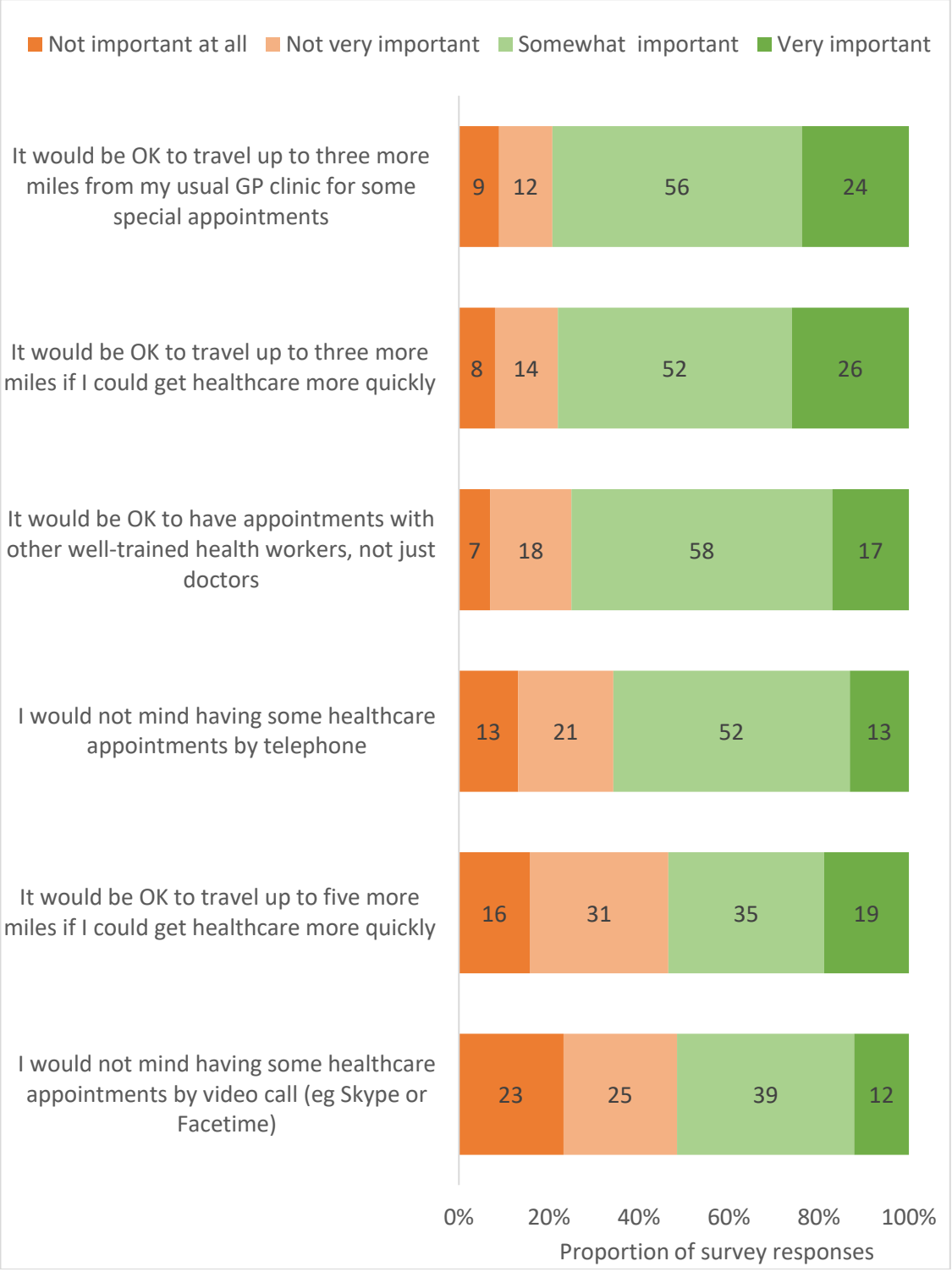
People who answered the survey also commented about the possibility of grouping some services together at one location. The *Healthy Weston* programme is considering this in the context of clusters of general practices working together as well as a hub of community services. About eight out of ten people said it would be acceptable to travel three more miles than their current general practice for some special appointments (80%) or if they were able to get healthcare more quickly. The same proportion said it would be acceptable to see another health worker rather than always seeing a doctor (75%). Two thirds said that they would not mind having appointments by telephone (65%, see Figure 5). Fewer people were positive about potentially travelling five miles more for quicker care (54%) or having appointments by videoconference (51%). The trends were similar no matter where people lived or their age, gender or ethnicity.

Figure 4: Perceived importance of various aspects of health services in the community



Noted: based on 1,342 survey responses to the question 'Now we'd like to focus on health services outside hospital. How important are these things to you?' Not all responses commented about every issue.

Figure 5: Perceived importance of factors that may make it possible to group services

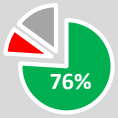


Note: based on 1,342 survey responses to the question 'We may be able to provide better care if some services are grouped together in one location. Do you agree or disagree with these things?' Not all responses commented about every issue.

Community hub

Key points

Healthy Weston is considering providing a 'one-stop shop' on the site of Weston General Hospital with many community health services in one place, especially for people who might have extra needs such as children, older people or those with long-term physical or mental health conditions. 1,308 pieces of feedback commented about the potential for developing a hub of services on the site of Weston General Hospital (80%).



76% of pieces of feedback that commented about this thought it was a good idea to develop a hub of health and care services in one place, 9% did not and 15% did not mind either way.

Areas of concern included:

- worries about accessibility, including issues with public transport from rural areas and a lack of parking (61 pieces of feedback)
- concern that this approach would result in less quality or quantity of services (55 pieces of feedback)
- perception that services need to be specialised, not all 'lumped together' (27 pieces of feedback)
- the potential need to separate some groups from others, for instance older people or those with mental health needs could be seen in a different area from children (25 pieces of feedback)

Design ideas proposed for consideration in further planning were:

- inclusion of a **broader range of services** in the hub, including voluntary sector services and social care (31 pieces of feedback)
- including 'step down care' to **support people after discharge** from hospital (17 pieces of feedback)
- **more than one hub** in different locations or using a hub and spoke model to provide some services more locally (12 pieces of feedback)
- having a **care coordinator** to help people navigate through services (7 pieces of feedback)
- having a **mobile hub** of professionals visiting villages (6 pieces of feedback)

A cornerstone of the *Healthy Weston* vision is having a 'hub' of community healthcare services on the site of Weston General Hospital. This community hub may include rapid access to diagnostic tests, specialist mental health advice, physical and mental healthcare for children, chemotherapy and cancer services, clinics for people with long-term conditions and blood transfusions, for example. The stated aim is for general practitioners, hospital, mental health and social care staff and volunteers to work more closely together to meet the needs of local people. *Healthy Weston* suggested that Weston General Hospital could become a recognised centre of excellence for key services such as caring for frail older people and delivering planned surgery such as hip and knee replacements.[4] This section describes people's feedback about the *Healthy Weston* vision for a community hub on the site of Weston General Hospital.

Surveys and comments at meetings were largely positive, with 76% of pieces of feedback that commented about this saying they would be happy with this approach, 9% not being happy and 15% not minding either way. People from different parts of North Somerset, men and women and those from different age and ethnic groups were all equally likely to be supportive or challenging.

In the *Healthy Weston* survey, almost nine out of ten responses said that Weston General Hospital would be a good centre for people who might need many types of services in one place (86%). One in seven responses did not think this was the case (14%). Box 5 describes some of the key points made in a workshop to consider this approach.

Members of the public and health and care professionals often spoke positively about the potential of this idea to encourage more joined up working between services, convenience for people using services and efficient use of resources.

> *"It makes sense to have access to everything in one place. Sometimes people have to travel quite a distance to appointments and for hospital stays which can be problematic for the patient and the family. To have everything in one place just saves people time from going from one place to another. Working people could also benefit from this. I would think that bringing services together would also help cut some costs and overheads for the NHS."* (Survey from member of the public)

> *"One base enables multiagency input, communication and cross agency resolutions for complex needs but a nominated key worker for each individual is necessary to coordinate and ensure outcomes are adequate to meet the needs of the patient. If implemented successfully it provides more efficiency, patient focused services and less stress for the patient by not needing to repeat the same facts several times to different agencies."* (Survey from person who provides health or care services)

> *"I have worked in many different services over 48 years, health, education and social services and many people suffer from more than one difficulty. Joined up services will support people better and also make it easier for professionals to network productively."* (Survey from a retired health professional)

4 Wording drawn from *Healthy Weston: Joining up services for better care in the Weston area* released by the NHS in October 2017.

Box 5: Suggestions made in a workshop about developing a community hub

In February 2018, 31 people took part in a workshop to consider approaches for bringing community health services together in one location on the site of Weston General Hospital. Participants included members of the public, voluntary groups, health and care professionals, care homes and others. Some of the workshop comprised brainstorming possible services to include in such a hub. However some overarching suggestions included.

- the hub should include a mix of health, voluntary, mental health and social services
- navigators and care coordinators could help signpost people to services
- transport to and from the site is a challenge so need to explore ways to tackle this including volunteer transport services, virtual bus tickets and a virtual hub
- a virtual hub available by telephone or online could signpost and provide advice
- offer workshops, clubs and drop-in sessions to support self-care and healthy living
- there could be a wellbeing café, food café and Citizens Advice Bureau
- vulnerable people such as rough sleepers or individuals with learning disabilities may find it physically and psychologically challenging to visit the hospital site so multiple hubs or 'spokes' may be needed to enhance access
- could consider looking at records to identify those in most need and inviting them to attend the hub proactively
- good IT systems need to be in place to share records and support referrals
- multiagency access to a single patient record would improve coordination
- services should not be duplicated as a result of the hub, so existing services may need to move or be joined up as 'spokes'
- staff should be trained together to support better coordination and cross-organisation working
- the hub needs to look and feel nice and help people find their way around

This box does not seek to replicate the detailed notes taken at the workshop, which were reportedly used by the *Healthy Weston* team to shape ongoing planning.

693 pieces of feedback provided 1048 comments about the potential for a community hub. Sixty percent of the comments were positive (631 comments). The most commonly mentioned positive aspects of a community hub approach included:

- the opportunity for better coordination and person-centred care (178 pieces of feedback)
- the potential for easier access to services, including for children, the elderly and vulnerable groups (136 pieces of feedback)
- support for mixing physical and mental health and health and social care (87 pieces of feedback)
- convenience, including the potential to save time and reduce stress as long as people could visit all the services they needed on the same day (78 pieces of feedback)
- perceived good use of resources (69 pieces of feedback)
- the potential for reduced travel if services were available at one location (53 pieces of feedback). These pieces of feedback tended to emphasise that there would need to be good public transport services seven days per week or free / subsidised transport services
- the value of this approach in addressing the needs of the growing local population (12 pieces of feedback)
- the potential to enhance staff capacity using integrated models so specialists could see those with the most complex needs (12 pieces of feedback)
- the potential to use IT effectively using this approach (6 pieces of feedback)

The most commonly perceived challenges with a community hub approach included:

- concern about accessibility, including issues with public transport from rural areas and a lack of parking (61 pieces of feedback)
- concern that this approach would result in less quality or quantity of services (55 pieces of feedback)
- perception that services need to be specialised, not all 'lumped together' (27 pieces of feedback)
- the potential need to separate some groups from others, for instance older people or those with mental health needs may be seen in a different area from children (25 pieces of feedback). It is important to note that in the *Healthy Weston* survey the 113 people who said they had mental health needs did not raise this as an issue
- the importance of having good infrastructure to support the approach, including adequate staffing and an appropriate environment (23 pieces of feedback)
- perception that there may be less consistency and continuity of care and fewer relationships built with professionals (17 pieces of feedback)
- perception that the aim is to reduce cost rather than improve services (13 pieces of feedback)
- concern that there would be long waiting lists (10 pieces of feedback)
- worry that the location would be unsafe if it is too far from people who need help (7 pieces of feedback)
- concern that this approach will not address growing population numbers (6 pieces of feedback)
- dislike of the term 'care campus' or 'community'. Alternatives suggested included healthy living hub or wellbeing hub (5 pieces of feedback)
- barriers to overcome with IT and sharing records (5 pieces of feedback)
- difficulties with financing or sharing funding (3 pieces of feedback)

Whilst travel issues and accessibility were the most common concerns about developing a community hub, people were also worried that this may mean a downgrading of existing services or a reduction in funding.

> *"The approach to the Care Campus model appears to us to be a methodology utilised solely to narrow or close the funding deficit."* (Email from group)

Thirty-two responses said there was not enough information to draw conclusions and that more information was needed about the location, access using public transport and services to be included. Some wanted to see evidence or examples of where this approach had worked elsewhere (3 pieces of feedback) and others wanted to know if the hub would be a separate building (9 pieces of feedback).

Other suggestions about a community hub

Some pieces of feedback suggested other approaches to consider alongside a community hub. People wanted to know more about the **types of services** that would be available in the hub, with suggestions such as a food café, crisis café, night sitting service, domestic abuse support, diagnostic services and Citizens Advice Bureau (8 responses). Others suggested that the community hub should work more with the voluntary sector (9 pieces of feedback), mental health services (2 pieces of feedback), and promote sharing between health and social care (12 pieces of feedback).

Some suggested that there should be **multiple 'one stop shops'** available, perhaps using a hub and spoke model to offer more localised services (12 pieces of feedback).

Some pieces of feedback said that the idea of integrating services was welcome, but that this need not solely focus on a physical location. It was suggested that **mobile hubs** would be useful, perhaps comprising a vehicle full of professionals and equipment travelling to different villages regularly and setting up in a community centre or church hall for the day. Alternatively a hub could be virtual, offering services online, by telephone or by videoconference (6 pieces of feedback).

> *"Campus concept: The essence is to have the resources needed and the person concerned all in one place. This does not automatically mean a fixed single 'bricks and mortar' campus. It could mean a travelling 'road show' with a team accompanied by key bits of kit in vehicles (as for collecting blood donations, chest x-ray clinics etc)."* (Email from member of the public).

Others thought that there needed to be a central agency or **care coordinator** navigating a person's journey through the system and good information about the services on offer and how to access them (7 pieces of feedback). There was a desire to focus on transitions of care and wrap services in any hub around the needs of people using services and their families (9 pieces of feedback). Some felt that focusing on specific groups of people such as those who are frail would be useful, as more support may help these people avoid admission to hospital (3 pieces of feedback).

Another suggestion was to include ongoing support after hospital discharge in the hub, such as 'step down' **rehabilitation flats** on the hospital grounds whereby people could stay for a few days if they were not able to return home immediately after discharge (17 pieces of feedback).

Stronger hospital

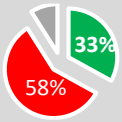
Key points

Healthy Weston contained a number of suggestions for developing a stronger, more focused hospital. 1,227 pieces of feedback commented about urgent and emergency services at Weston General Hospital (75%).

People were concerned with the temporary overnight closure of the Accident and Emergency Department. They thought there should be a 24 A&E service available locally due to the growing and aging population, the presence of tourists, concerns over safety when travelling elsewhere, lack of public transport, cost and inconvenience of travelling to another hospital for people using services and family members and concerns over impacts on the ambulance service.

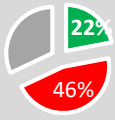
Ideas suggested for consideration when planning A&E services included:

- setting up a minor injuries unit to cope with issues that are not emergencies (32 pieces of feedback)
- mobile clinics / buses to support people with minor injuries or 'pop up' clinics in shops or sports grounds (8 pieces of feedback)
- educating people about when to use various services, including 111 and A&E (7 pieces of feedback)



33% of pieces of feedback that commented about having direct admissions to wards rather than always admitting via A&E Departments thought this was a good idea. 58% did not and 9% did not mind either way.

754 pieces of feedback commented about families that wanted to use a midwife-led birth unit going to Bristol, with care before and after the birth being available in Weston (46%).



22% of pieces of feedback that commented about this said they would be happy if families who wanted to use a midwife-led unit went to Bristol. 46% were not happy and the rest said they would not mind either way (32%).

Design ideas to consider during planning about maternity services included:

- extending the range of services available in Weston to accommodate women at higher risk (80 pieces of feedback)
- more promotion of the midwife-led unit (24 pieces of feedback)
- rotating midwives through different centres to keep their skills up to date (22 pieces of feedback)

Urgent and emergency care

The *Healthy Weston* vision suggested that the care at Weston General Hospital needs to change to provide the services that people need most and to address financial and clinical challenges. The programme planned to work with neighbouring hospitals in Bristol and Somerset to identify the services that Weston General Hospital is best placed to provide and which services may be more effectively offered by another hospital.[5]

The Accident and Emergency (A&E) Department at Weston General Hospital is temporarily closed from 10pm-8am due to difficulties recruiting the right number of permanent doctors to run the service safely at night. *Healthy Weston* examined alternative ways of offering care to people traditionally seen in A&E and the types of urgent and emergency services best provided by Weston Hospital or by a neighbouring hospital.

Comments about A&E were the most common feedback received during the public dialogue period. 75% of all pieces of feedback received contained one or more comments about A&E. 1,227 pieces of feedback provided 1,696 comments about this.

In the Healthy Weston survey, seven out of ten responses said they understood the reasons why the A&E at Weston General Hospital needed to look at different ways to do things (70%) and three out of ten did not (30%). Two fifths said they had enough information about how people who need emergency care overnight can get help (40%) and three fifths did not (60%). The older people were, the less likely they were to say they understood the stated reasons or had enough information about how to get help in an emergency.

People provided passionate feedback about why an A&E Department was important for Weston and the surrounding areas:

> *"How can a town that is getting thousands of new houses not have a functional A&E Department at night? This is a disgrace! Plus anyone having a cardiac arrest or life threatening conditions will have an approximate journey time to the nearest hospital of about 1 hour from Weston. Lives maybe lost because of this."* (Facebook post from member of the public)

> *"As a type 1 diabetic I have needed to be admitted to Weston General a few times via A&E, often out of hours. When admitted I rely on the support of the diabetic nurse at Weston hospital who knows me well. I know of other diabetic patients who have been admitted to other hospitals since the overnight closure which has resulted in longer stays due to communication issues between hospitals and unnecessary changes of medication due to different treatment regimes at different hospitals… As things are I am likely to put off coming in to hospital until the A&E is open again, which ultimately could put my life at risk."* (Survey from member of the public)

5 Wording drawn from *Healthy Weston: Joining up services for better care in the Weston area* released by the NHS in October 2017.

Common themes in comments about A&E were:

Population needs

- a perception that the number of residents, elderly people and tourists is growing in Weston so a 24-hour A&E is needed (239 pieces of feedback)
- perception that emergencies happen at night time, not just daytime, so a 24-hour A&E is needed in Weston (149 pieces of feedback)
- perception that A&E needs to be provided locally, whereas non-emergency services might involve travel (108 pieces of feedback)

Travel

- concern that Bristol and Taunton are too far away (153 pieces of feedback)
- concern about extra pressure on the ambulance service needing to take people to other hospitals (90 pieces of feedback)
- concern that many people rely on public transport so getting to other hospitals would be difficult and expensive (76 pieces of feedback)
- perception that Bristol and Taunton are not convenient for relatives or visitors and this may be especially important for those who are disadvantaged and those with limited transport (57 pieces of feedback)
- concern about returning home after being taken to a hospital in Bristol or Taunton, particularly when reliant on public transport (29 pieces of feedback)

Safety

- concern that delays incurred when travelling to a hospital elsewhere are unsafe and stressful (196 pieces of feedback)

Other services

- suggestion that A&E Departments in neighbouring hospitals are already busy and may not be able to cope with extra demand (48 pieces of feedback)
- perception that A&E is needed for minor injuries, not just admissions (32 pieces of feedback)

Other issues

- suggestion that politicians should get involved to support reopening A&E (31 pieces of feedback)
- concern that the A&E closure was supposed to be temporary (20 pieces of feedback)
- not believing the statistics provided by the *Healthy Weston* programme about the number of people using A&E overnight are accurate (16 pieces of feedback)
- concern that the temporary closure was having negative impacts, such as the hospital rushing to admit people prior to closing time, long ambulance queues outside A&E or people waiting until morning to visit (10 pieces of feedback)
- wanting to know more about potential partnership arrangements, mergers or links with Bristol (9 pieces of feedback)

Direct admissions to wards

People in the Weston area with life threatening emergencies such as heart attacks or serious road traffic accidents were always taken to Bristol or Taunton, so the temporary overnight closure of A&E reportedly had no impact on these emergencies. However, during the temporary closure people with non-life threatening emergencies needed to use other services. The *Healthy Weston* programme stated that during the temporary closure an average of about ten people per night from the Weston area travelled to A&E Departments in other hospitals (by ambulance or on their own) and about half of these people were admitted to another hospital. Instead of these people needing to travel to another hospital, the *Healthy Weston* programme is considering the potential for directly admitting people to wards at Weston General Hospital during the night, rather than all admissions needing to pass through an A&E Department.

The *Healthy Weston* survey asked how respondents would feel if people who needed to be admitted to Weston General Hospital between 10pm and 8am were directly admitted onto a ward rather than needing to be admitted through A&E. 33% of survey responses said they would be happy about this, 58% said they would not be happy and 9% said they would not mind either way. It is difficult to interpret this feedback because some respondents are likely to have been commenting about the temporary closure of the A&E Department rather than the concept of direct admissions to wards. Thus people may have said they were happy or not happy in relation to the temporary closure, not about direct admission to wards. Those from North Sedgemoor and the Mendips were least likely to be supportive compared to those living in other areas. There were no differences in the trends in feedback from women and men or those from different age or ethnic groups.

Some people said that they thought that direct admissions to wards would be feasible and a better use of resources.

> *"I hadn't realised that the serious accidents/life threatening emergencies go to Bristol and Taunton anyway. Dealing with other emergencies by admission directly to hospital seems a good idea."* (Survey from a person working in the voluntary sector)

> *"I appreciate that it is costly to keep an A&E service open just to deal with 8 people. Would be better to put the funding towards more ambulances."* (Survey from member of the public)

A total of 281 positive comments were provided about the potential for direct admissions to wards. They focused on the following areas:

- direct admission pathways mean that resources can be targeted to life saving incidents and those with the most serious needs (105 pieces of feedback)
- perception that the usage figures presented supported the potential for direct admissions rather than needing 24-hour A&E services (33 pieces of feedback)
- the potential for better use of resources (32 pieces of feedback)
- the principle being acceptable, as long as the methodology used was robust to ensure accessible care (29 pieces of feedback)
- direct admissions being a good approach given that there is no ‘quick fix’ to shortages of the staff needed to run A&E (27 pieces of feedback)
- perceived better care available at hospitals other than Weston, so people may rather go there (23 pieces of feedback)
- acceptability given ease of access to other hospitals at night (21 pieces of feedback)
- direct admission to wards may save ambulances time taking people to other hospitals (11 pieces of feedback)

Others raised questions about how direct admissions to wards would be managed in practical terms or suggested that there may be impacts on other services or safety issues.

> *“I would need to understand HOW those admissions would work. Weston is chronically understaffed as it is - how could they take patients at night?”* (Survey from member of the public)

> *“Because of the closure, ambulances are taking people further away. Even if some could be directly admitted to a ward others will still need to be taken to further hospitals, this means ambulances are not always available when needed by others or people in the area have to wait longer for ambulances to arrive. In some instances people feel it’s quicker to get themselves to another hospital. All of this could lead to unnecessary fatalities.”* (Survey from person who provides health or care services)

> *“As a person with a chronic life threatening illness I feel very vulnerable with no local overnight emergency care. I don't drive and my condition is such that the current long wait for an ambulance and then 30 minute journey to Bristol or Taunton would quite possibly prove too late to save my life in an emergency. The inevitable red tape and procedure and box ticking for any relevant services to deem me 'appropriate' for admittance to a ward at Weston General Hospital could very possibly also be too long a delay and my life would be seriously at risk.”* (Survey from member of the public)

In total 118 pieces of feedback challenged direct admissions to wards, including:

- staff shortages may mean there are not enough staff available to undertake direct admissions (27 pieces of feedback)
- concerns over who would decide about direct admissions, with worries that this may mean being seen by junior staff (20 pieces of feedback)
- it may be difficult to judge needs so people may not be admitted even though they should be (19 pieces of feedback)
- it could be confusing for people using services and ambulance crews about where people should go if it is uncertain whether or not they would be admitted (13 pieces of feedback)
- there may be an increase in avoidable admissions as professionals will not be able to undertake tests before admitting, as might be the case in A&E (9 pieces of feedback)
- it may reduce continuity of care if people not eligible for direct admissions are transferred to other A&E Departments rather than being cared for by practitioners they know in Weston (9 pieces of feedback)
- there is a lack of information available about the direct admission process so it is difficult to understand (8 pieces of feedback)
- direct admissions may impact negatively on the care of other patients in wards (7 pieces of feedback)
- direct admissions may take longer to access than A&E care so may not be safe (3 pieces of feedback)
- this approach may impact negatively on staff training and accreditation (2 pieces of feedback)
- there may not be beds available to admit people to wards (1 piece of feedback)

Other suggestions about A&E care

Other design ideas about A&E put forward for consideration included:

- setting up a **minor injuries unit** to cope with issues that are not emergencies (32 pieces of feedback)
- **mobile clinics** / buses to support people with minor injuries or 'pop up' clinics in shops or sports grounds (8 pieces of feedback)
- **staff rotations** between different hospitals, using visiting specialists from other trusts or using telephone or IT support to keep services available at Weston (7 pieces of feedback)
- **educating people** about when to use various services, including 111 and A&E (7 pieces of feedback)
- A&E front of house service run by **general practitioners** (3 responses)
- offering a **transport service** to Bristol for care that does not require an ambulance, perhaps in partnership with the voluntary sector (3 responses)
- a more local **111 service**, including contact via video messaging (2 responses).
- **redirecting non-urgent cases** to other services rather than seeing them in A&E (2 pieces of feedback)

"Sadly you cannot safely staff a level one emergency department, and any department not seeing regular emergency trauma type patients becomes deskilled and will not attract appropriately trained and experienced doctors or nurses. Therefore realistically you are looking at a minor injury unit." (Survey from person who provides health or care services)

Maternity services

The midwife-led unit at Weston General Hospital is a centre for families with low-risk pregnancies where all care is provided by midwives and midwifery assistants. *Healthy Weston* stated that, based on national guidance, these midwifery teams need to see about 500 families per year to keep their skills up to date. About 170 families per year use the midwife-led unit at Weston General Hospital. *Healthy Weston* stated that maternity services need to be reviewed in partnership with other hospitals to consider how to provide birthing facilities that are sustainable and make best use of NHS resources.[6]

About eight out of ten responses to the *Healthy Weston* survey thought that it was worrying that the midwife-led unit sees 170 births per year rather than the 500 that might be needed (81%). One in five did not think this was worrying (20%). These trends were evident no matter where people lived or their age, gender or ethnicity.

In the *Healthy Weston* survey, meeting notes and other pieces of feedback, people provided feedback about how they would feel if families who wanted to use a midwife-led unit needed to go to Bristol to have their baby, with care before and after birth available locally in Weston. 22% of pieces of feedback that commented about this said they would support this, 46% said they would not and 33% said they did not mind either way. A number of survey respondents noted that they did not mind as they did not feel the question was relevant to their personal circumstances. There were no differences in the opinions of men and women or people living in different areas. Those aged 35-49 years were least likely to support travelling to a midwife-led unit in Bristol and those from minority ethnic groups were more supportive than others.

In total 754 pieces of feedback provided 1,008 comments about maternity care. One quarter of comments about this supported families having their babies in Bristol rather than Weston (262 pieces of feedback). These pieces of feedback commonly said:

- Bristol has specialised facilities available so it may be safer for families to have babies there (119 pieces of feedback)
- the Weston service is perceived to be unsafe currently (42 pieces of feedback)
- they themselves had a good experience at Bristol or elsewhere, with local antenatal and postnatal care in Weston so this approach can work well (40 pieces of feedback)
- this would be good compromise so the local midwifery service is not removed completely (36 pieces of feedback)
- this would be a better use of resources (25 pieces of feedback)

Examples of the feedback supporting birth care based in Bristol included:

> *"The maternity unit is not well used and it can't be cost effective to keep it open for the numbers that use it."* (Survey from member of the public)

> *"Need to ensure staff maintain their competencies and provide an effective service. Discharge is often swift following childbirth so an alternative location would have impact for short duration."* (Survey from person who manages health or care services)

6 Wording drawn from *Healthy Weston: Joining up services for better care in the Weston area* released by the NHS in October 2017.

In total 677 pieces of feedback outlined reasons to oppose families needing to have their babies in Bristol. These people were most concerned about:

- it not being practical to travel to Bristol when in labour or visiting, including families travelling with siblings (193 pieces of feedback)
- wanting to use local services, which were perceived to be of good quality (185 pieces of feedback)
- ensuring that services were available for the large and growing population of Weston, including new housing developments (74 pieces of feedback)
- not being practical for those without cars, so may disadvantage the most vulnerable (44 pieces of feedback)
- potential safety issues for mothers and unborn babies needing to travel to Bristol during labour (40 pieces of feedback)
- lack of continuity of care from local midwives (37 pieces of feedback)
- wanting families to have a choice (37 pieces of feedback)
- concern that services in Bristol were already stretched (31 pieces of feedback)
- prohibitive costs to travel to Bristol (18 pieces of feedback)
- placing more pressure on the ambulance service (7 pieces of feedback)
- not believing the statistics provided about numbers of births or requirements for staff competencies (6 pieces of feedback)
- perceiving the approach as a way of saving money and cutting services (5 pieces of feedback)

Examples of comments challenging the suggestion to offer all birth services in Bristol included:

"The only reason only 170 families per year use the maternity unit at Weston Hospital is that many people experience the slightest issues meaning they have to go to a hospital with obstetricians or if something went wrong during labour they would have to wait for an ambulance and then travel to Bristol. There quite often isn't enough time to do this before serious complications occur so people don't want to take the risk. If there were obstetricians based at this unit, thousands of families would use the services." (Survey from member of the public)

"I don't think it's right to medicalise straightforward, uncomplicated deliveries. In the vast majority of normal low-risk pregnancies, the baby arrives just fine. And in those situations the most important factors for a straightforward birth are a calm, relaxing home-from-home environment and being supported by the people with the right skills. It's best if this is someone who knows you already from antenatal appointments and can judge how best to support you through labour. We should be thinking how we can provide parents with better information about midwife-led birthing units and the evidence of positive outcomes." (Survey from member of the public)

"Not everyone needs the same amount of care during childbirth, and transferring low-risk pregnancies to Bristol could mean there is then less care available for higher risk pregnancies who need more advanced care. It is essential that a woman has a choice of services and a low-risk unit in Weston could be much more convenient for a number of women. It also means that continuity of care is more likely, as it is important that a woman has a midwife she knows / trusts to help her through childbirth." (Survey from member of the public)

Box 6 summarises key points from a workshop exploring some specific approaches to maternity care.

Box 6: Feedback from a workshop exploring two approaches to maternity care

In February 2018, 20 people took part in a workshop to provide feedback about possible models for maternity services in Weston. The participants were health professionals working in maternity services in Weston and Bristol. No people using services or voluntary groups took part. Participants were asked for feedback about two models. In one approach, the midwife-led unit would be available in Weston, but not be open at all times. Women wanting to use it would need to telephone when in labour and the unit would be opened for them. All midwives would be based in the community rather than in hospital. In the second model, there would be no midwife-led unit in Weston. Midwives based in the community would continue to support home births but families wanting to give birth in a midwife-led unit or hospital would need to travel to Bristol.

After hearing information presented by the *Healthy Weston* team, the health professionals that attended the workshop reportedly thought that it was not sustainable to continue offering a midwife-led unit in Weston 24-hours a day, seven days a week. They did not support one of the models proposed more than the other. In any forward planning, they asked for the following to be considered:

- adequate staff and funding would be necessary to implement either model
- current staff are valued and should be kept
- reducing or removing midwife-led birth services reduces choice for families
- travel may be uncomfortable in labour
- there are issues with public transport availability and travel costs to Bristol
- there may be confusion and safety issues if families arrive at the centre without phoning in advance or if they arrive before a community midwife
- any changes may put pressure on the ambulance service, which may be called on to transport more women in labour to Bristol and may need to have a team specialising in maternity
- the midwife-led unit could be located in an accessible location near the motorway
- rotations of midwives between Weston and Bristol could be considered but may impact on continuity of care
- information technology needs to be set up to support this way of working

This box does not seek to replicate the detailed notes taken at the workshop, which were reportedly used by the *Healthy Weston* team to shape ongoing planning. Feedback about the models is not generalisable to the views of others, particularly as the sample was small and people using services did not attend. Seven women attending a postnatal yoga class, none of whom had their babies at Weston, were later asked to comment about the two models but others were not publicly asked for feedback about this during the dialogue period. The women asked raised concerns about travel, choice and safety, and also said they could see merits in further promotion of home birth.

Other suggestions about maternity care

Other ideas proposed for consideration in planning services around the time of birth included:

- extending the range of services available at Weston General Hospital to accommodate women with **higher risk pregnancies** (80 pieces of feedback)
- more **promotion** of the midwife-led unit to encourage more births there (24 pieces of feedback)
- **rotating midwives** through different centres to keep their skills up to date. In this view, midwives could work at both Bristol and Weston, and thus see the number of families they needed to maintain their skills (22 pieces of feedback)
- finding out why families do not want to have babies at Weston (17 pieces of feedback)
- virtual hubs with midwives and health visitors, not necessarily based at the hospital (1 piece of feedback)

Other hospital services

In the *Healthy Weston* survey, nine out of ten responses agreed that it would make the most of NHS resources if Weston General Hospital **worked more closely with other hospitals** and services (90%). People had similar opinions no matter where they lived or their age, gender or ethnicity.

Nine out of ten survey responses thought that it would be good to **have more planned operations** at Weston General Hospital (90%) and one in ten did not agree with this (10%). One other piece of feedback recommended implementing volume-based surgery lists, whereby each surgical team has a set number of operations to perform and works until the number is complete rather than allocating a set finishing time for surgery.

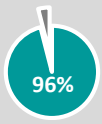
There were a small number of comments about other aspects of acute services. Some reported a lack of clarity or understanding about the model(s) being discussed related to critical care and elective surgery (7 pieces of feedback).

Others suggested that the hospital should offer a wider range of services, particularly for vulnerable groups (5 pieces of feedback).

Some responses suggested that the hospital should draw more on technology and link records with others (4 pieces of feedback) and others said that it would be useful to promote the good services available at the hospital to improve staff morale and local perceptions (3 pieces of feedback)

Planning next steps

Key points



People who answered the *Healthy Weston* survey were asked what criteria the NHS should prioritise when weighing up models and planning next steps. 1,286 pieces of feedback commented about this (96% of survey responses).

The top three things that people wanted the NHS to use as decision-making criteria were:

- population numbers and needs
- time taken to travel to services in an emergency
- number and type of staff available to run the service safely

The *Healthy Weston* survey invited respondents to select the top three things that the NHS should take into account when deciding on next steps. People could select from a list or add their own priorities. The criteria are listed below in the order prioritised by survey responses:

- population numbers and needs (48% of survey responses)
- time to travel to services when it is an emergency (48%)
- number and type of staff available to run the service safely (41%)
- ways the NHS could be more efficient (23%)
- what local people say (21%)
- the needs of the most vulnerable groups such as older people and children (21%)
- what health professionals say (18%)
- helping people to look after themselves (16%)
- making sure that services support family and carers (10%)
- using resources for the most urgent needs (8%)
- seasonal changes in population numbers (7%)
- evidence, research and statistics (7%)
- time to travel to services when it is not an emergency (7%)
- seeing the same staff consistently (6%)
- the needs of the largest number of people (5%)
- accessibility by public transport (5% added this criteria, it was not included on the pre-specified list)
- coordination between services and providers (4% added, not included on list)
- financial costs (3%)
- person-centred care (2% added, not included on list)

Engagement

Key points

100 pieces of feedback commented about the approach that the *Healthy Weston* programme took to engage in dialogue (6%). Notes from workshops and meetings suggested that those who took part were positive about having an opportunity to engage and wanted to continue to be involved. 41 pieces of feedback were positive about the codesign process and 23 pieces of feedback suggested that wider engagement would be beneficial.

Comments about the approach that the *Healthy Weston* programme took to engage in dialogue included:

- positive feedback about the codesign approach and involvement of wide range of people giving feedback about *Healthy Weston* (41 pieces of feedback)
- a desire for wider participation in further discussions (23 pieces of feedback)
- concern that people's opinions would not be taken into account or that decisions have been made (21 pieces of feedback)
- concern about the questions asked in the *Healthy Weston* survey, in case these were leading towards particular outcomes (10 pieces of feedback)
- suggestions to work with local media and social media to promote messages, including access to services and self-care (5 pieces of feedback)

Examples of comments in this regard included:

> *"Great to be involved and get the opportunity to talk to colleagues from a wide variety of backgrounds but also to see members of the public involved!"* (Twitter post from someone who provides health or care services)

> *"Bringing together all stakeholders to discuss issues and resolutions was felt to be a positive new step."* (Notes from workshop)

Summary

This independent summary of themes from 1,627 pieces of feedback received during the *Healthy Weston* public dialogue and codesign period suggests:

- The overall *Healthy Weston* vision for closer working between health and social care was positively regarded by eight out of every ten pieces of feedback. However there were questions about how the vision would be implemented and whether it was based on a desire to save money or withdraw services.

- The key issues that people wanted taken into consideration when developing plans where characteristics of the local population; staffing; considering how services could be better interlinked; public transport, transport costs and parking; resourcing and infrastructure, and clarity around implementation.

- Relatively few pieces of feedback commented about ways to improve general practice services, apart from answers to survey questions about relative priorities. The highest priorities were services working closely together; being able to get a healthcare appointment on the same day and health services helping people to look after themselves and stay well.

- The idea of a 'one stop shop' or hub of services on the site of Weston General Hospital was well received by most (76%), with a desire to include health services, voluntary services and social care. It was thought that this may improve coordination between services and improve accessibility. There were concerns about whether it would be appropriate to house some services together, such as those for children and people with mental health issues. There were also concerns about a lack of public transport and accessibility of the hospital site.

- The most feedback was provided about urgent and emergency care services. People thought that it was essential to have a 24-hour A&E service at Weston General Hospital due to the population of Weston; reduced safety if travelling to other hospitals; cost and inconvenience of travel to and from other hospitals; and lack of capacity elsewhere. 33% of pieces of feedback commenting about this supported direct admissions to wards rather than admissions through A&E.

- 22% commenting about maternity services said they would be happy if families that wanted to use a midwife-led unit went to Bristol rather than Weston. Half did not support this (46%) and the rest said they would not mind either way (32%). Concerns centred around the impracticality, safety and cost of travelling to Bristol; the desire to keep services available locally; and reduction in choice.

People from different areas, those from various age groups and those who had physical or mental health conditions expressed similar views. Table 2 summarises any differences between groups in answer to the *Healthy Weston* survey questions.

The *Healthy Weston* programme has committed to consider all feedback when planning next steps.

Table 2: Summary of group differences in Healthy Weston survey responses

Survey topic	Overall feedback	Differences by gender	Differences by age	Differences by ethnicity	Differences by area
Encouraging health and care services to work together	89% support	No differences	The older people are, the less likely to support	No differences	North Sedgemoor and Mendips least likely to support
One-stop shop	76% support	No differences	No differences	No differences	No differences
Health services supporting self-care	92% think important	No differences	No differences	No differences	No differences
Getting all services in one place	82% think important	No differences	No differences	Most important to minority groups	Less likely to be important for Winscombe
Always seeing same professional for non-urgent appointments	71% think important	Women more likely to think important	No differences	No differences	No differences
Always seeing a doctor	61% think important	No differences	The older people are, the more likely they are to say this is important	Minority groups most likely to think important	Weston area least likely to say this is important
Travelling no more than 2 miles from now	71% think important	Women more likely to say important	No differences	No differences	No differences
Travelling no more than 5 miles from now	81% think important	No differences	No differences	No differences	No differences
Appointments via telephone or Skype	57% think important	No differences	No differences	No differences	No differences
Appointments same day	89% think important	No differences	No differences	Minority groups more likely to think important	No differences
Always going to same clinic	76% think important	No differences	No differences	No differences	Winscombe less likely to say important
Services working together	98% think important	No differences	No differences	No differences	No differences
Most important factor	Working together, same day appointments and self-care	No differences	No differences	No differences	No differences

Survey topic	Overall feedback	Differences by gender	Differences by age	Differences by ethnicity	Differences by area
OK to travel up to 3 more miles for special appointments	80% agree	No differences	No differences	No differences	No differences
OK to travel up to 3 more miles if quicker access	78% agree	No differences	No differences	No differences	No differences
OK up to 5 more miles if quicker access	54% agree	No differences	No differences	No differences	No differences
OK to see other professionals	75% agree	No differences	No differences	No differences	No differences
OK to have some appointments via video call	51% agree	No differences	No differences	No differences	No differences
OK to have some appointments via phone	65% agree	No differences	No differences	No differences	No differences
Direct admissions to wards instead of via A&E	33% support, 9% don't mind	No differences	No differences	No differences	North Sedgemoor least supportive
Midwife-led unit in Bristol, with ante and postnatal care in Weston	22% support, 32% don't mind	No differences	Those aged 35-49 least likely to support	Minority groups more likely to support	No differences
Understand reasons why A&E needs to look at different ways of working	70% agree	No differences	The older people are, the less likely to agree	No differences	No differences
Have enough info about how to get emergency care overnight	40% agree	No differences	The older the person, the less likely to agree	No differences	No differences
Worry that midwife-led birth unit sees 170 births per year	81% agree	No differences	No differences	No differences	No differences
Weston General is a good place to have more planned operations	90% agree	No differences	No differences	No differences	No differences
Weston General is a good centre for people who need many services in one place	86% agree	No differences	No differences	No differences	No differences
Make the most of resources if hospitals work together	90% agree	No differences	No differences	No differences	No differences
Highest priority factors to consider in decision-making	Travel time in emergency, population numbers and needs, staff available	No differences	No differences	No differences	No differences

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Appendix 13: Evaluation Criteria

APPROVED BY BNSSG CCG GOVERNING BODY
2ND October 2018

Proposed evaluation criteria

Evaluation criteria	Defined as
 **1 Quality of Care**	1.1 Clinical effectiveness 1.2 Patient and carer experience 1.3 Safety
 **2 Access to care**	2.1 Impact on patient choice 2.2 Distance, cost and time to access services 2.3 Service operating hours
 **3 Workforce**	3.1 Scale of impact 3.2 Impact on recruitment, retention, skills
 **4 Value for money**	4.1 Forecast income and expenditure at system and organisation level 4.2 Capital cost to the system 4.3 Transition costs required 4.4 Net present value (10, 20 and 60 year)
 **5 Deliverability**	5.1 Expected time to deliver 5.2 Co-dependencies with other strategies/strategic fit

1 Proposed sub-criteria: Quality of care

Evaluation criteria	Questions to test
▪ Clinical effectiveness	▪ Will this option lead to people receiving equal or better quality care/outcomes of care in line with national standards and local or best practice? ▪ Will this option result in more effective prevention in order to improve life expectancy in the system and reduce health inequalities? ▪ Will this option account for future changes in the population size and demographics? ▪ Will this option lead to more people being treated by teams with the right skills and experience in the right place?
▪ Patient and carer experience	▪ Will this option improve continuity of care for patients? (e.g. reduce number of hand offs across teams / organisations, increase frequency of single clinician / team being responsibility for a patient)? ▪ Will this option enable greater opportunity to link with voluntary / community sector health and wellbeing services? ▪ Will this option improve quality of environment in which care is provided?
▪ Patient safety	▪ Will this option allow for patient transfers/emergency intervention within a clinically safe time-frame? Will travel time impact on patient outcome? ▪ Will this option offer reduced levels of risk (e.g., staffed 24/7 rotas, provide networked care, implement standardisation)?

Source: CSDDG, Patient and Public Liaison Groups, Steering Group

2 Proposed sub-criteria: Access to care

Evaluation criteria	Questions to test
▪ Impact on patient choice	▪ Does this option increase or decrease choice for patients? ▪ Will this option make it easier for people to understand which services they can access when and where?
▪ Distance, cost and time to access services	▪ Will this option increase/reduce travel time and/or cost for patients to access specific services? ▪ Will this option involve patients travelling more/less frequently, change the number of journeys to access urgent medical intervention? ▪ Will this option reduce/increase patients' waiting time to access services? ▪ Will this option increase/reduce travel time and/or cost for carers and family? ▪ Will this option support the use of new technology to improve access?
▪ Service operating hours	▪ Will this option improve operating hours in line with the needs of the population? ▪ Does the option reduce the risk of unplanned changes and improve service resilience?

Source: CSDDG, Patient and Public Liaison Groups, Steering Group

3 Proposed sub-criteria: Workforce

Evaluation criteria	Questions to test
▪ Scale of impact	▪ What proportion of current staff will be impacted by the changes across the system?
▪ Impact on recruitment, retention, skills	▪ Will this option improve the recruitment and retention of permanent staff with the right skills, values and competencies? Will it enable staff to maintain or enhance competencies? (e.g., impact on volumes of activity / specialism; increased training / opportunity for accreditation and career progression) ▪ Is the staff travel, relocation or retraining required for this option acceptable? ▪ Is it possible to develop the skills base required in an acceptable time frame? ▪ Will this option optimize the use of clinical staff and enable them to work at the "top of their license"? ▪ Will this option enable accountability and governance structures to support staff? ▪ Will this option increase multi-disciplinary / cross-organisational working?

Source: CSDDG, Patient and Public Liaison Groups, Steering Group

4 Proposed sub-criteria: Finance/value for money

Evaluation criteria	Questions to test
▪ Costs & income	▪ What are the implications on income and expenditure for each acute Trust within the system? ▪ Does this option reduce the requirement for additional provider subsidy? ▪ What are the implications for total acute spend across the health and care system? ▪ What are the opportunities for investing in more appropriate / alternative settings of care?
▪ Capital cost to the system	▪ What would the capital costs be to the system of each option, including refurbishing or rebuilding capacity in other locations? ▪ Can the required capital be accessed and will the system be able to afford the necessary financing costs?
▪ Transition costs	▪ What are the transition costs (e.g., relocating staff, training and education costs)?
▪ Net present value	▪ What is the 10, 20 and 60 year NPV (net present value) of each option, taking into account capital costs, transition costs and operating costs?

Source: CSDDG, Patient and Public Liaison Groups, Steering Group

5 Proposed sub-criteria: Deliverability

Evaluation criteria	Questions to test
▪ Expected time to deliver	▪ Is this option deliverable within 5 years? ▪ How quickly could this option deliver benefits?
▪ Co-dependencies	▪ Is this option compatible with the Healthier Together STP vision? ▪ Does this option support the Healthy Weston vision? ▪ Does this option enable the system to maximise the role of and adapt to new technologies? ▪ Will this option rely on other models of care / provision being put in place and if so, are these deliverable within the necessary timeframe? ▪ Will the wider system be able to deliver on this change including the community and voluntary sector? Can the additional capacity requirements be delivered? Will it destabilize any other providers in a way that can not be managed (e.g. cost, safety)? ▪ Does the system have access to the infrastructure, capacity and capabilities to successfully implement this option?

Source: CSDDG, Patient and Public Liaison Groups, Steering Group

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Evaluation criteria – Section 2 PPRG input

Comments from Public and Patient Reference Group from August 2018 are shown in red in the following slides to demonstrate how the Public and Patient Reference Group has fed into the evaluation criteria.

Proposed evaluation criteria

Evaluation criteria	Defined as
1 **Quality of Care**	1.1 Clinical effectiveness 1.2 Patient and carer experience 1.3 Safety
2 **Access to care**	2.1 Impact on patient choice 2.2 Distance and time to access services 2.3 Service operating hours
3 **Workforce**	3.1 Scale of impact 3.2 Impact on workforce (e.g. recruitment, retention, skills)
4 **Value for money**	4.1 Forecast income and expenditure at system and organisation level 4.2 Capital cost to the system 4.3 Transition costs required 4.4 Net present value (10, 20 and 60 year)
5 **Deliverability**	5.1 Expected time to deliver 5.2 Sustainability 5.3 Co-dependencies with other strategies/strategic fit

1 Proposed sub-criteria: Quality of care

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Evaluation criteria	Questions to test
▪ Clinical effectiveness	▪ Will this option lead to ~~patients~~ people ~~across BNSSG~~ receiving equal or better quality care/outcomes of care ~~and operate~~ in line with national standards or best practice? ▪ Will this option result in more effective prevention in order to improve life expectancy in the system and reduce health inequalities? ▪ Will this option account for future changes in the population size and demographics? ▪ Will this option lead to ~~patients~~ people being treated ~~in a site with appropriate staffing and activity~~ by teams with the right skills and experience?
▪ Patient and carer experience	▪ Will this option improve continuity of care for patients? (e.g., reduce number of hand offs across teams / organisations, increase frequency of single clinician / team being responsibility for a patient)? ▪ Wil this option enable greater opportunity to link with voluntary / community sector health and wellbeing services? ▪ Will this option improve quality of environment in which care is provided? ~~for patients?~~
▪ Patient safety	▪ Will this option allow for patient transfers/emergency intervention within a clinically safe time-frame? ▪ Will travel time impact on patient outcome? ▪ Will this option offer reduced levels of risk (e.g., staffed 24/7 rotas, provide networked care, implement standardization)?

Source: Health Weston Clinical Service Design & Delivery Group - July 26 and August 9 2018 Workshops

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2 Proposed sub-criteria: Access to care

Evaluation criteria	Questions to test
▪ Impact on patient choice	▪ Will this option support informed patient choice? (Note: may not be applicable to emergency situations)? ▪ Will this option enable ~~Is the option simple enough for~~ a person to know which services they can access when and where?
▪ Distance and time to access services	▪ Will this option increase/reduce travel time and/or cost for patients to access specific services? ▪ Will this option involve patients travelling more/less frequently, change the number of journeys to access urgent medical intervention? ▪ Will this option reduce/increase patients' waiting time to access services? ▪ Will this option increase/reduce travel time and/or cost for carers and family? ~~improve carer and family travel time?~~ ▪ Does this option maximise the use of new technology to improve access?
▪ Service operating hours	▪ Will this option improve operating hours for the service? ▪ Does the option reduce the risk of unplanned changes and improve service resilience? ~~pre-emptive action such as temporary A&E closure due to lack of service scale?~~

Source: Health Weston Clinical Service Design & Delivery Group - July 26 and August 9, 2018 Workshops

3 Proposed sub-criteria: Workforce

Evaluation criteria	Questions to test
▪ Scale of impact	▪ How many staff will be impacted by the changes across the system?
▪ Impact on workforce	▪ Will this option improve the recruitment and retention of ~~availability of~~ permanent staff with the right skills, values and competencies? Will it enable staff to maintain or enhance competencies? (e.g., impact on volumes of activity / specialism; increased training / opportunity for accreditation) ▪ Is the staff travel, relocation or retraining required for this option acceptable and sustainable? ▪ Is it possible to develop the skills base required in an acceptable time frame? ▪ ~~Will this option reduce use of temporary workforce? Will this option increase attractiveness to all staff?~~ ▪ Will this option optimize use of staff? ▪ ~~Will it enable recruitment of new staff?~~ ▪ Will this option enable accountability and governance structures to support staff

Source: Health Weston Clinical Service Design & Delivery Group - July 26 and August 9, 2018 Workshops

4 Proposed sub-criteria: Finance/value for money

Evaluation criteria	Questions to test
▪ Costs & income	▪ What are the implications for the distribution and total spend within the system? ▪ What are the implications for income and expenditure for each acute Trust (? and SWAST) within the system?
▪ Capital cost to the system	▪ What would the capital costs be to the system of each option, including refurbishing or rebuilding capacity in other locations? ▪ Can the required capital be accessed and will the system be able to afford the necessary financing costs?
▪ Transition costs	▪ What are the transition costs (e.g., relocating staff, training and education costs)?
▪ Net present value	▪ What is the 10, 20 and 60 year NPV (net present value) of each option, taking into account capital costs, transition costs and operating costs?

Source: Health Weston Clinical Service Design & Delivery Group - July 26 and August 9, 2018 Workshops

Healthy Weston Pre-Consultation Business Case

Appendix 14: Technical Data to support the Case for Change

Healthier Together

Improving health and care in Bristol,
North Somerset and South Gloucestershire

HEALTHY WESTON

Healthy Weston: Data to support the Case for Change for services provided at Weston General Hospital

FINAL VERSION

Introduction

Context and purpose

- This document draws together data which supports the case for change to ensure a vibrant and dynamic future for WGH as part of a sustainable integrated local health and care system that meets local people's needs in the long term. While primarily produced for a 'professional' audience, it will be a public document and a separate public facing summary will also be produced for wider use
- The Commissioning Context for North Somerset published in October 2017 set out the intent to work in close collaboration with local providers, key stakeholders, service users and the public to co-design a model of care focusing on primary care (General Practice) working at scale & providing strong system leadership; stronger, more integrated community services and a stronger, more focused hospital in Weston. It recognised the long standing issues and the need to secure a clinically and financially sustainable model of care
- Through the co-design work with health and social care colleagues, the public, patients and partners from the voluntary, community and social enterprise sector opportunities for change to better meet the needs of the local population were considered. In parallel, Weston Area Health Trust and University Hospitals Bristol Trust commissioned specific work to inform their intent to explore a merger. This showed that improving efficiency and market share alone would not lead to a sustainable future for WGH

What is included?

The document is focusing on the case for change for services for the Weston Area population, drawing on:

- Data on population and population health, which is generally at a Local Authority level e.g. North Somerset
- Primary and community care service data
- Hospital service data
- Information captured through patient and public insight and feedback

Wherever possible it has used the **most recent data** from publicly available sources (e.g. NHS Digital) or from local sources where available at the point in time in preparing this document. This is not consistently of the exact same time period– e.g. national activity data is from 2016/17 while local data is from 2017/18.

Comparisons are made against **England national average / quartiles / deciles** and against **peer group** CCGs / local populations with similar characteristics (e.g. Somerset, BaNES), or neighbouring Trusts with similar population flows (e.g. UHB, NBT, T&S)

What is not included?

- Data supporting a case for change across the **entire BNSSG or STP area** – the focus is on the sustainability of services for the wider Weston Area population only
- **Detailed recommendations for service transformation** – these will be developed as part of the Healthy Weston Programme with input from clinicians, patients and other stakeholders
- Evidence base and case for **best practice**
- Any **patient identifiable data** or non-anonymised information

Executive Summary

Why we need to change

1. **Changing health needs:** Our population is growing, getting older, living with more long term conditions and there are significant inequalities in health

2. **Variations in care and access in primary and community care:** There are differences in the way care is currently provided, with some patients finding access more difficult than others

3. **Meeting national clinical quality standards:** Some services at Weston General Hospital don't have sufficient volumes of certain cases and there is a shortage of specialist staff

4. **Getting value for money:** We must live within our financial means and make sure we use our available resources most effectively to meet local needs

Case for Change

- **Local population and their health and care needs**
- Acute care
- Out of hospital: Primary care
- Out of hospital: Community, mental health and social care
- Out of hospital: Ambulance services
- Financial position

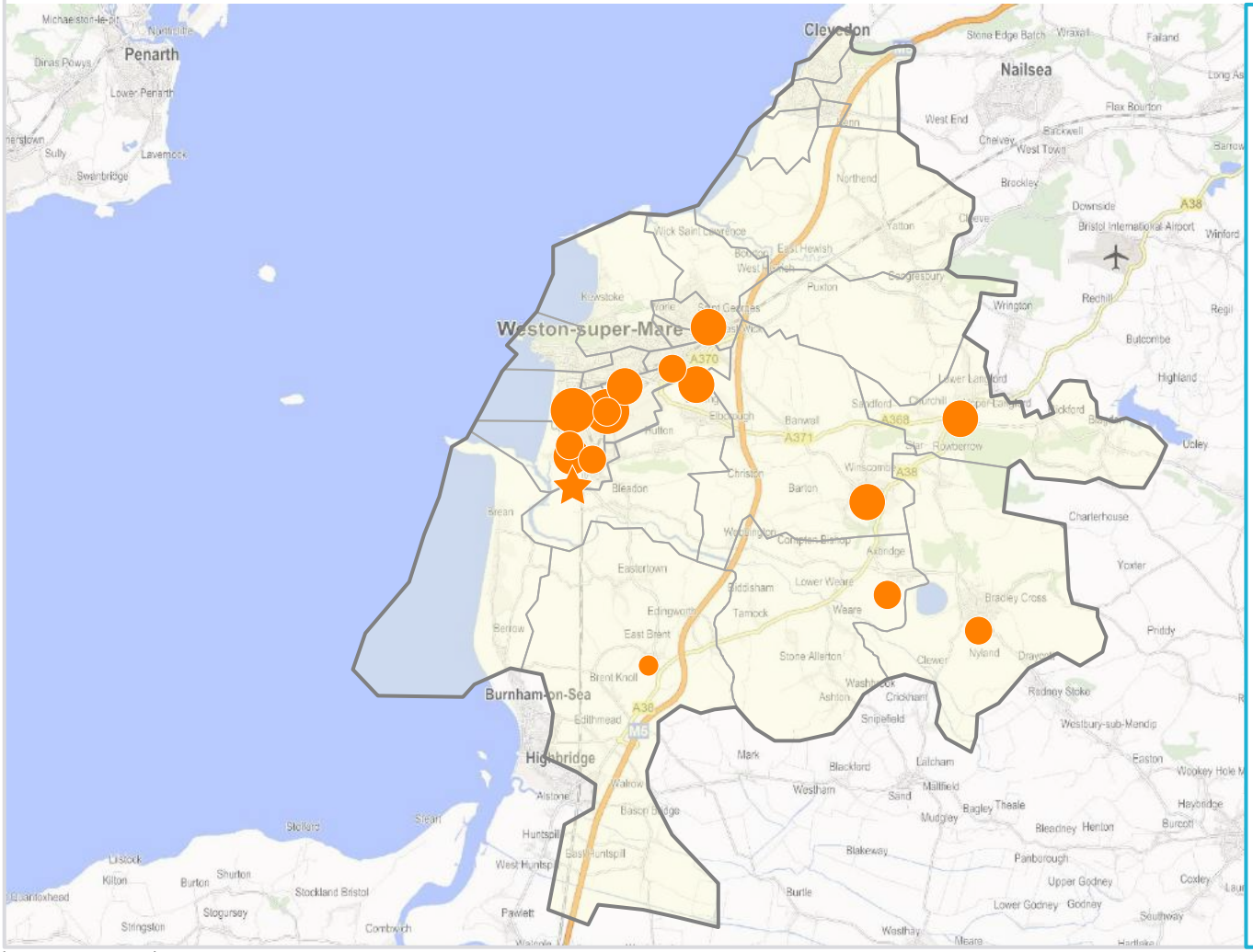
The current catchment population of WAHT is ~ 150,000, as determined by registered population of referring practices for A&E

GP practice weighted pop'n

5,000 — 16,000

Proposed catchment

The catchment area, based on the primary A&E that local GPs refer to, consists of 4 Somerset wards and 21 North Somerset wards



Somerset County

- Berrow
- Knoll
- Axevale
- Cheddar and Shipham

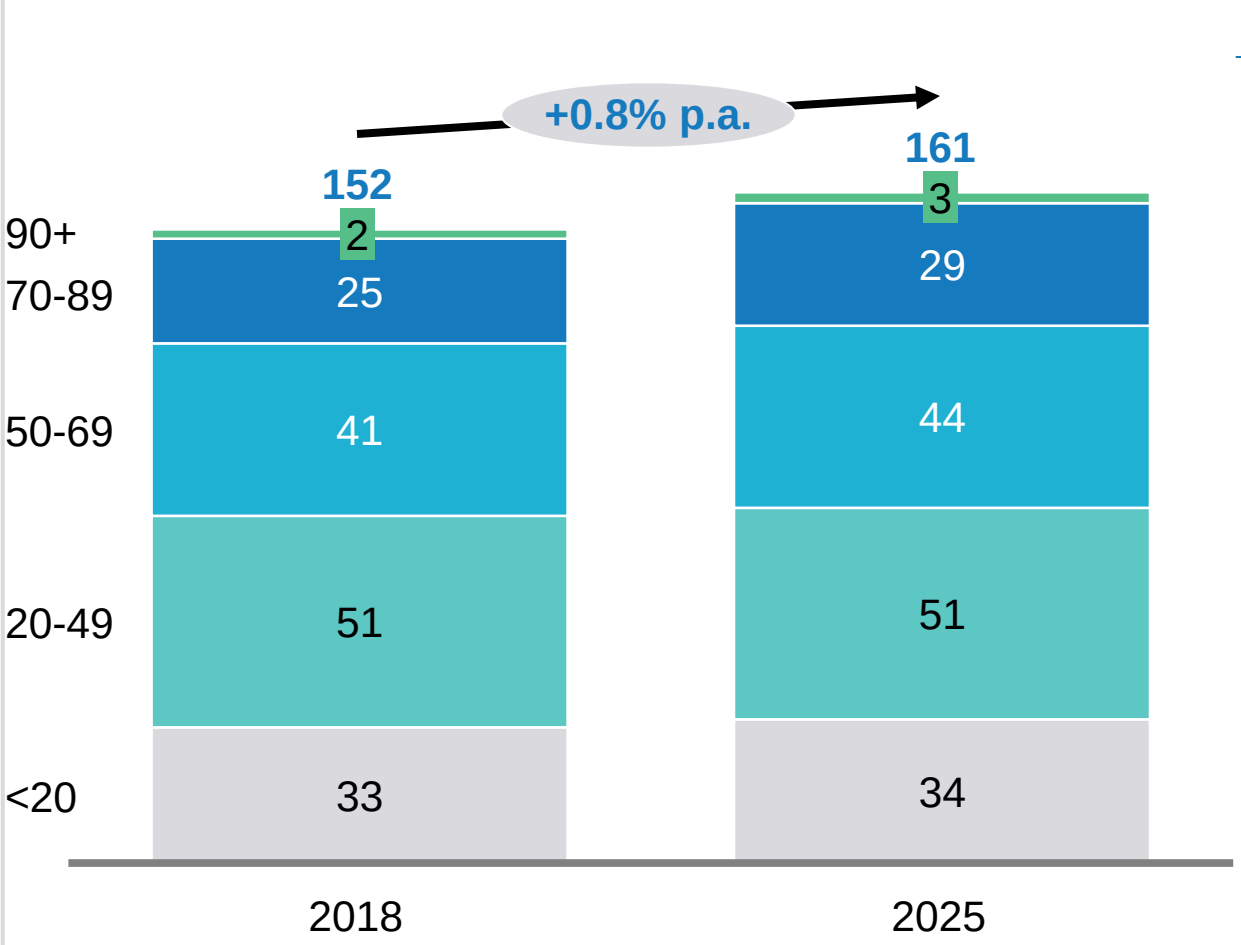
North Somerset

- Blagdon and Churchill
- Congresbury and Puxton
- Yatton
- Clevedon East
- Clevedon Walton
- Clevedon West
- Clevedon South
- Clevedon Yeo
- Wick St Lawrence and St Georges
- Weston-super-mare North Worle
- Weston-super-mare Mid Worle
- Weston-super-mare South Worle
- Hutton and Locking
- Weston-super-mare Uphill
- Weston-super-mare Central
- Weston-super-mare Hillside
- Weston-super-mare Kewstoke
- Weston-super-mare Milton
- Weston-super-mare South
- Weston-super-mare Winterstoke
- Banwell and Winscombe

Source: HES 2016/17

The population across the catchment area is set to increase by ~ 0.8% p.a. by 2025 with higher increases in the over 70's

Population projection by age, area in scope, '000



2018-25 CAGR	WAHT catchment	England
90+	2.4%	2.6%
70-89	2.3%	2.0%
50-69	0.8%	0.9%
20-49	0.0%	-0.2%
<20	0.8%	0.7%

Source: ONS 2016-based Sub National Population Projections; catchment are defined as the following wards: Blagdon & Churchill, Congresbury & Puxton, Yatton, Clevedon East, Clevedon Walton, Clevedon West, Clevedon South, Clevedon Yeo, Wick St Lawrence & St Georges, Weston-super-mare North Worle, Weston-super-mare Mid Worle, Weston-super-mare South Worle, Hutton & Locking, Weston-super-mare Uphill, Weston-super-mare Central, Weston-super-mare Hillside, Weston-super-mare Kewstoke, Weston-super-mare Milton, Weston-super-mare Winterstoke, Banwell & Winscombe, Berrow, Knoll, Axevale, Cheddar and Shipham

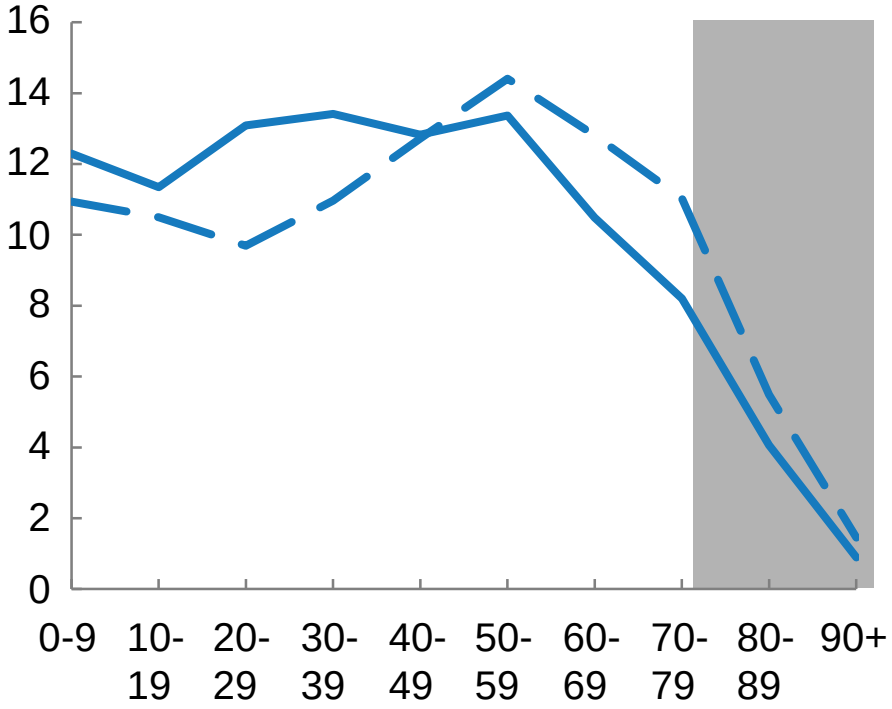
The population served by WAHT is older than the England average with 20% >70yrs by 2025

70+ years — England — Catchment

Age distribution of population, 2018

%

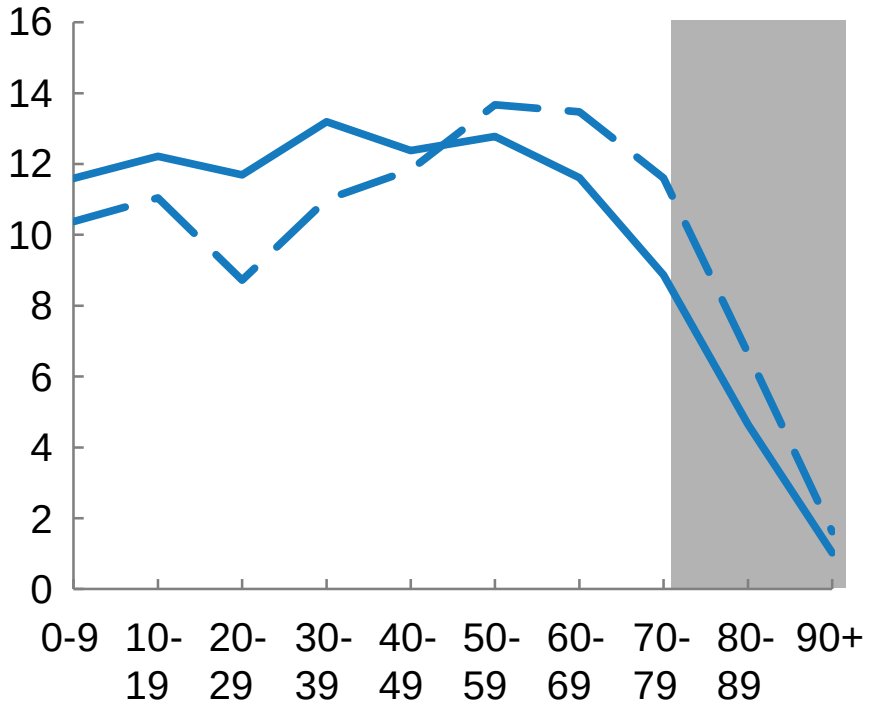
Catchment >70: **18.0%**
England >70: **13.2%**



Projected age distribution of population, 2025

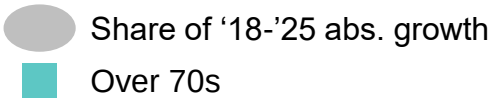
%

Catchment >70: **19.9%**
England >70: **14.5%**



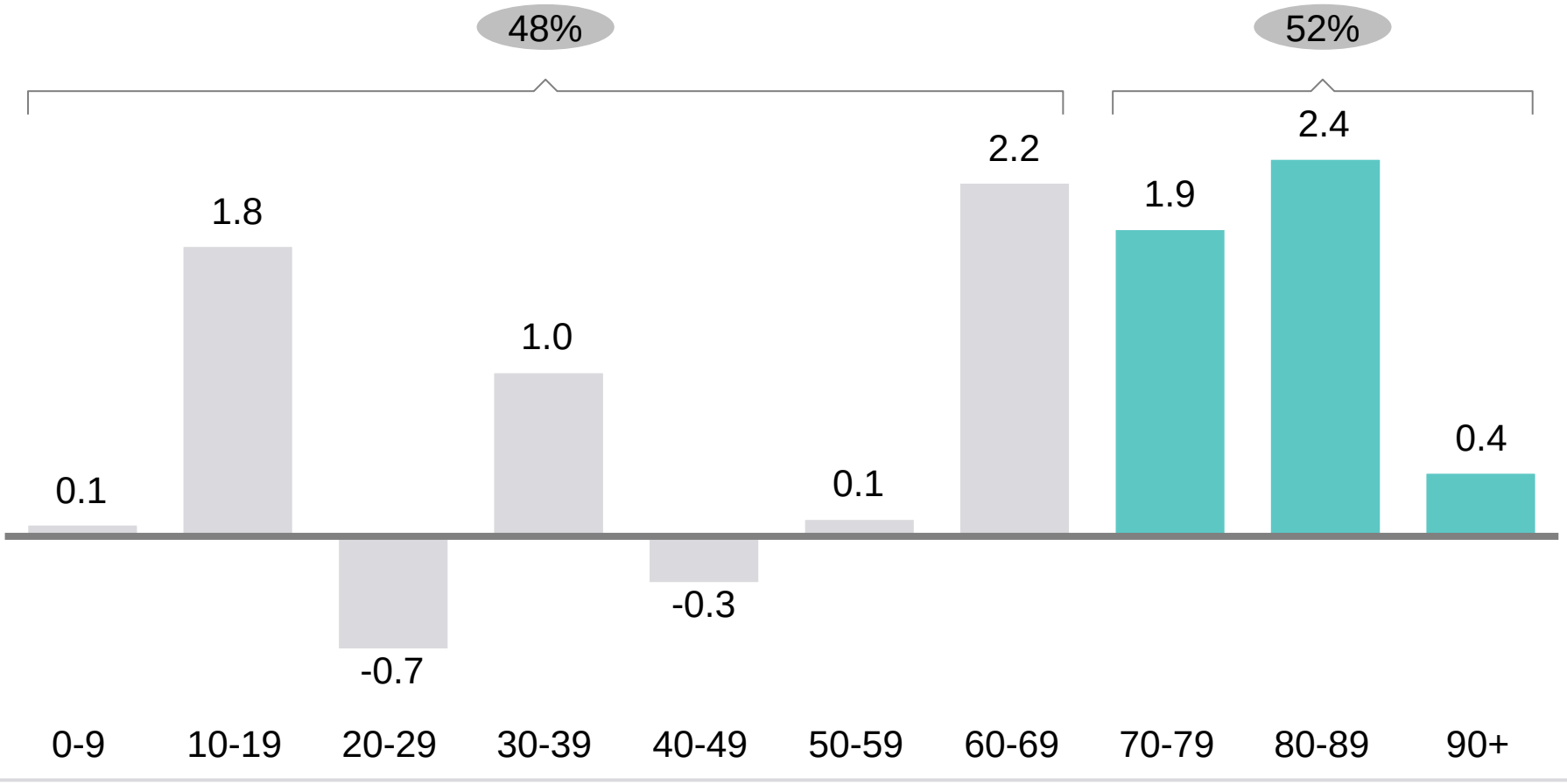
Source: ONS 2016-based Sub National Population Projections; catchment are defined as the following wards:Blagdon & Churchill, Congresbury & Puxton, Yatton, Clevedon East, Clevedon Walton, Clevedon West, Clevedon South, Clevedon Yeo, Wick St Lawrence & St Georges, Weston-super-mare North Worle, Weston-super-mare Mid Worle, Weston-super-mare South Worle, Hutton & Locking, Weston-super-mare Uphill, Weston-super-mare Central, Weston-super-mare Hillside, Weston-super-mare Kewstoke, Weston-super-mare Milton, Weston-super-mare Winterstoke, Banwell & Winscombe, Berrow, Knoll, Axevale, Cheddar and Shipham

Over half of the total population increase between 2018 and 2025 will be in the over 70's



Change in population, 2018 to 2025 by age bands

%



Source: ONS 2016-based Sub National Population Projections; catchment are defined as the following wards:Blagdon & Churchill, Congresbury & Puxton, Yatton, Clevedon East, Clevedon Walton, Clevedon West, Clevedon South, Clevedon Yeo, Wick St Lawrence & St Georges, Weston-super-mare North Worle, Weston-super-mare Mid Worle, Weston-super-mare South Worle, Hutton & Locking, Weston-super-mare Uphill, Weston-super-mare Central, Weston-super-mare Hillside, Weston-super-mare Kewstoke, Weston-super-mare Milton, Weston-super-mare Winterstoke, Banwell & Winscombe, Berrow, Knoll, Axevale, Cheddar and Shipham

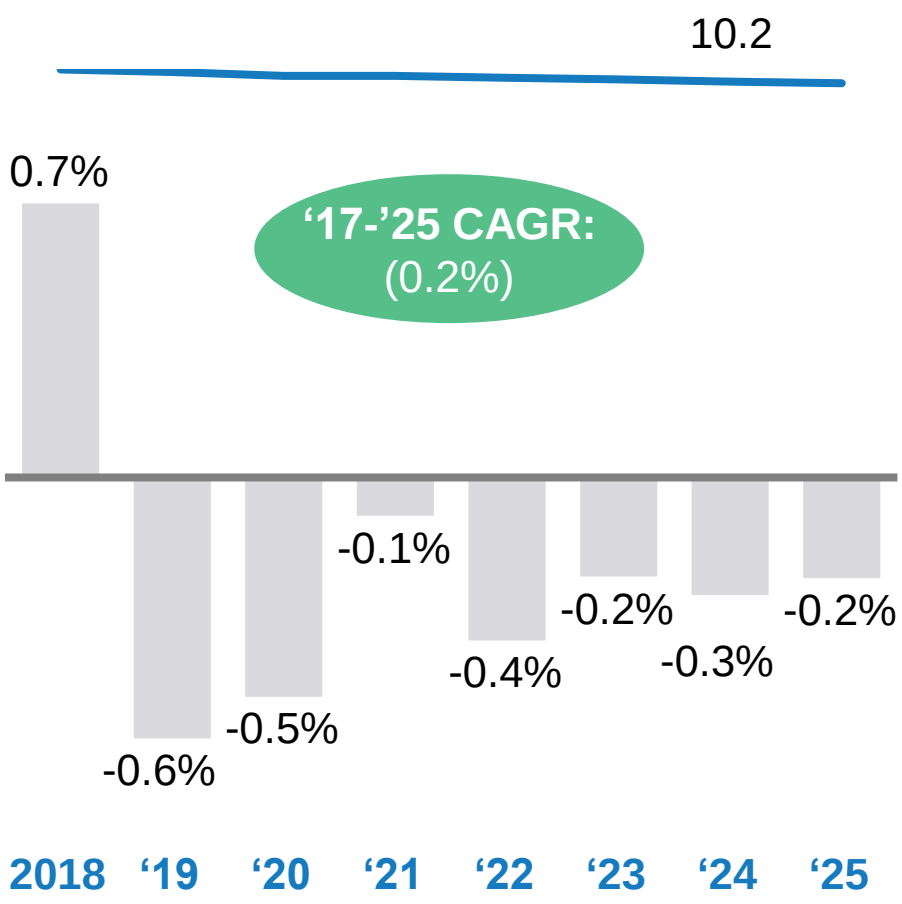
The birth rate is expected to decline 0.2% p.a. until 2025 in both North Somerset and Sedgemoor

HEALTHY WESTON

Birth rate per 1,000
Annual % change

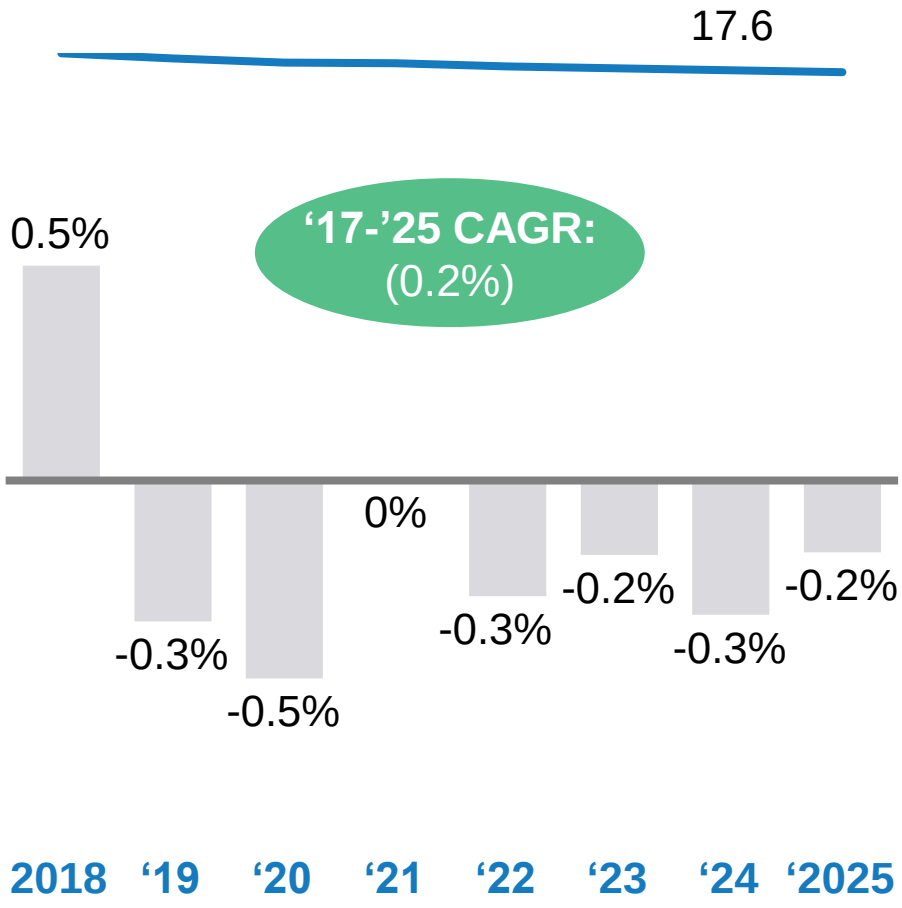
North Somerset birth rate evolution

Births per 1,000 inhabitants; annual % change in birth rate



Sedgemoor birth rate evolution

Births per 1,000 inhabitants; annual % change in birth rate



SOURCE: ONS 2016-based Sub National Population Projections

Healthier Together
Improving health and care in Bristol, North Somerset and South Gloucestershire

New housing developments in North Somerset are expected to create an additional 25,000 dwellings in the next 30 years

North Somerset 2006-36 development plans

Number of dwellings

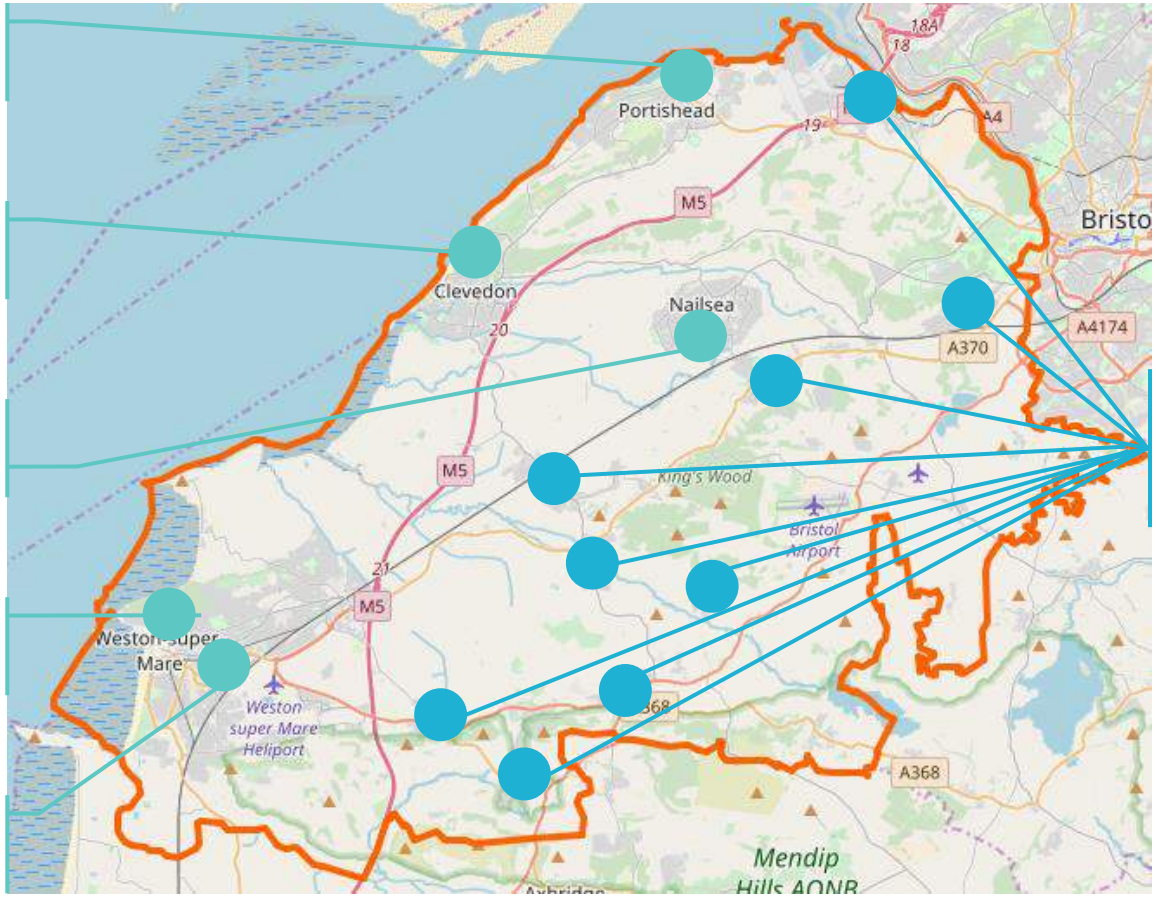
Portishead: 3,300

Clevedon: 700

Nailsea: 3,675

Weston Urban: 6,300

Weston Villages: 6,500



Service villages: 7,375

Other: 4,285

Total: 32,135
Already built: 7,053

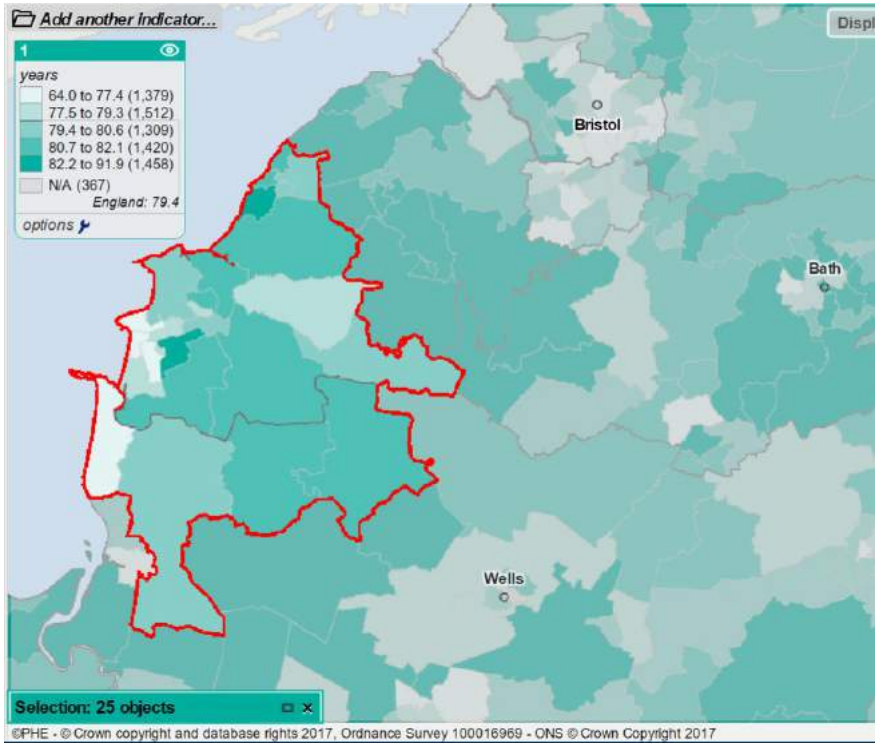
To be built: 25,082

SOURCE: North Somerset council "Core Strategy" and draft 2036 planning strategy, OpenStreetMap

Life expectancy in the WAHT catchment population is broadly in line with the England average, but varies by ward

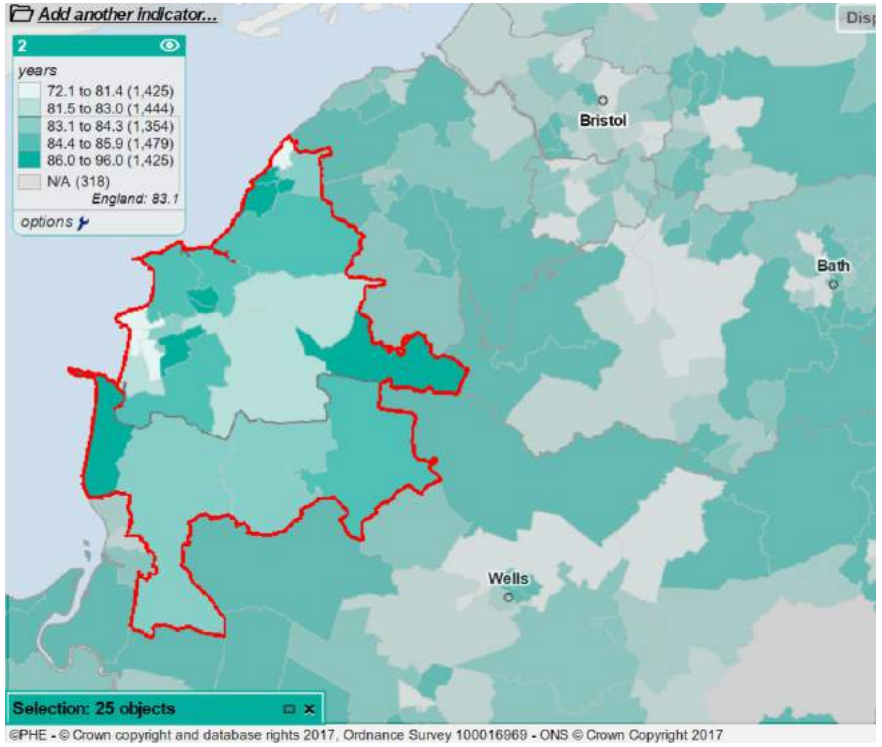
Life expectancy at birth for males, 2011-15 *(lighter colour is associated with lower life expectancy)*

Catchment area life expectancy: 79.9 years (England average 79.4)



Life expectancy at birth in females, 2011-15 *(lighter colour is associated with lower life expectancy)*

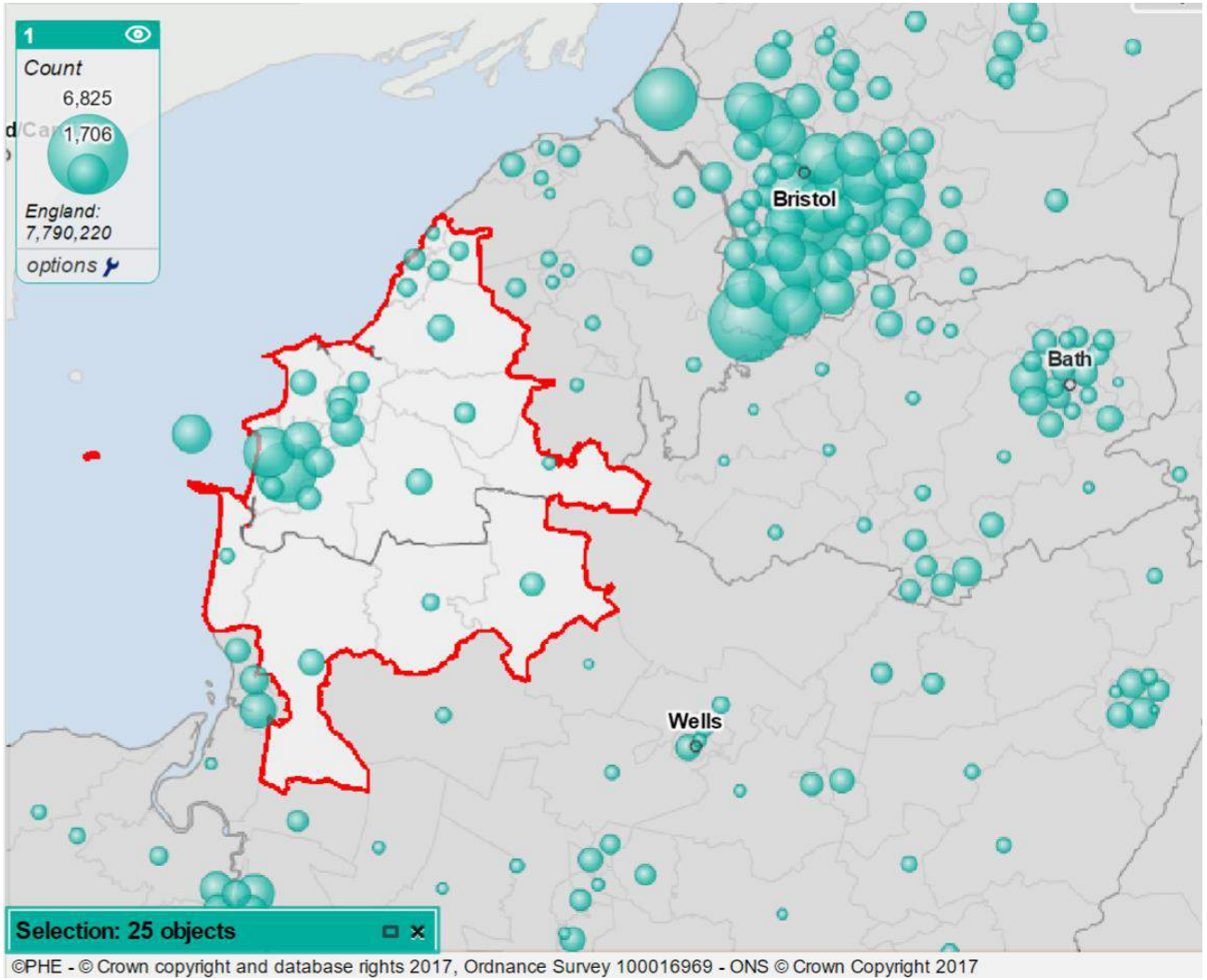
Catchment area life expectancy: 84.2 years (England average 83.1)



SOURCE: PHE local health tool, accessed online in July 2018 [http://www.localhealth.org.uk]

Pockets of deprivation exist, particularly around Weston-super-Mare town. There is also significant deprivation in Bristol

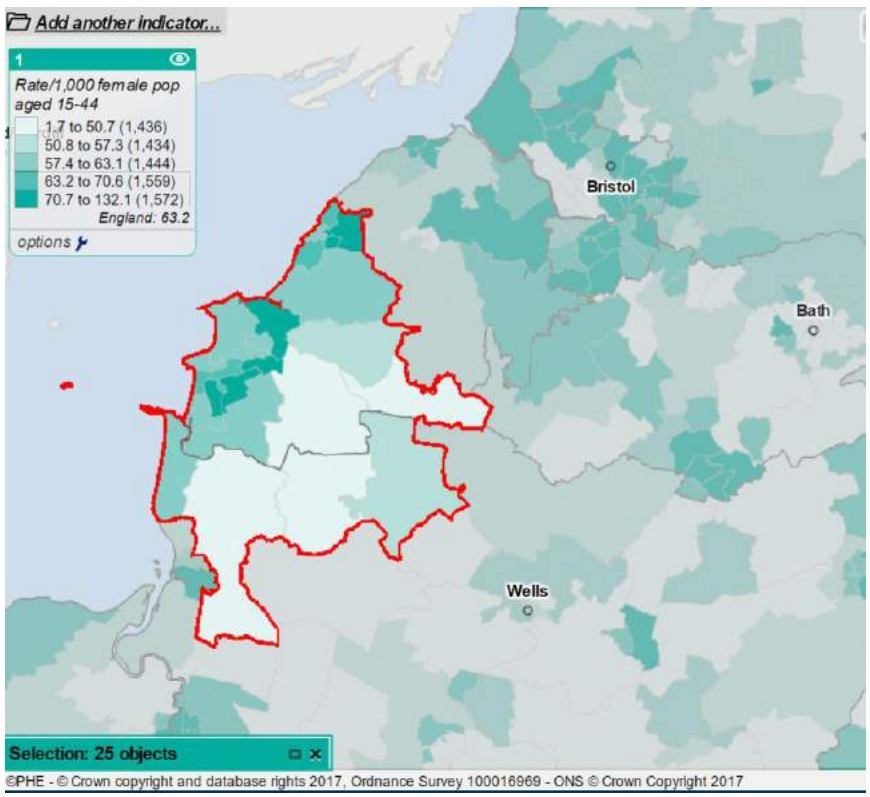
Income deprivation *(larger bubbles are associated with higher deprivation)*



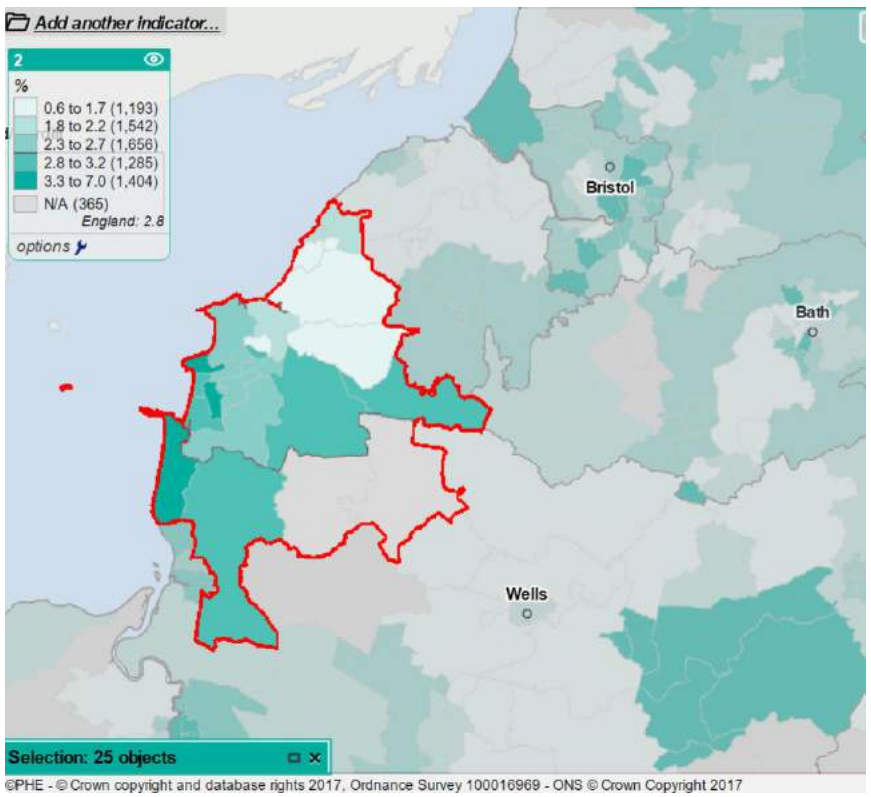
Source: PHE local health tool, accessed online in July 2018 [http://www.localhealth.org.uk]

There is limited overlap between those areas with high fertility rates and those with low birth weight term babies

Fertility rate *(darker areas indicate higher fertility rate per 1,000 female population)*



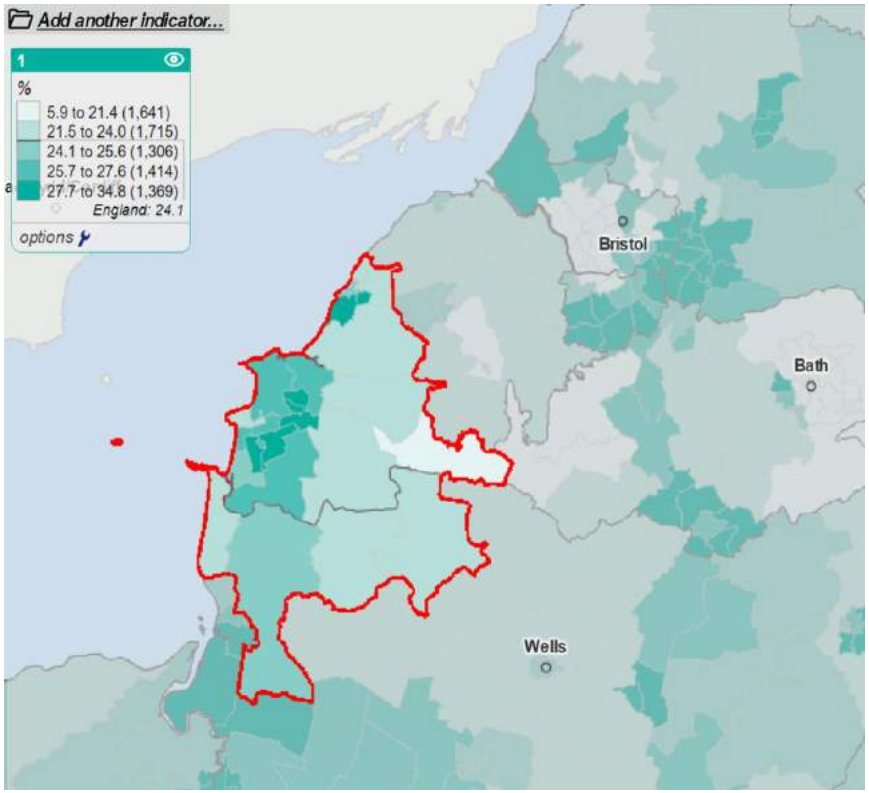
Low birth weight of term babies *(darker areas indicate higher %)*



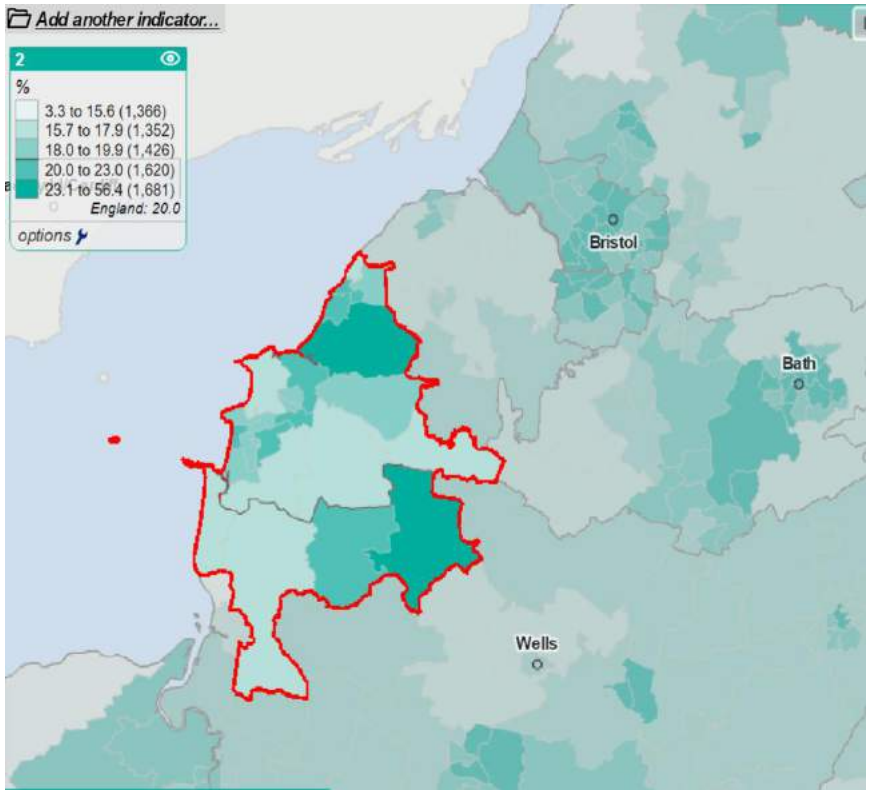
Source: PHE local health tool, accessed online in July 2018 [http://www.localhealth.org.uk]

Obesity and binge-drinking are particularly prevalent around Winterstoke and South Worle

Obese adults *(darker areas indicate a higher %)*



Binge drinking adults *(darker areas indicate higher %)*

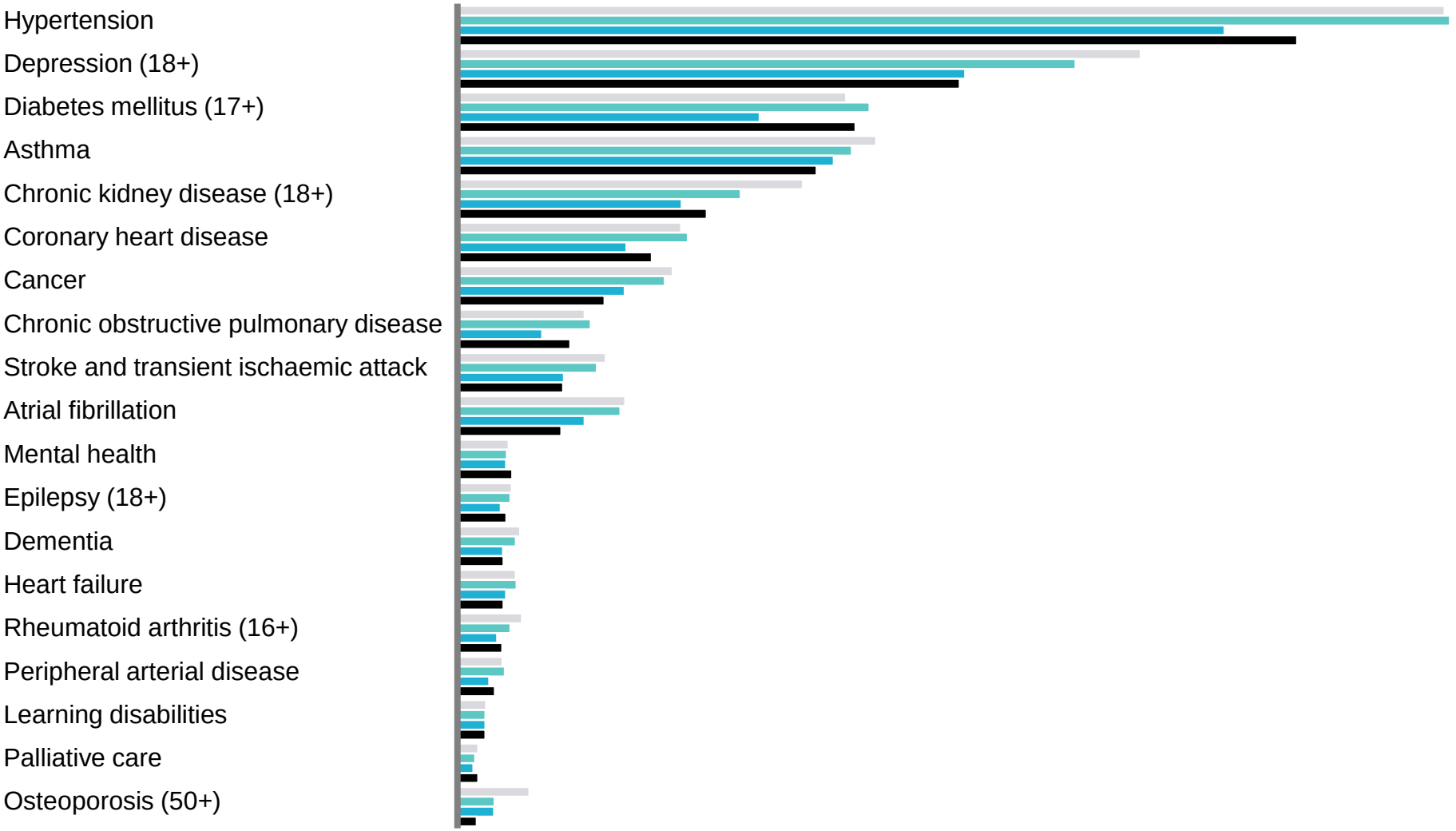


Source: PHE local health tool, accessed online in July 2018 [http://www.localhealth.org.uk]

Prevalence of diseases in North Somerset is broadly similar to peer CCGs and England average

NS Somerset BaNES England Average

Prevalence of diseases – NS, Somerset and BaNES vs. England average, % of population[1], 2016/17



1 Percentage of age-specific group for Diabetes (ages 17), Depression (18+), Learning Disabilities (ages 18+)

Source: QOF 2016/17—Prevalence, achievements and exceptions at CCG level

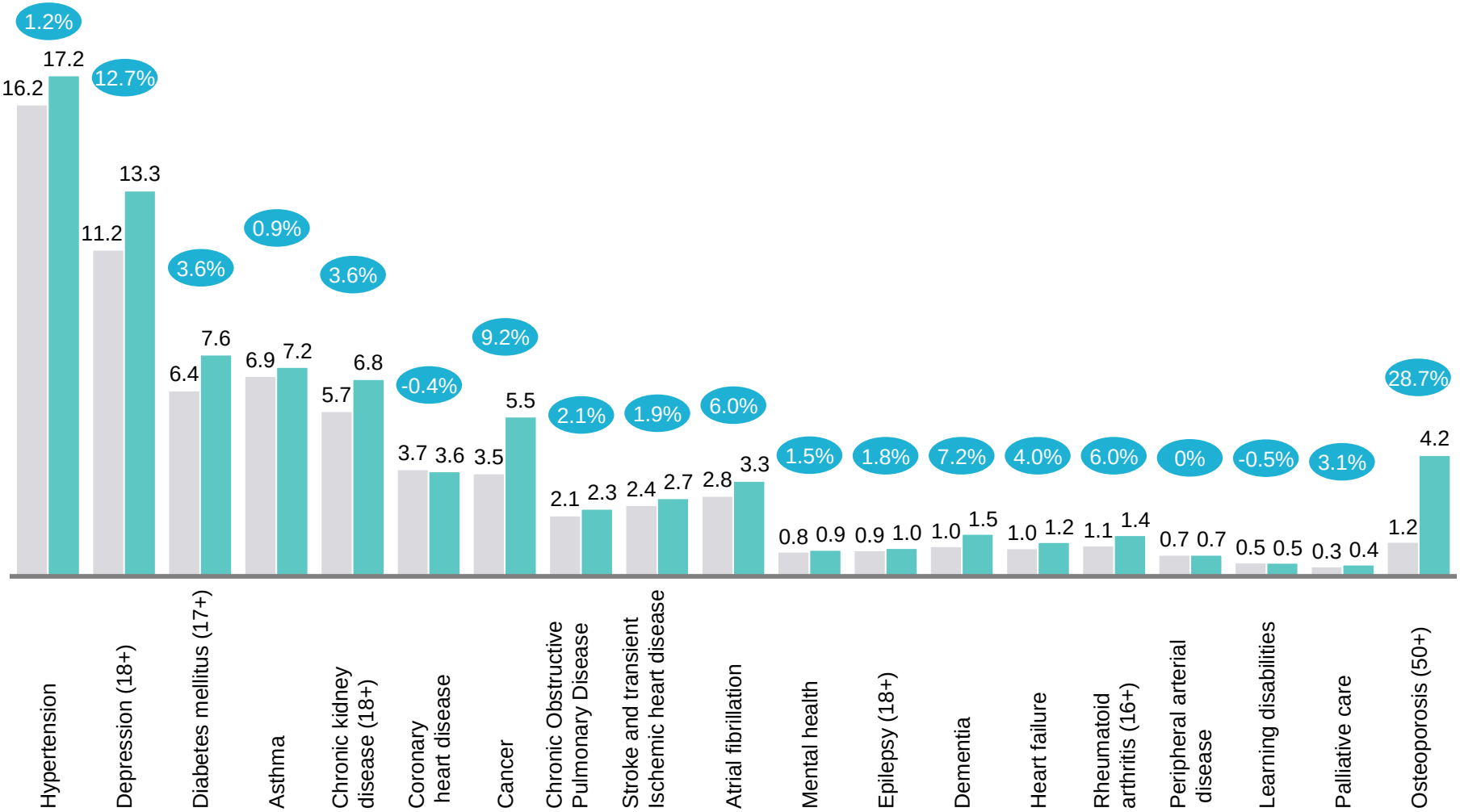
Projected trends in disease prevalence over time—North Somerset

x% CAGR, based on historical growth over 5 years (from 2012/13 - 2016/17)

2016/17 2021/22

Prevalence of disease and projection based on historical trends

Percent, 2016/17 – 2021/22



Source: QOF 2016/17—Prevalence, achievements and exceptions at CCG level

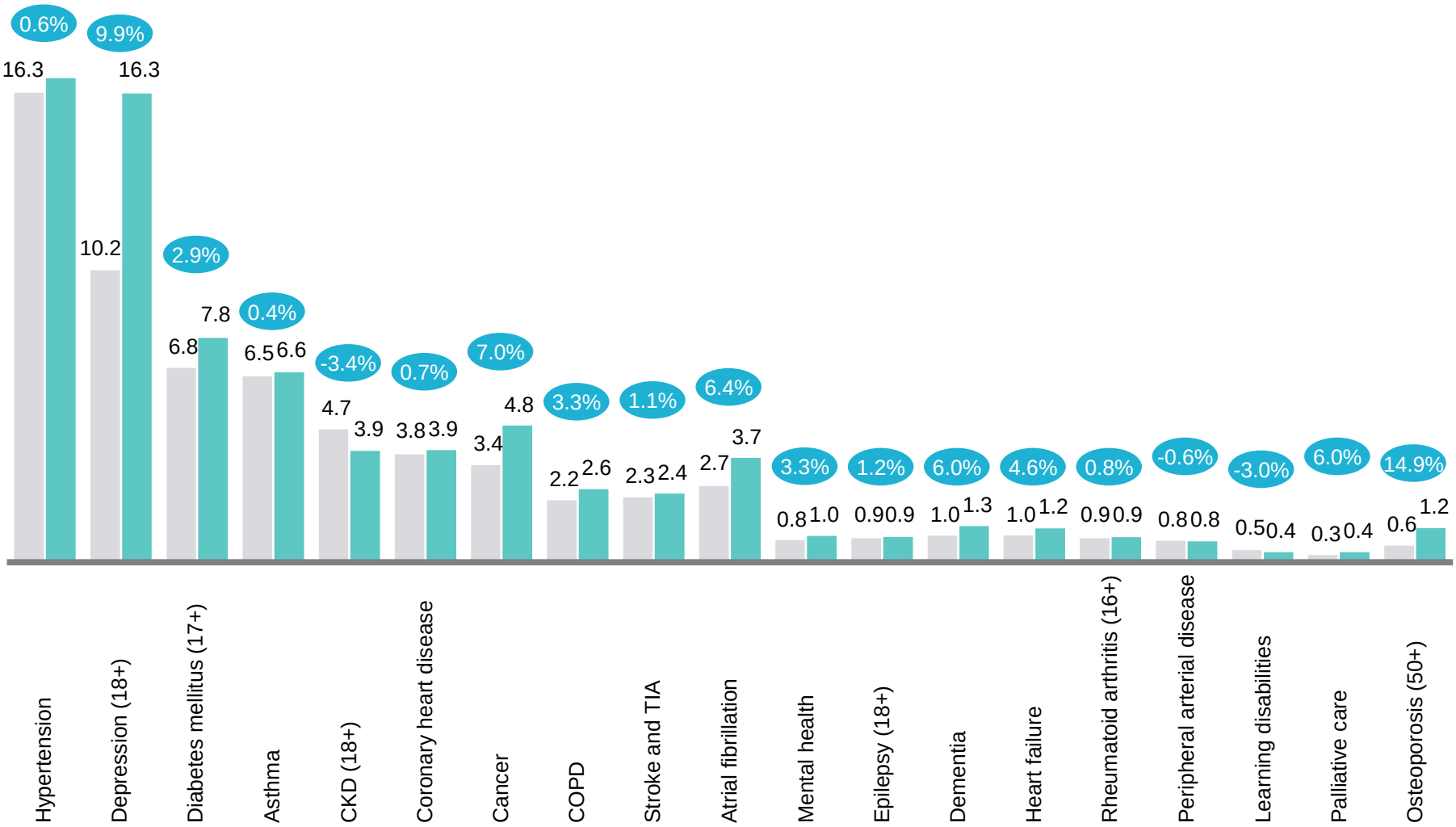
Projected trends in disease prevalence over time—Somerset

x% CAGR, based on historical growth over 5 years (from 2012/13 - 2016/17)

2016/17 2021/22

Prevalence of disease and projection based on historical trends

Percent, 2016/17 – 2021/22



Source: QOF 2016/17—Prevalence, achievements and exceptions at CCG level

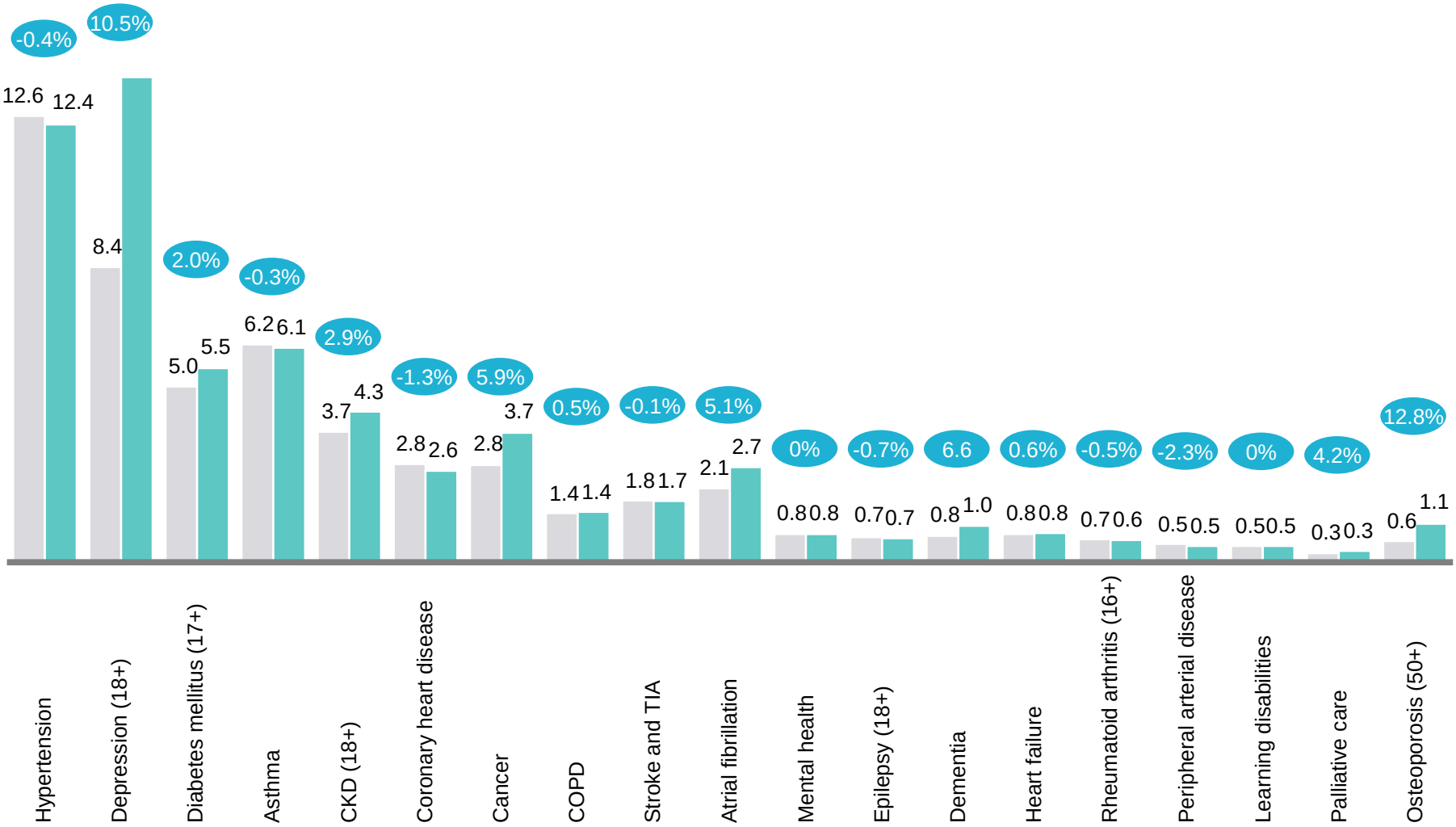
Projected trends in disease prevalence over time—Bath & North East Somerset

x% CAGR, based on historical growth over 5 years (from 2012/13 - 2016/17)

2016/17 2021/22

Prevalence of disease and projection based on historical trends

Percent (absolute), 2016/17 – 2021/22



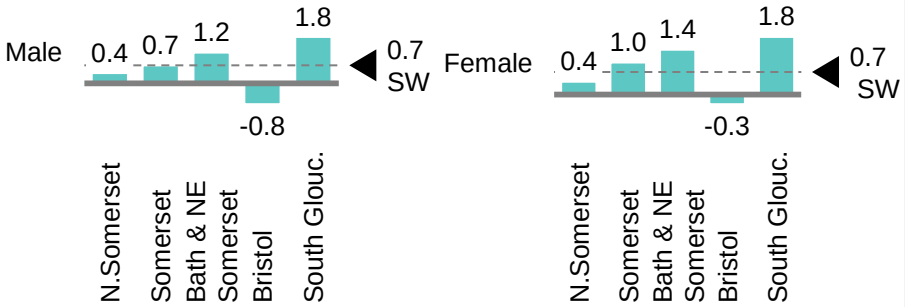
Source: QOF 2016/17—Prevalence, achievements and exceptions at CCG level

Regional performance varies across mortality, life expectancy, preventable deaths indicators

Better than National avg

Worse than National avg

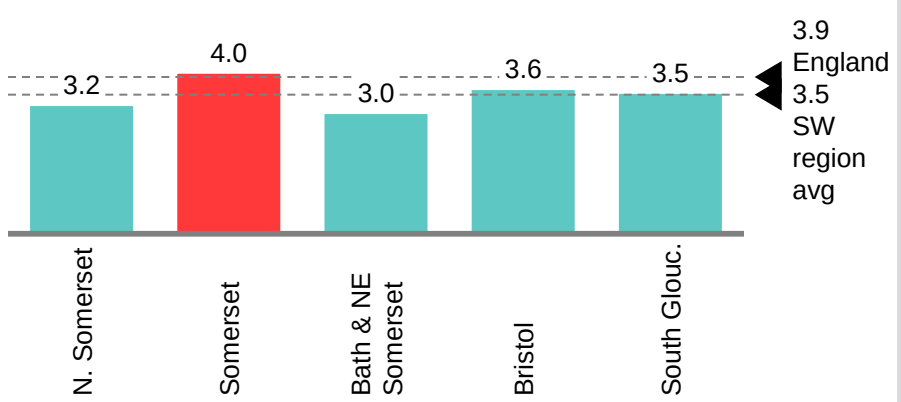
Gap in life expectancy at birth between each local authority and England as a whole



- A positive figure shows that the area has a higher life expectancy than England
- 0.7 is the avg gap for male and female for South West region

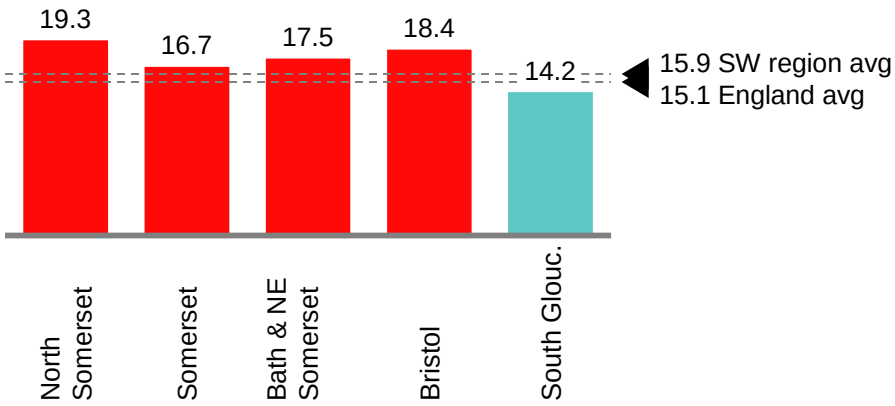
Infant mortality

Rate of deaths in infants aged under 1 year per 1,000 live births



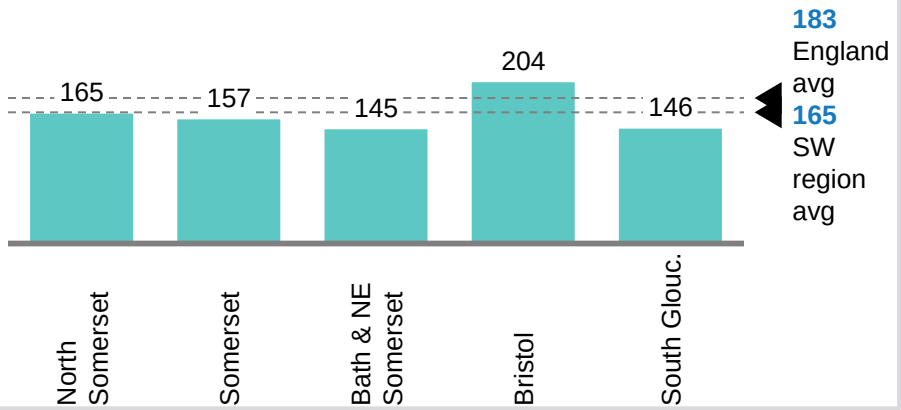
Excess winter deaths

Index, single year, all ages



Mortality rate from all preventable causes

Age-standardised rate per 100,000 population



Source: Public Health Outcomes Framework, 2014/16, Healthcare and Premature Mortality

Case for Change

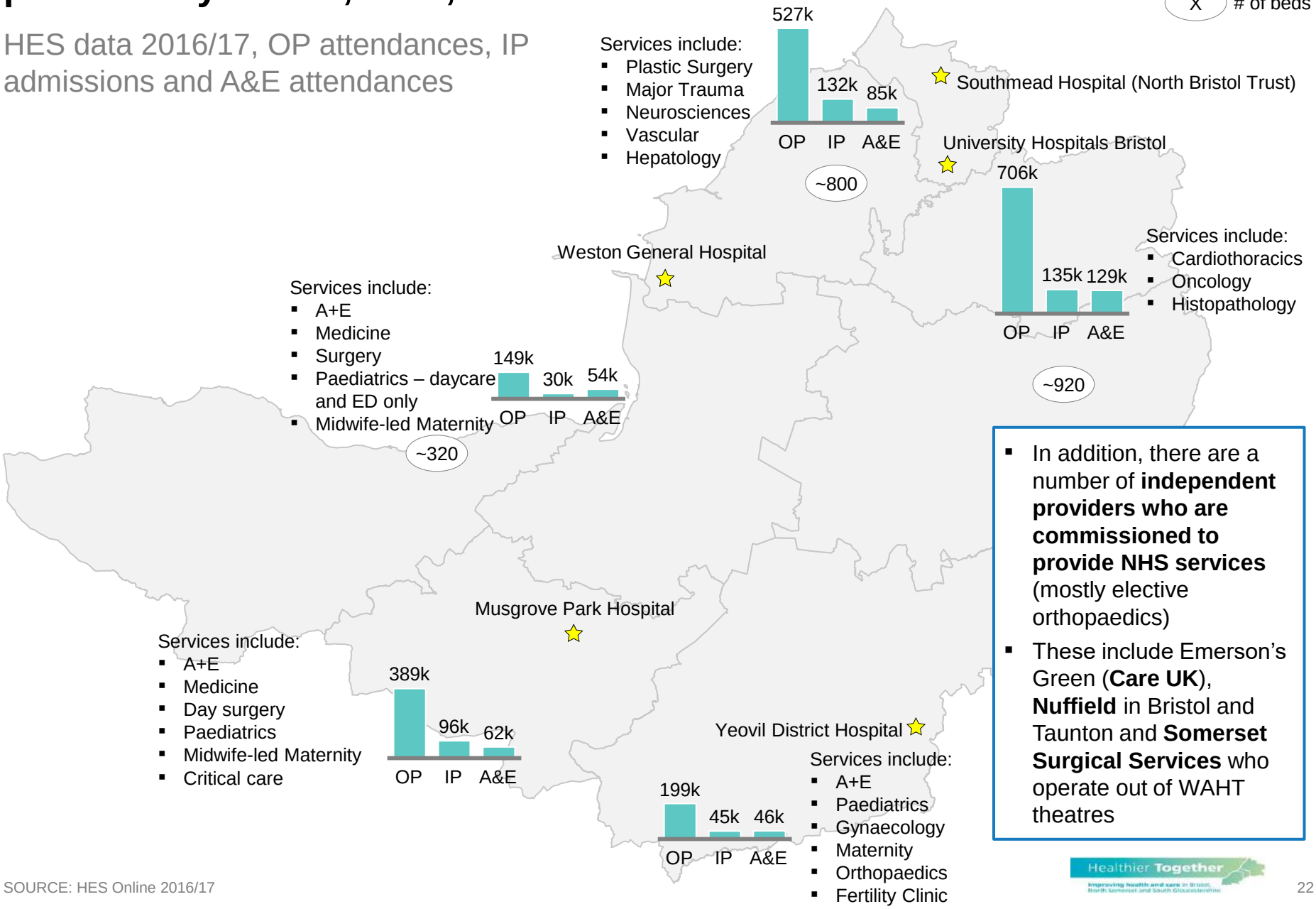
- Local population and their health and care needs
- **Acute care**
- Out of hospital: Primary care
- Out of hospital: Community, mental health and social care
- Out of hospital: Ambulance services
- Financial position

Acute hospital care for the Weston catchment population is provided by WAHT, UHB, NBT and T&S

HES data 2016/17, OP attendances, IP admissions and A&E attendances

HEALTHY WESTON

X # of beds



- In addition, there are a number of **independent providers who are commissioned to provide NHS services** (mostly elective orthopaedics)
- These include Emerson's Green (**Care UK**), **Nuffield** in Bristol and Taunton and **Somerset Surgical Services** who operate out of WAHT theatres

SOURCE: HES Online 2016/17

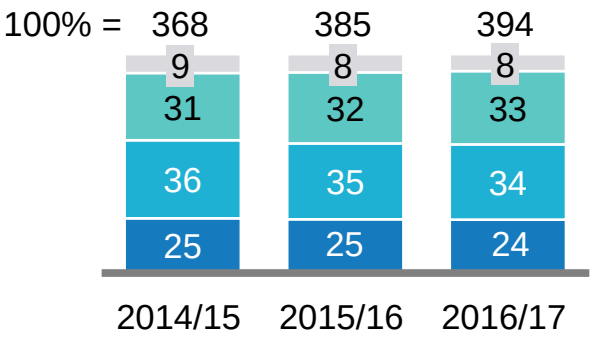
Healthier Together

Share of acute activity by Trust

WAHT UHB NBT T&S

Yearly activity by trust

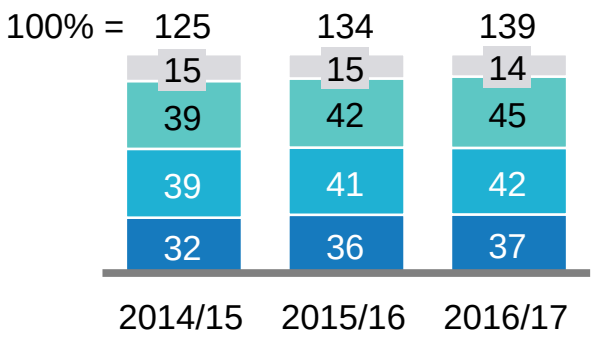
Total Inpatient Admissions
% (100% in 'k)



Activity Growth
% CAGR

3% -3% 8% 1% 2%

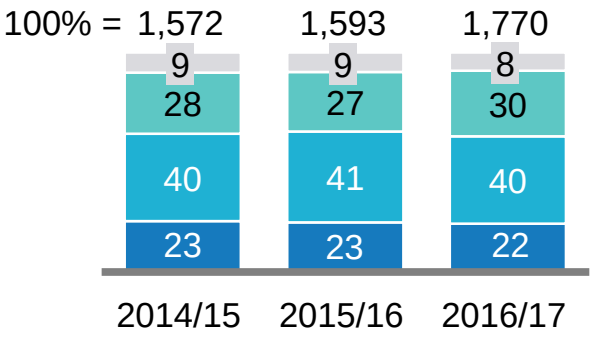
Emergency Inpatient Admissions
% (100% in 'k)



Activity Growth
% CAGR

5% -4% 8% 4% 9%

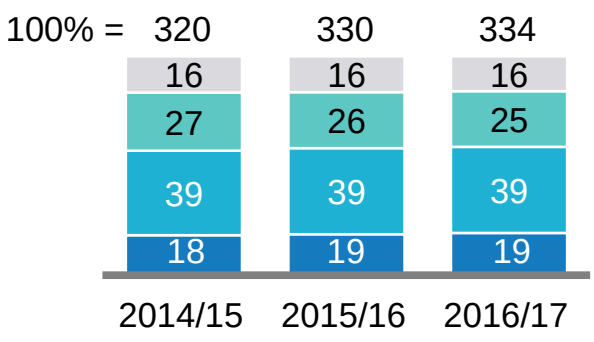
Outpatient Attendances
% (100% in 'k)



Activity Growth
% CAGR

6% 2% 9% 6% 3%

A&E Attendances
% (100% in 'k)



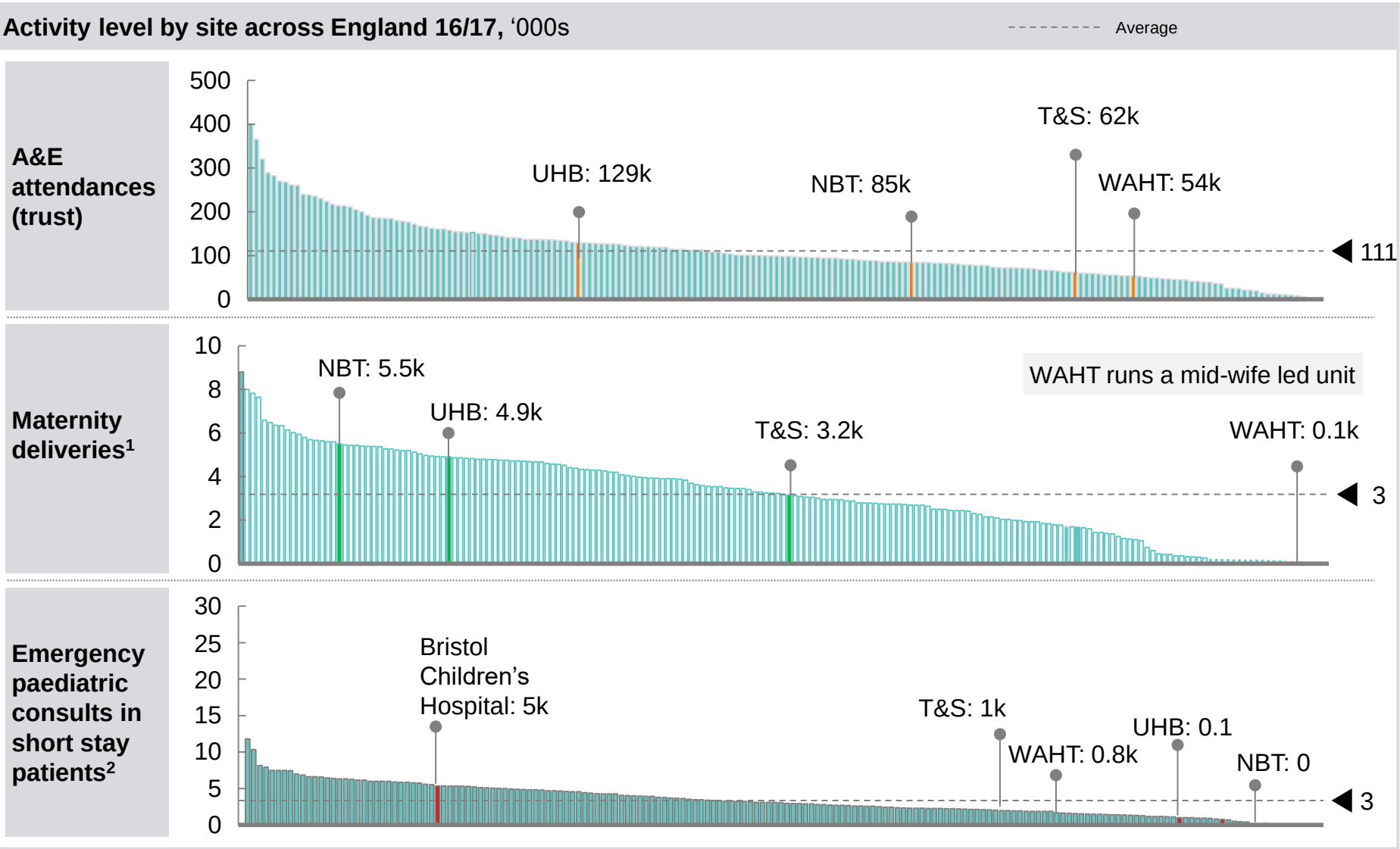
Activity Growth
% CAGR

2% 1% 0% 3% 5%

SOURCE: HES Online 2014/15-2016/17

Acute A&E and paediatric activity by Trust

Activity level by site across England 16/17, '000s

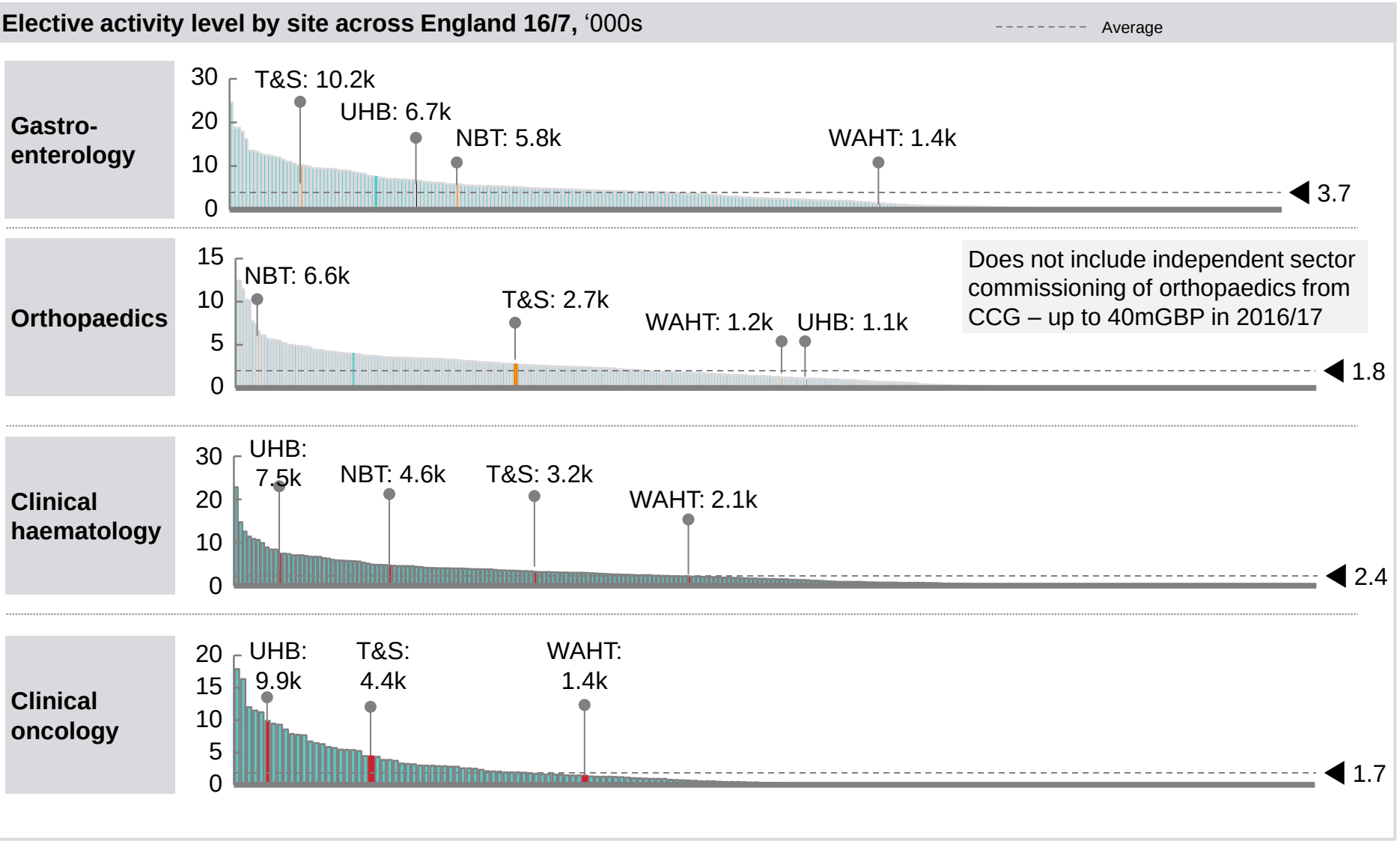


1Excluding sites with <100 births per year. Defined by relevant HRG codes for births.
2 Excluding sites with <25 consults

SOURCE: HES 2016/17

Elective activity by Trust

Elective activity level by site across England 16/7, '000s



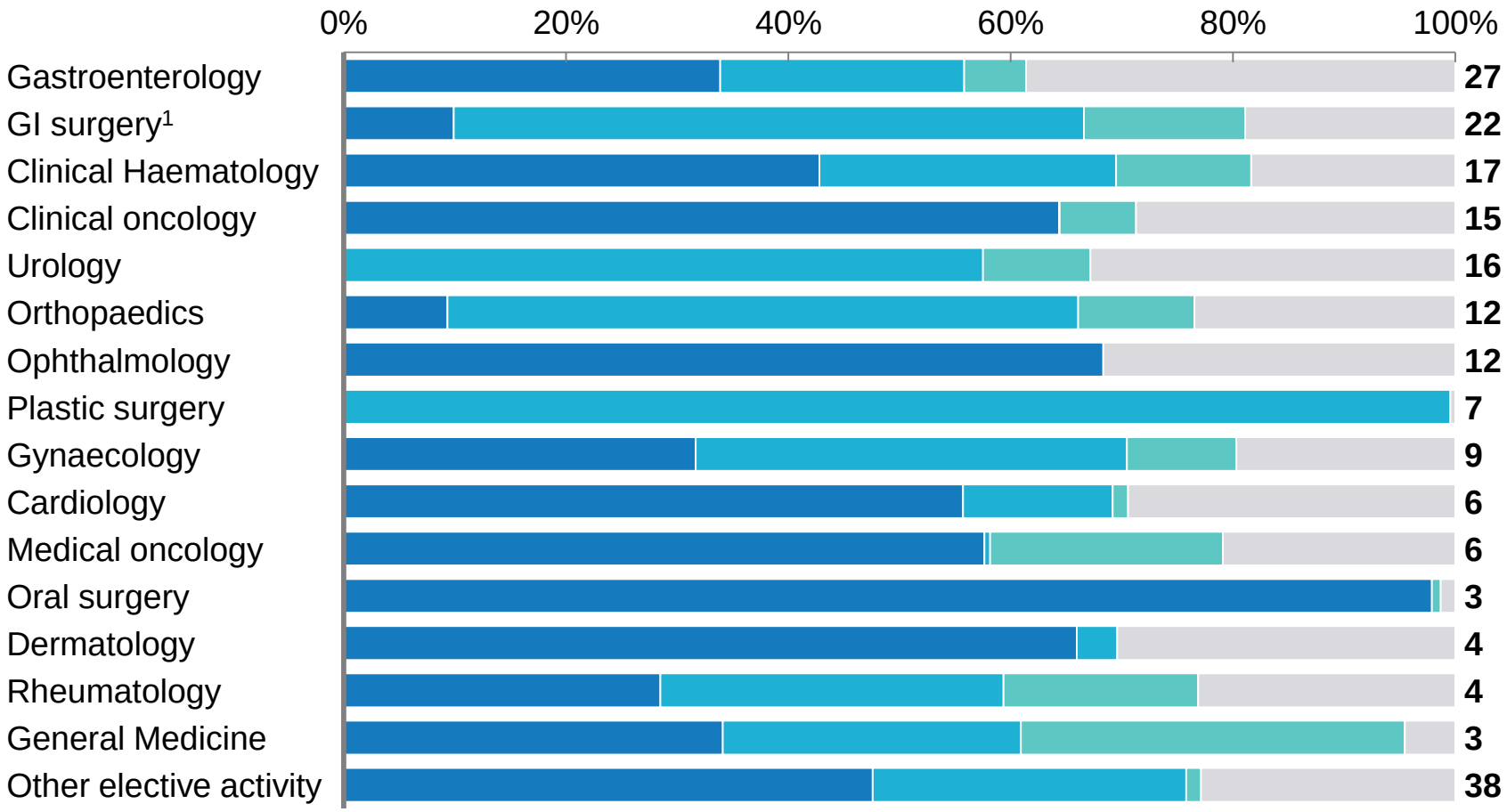
SOURCE: HES 2016/17, CQC

Elective activity share by Trust

UHB WAHT NBT T&S

HEALTHY WESTON

Breakdown of elective activity by trust for top specialties, % share, activity totals in '000s



Note: There are services completed at WAHT that are counted by other trusts (e.g., dermatology and ophthalmology).

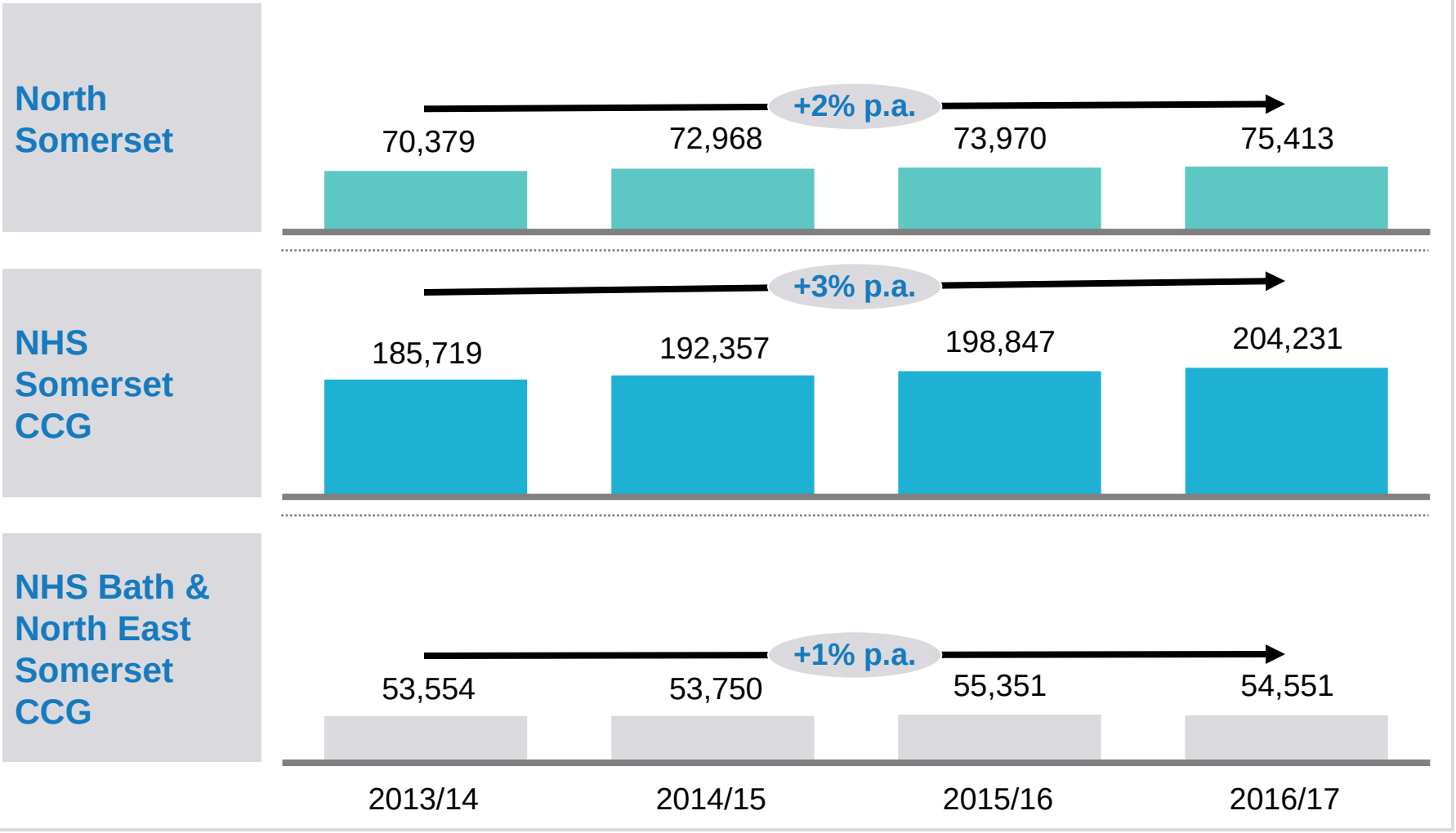
1 Includes general surgery, colorectal surgery, hepatobiliary and pancreatic surgery, and upper GI surgery treatment specialties
SOURCE: HES APC M13 2016/17, c/o NHS Digital;

Healthier Together

Overall inpatient activity has been increasing across the region

Yearly activity at local CCGs

Inpatient activity by CCG



Source: HES Online 2013/14, 2014/15, 2015/16, 2016/17

2016/17 activity paid for at WAHT

Inpatient Hospital Admissions per year[1]

Treatment Specialty		# of admissions	% share of adm.	# of procedures[2]
Surgical	General surgery	3,017	10%	2,094
	Trauma & orthopaedics	2,429	8%	2,141
	Urology	1,758	6%	1,595
	Colorectal surgery	1,680	6%	1,626
	Upper gastrointestinal surgery	691	2%	636
	Accident & emergency	385	1%	138
	Breast surgery	173	1%	171
	Oral surgery	27	0%	27
	Plastic surgery	6	0%	6
	Other	2	0%	1
Medical	General medicine	9,560	32%	3,831
	Clinical haematology	2,128	7%	2,085
	Gastroenterology	1,514	5%	1,425
	Gynaecology	1,192	4%	1,049
	Rheumatology	629	2%	622
	Cardiology	116	0%	95
	Stroke medicine	92	0%	79
	Respiratory medicine	90	0%	79
	Geriatric medicine	75	0%	32
	Endocrinology	67	0%	65
	Rehabilitation	26	0%	25
	Anaesthetics	5	0%	5
	Other	3	0%	2
Obstetrics	Midwife Episodes[3]	451	2%	N/A
Cancer	Radiology / Clinical Oncology	1,058	4%	N/A
	Medical Oncology	1,196	4%	N/A
Paediatrics (0 – 18y.o.)	Day Cases	245	1%	N/A
	ELIP	3	0%	N/A
	NEIP	1,005	3%	N/A
Private	Private Patients	203	1%	N/A

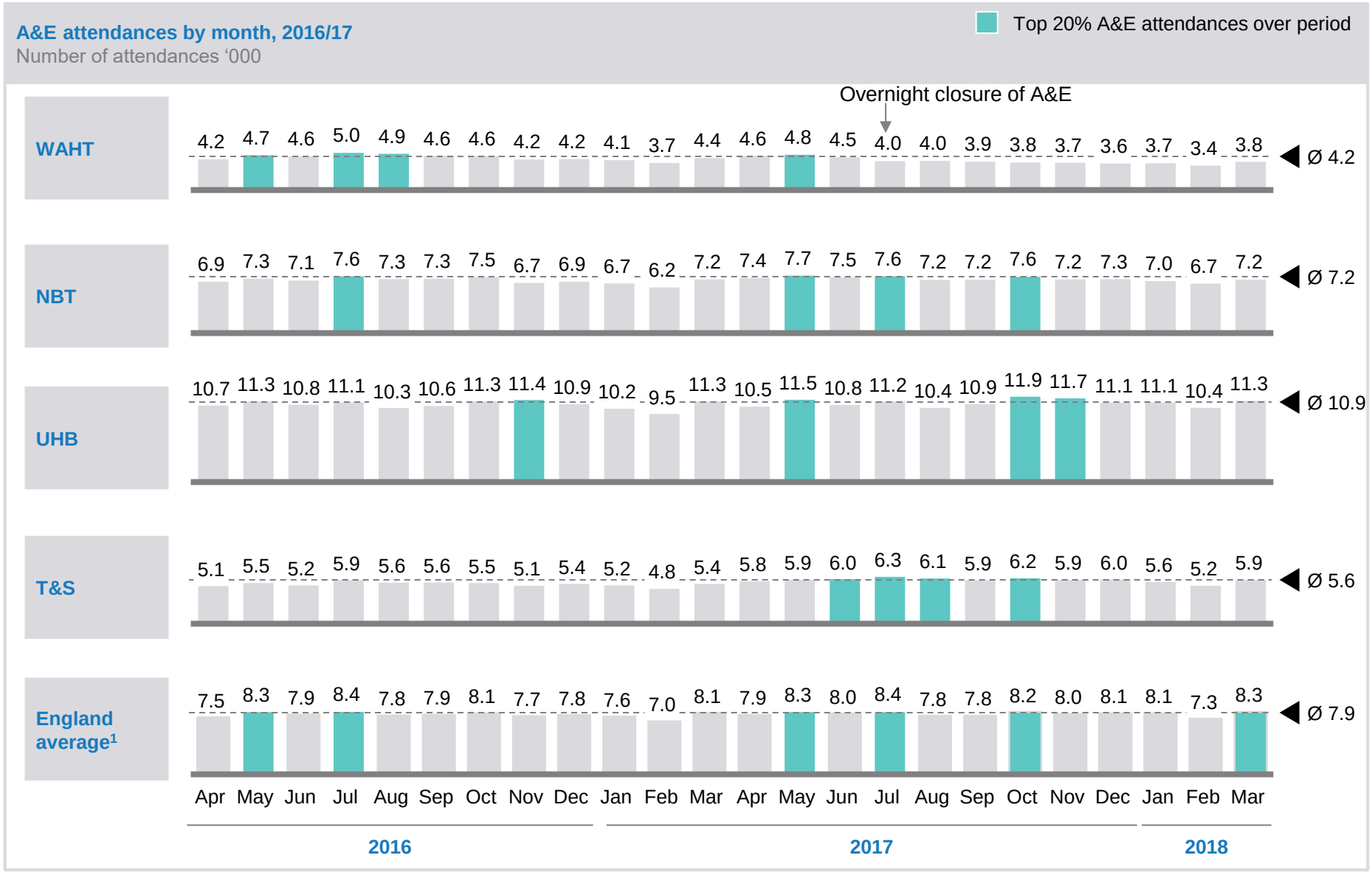
Overall Admissions per year

Outpatient consultations	148,658
A&E Attendances	53,242
Inpatient admissions[1]	29,625

1 Including Inpatient Non-elective, Elective, Maternity, Paediatrics, Private patients; Excluding Regular Attenders and 'Other' (not recorded type) categories
2 Intervention defined as OPCS coded procedure
3 Includes 151 births

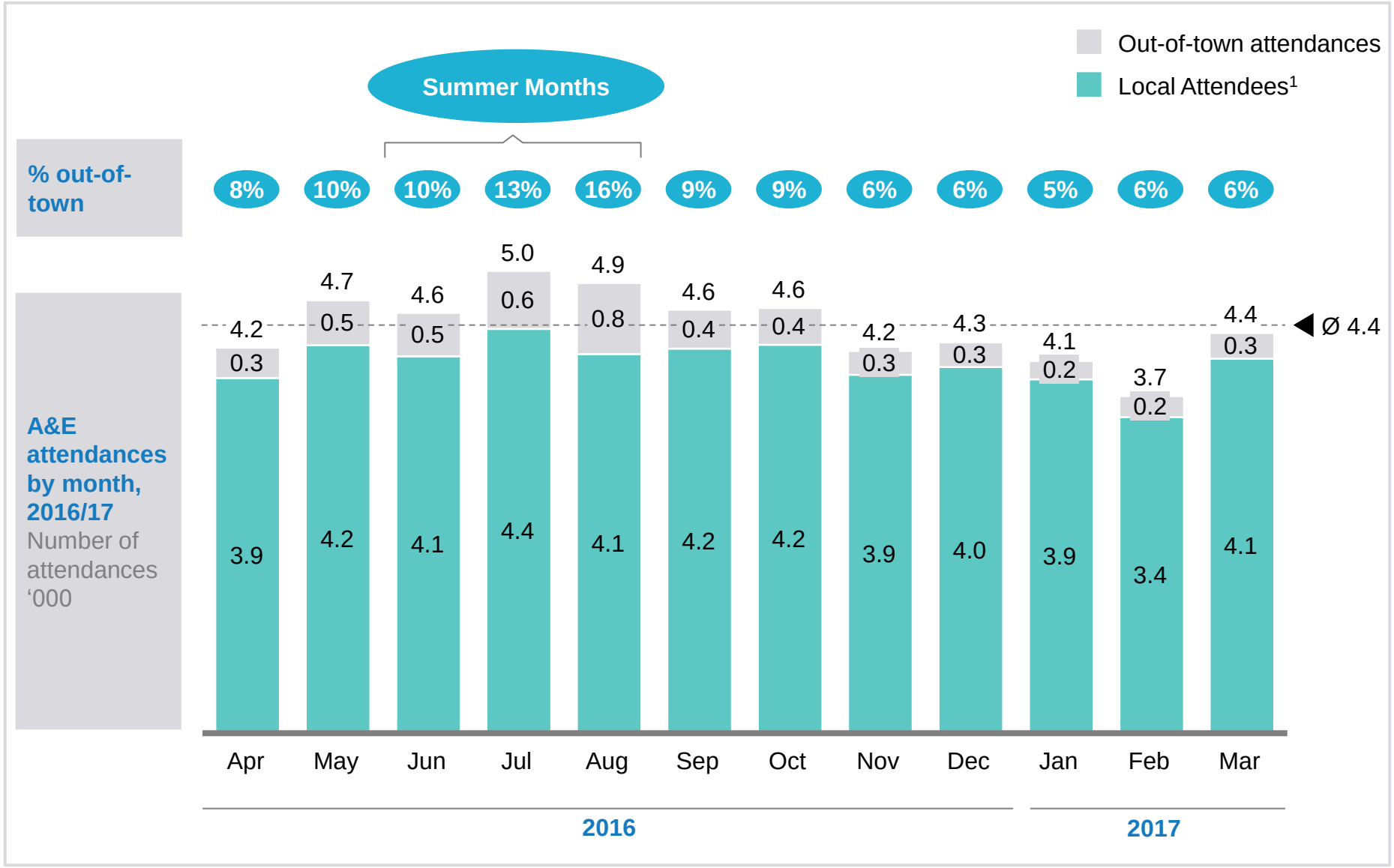
SOURCE: HES 2016/17 Inpatient and A&E datasets; HES Online 2016/17 for Outpatient data

Historical evolution of A&E attendances



1: Includes UCCs
Source: NHSE A&E Unify2 data collection - MSitAE

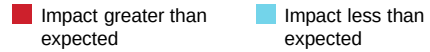
WAHT sees an increase in the proportion of out-of-town A&E attendances during summer months



1 Defined as residents of Bristol, North Somerset, and South Gloucestershire CCGs

Source: NHSE A&E Unify2 data collection - MSitAE

Impact of temporary overnight closure of Weston A&E after 6 months



Figures are per day		BRI (UHB)	Southmead (NBT)	Musgrove (T&S)	Total
ED - Walk-ins	Actual	0.8	0.4	1.3	2.6
	Fore-cast	0.4	0.5	0.1	1.1
ED – Ambulance arrivals	Actual	4.3	0.9	3.3	8.5
	Fore-cast	4.0	4.5	1.4	10.0
EM Admits	Actual	2.9	0.5	2.1	5.5
	Fore-cast	2.8	3.0	0.9	6.7
Beds in use[1]	Actual	7.0	2.0	9.4	18.4
	Fore-cast	5.5	6.1	1.9	13.5

SOURCE: BNSSG CCG Weston A&E Temporary Overnight Closure report

HRG codes can be used to categorise A&E visits into major, normal and minor

HEALTHY WESTON

PRELIMINARY

Category	Typical investigation	Typical treatment
5		▪ CPR ▪ Thrombolysis
4		▪ General anaesthetic ▪ Manipulation of limb fracture ▪ External pacing
3	▪ Ultrasound ▪ MRI ▪ CT	▪ Primary sutures ▪ Intramuscular injection ▪ Occupational therapy assessment
2	▪ Plain X-ray ▪ Cross-match ▪ Bacteriology	▪ Wound closure with steristrips ▪ Physio for falls prevention ▪ Local anaesthetic
1	▪ ECG ▪ Biochemistry ▪ Urine dip	▪ Remove sutures ▪ Eye drops ▪ Advice/guidance

Category combination

Typical investigation	Typical treatment	
Any	5	MAJOR
3	1-4	
2	4	
2	1-3	NORMAL
1	3-4	
1	1-2	MINOR
None	None	

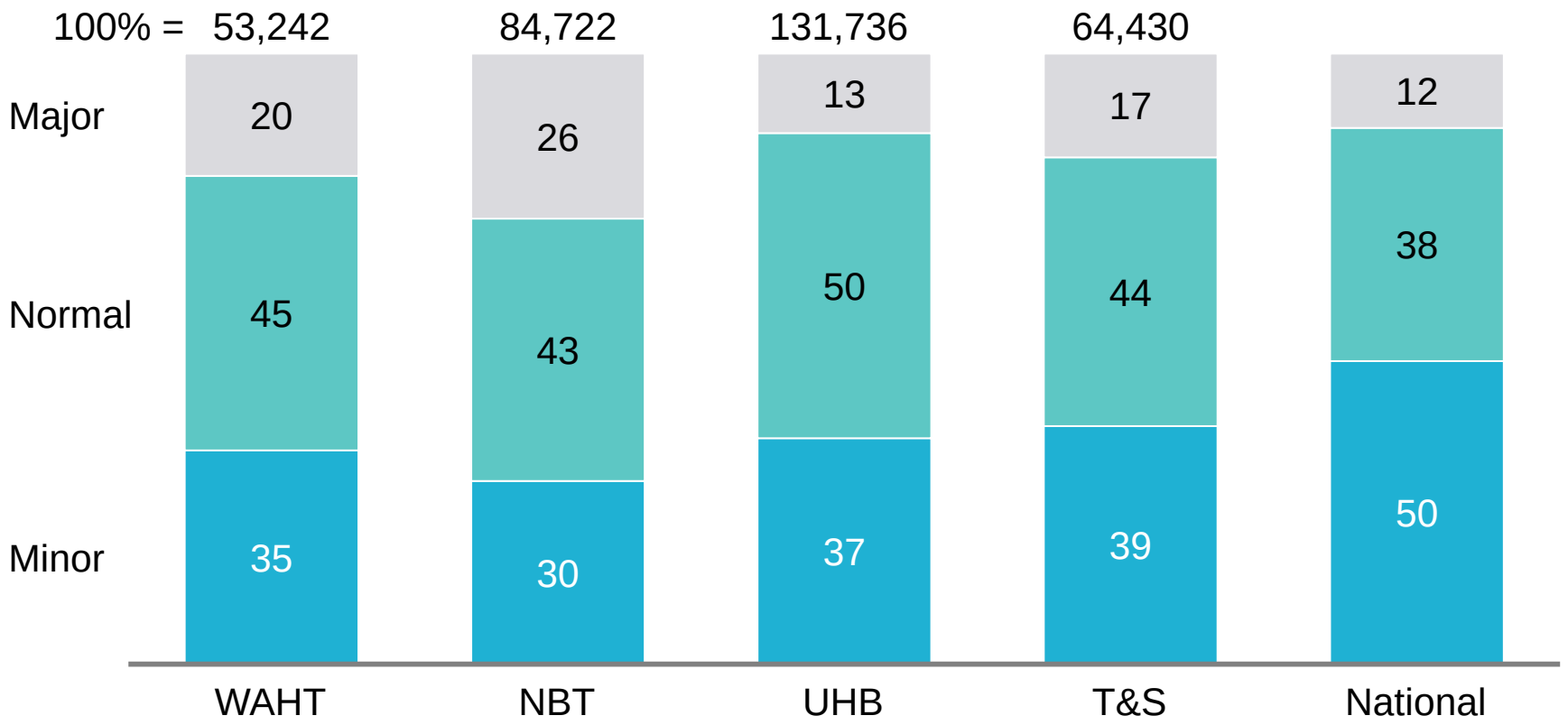
Source: HES data

Healthier Together

Coding of ED attendances by category in 2016/17

A&E attendances by category for WGH vs nationally

A&E attendances (% of total), 2016/17

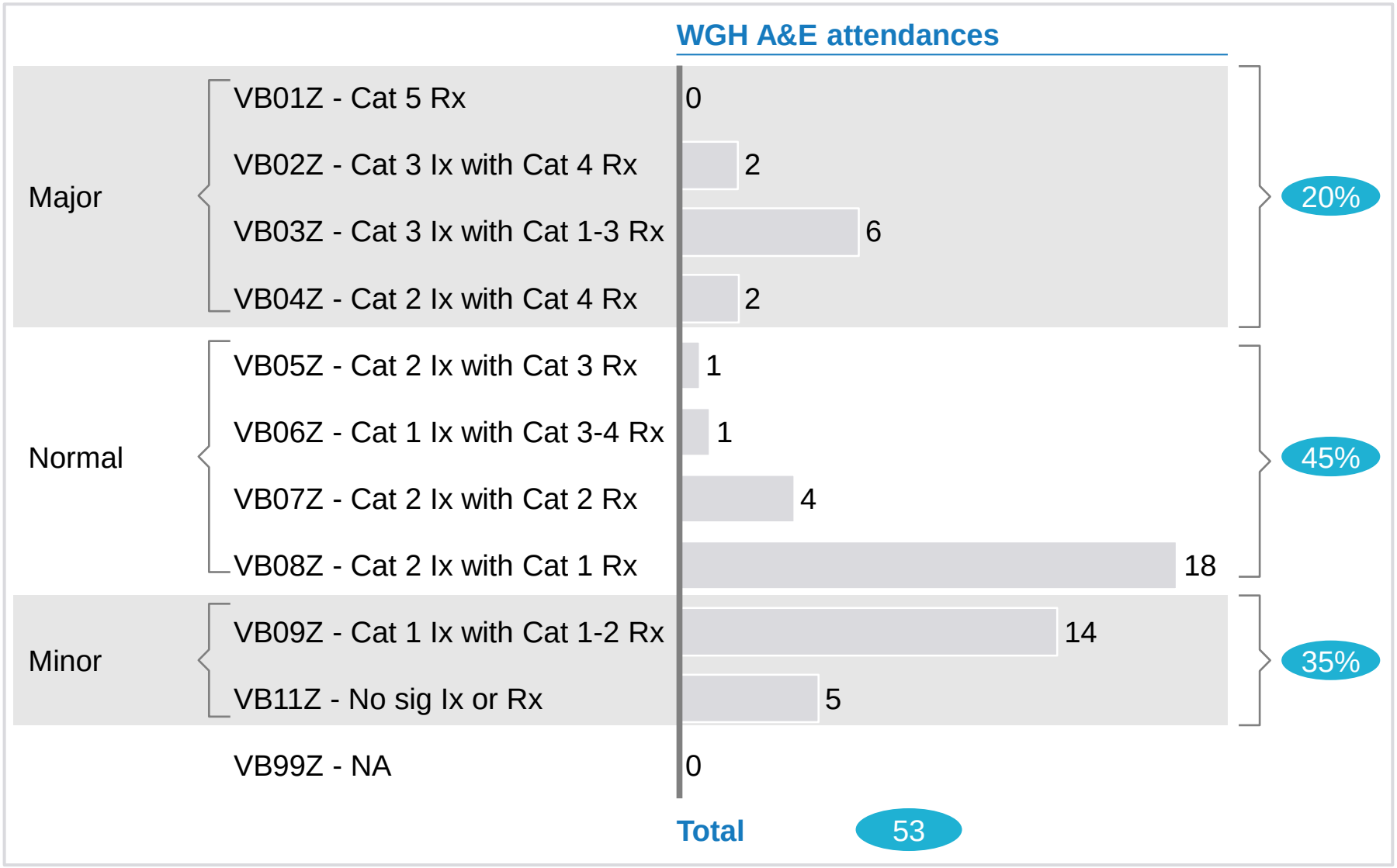


Note: NBT is a major trauma centre

Source: A&E HES data 2016/17

35 % of the ~53,000 ED attendances at WAHT in 2016/17 were coded as minors

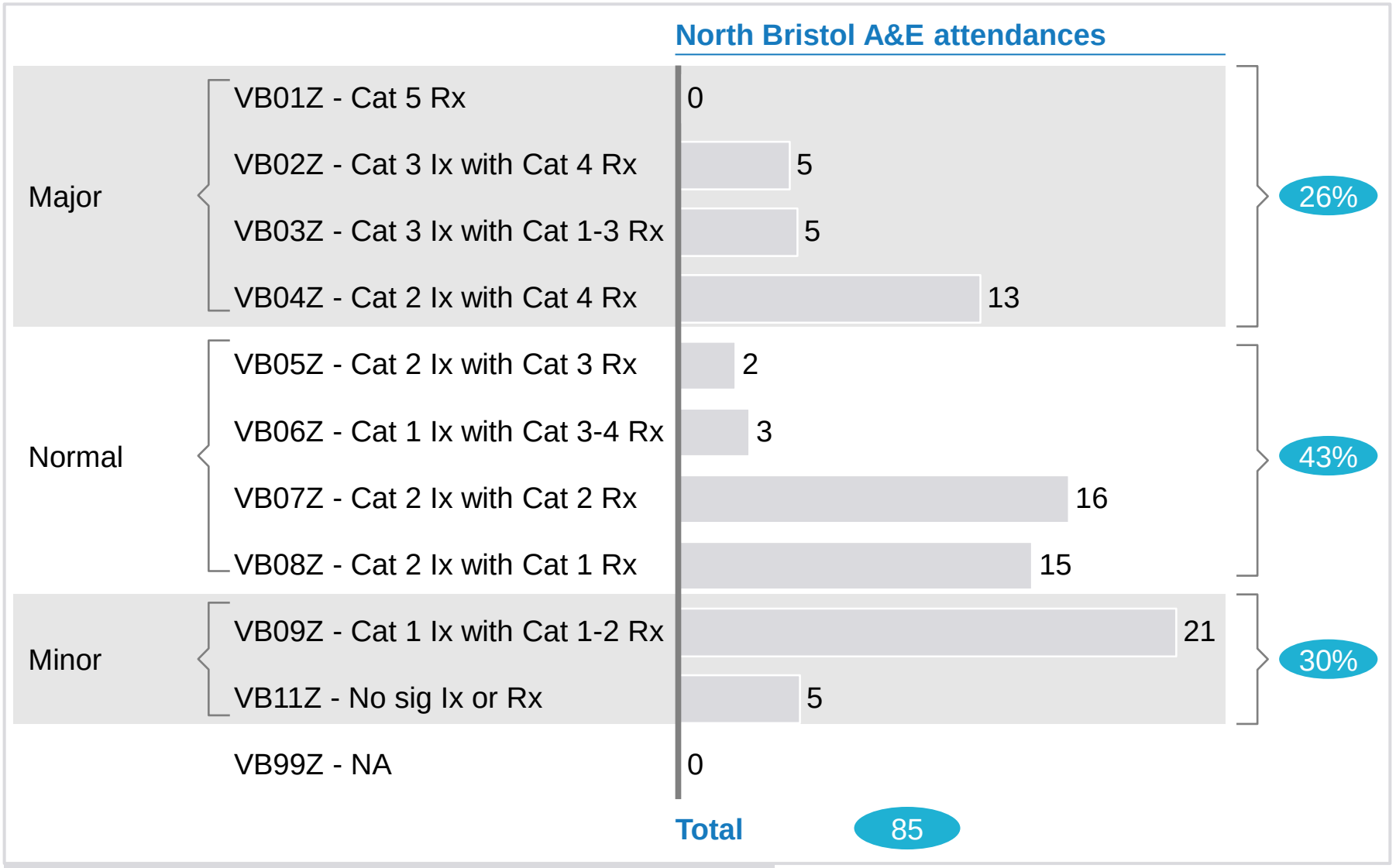
Adult A&E attendances ('000), 2016/17



Source: A&E HES data 2016/17

30 % of the ~85,000 ED attendances at NBT in 2016/17 were coded as minors

A&E attendances ('000), 2016/17

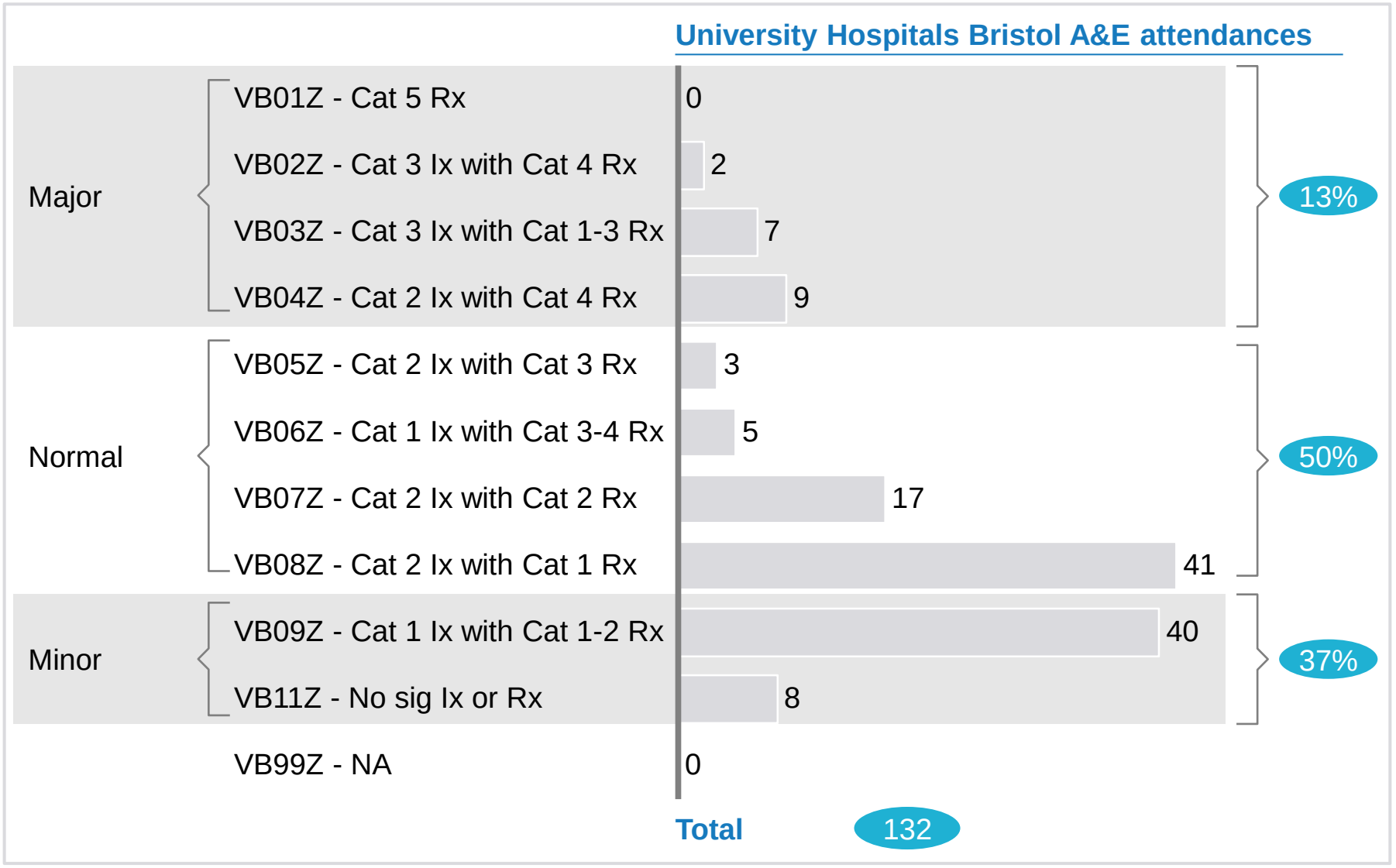


Note: NBT is a major trauma centre

Source: A&E HES data 2016/17

37 % of the ~132,000 ED attendances at UHB in 2016/17 were coded as minors

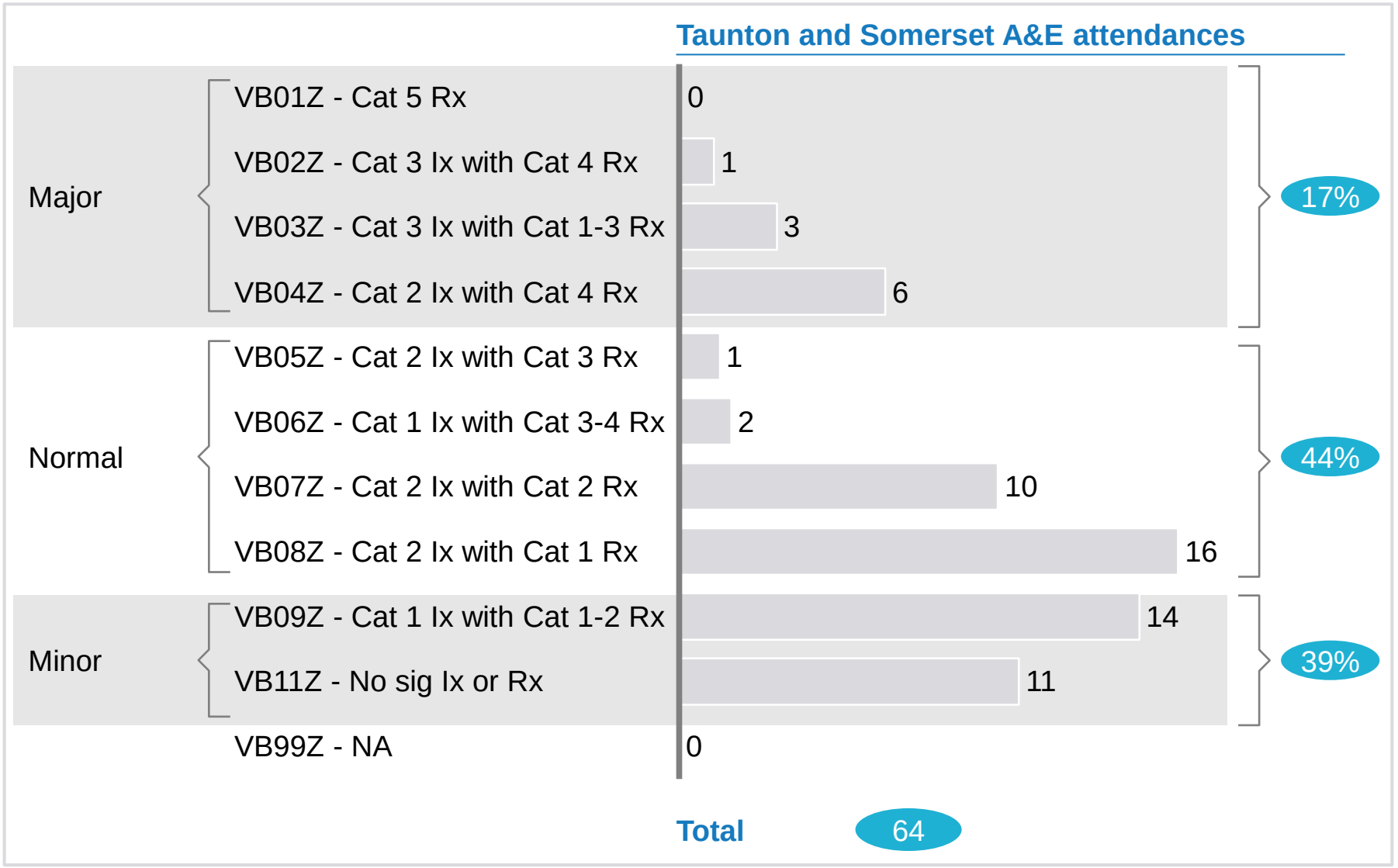
A&E attendances ('000), 2016/17



Source: A&E HES data 2016/17

39 % of the ~64,000 ED attendances at T&S in 2016/17 were coded as minors

A&E attendances ('000), 2016/17



Source: A&E HES data 2016/17 A&E M13, c/o NHS Digital

Latest CQC reports for WAHT, UHB, NBT, and T&S

☆ Outstanding ● Good ● Requires improvement ● Inadequate

WAHT Jun 2017	**UHB (specific services shown for main site),** Dec 2016	**NBT (specific services shown for Southmead site),** Nov 2017	**T&S (specific services shown for Musgrove Park site),** Dec 2017
Overview and CQC inspections			
Overall requires improvement	**Overall outstanding**	**Overall requires improvement**	**Overall good**
Safe ●	Safe ●	Safe ●	Safe ●
Effective ●	Effective ☆	Effective ●	Effective ●
Caring ●	Caring ●	Caring ●	Caring ☆
Responsive ●	Responsive ●	Responsive ●	Responsive ●
Well-led ●	Well-led ☆	Well-led ●	Well-led ●
CQC inspections and ratings of specific services			
Medical care (including older people's care) ●	Outpatients and diagnostic imaging ●	Outpatients and diagnostic imaging ●	Outpatients and diagnostic imaging ●
Urgent and emergency services (A&E) ●	Maternity and gynecology ●	Maternity and gynecology ●	Maternity and gynecology ●
Surgery ●	Medical care (including older people's care) ●	Medical care (including older people's care) ●	Medical care (including older people's care) ●
Outpatients and diagnostic imaging[1] ●	Urgent and emergency services (A&E) ●	Urgent and emergency services (A&E) ●	Urgent and emergency services (A&E) ●
Intensive/critical care ●	Surgery ☆	Surgery ●	Surgery ●
Maternity & gynaecology[1] ●	Intensive/critical care ●	Intensive/critical care ●	Intensive/critical care ●
Services for children and young people[1] ●	Services for children and young people ●	Services for children and young people ●	Services for children and young people ●
End of life care[1] ●	End of life care ●	End of life care ●	End of life care ●

1 Rating from May 2015 CQC report & have not been rated since

Source: CQC website

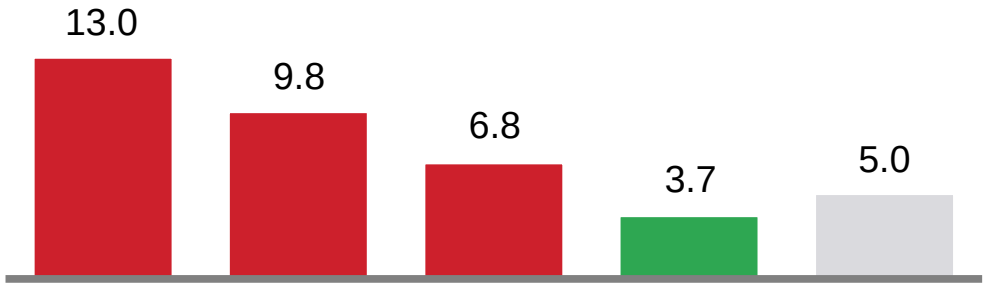
ICNARC Annual Quality Report findings for adult critical care across neighbouring trusts

Trust performance above National average | Trust performance similar to National average | Trust performance below National average

Key Results[1]

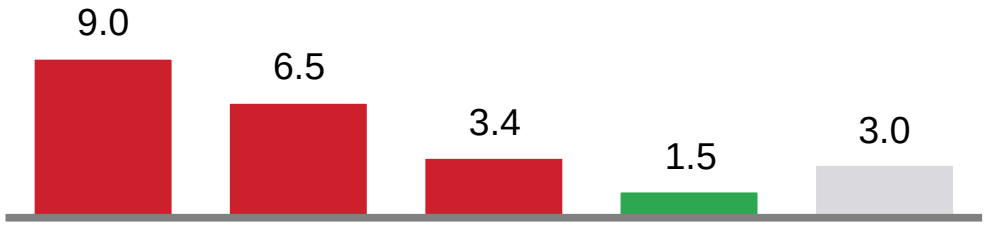
Bed days of care post 8-hour delay (%)

Percent of bed days used on critical care survivors **more than 8 hours** after reported time fully ready for discharge



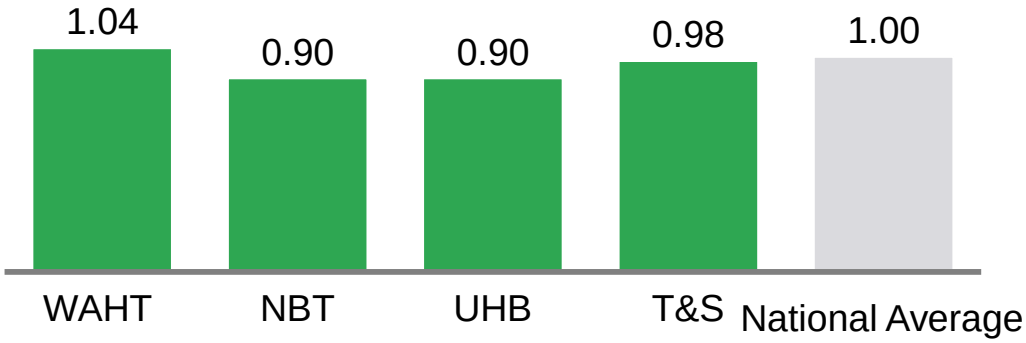
Bed days of care post 24-hour delay (%)

Percent of bed days used on critical care survivors **more than 24 hours** after reported time fully ready for discharge



Risk-adjusted acute hospital mortality rate

Ratio of actual hospital mortality rate to expected mortality rate (based on ICNARC risk prediction model)



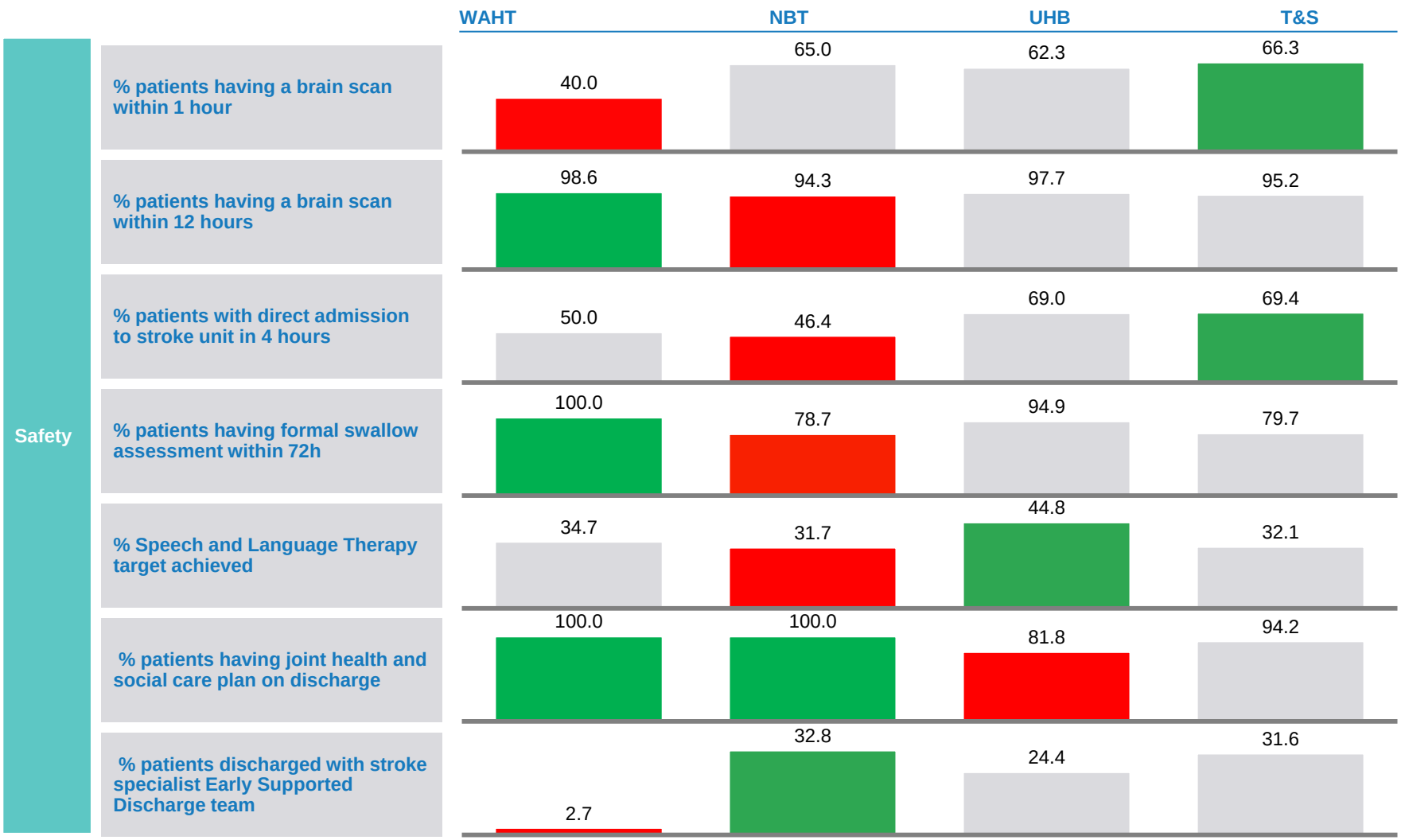
1 Results are published in graphical form, so numbers used are an estimation based on these graphs

Source: ICNARC Annual Quality Report 2016/17 for adult critical care

A range of indicators showing stroke performance (from SSNAP)

Highest performance regionally | Performance in line with regional peers | Poorest performance regionally

SSNAP audit for stroke

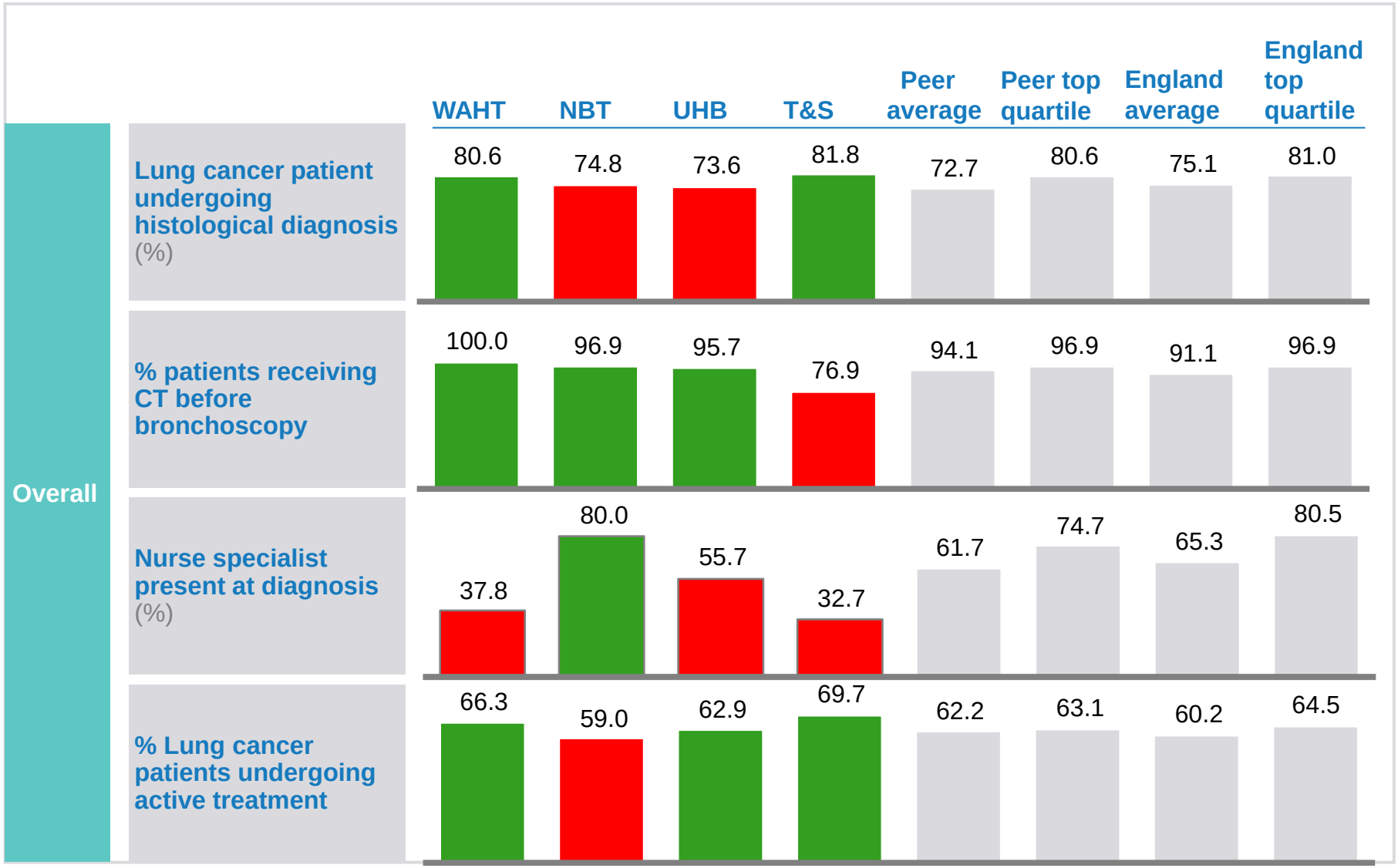


Source: SSNAP August- November 2017

Lung cancer management

HEALTHY WESTON

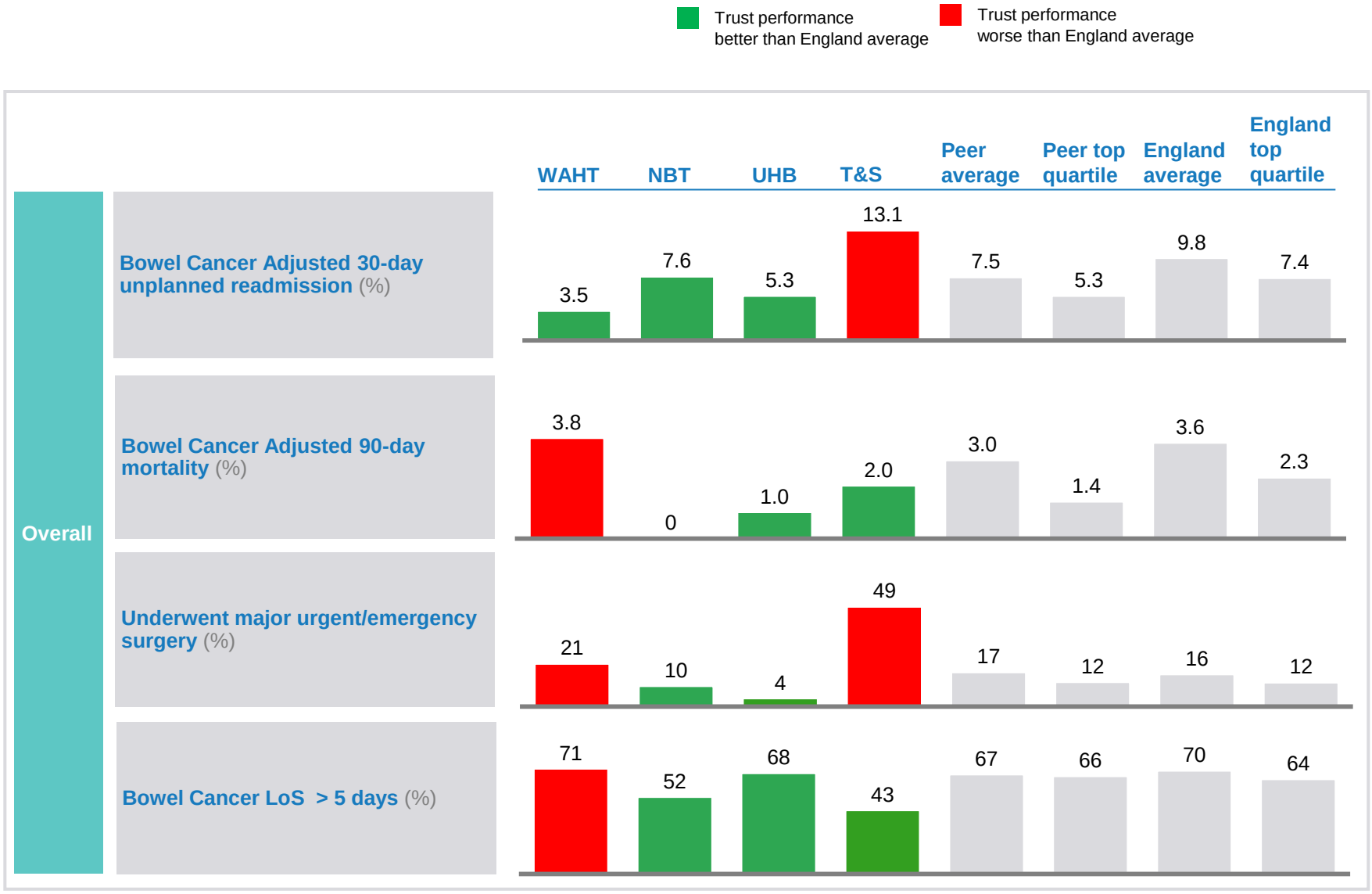
WORK IN PROGRESS



Source: 2014 NCLA Table 2a Process nursing, imaging and clinical measures

Healthier Together

Bowel cancer management



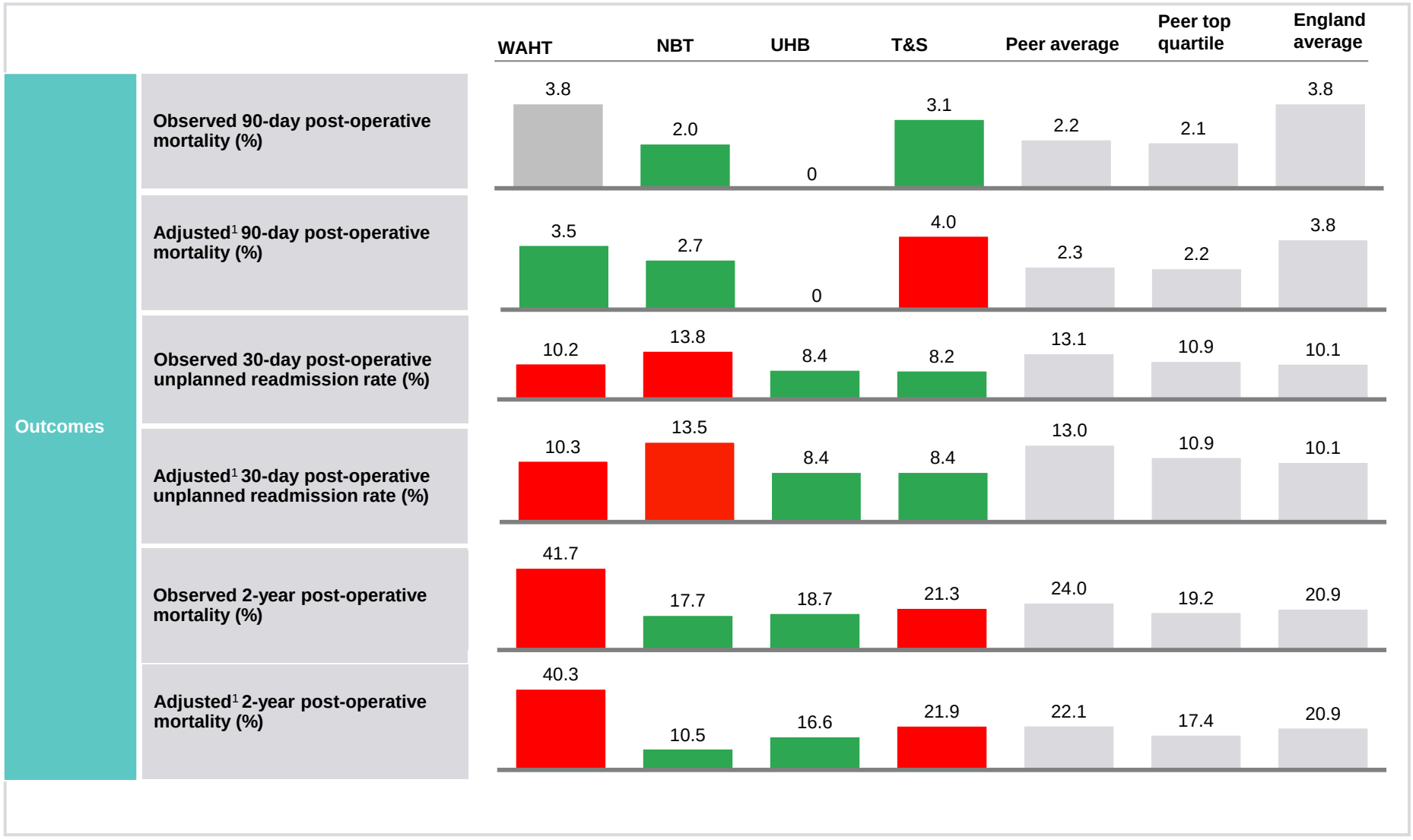
Source: Bowel Cancer Audit 2017 (2015/16 date)

Post-operative outcomes for bowel cancer

Trust performance above England average

Trust performance at England average

Trust performance below England average



1 Risk-adjusted for patient case mix

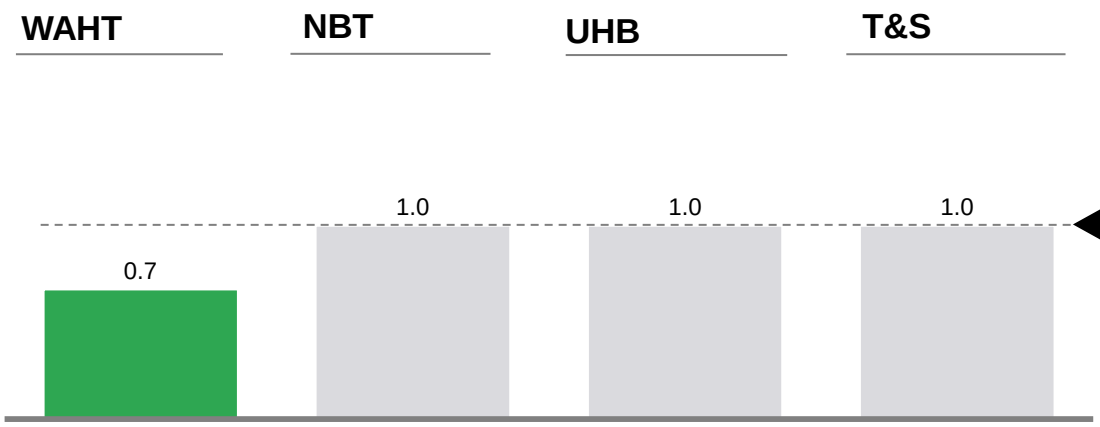
SOURCE: National Bowel Cancer Audit, Annual Report 2016

5-year revision rate for hip replacement surgery

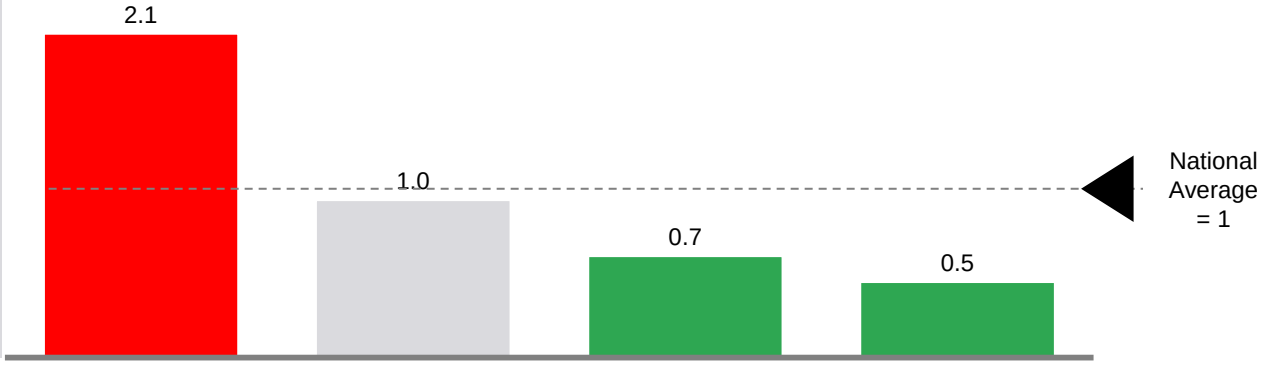
Trust performance better than expected | Trust performance as expected | Trust performance worse than expected

Outcomes

90-day mortality: the number of actual deaths within 90 days of the operation divided by the number of deaths that would be expected based on national average (calculated after adjustments for age, gender and ASA grade of patients)



5-year revision rate: number of actual revision procedures divided by the number of expected revision procedures (after adjustments for age, gender, ASA grade of patients) for that time period



SOURCE: NJR Surgeon and Hospital Profile 2017

Local quality of care for people with heart failure

Trust performance above England average

Trust performance below England average

		WAHT[1]	NBT	UHB	T&S	Peer average	Peer top quartile	England average
Safety	Received echo (%)	92.7	74.5	100.0	88.2	84.4	94.0	90.1
	Cardiology inpatient (%)	0	40.5	63.2	56.2	40.9	63.2	45.7
	Input from consultant cardiologist (%)	41.0	49.0	55.1	59.9	50.9	55.1	56.9
	Input from specialist (%)	43.6	58.4	98.9	74.7	67.8	96.0	79.0
	ACEI on discharge (%)	54.4	51.1	81.7	82.4	74.6	89.5	61.1
	Beta blocker on discharge (%)	83.1	78.4	88.7	93.3	85.9	88.7	73.7
	ACEI/ARB on discharge (%)	64.9	66.9	90.7	94.3	82.2	92.0	73.7
Expe-rience	Received discharge planning (%)	35.3	97.3	97.6	64.3	82.7	97.6	80.4
	Referral to HF liaison service (%)	9.4	17.6	58.3	55.7	38.5	58.3	54.8
	LVSD referral to HF liaison service (%)	13.3	21.5	52.5	65.5	43.6	52.5	70.8
	Referral to cardiology follow-up (%)	38.5	30.4	49.1	39.5	36.0	43.1	47.2

1 WAHT has lower cardiology activity than other Trusts and no cardiology inpatients and some performance measures may reflect lack of scale

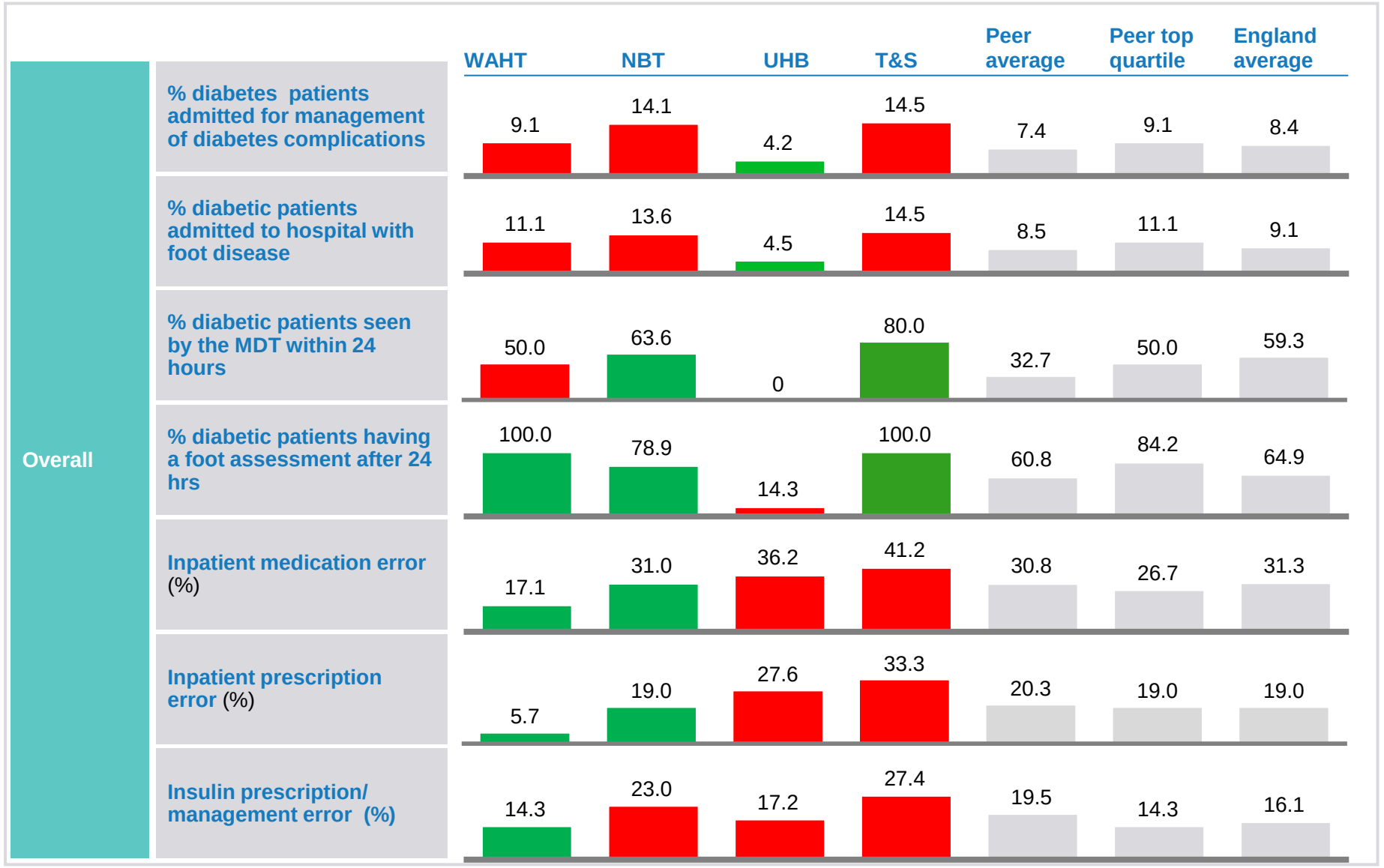
Source: Heart Failure Audit 2017 (2015-16 data)

Local quality of care for people with diabetes

Trust performance above England average

Trust performance at England average

Trust performance below England average



Source: Diabetes Inpatient Audit, 2017

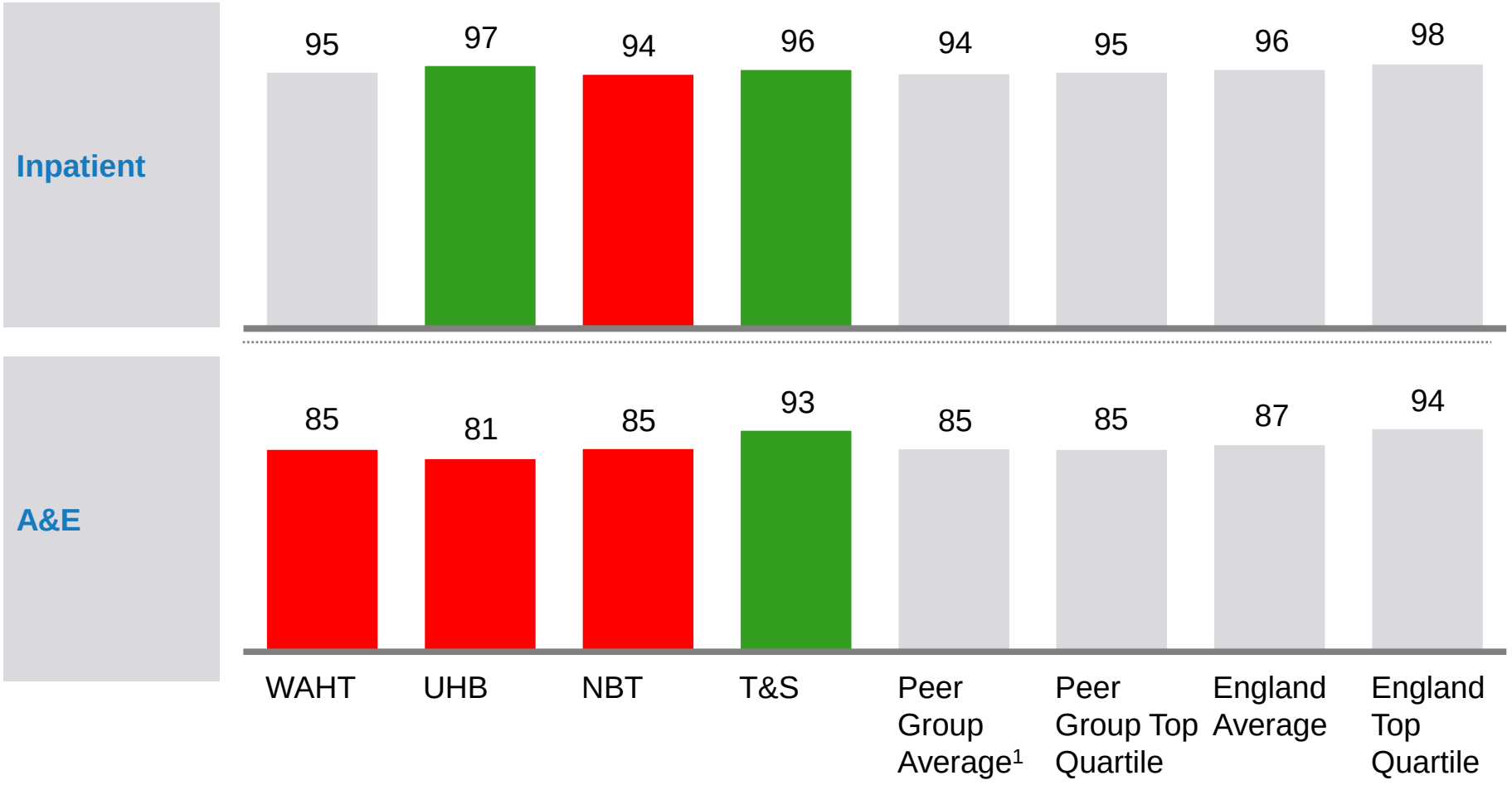
Friends and family test for inpatient care and A+E

Trust performance above England and Peer Group Top Quartile

Trust performance at England average and Peer Group Average

Trust below England average and Peer Group Average

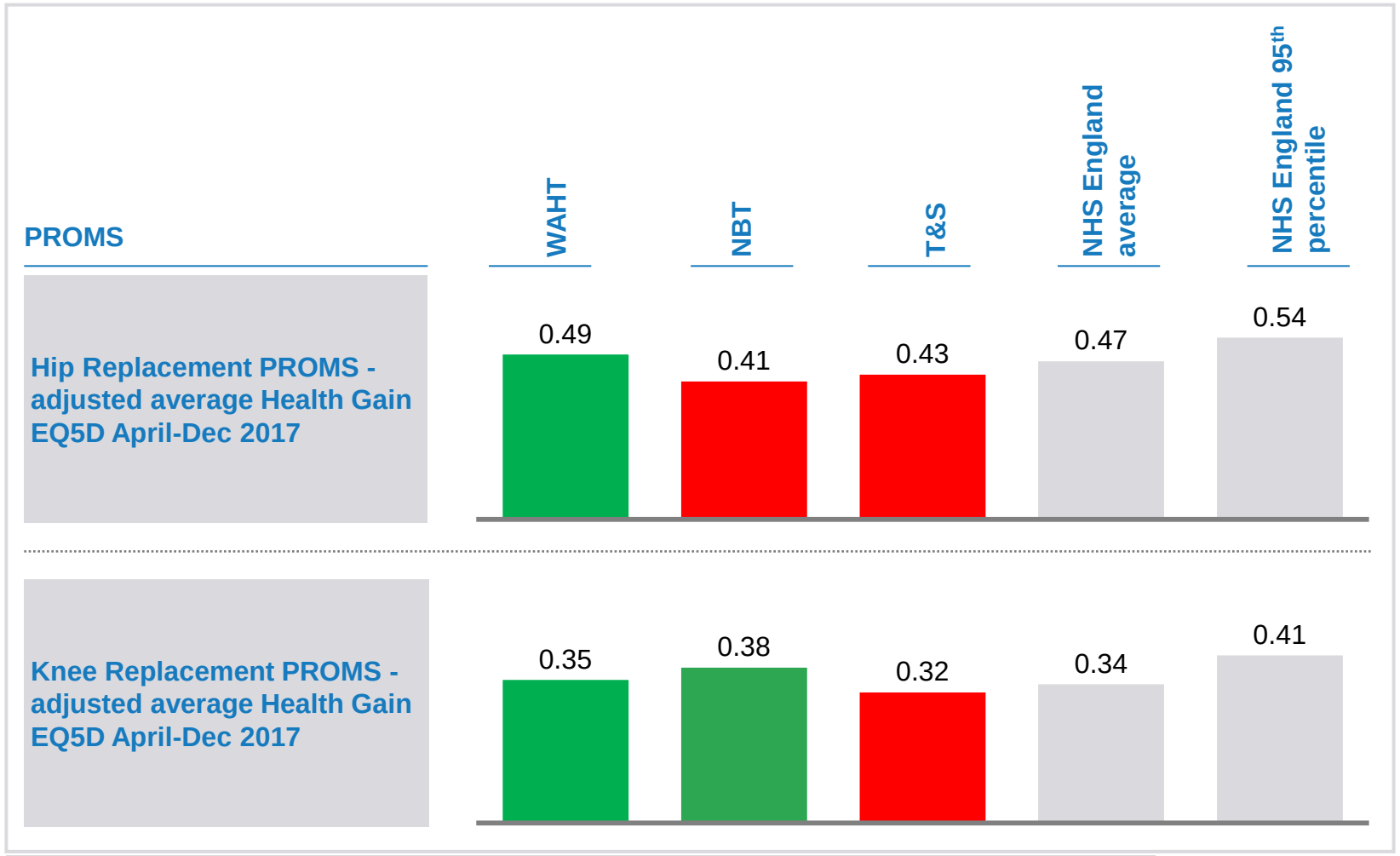
% patients who would recommend the service they received to friends and family who need similar treatment or care



1 Local peers as Yeovil, NBT, UHB and Gloucestershire Hospitals NHS Trust

Source: NHS Friends and Family Test - May 2018, NHS England

Patient satisfaction with elective orthopaedics care



Note: No data available for Somerset Partnership, Yeovil District, University Hospitals Bristol

Source: Patient Reported Outcomes Measures, NHS Digital: https://digital.nhs.uk/data-and-information/publications/statistical/patient-reported-outcome-measures-proms/provisional-quarterly-patient-reported outcome-measures-proms-in-england-april-2017-to-december-2017

Junior Doctor GMC 2018 survey results

Result is significantly below national average

Result is below national average but within confidence interval

Result is in line with or above national average

GMC survey aggregates feedback from doctors in training to compare training environments across the country

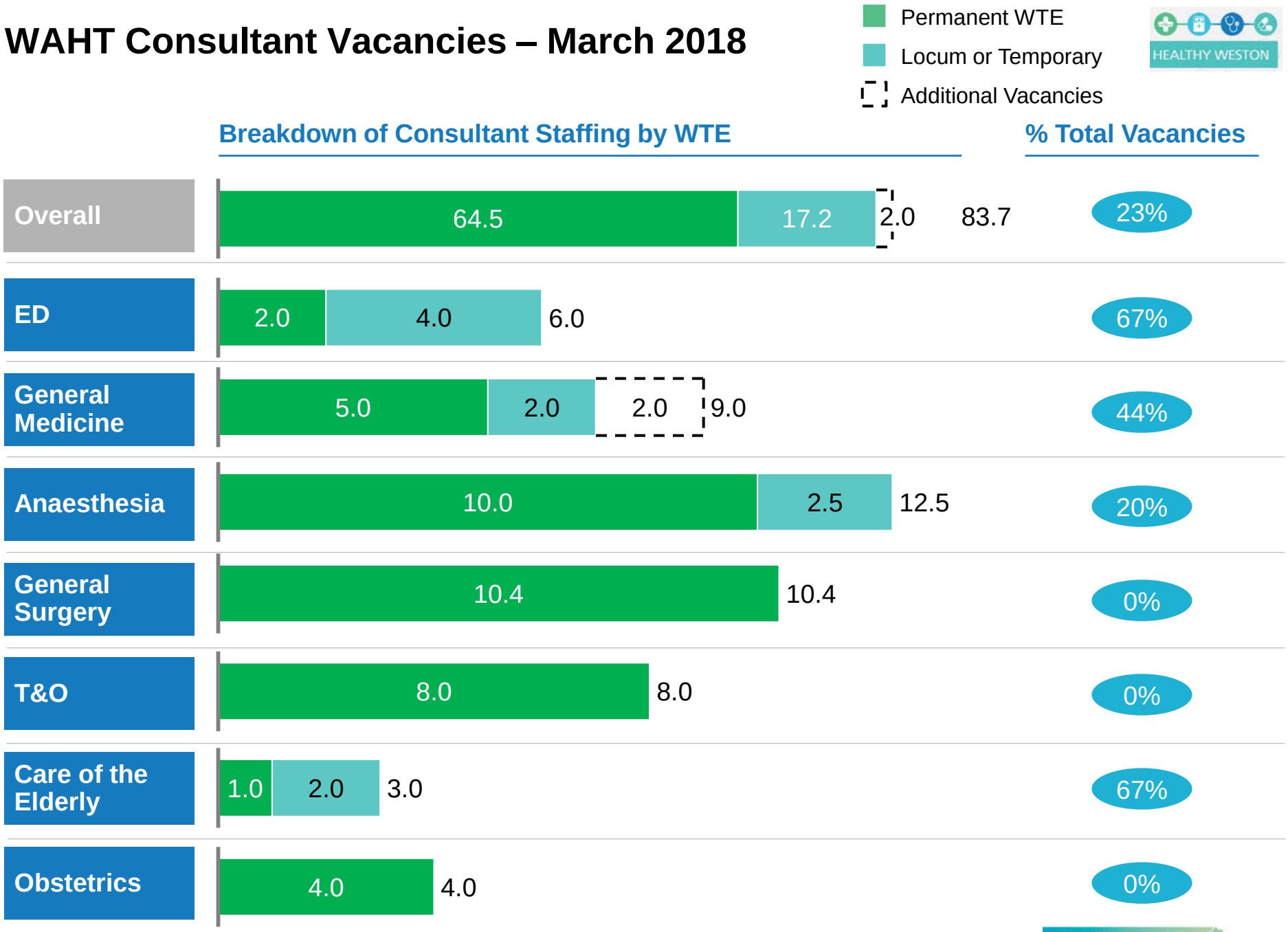
Trust / Board	Overall satisfaction	Handover	Clinical supervision	Rota design
NBT	79.0	65.4	91.0	57.1
UHBT	76.7	65.6	90.5	55.2
T&S	83.6	72.0	92.0	60.1
WAHT	68.5	57.5	78.9	44.9
National Average	79.0	65.3	90.3	56.2

WAHT Deep Dive

Post Specialty	Overall satisfaction	Handover	Clinical supervision	Rota design
Acute Internal Medicine	75.4	54.0	79.0	40.0
Emergency Medicine	50.5	54.2	57.5	23.9
Geriatric medicine	61.8	57.8	78.0	42.5
Obstetrics and gynecology	63.3	64.6	68.7	56.2

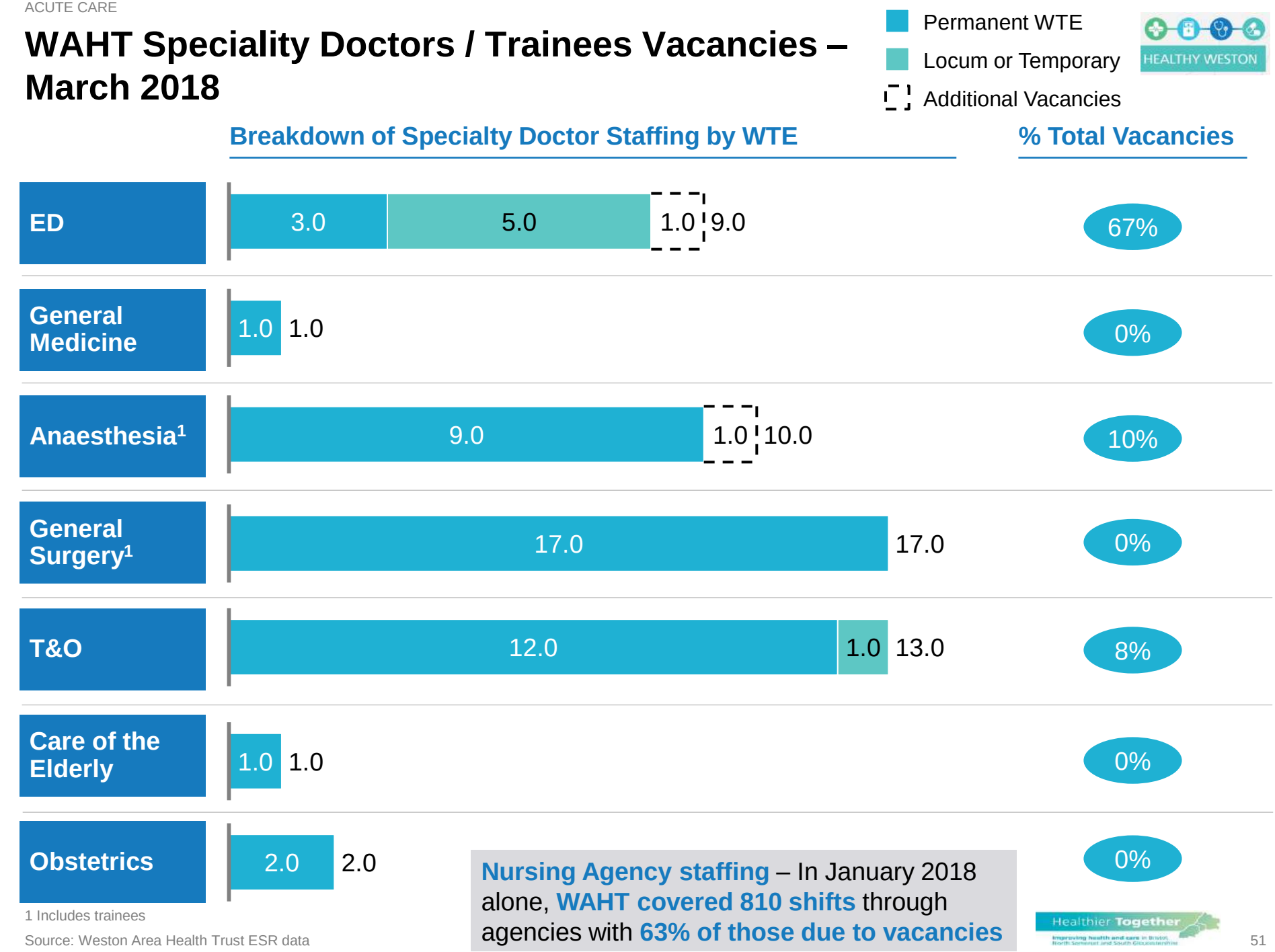
Source: General Medical Council National Training Survey 2017-18

WAHT Consultant Vacancies – March 2018



Source: Weston Area Health Trust ESR data

WAHT Speciality Doctors / Trainees Vacancies – March 2018



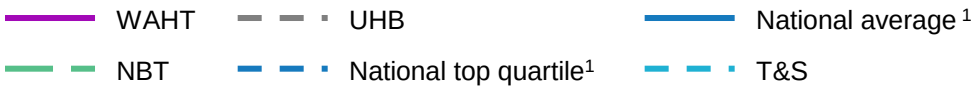
1 Includes trainees

Source: Weston Area Health Trust ESR data

Nursing Agency staffing – In January 2018 alone, **WAHT covered 810 shifts** through agencies with **63% of those due to vacancies**

Healthier Together

Cancer waiting time performance is below the top quartile for WAHT, NBT and UHB

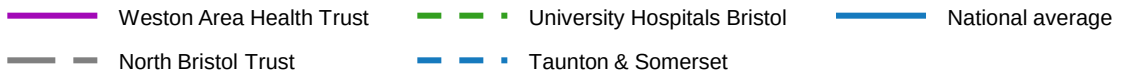


Performance against 62 day cancer waiting time target, %

1 Specialist centres not excluded

Source: HSJ Intelligence

18week RTT performance at WAHT is better than national average



RTT performance against 18 week target, %

98
96
94
92
90
88
86
84
82
80

2015-2016, Q4
2016-2017, Q1
2016-2017, Q2
2016-2017, Q3
2016-2017, Q4
2017-2018, Q1
2017-2018, Q2
2017-2018, Q3
2017-2018, Q4
2018-2019, Q1

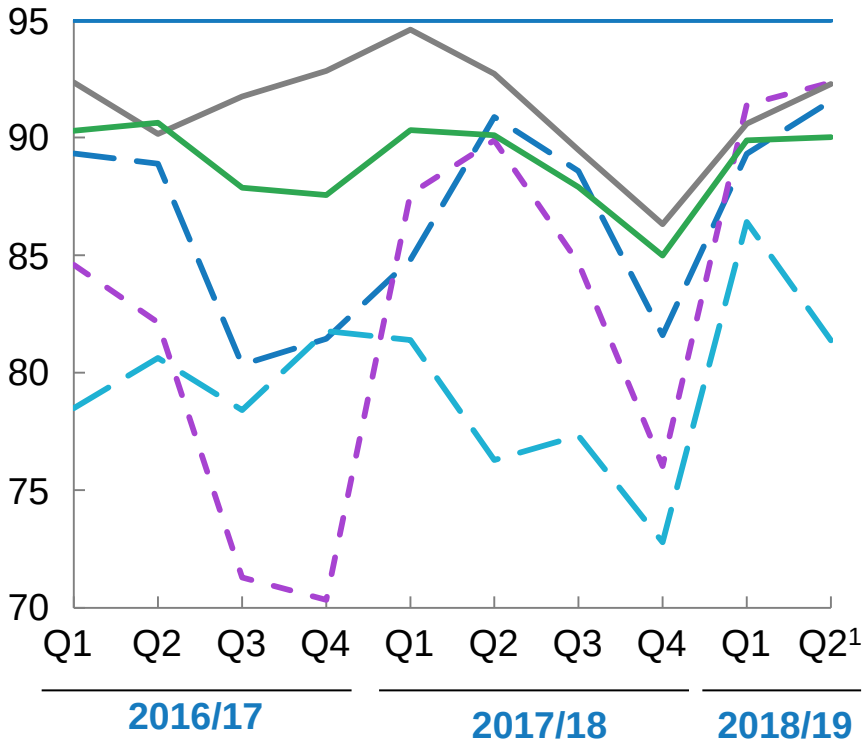
Source: HSJ Intelligence 2018

4hr A&E performance at WAHT, UHB, NBT, and T&S for Type 1 and All Attendances

UHB WAHT National Average
NBT T&S Target

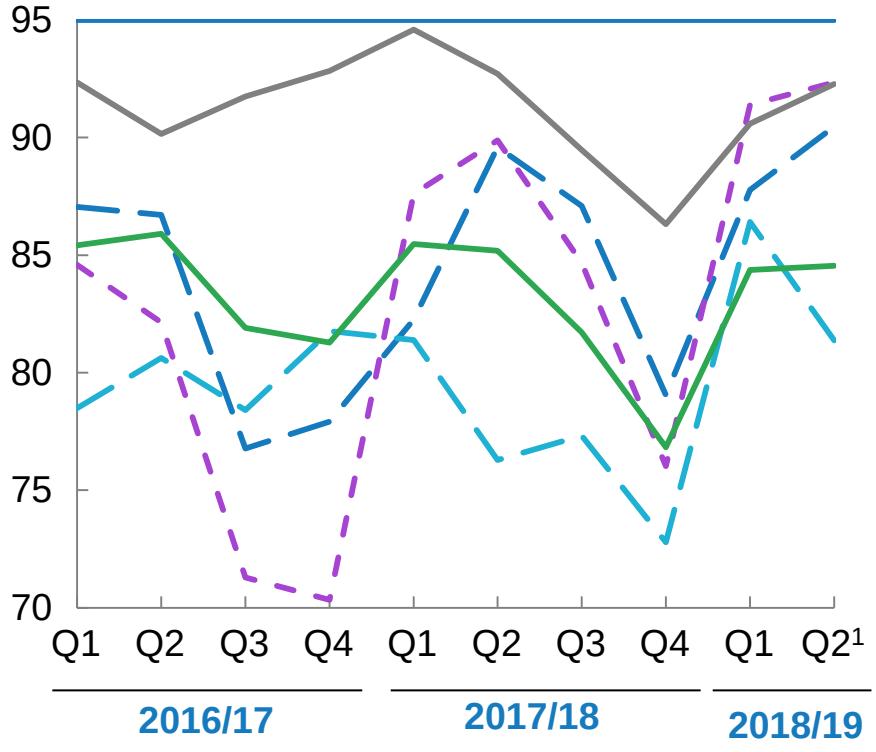
A&E attendances percentage seen in 4 hours or less, 2016/17 – 2017/18, All Attendances

% of attendances



A&E attendances percentage seen in 4 hours or less, 2016/17 – 2017/18, Type 1 Attendances

% of attendances

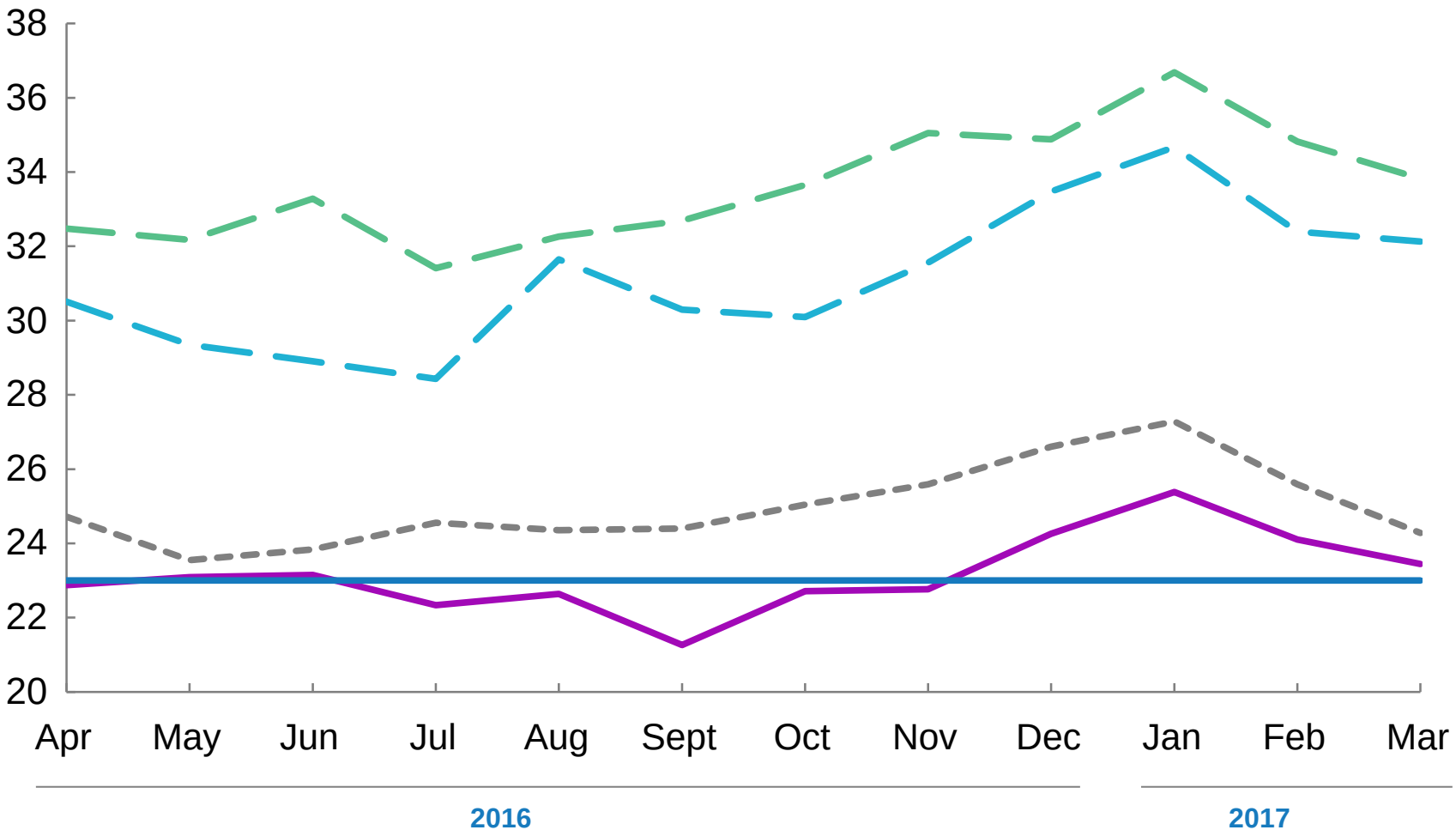


1 Q2 2018 data only includes average of first two months due to availability of data

Source: NHSE A&E Unify2 data collection - MSitAE

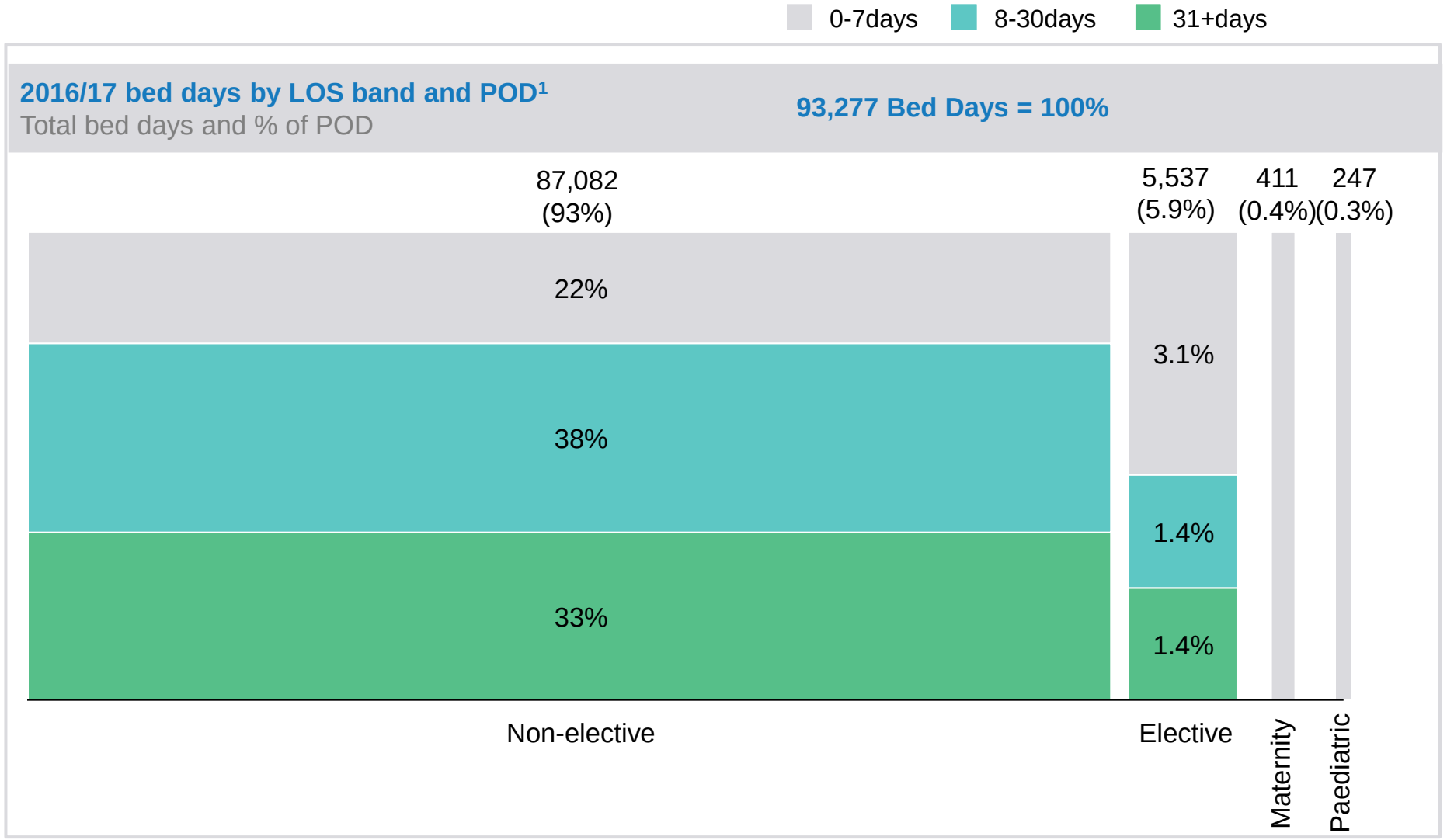
A&E attendances conversion to NEL rate

A&E attendees converted, %



Source: HES 2016/17 data

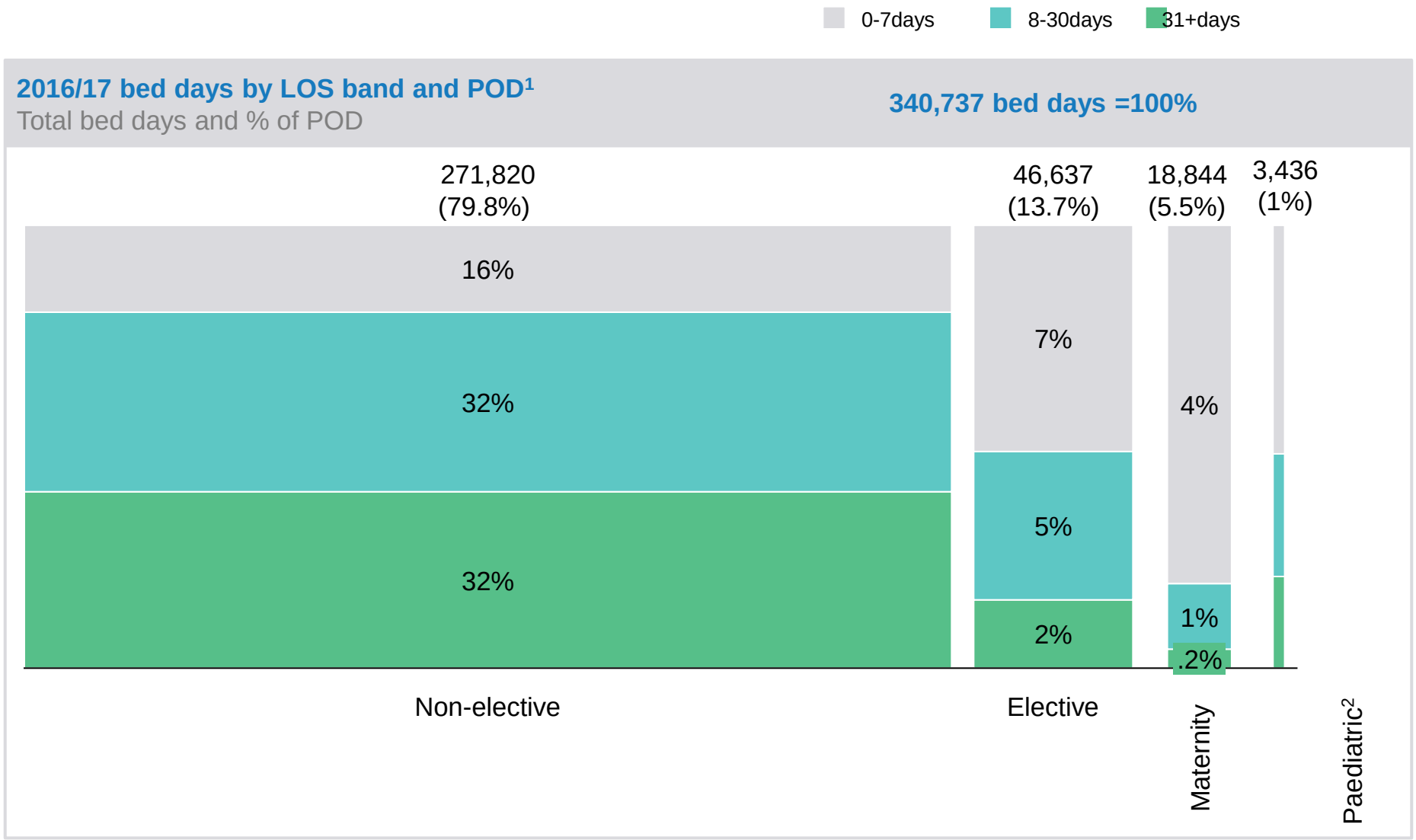
Bed days at WAHT in 2016/17 by line of service and point of delivery



1 Excluding RA (Regular Attenders) and Other (not recorded type), Paediatrics patients are defined by age 0-18 y.o.
2 Figures calculated assuming that all patients in this category currently stay for 31 days, will go down to trust average LOS for NEL patients, and each reduction of a 20 bed unit saves a hospital £2M

Source: HES 2016/17

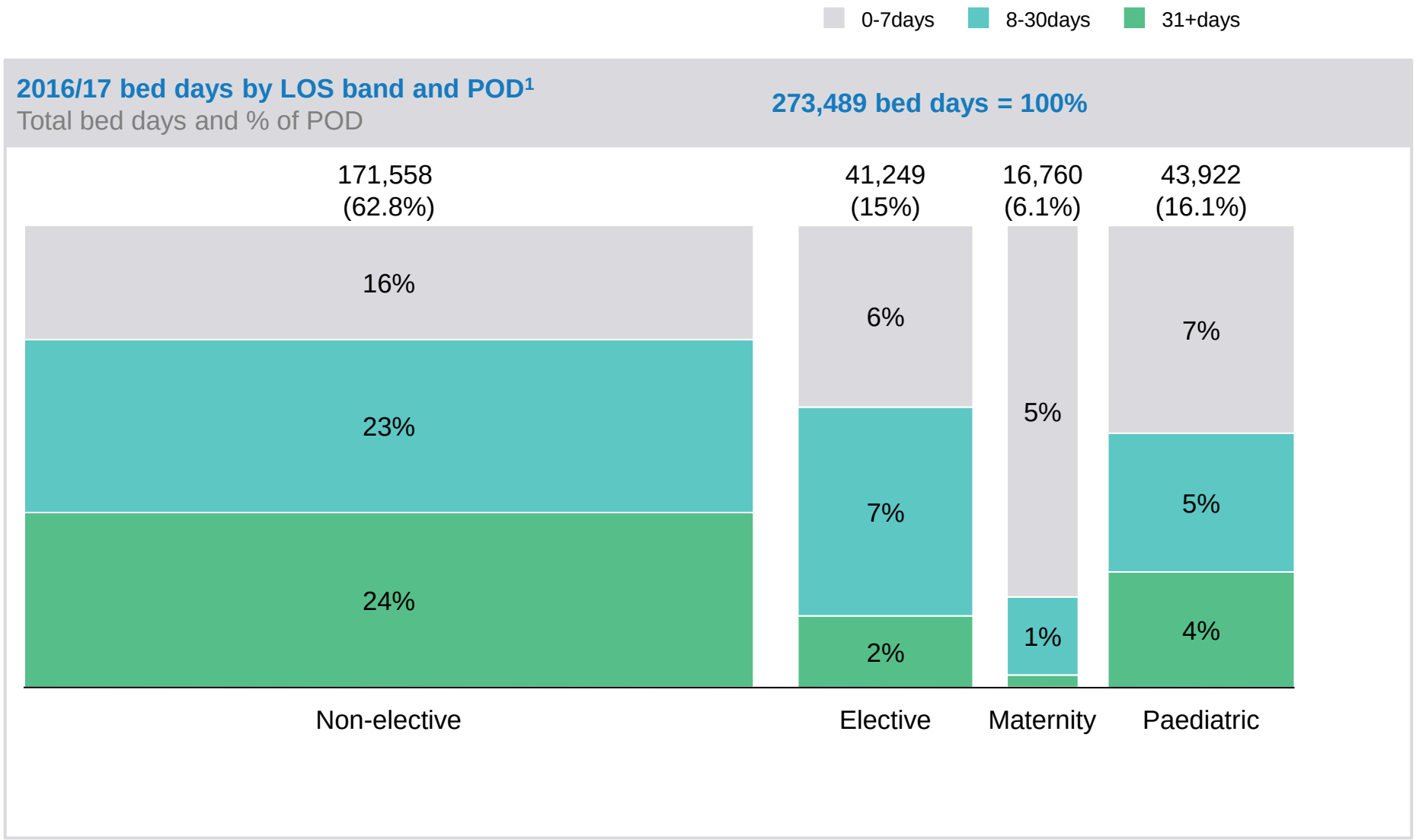
Bed days at NBT in 2016/17 by line of service and point of delivery



1 Excluding RA (Regular Attenders) and Other (not recorded type), Paediatrics patients are defined by age 0-18 y.o.
2 Although NBT does not have a paediatric ward, a small percentage of children are admitted each year
3 Figures calculated assuming that all patients in this category currently stay for 31 days, will go down to trust average LOS for NEL patients, and each reduction of a 20 bed unit saves a hospital £2M

Source: HES 2016/17

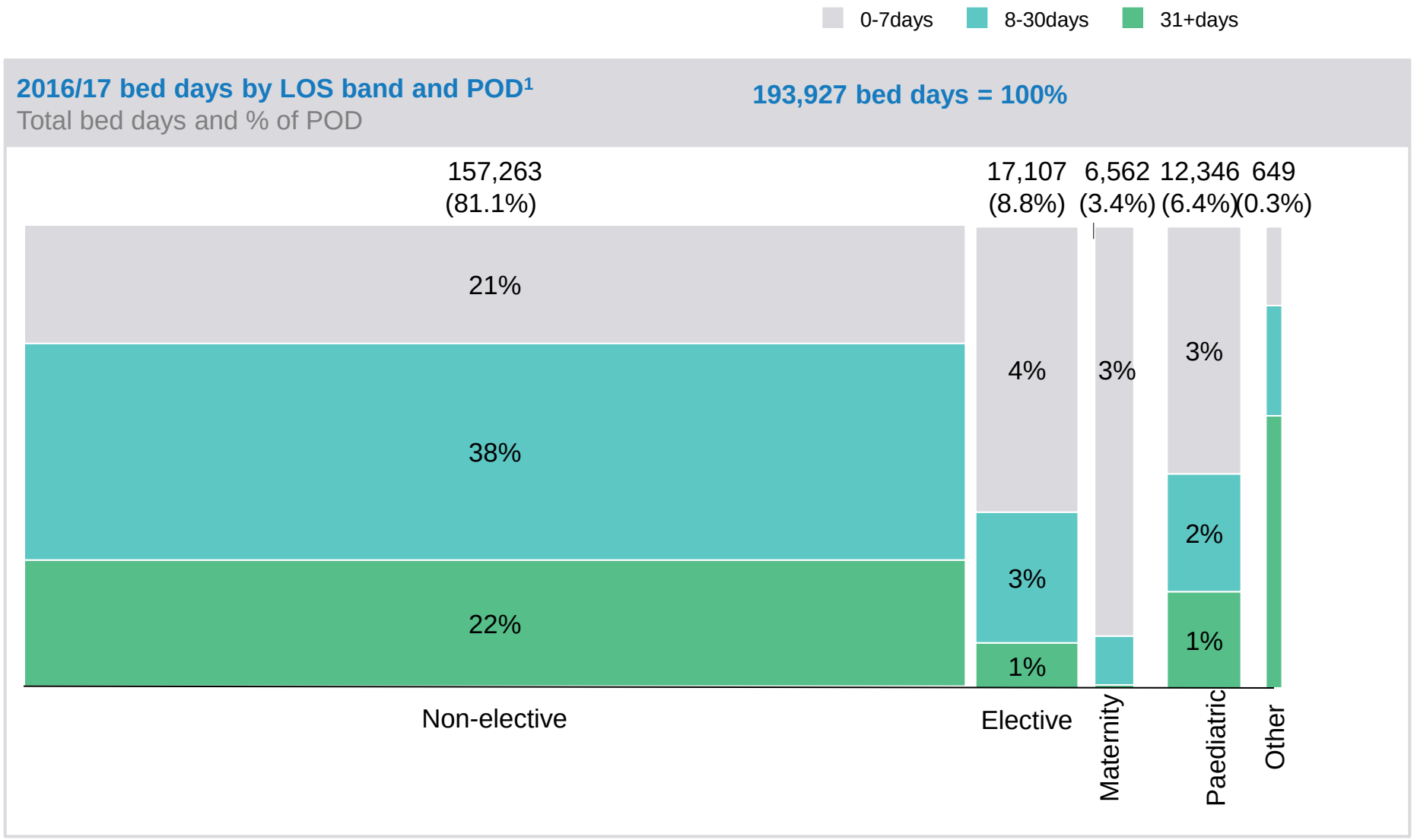
Bed days at UHB in 2016/17 by line of service and point of delivery



1 Excluding RA (Regular Attenders) and Other (not recorded type), Paediatrics patients are defined by age 0-18 y.o.
2 Figures calculated assuming that all patients in this category currently stay for 31 days, will go down to trust average LOS for NEL patients, and each reduction of a 20 bed unit saves a hospital £2M

Source: HES 2016/17

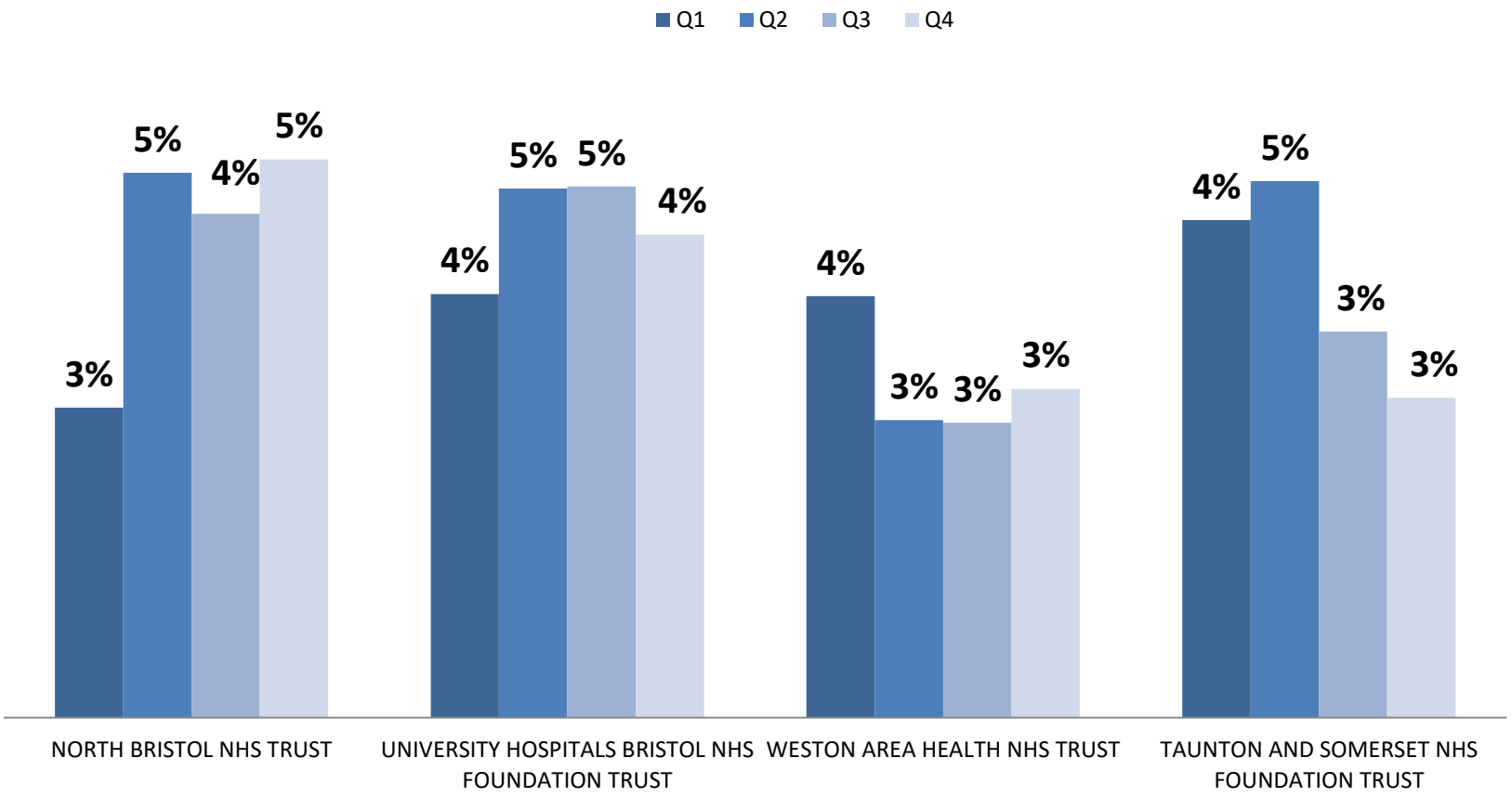
Bed days at T&S in 2016/17 by line of service and point of delivery



1 Excluding RA (Regular Attenders) and Other (not recorded type), Paediatrics patients are defined by age 0-18 y.o.
2 Figures calculated assuming that all patients in this category currently stay for 31 days, will go down to trust average LOS for adult NEL patients, and each reduction of a 20 bed unit saves a hospital £2M; assumes 82% bed occupancy (Q4 2016/17 bed occupancy figures)

Source: HES 2016/17

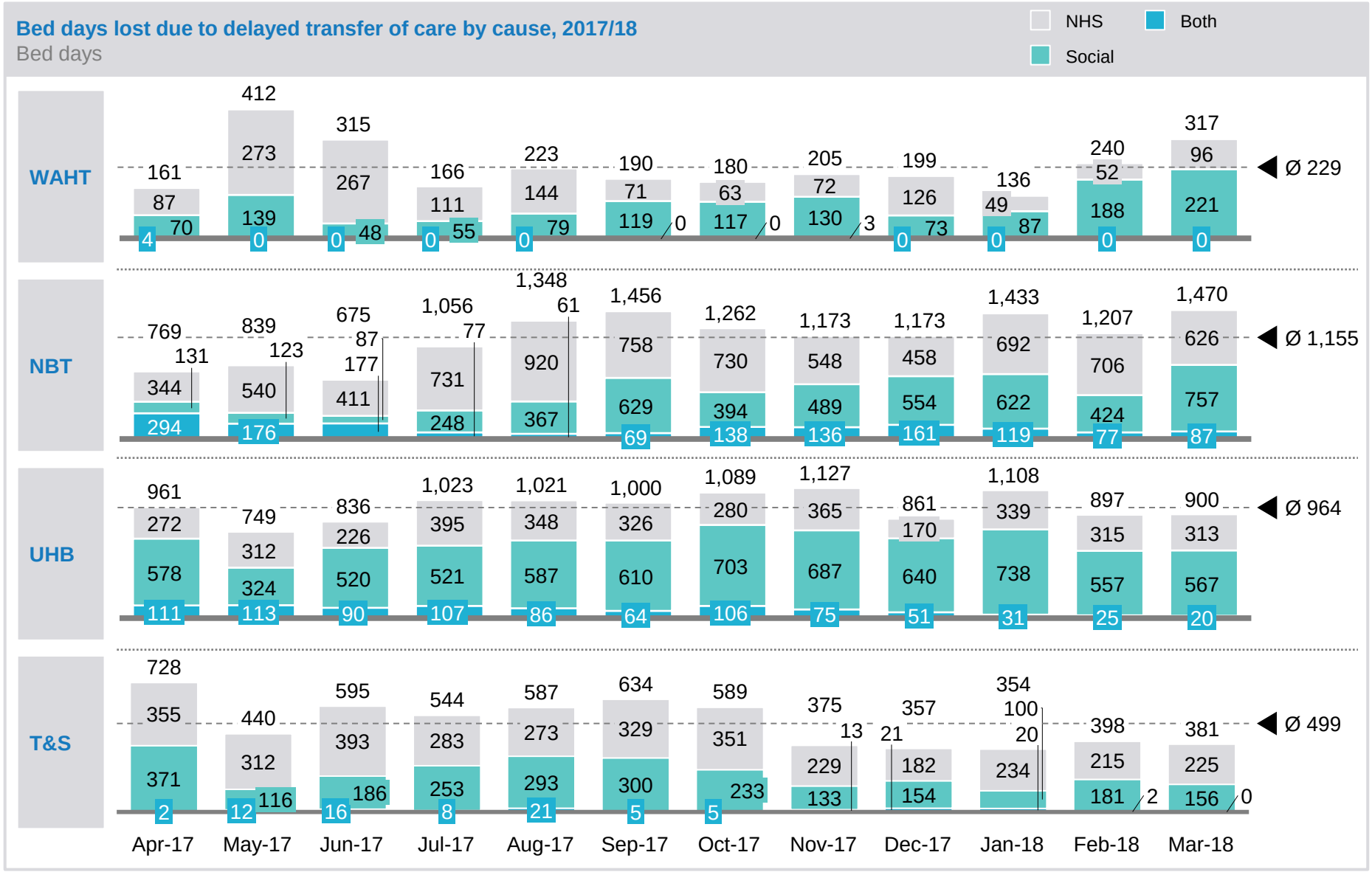
Delayed Transfers of Care 2017/18 - % Occupied Bed Days



National Target: 3.5%

1 Source: BNSSG BI Team

On average of 229 bed days at WAHT are lost every month due to delayed transfer of care

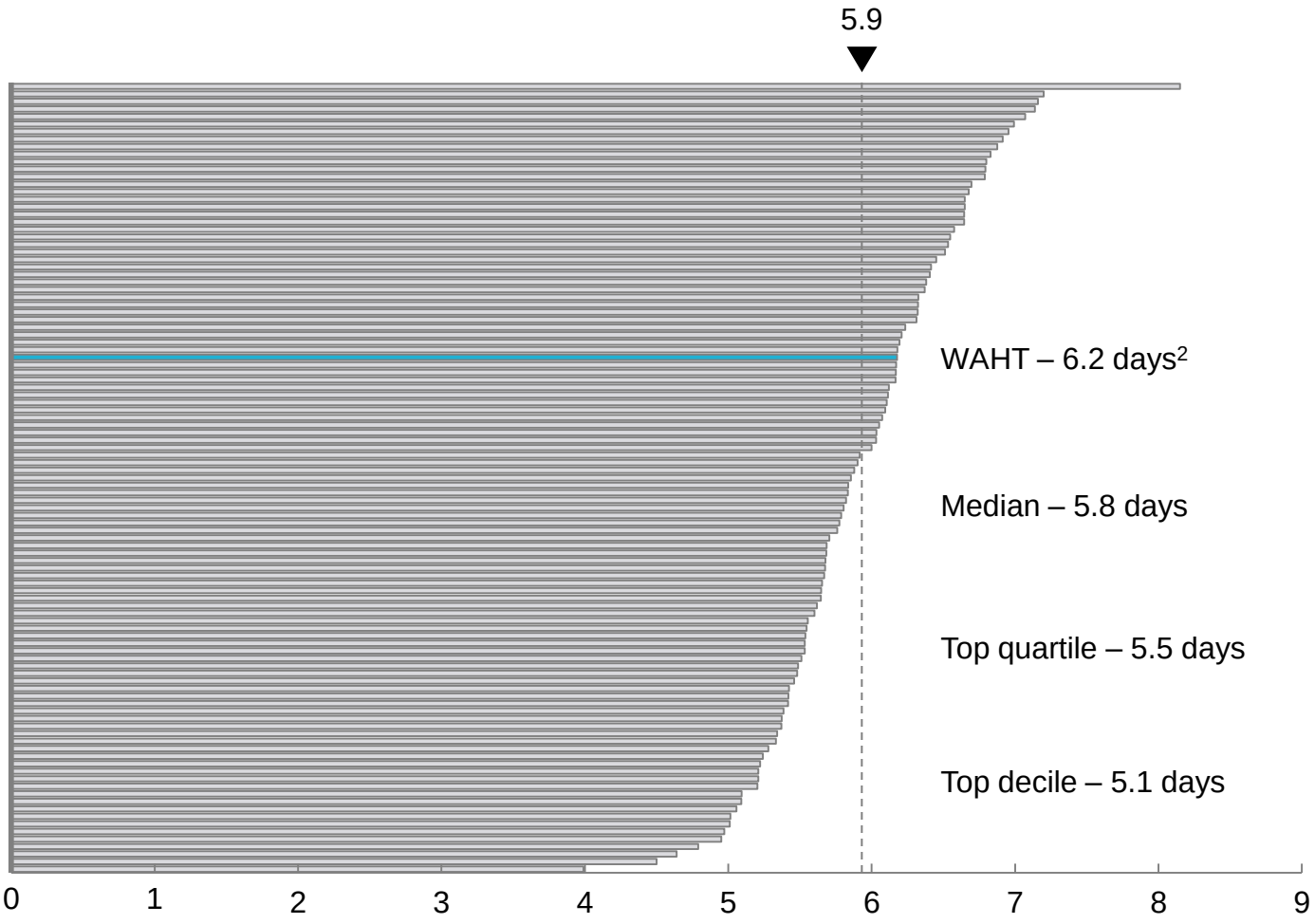


Source: NHSE DTOC Unify2 data collection - MSitAE

WAHT has slightly worse than average case-mix adjusted length of stay

Case-mix adjusted non-elective[1] average length of stay, for Weston General, against all non-specialist acute Trusts in England, 2016/17, Days

Case-mix adjustment separates Trust performance from the complexity of the case-mix



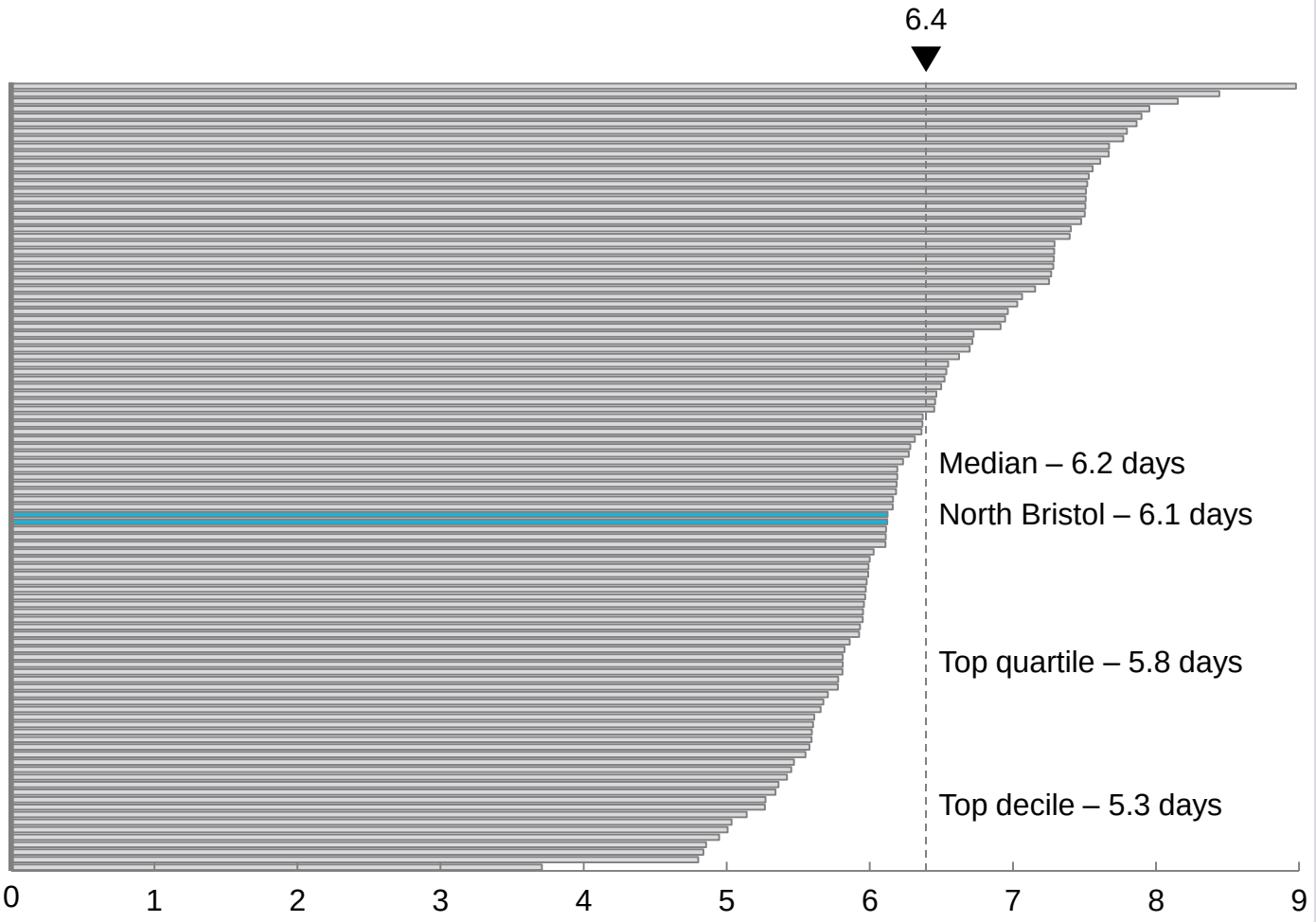
1 Excluding maternity and for acute hospitals only 2 Case mix adjusted to Weston's activity mix

Source: HES 2016/17 IP 2017/17 APC dataset M13, c/o NHS Digital

North Bristol has slightly better than average case-mix adjusted non-elective average length of stay compared to its peer group

Case-mix adjusted[1] non-elective inpatient[2] average length of stay for North Bristol, compared to all non-specialist acute Trusts in England[3], 2016/17, Days

Case-mix adjustment separates Trust performance from the complexity of the case-mix



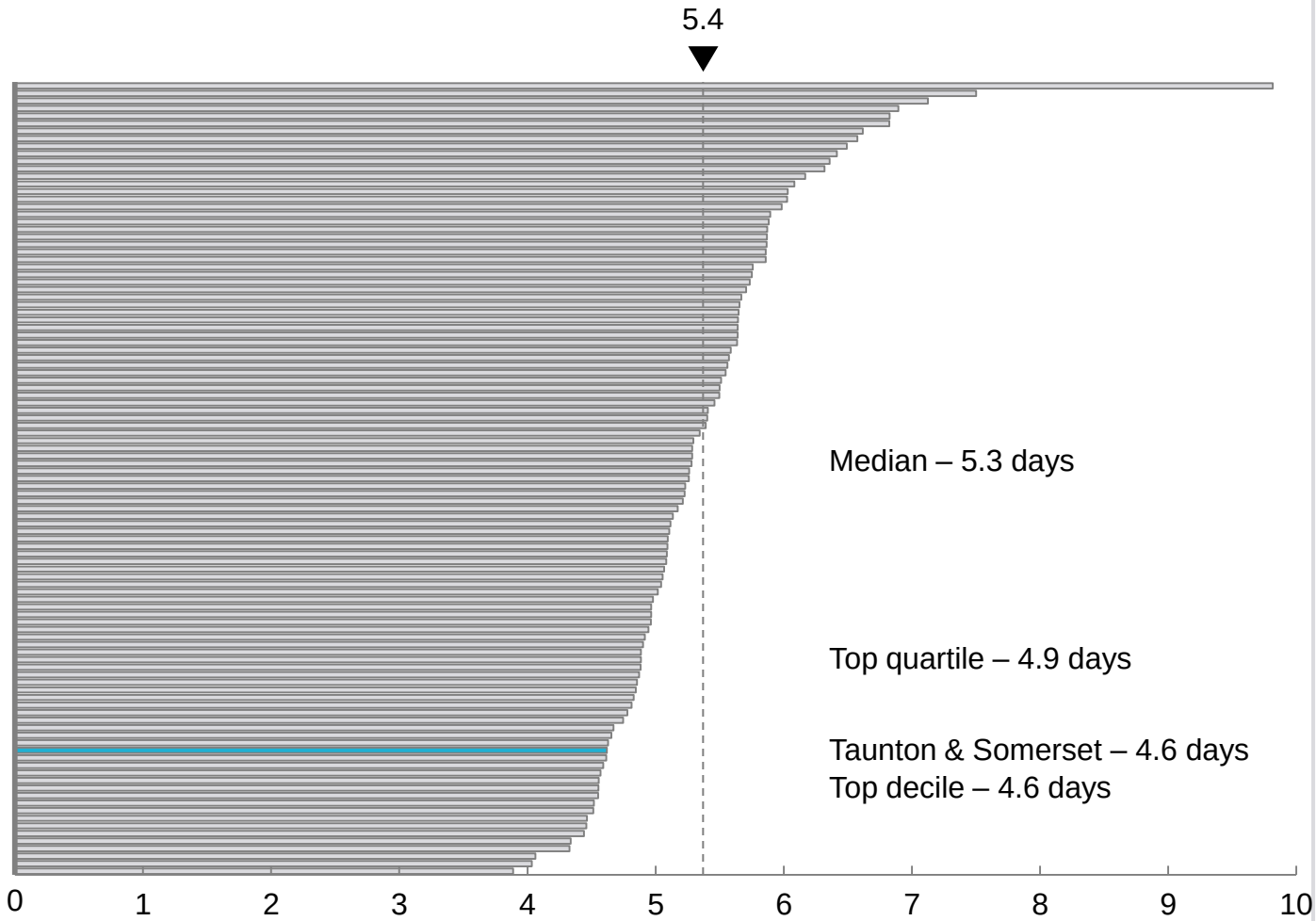
1 Case mix adjusted for North Bristol's non-elective activity mix. 2 Non-elective inpatients only (excluding maternity). 3 All Trusts categorised as Acute Small, Acute Medium, Acute Large, and Acute Multi-Service.

Source: HES 2016/17 APC dataset M13, c/o NHS Digital

Taunton & Somerset has top decile case-mix adjusted non-elective average length of stay for its peer group

Case-mix adjusted[1] non-elective inpatient[2] average length of stay for Taunton & Somerset, compared to all non-specialist acute Trusts in England[3], 2016/17, Days

Case-mix adjustment separates Trust performance from the complexity of the case-mix



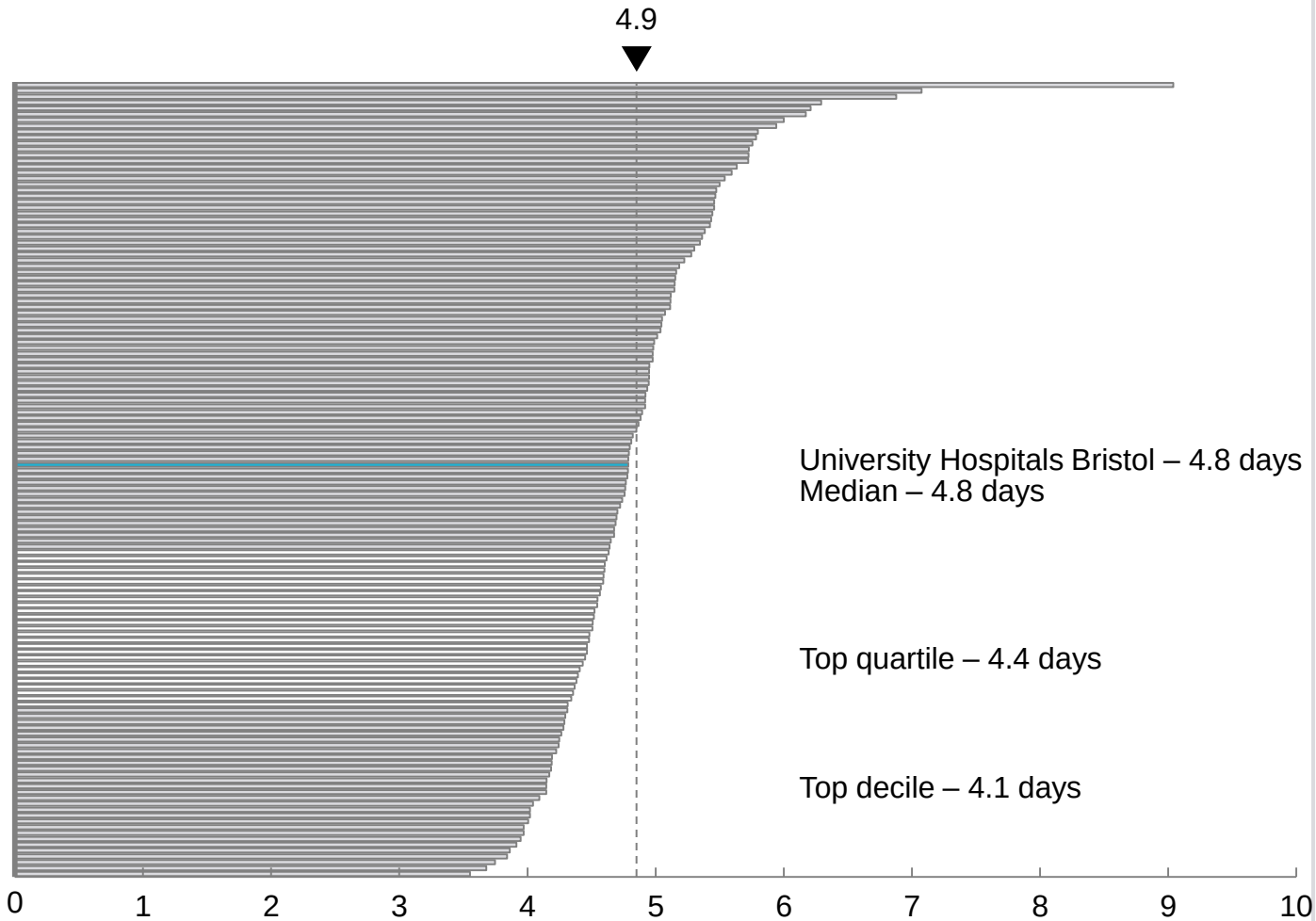
1 Case mix adjusted for Taunton & Somerset's non-elective activity mix. 2 Non-elective inpatients only (excluding maternity). 3 All Trusts categorised as Acute Small, Acute Medium, Acute Large, and Acute Multi-Service.

Source: HES 2016/17 APC dataset M13, c/o NHS Digital

University Hospitals Bristol has average case-mix adjusted non-elective average length of stay for its peer group

Case-mix adjusted[1] non-elective inpatient[2] average length of stay for Taunton & Somerset, compared to all non-specialist acute Trusts in England including teaching Trusts[3], 2016/17, Days

Case-mix adjustment separates Trust performance from the complexity of the case-mix

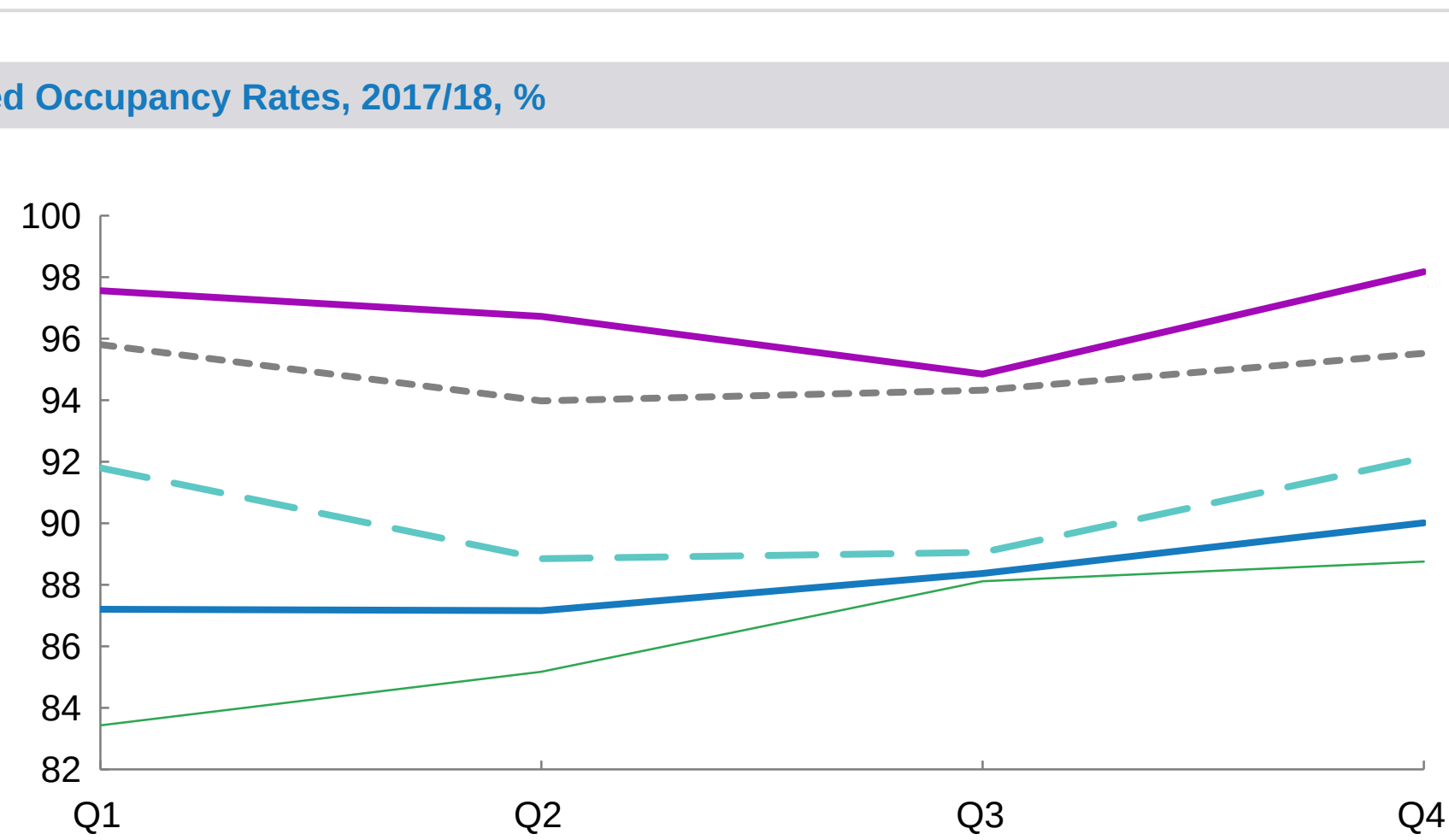


1 Case mix adjusted for University Hospitals Bristol's non-elective activity mix. 2 Non-elective inpatients only (excluding maternity). 3 All Trusts categorised as Acute Small, Acute Medium, Acute Large, Acute Multi-Service, and Acute Teaching.

Source: HES 2016/17 APC dataset M13, c/o NHS Digital

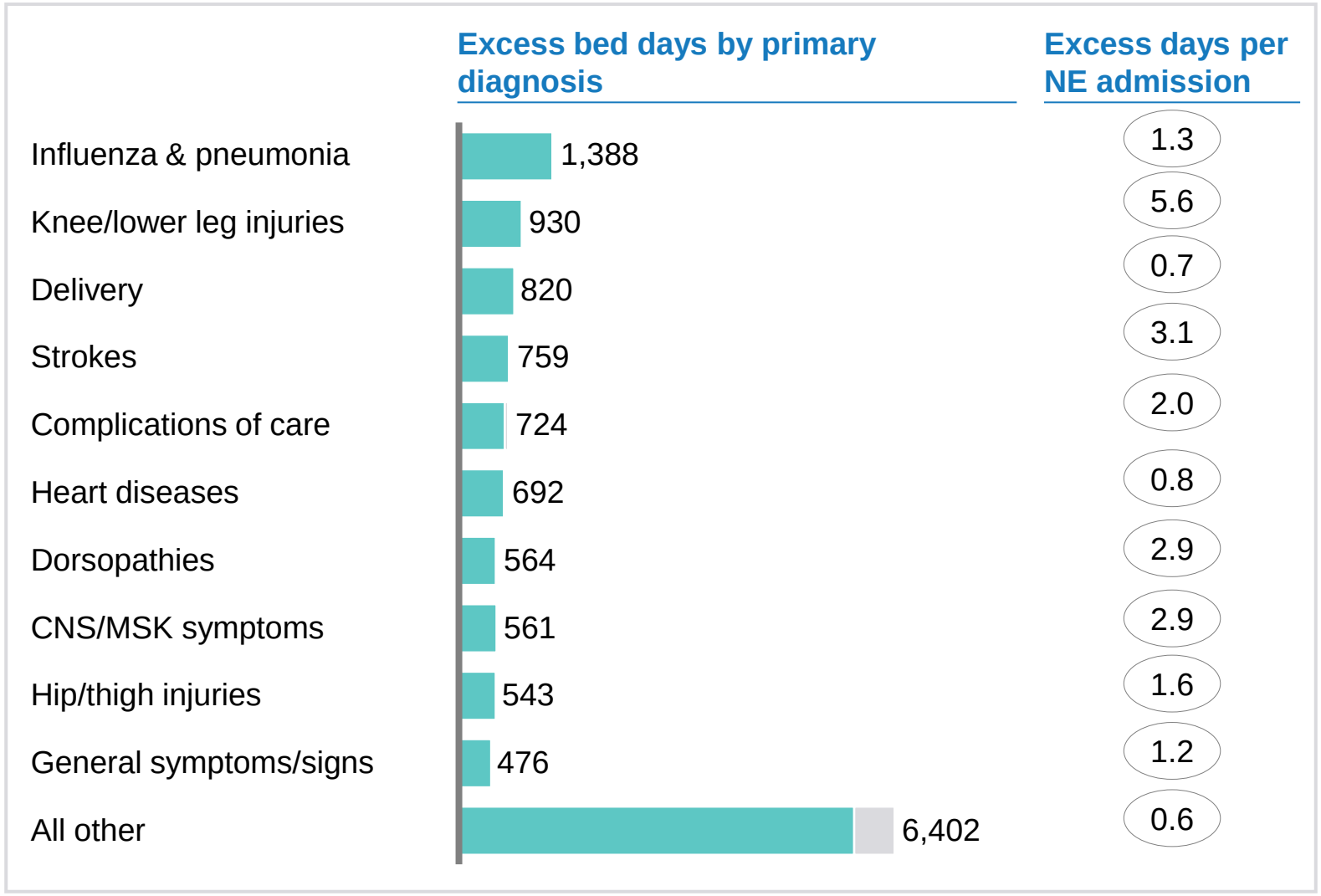
Bed occupancy rates at WAHT, UHB, and NBT are consistently above the national average

Bed Occupancy Rates, 2017/18, %



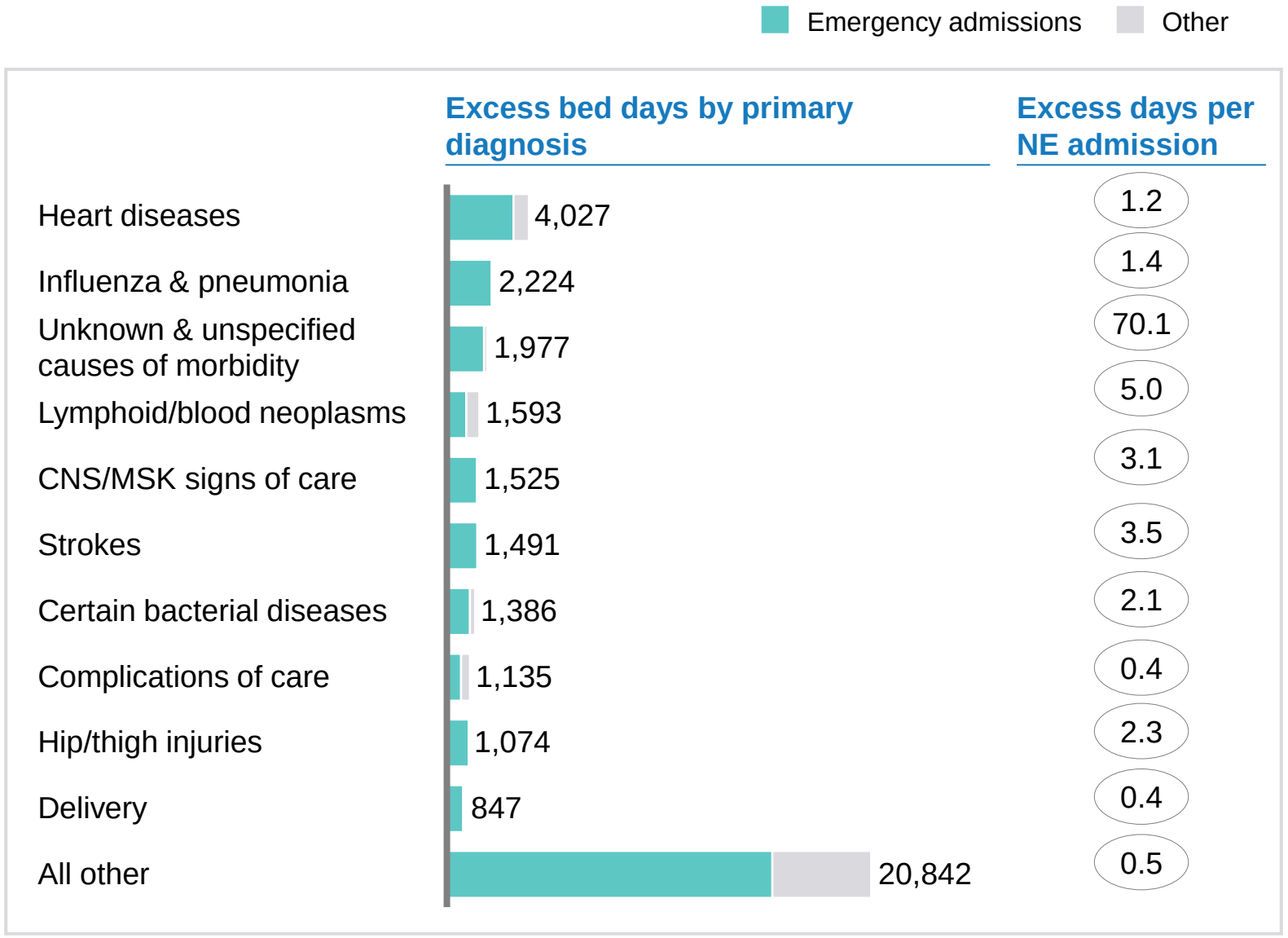
SOURCE: NHS website – Bed Availability and Occupancy statistics 2017/18

1 in 10 excess bed days at WAHT are due to influenza and pneumonia patients



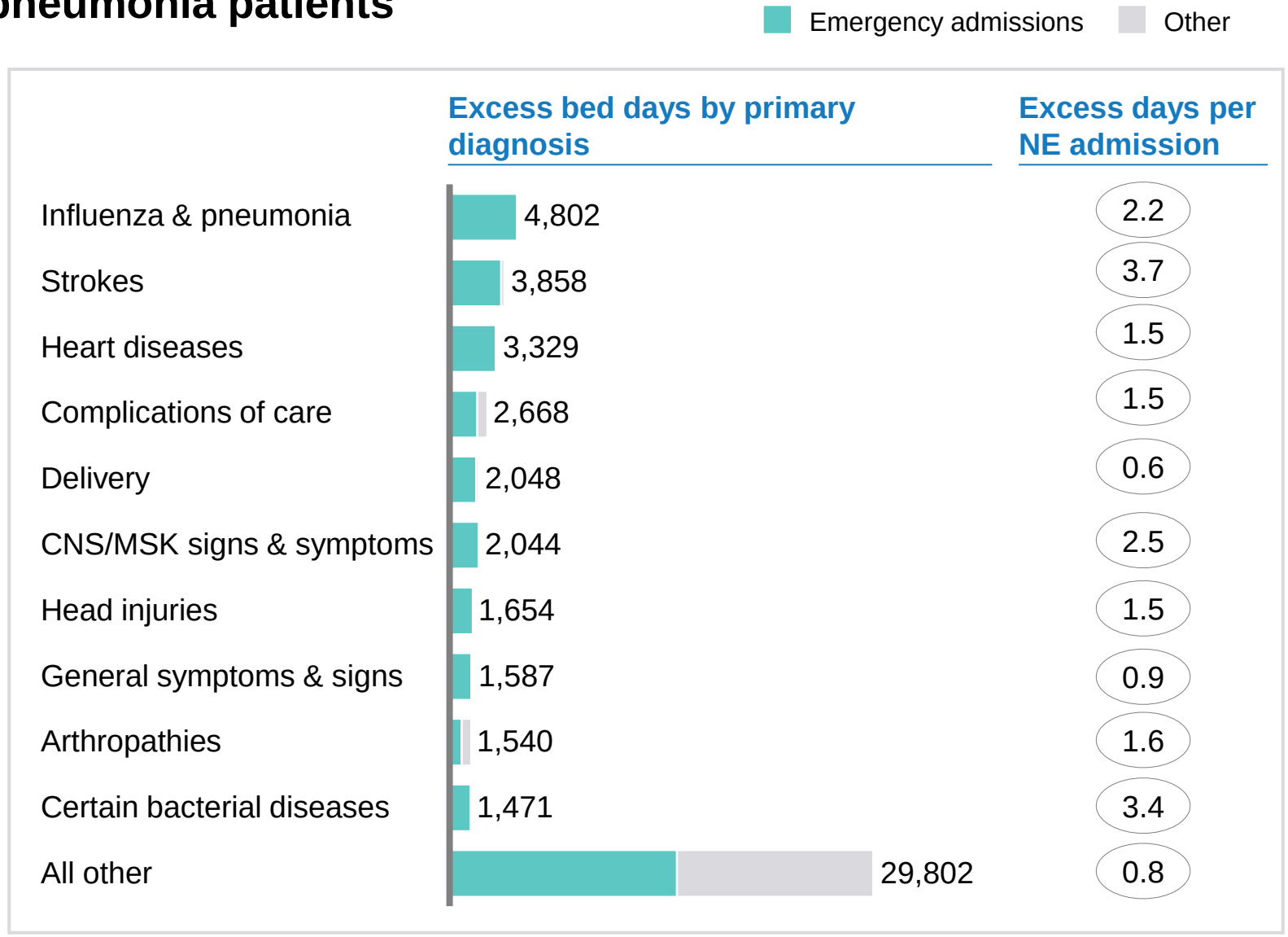
Source: HES 2016/17 M13 APC, C/o NHS Digital. Excludes regular attenders

1 in 10 excess bed days at UHB are in heart disease patients



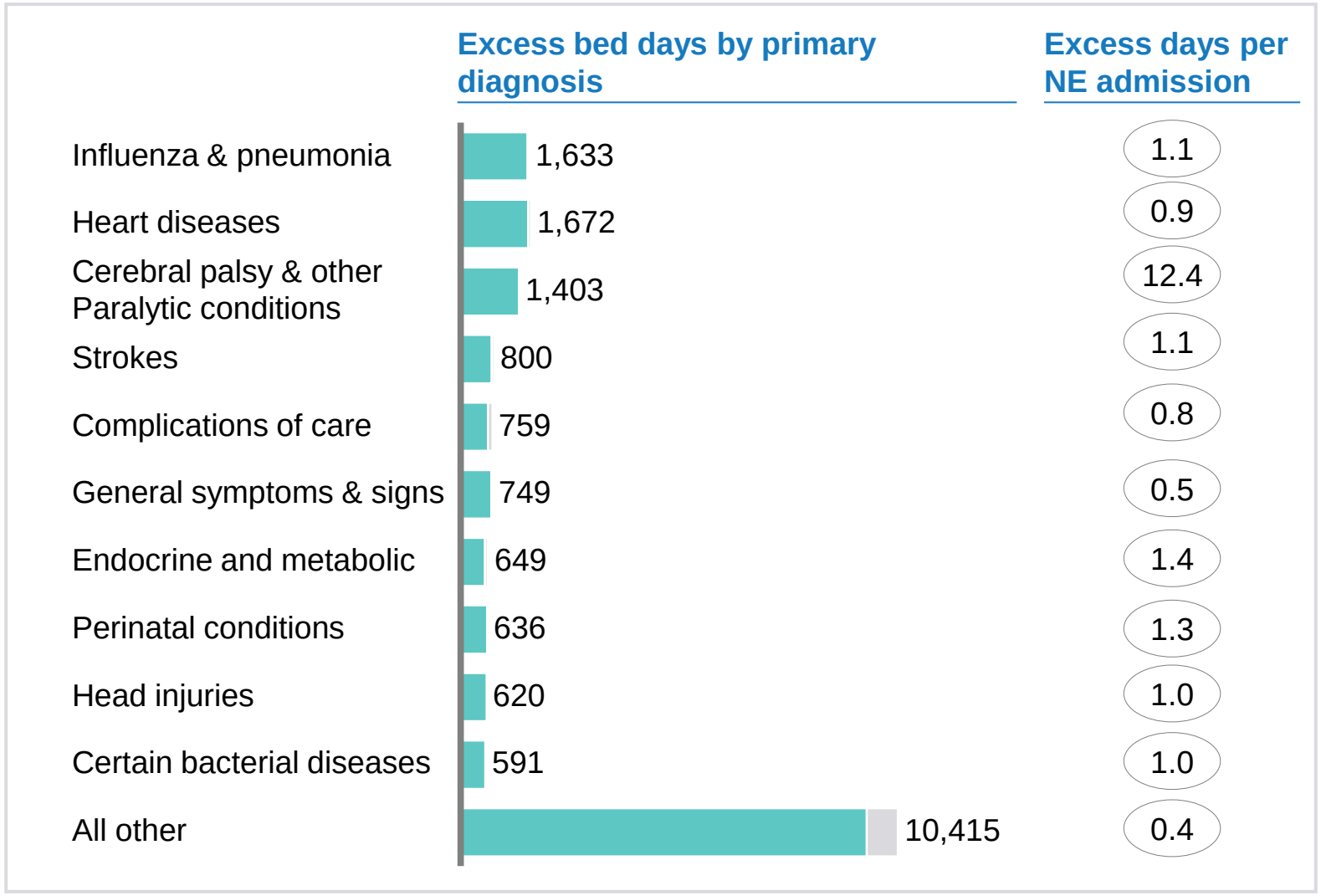
Source: HES 2016/17 M13 APC, C/o NHS Digital. Excludes regular attenders

1 in 10 excess bed days at NBT are due to influenza and pneumonia patients



Source: HES 2016/17 M13 APC, C/o NHS Digital. Excludes regular attenders

1 in 12 excess bed days at T&S are due to influenza and pneumonia patients

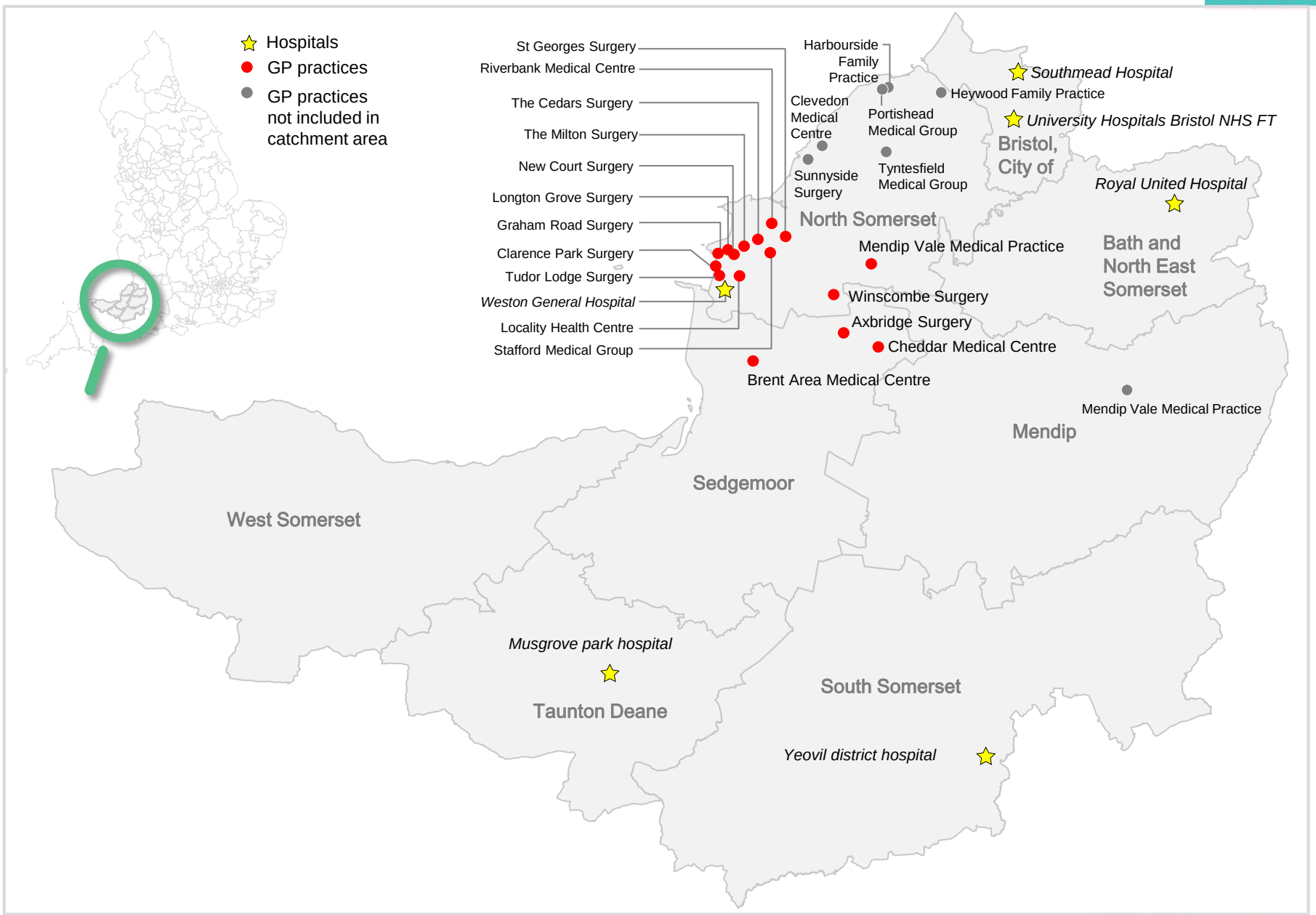


Source: HES 2016/17 M13 APC, C/o NHS Digital. Excludes regular attenders

Case for Change

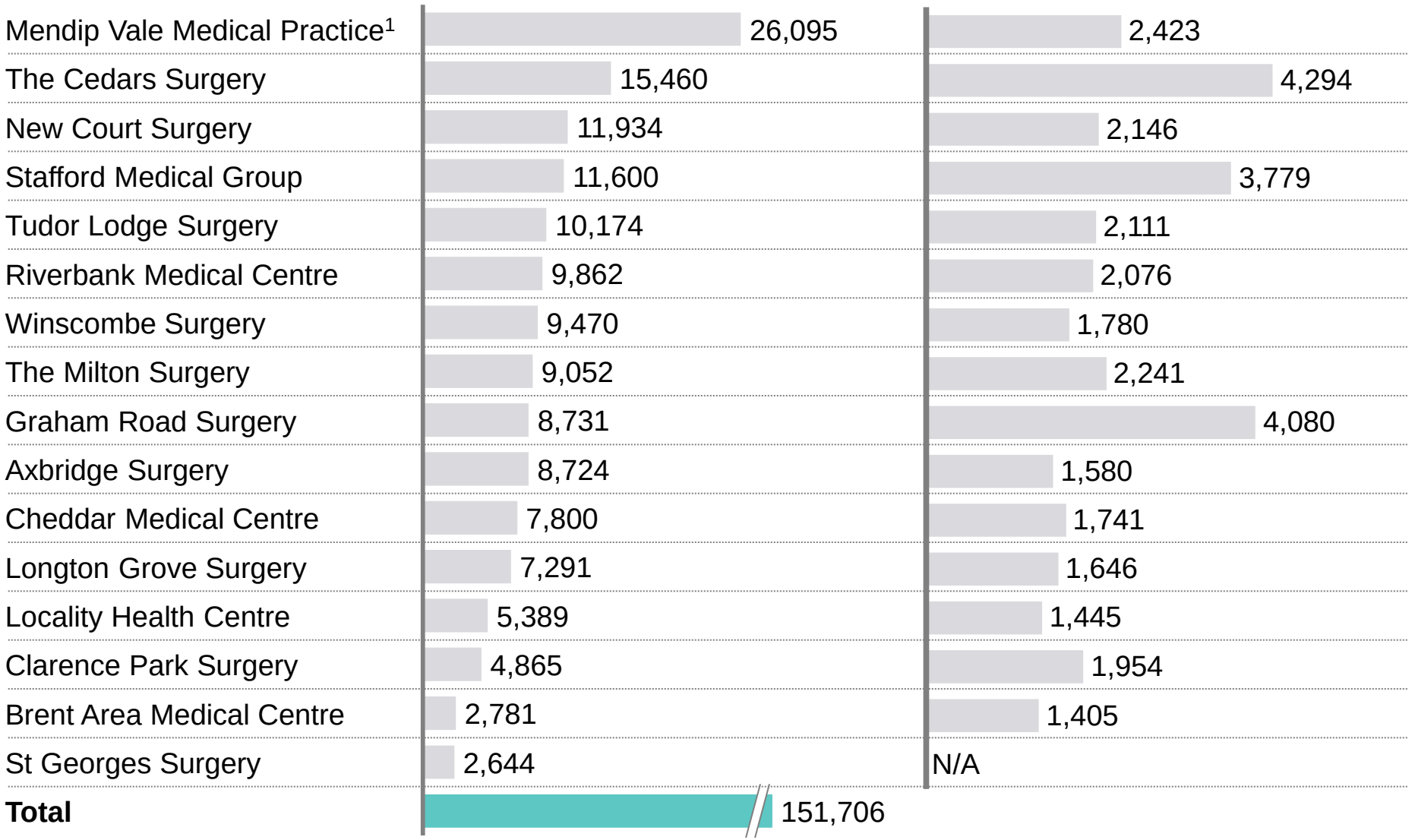
- Local population and their health and care needs
- Acute care
- **Out of hospital: Primary care**
- Out of hospital: Community, mental health and social care
- Out of hospital: Ambulance services
- Financial position

There are 16 GP practices in the WAHT catchment area



Note: Mendip Vale Medical Practice now includes St George's Surgery, Sunnyside Surgery and Riverbank Surgery

There are 151,706 registered patients in total across these 16 GP practices

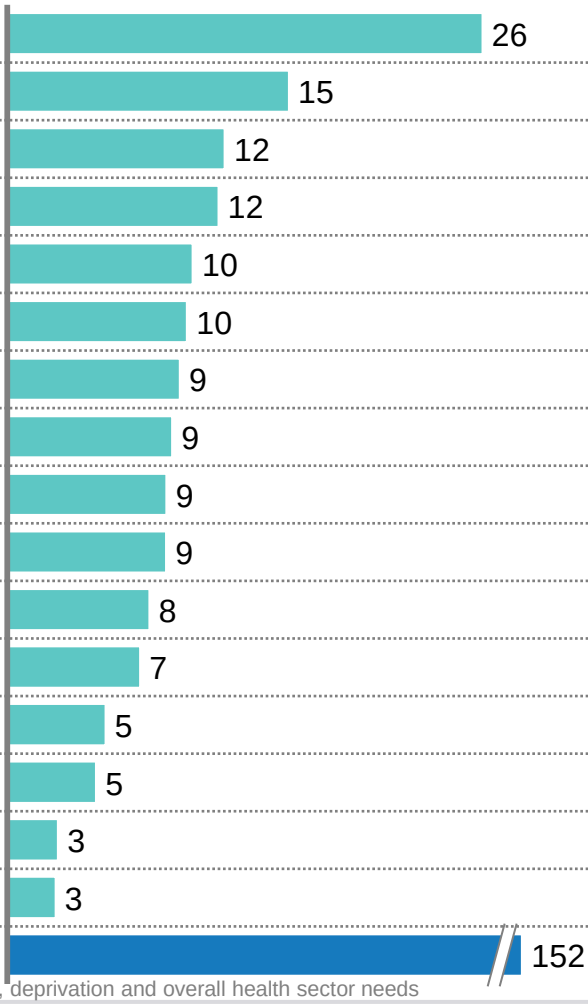


GP Practices	Number of Patients	Patients per WTE GP
Mendip Vale Medical Practice[1]	26,095	2,423
The Cedars Surgery	15,460	4,294
New Court Surgery	11,934	2,146
Stafford Medical Group	11,600	3,779
Tudor Lodge Surgery	10,174	2,111
Riverbank Medical Centre	9,862	2,076
Winscombe Surgery	9,470	1,780
The Milton Surgery	9,052	2,241
Graham Road Surgery	8,731	4,080
Axbridge Surgery	8,724	1,580
Cheddar Medical Centre	7,800	1,741
Longton Grove Surgery	7,291	1,646
Locality Health Centre	5,389	1,445
Clarence Park Surgery	4,865	1,954
Brent Area Medical Centre	2,781	1,405
St Georges Surgery	2,644	N/A
Total	151,706	

1 Mendip Vale Medical Practice is made up of multiple sites – here St Georges Surgery and Riverbank Med Ctr are shown separately

SOURCE: HES 2016/17

2016 GP provision by GP practice (WAHT catchment)



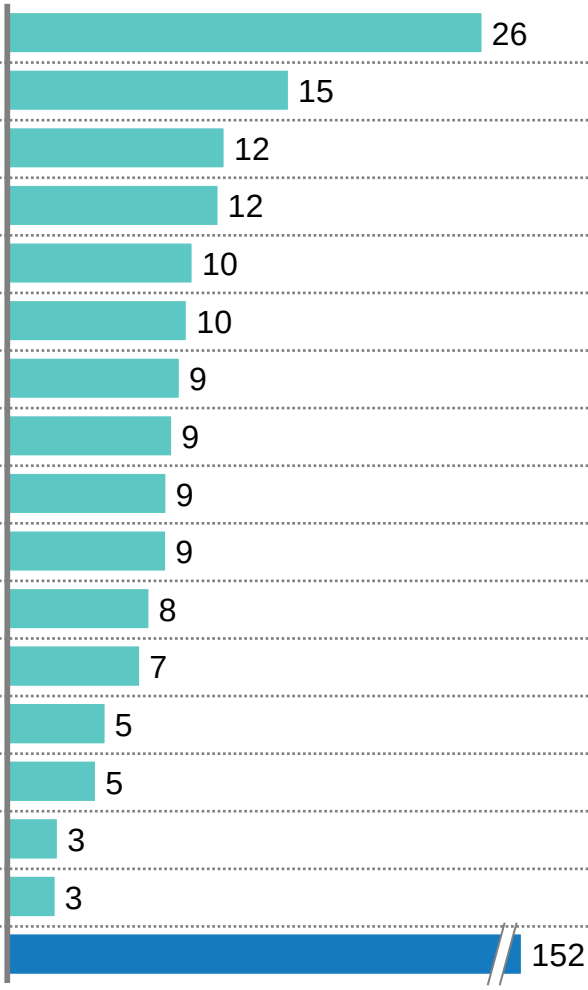
GP practice	List size - weighted population (WP)[1] 2016, '000s	Number of FTE GPs[2]	Number of Head Count GPs	Number of FTE GPs per 10,000 WP	% GPs over 55
Mendip Vale Medical Practice[3]	26	10.8	15.0	4.1	27%
The Cedars Surgery	15	3.6	4.0	2.3	50%
New Court Surgery	12	5.6	6.0	4.7	50%
Stafford Medical Group	12	3.1	4.0	2.6	25%
Tudor Lodge Surgery	10	4.8	7.0	4.7	29%
Riverbank Medical Centre	10	4.8	7.0	4.8	14%
Winscombe Surgery	9	5.3	7.0	5.6	29%
The Milton Surgery	9	4.0	6.0	4.5	17%
Graham Road Surgery	9	2.1	2.0	2.5	100%
Axbridge Surgery	9	5.5	8.0	6.3	0%
Cheddar Medical Centre	8	4.5	5.0	5.7	40%
Longton Grove Surgery	7	4.4	5.0	6.1	40%
Locality Health Centre	5	3.7	5.0	6.9	80%
Clarence Park Surgery	5	2.5	3.0	5.1	67%
Brent Area Medical Centre	3	2.0	2.0	7.1	100%
St Georges Surgery	3	N/A	N/A	N/A	N/A
Total	152	66.7	86.0	4.4	35%

1 Weighted population - adjusts for variation in age, deprivation and overall health sector needs
2 Total Nurse Headcount - includes practitioners authorised to practice within England. Includes practice nurses, specialist nurses, and advanced nurse practitioners. All figures exclude locums
3 3 Mendip Vale Medical Practice is made up of multiple sites and data on this page will include all sites

National median for Total FTE GPs per 10,000 WP is 5.0

Source: GP Workforce Census Health and Social Care Information Centre 2015-16

2016 Non-GP primary care staffing by GP practice



GP practice	List size - weighted population (WP)[1] 2016, '000s	Total nurse FTE[2]	Practice nurse FTE	Admin staff FTE	Total nurse FTE per 10,000 WP
Mendip Vale Medical Practice[3]	26	5.1	3.4	19.7	1.9
The Cedars Surgery	15	5.4	2.6	12.5	3.5
New Court Surgery	12	3	3	14.6	2.5
Stafford Medical Group	12	3.4	1.9	15.8	2.9
Tudor Lodge Surgery	10	4.7	3.7	0	4.6
Riverbank Medical Centre	10	2	2	10	2
Winscombe Surgery	9	2.7	1.7	10.4	2.8
The Milton Surgery	9	3.8	2.9	8.7	4.2
Graham Road Surgery	9	2.4	1.6	13.4	2.7
Axbridge Surgery	9	1.8	1.8	1	2.1
Cheddar Medical Centre	8	1.6	1.6	7.3	2
Longton Grove Surgery	7	1.7	1.7	9	2.4
Locality Health Centre	5	4.2	2.3	8.7	7.9
Clarence Park Surgery	5	2.8	2.3	7.9	5.7
Brent Area Medical Centre	3	0.6	0.6	3.5	2
St Georges Surgery	3	1	1	4	3.7
Total	152	46.1	34	146.4	3

1 Weighted population - adjusts for variation in age, deprivation and overall health sector needs
2 Total Nurse Headcount - includes practitioners authorised to practice within England. Includes practice nurses, specialist nurses, and advanced nurse practitioners. All figures exclude locums
3 Mendip Vale Medical Practice is made up of multiple sites and data on this page will include all sites

National median for Total Nurse FTE per 10,000 WP is 2.3

Source: GP Workforce Census Health and Social Care Information Centre 2015-16

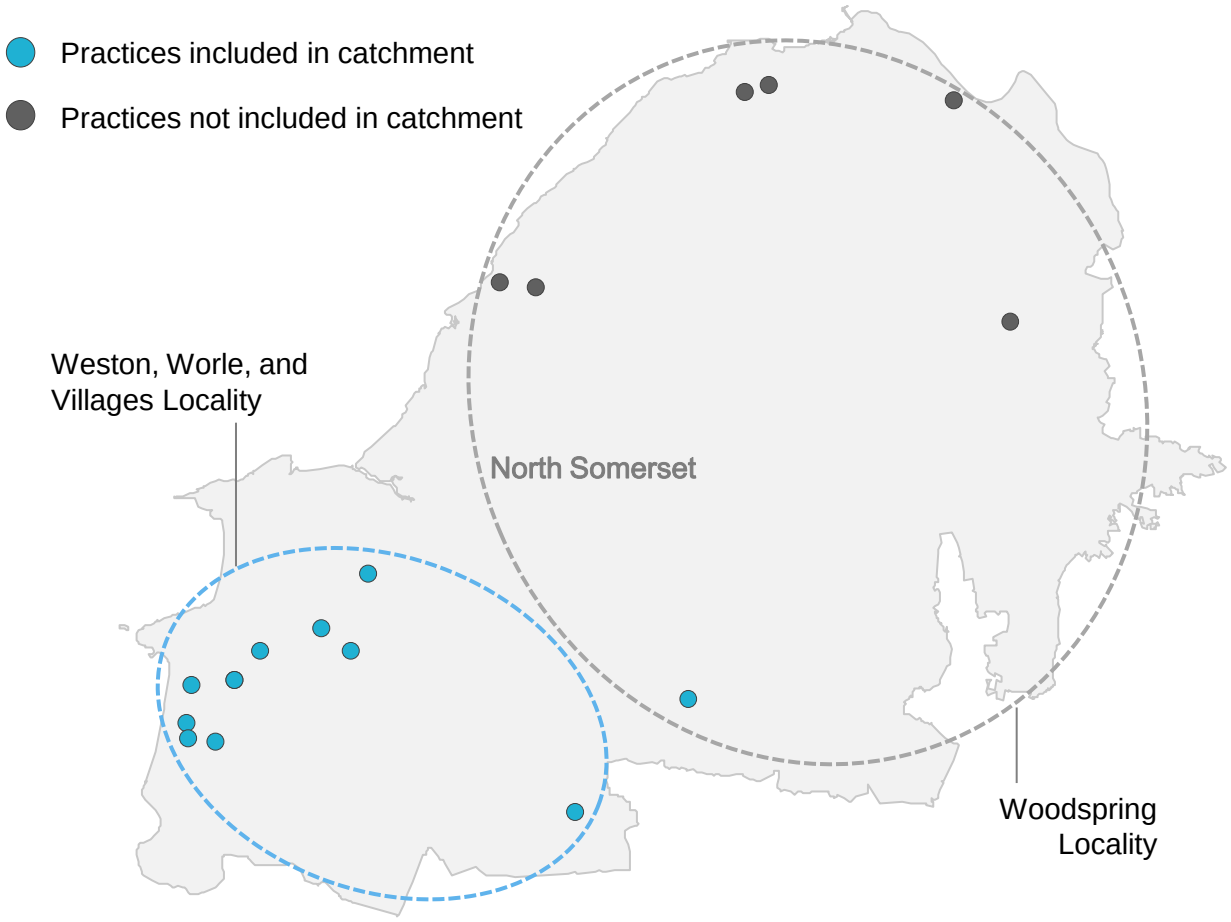
2018 GP and non-GP provision by GP practices

GP practice	List size 2018, '000s	Number of FTE GPs	% GP headcount over 55	Number of practice nurses WTEs	Number of other clinical staff	Number of admin staff
Mendip Vale Medical Practice[1]		N/A	N/A	N/A	N/A	N/A
The Cedars Surgery	15	4.9	38%	3.6	17.9	5.0
New Court Surgery	12	6.2	43%	2.2	16.1	3.6
Stafford Medical Group	12	2.7	100%	1.9	15.4	2.2
Tudor Lodge Surgery	10	4.6	29%	3.2	16.0	5.7
Riverbank Medical Centre	10	2.7	0%	1.2	3.9	9.3
Winscombe Surgery	9	5.9	38%	1.7	3.1	10.1
The Milton Surgery	9	4.1	33%	2.9	1.7	7.7
Graham Road Surgery	9	0.0	0%	0.0	11.3	0.0
Axbridge Surgery		N/A	N/A	N/A	N/A	N/A
Cheddar Medical Centre		N/A	N/A	N/A	N/A	N/A
Longton Grove Surgery	7	6.7	38%	2.5	1.3	10.5
Locality Health Centre	5	1.7	50%	2.6	3.0	7.8
Clarence Park Surgery	5	1.2	25%	0.5	1.4	2.5
Brent Area Medical Centre		N/A	N/A	N/A	N/A	N/A
St Georges Surgery		N/A	N/A	N/A	N/A	N/A

1 Mendip Vale Medical Practice is made up of multiple sites and data on this page will include all sites

Source: GP Workforce Census Health and Social Care Information Centre 2018

In North Somerset, primary care is organised into 2 localities of GP practices



Weston, Worle, and Villages
Clarence Park Surgery
Locality Health Centre[1]
Graham Road Surgery
Longton Grove Surgery
The Milton Surgery
New Court Surgery
Tudor Lodge Surgery
Winscombe & Banwell Family Practice
Stafford Medical Group
Riverbank Medical Centre
The Cedars Surgery

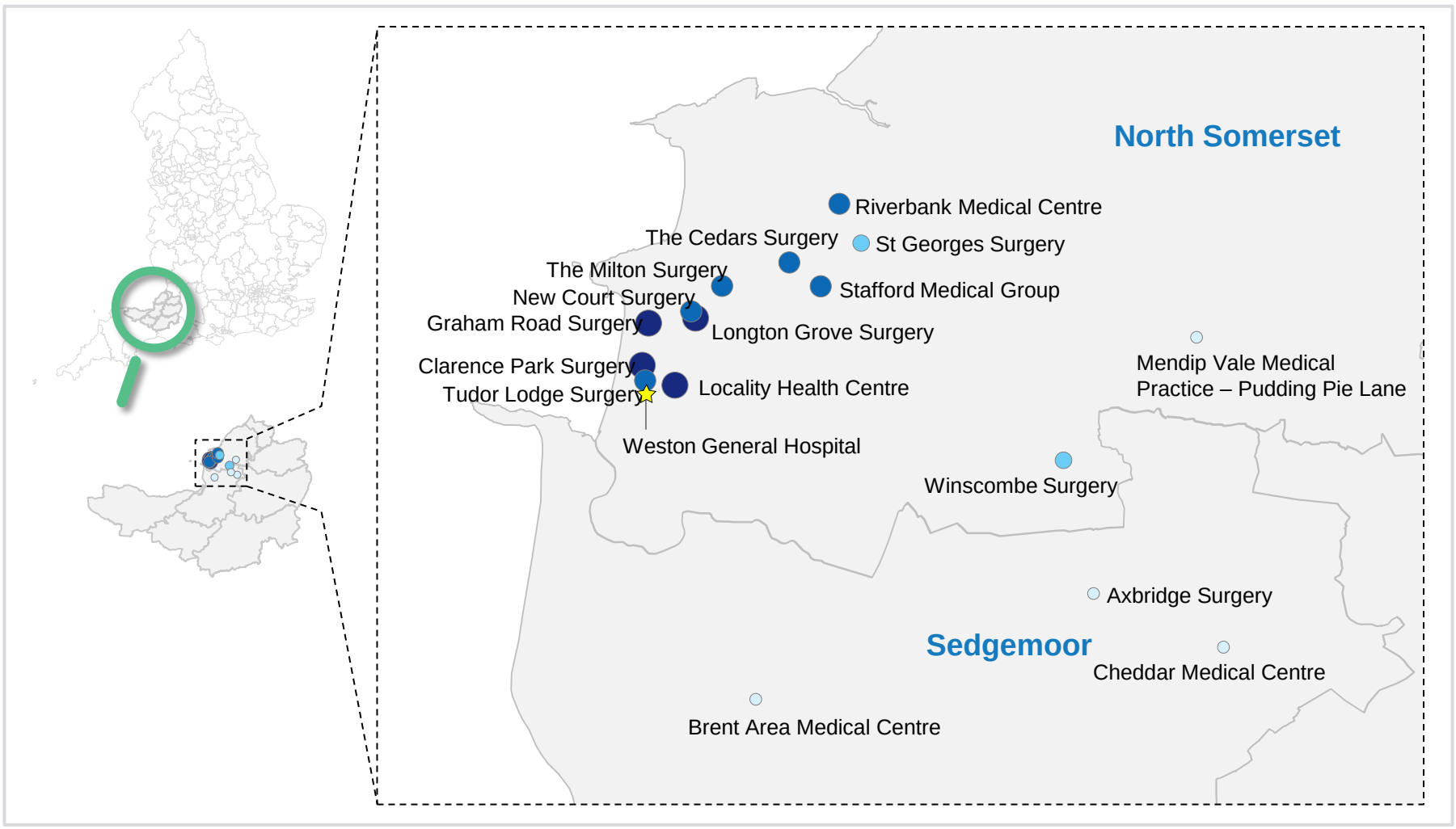
Woodspring
Clevedon Medical Practice
Harbourside Family Practice
Heywood Family Practice
Portishead Medical Group
Sunnyside Surgery
Mendip Vale Medical Centre
Tyntesfield Medical Group

- GP localities are **geographically based**; **locality based working** (e.g., shared services and back-office functions) is **still developing**
- The **majority of WAHT's catchment area** comes from **the Weston, Worle, and Villages locality**

1 Locality health centre has taken recently taken over management of Clarence Park and Graham Park Road surgeries

SOURCE: Health Weston Commissioning Context 2017

>80% ED referrals from local GP practices go to WAHT

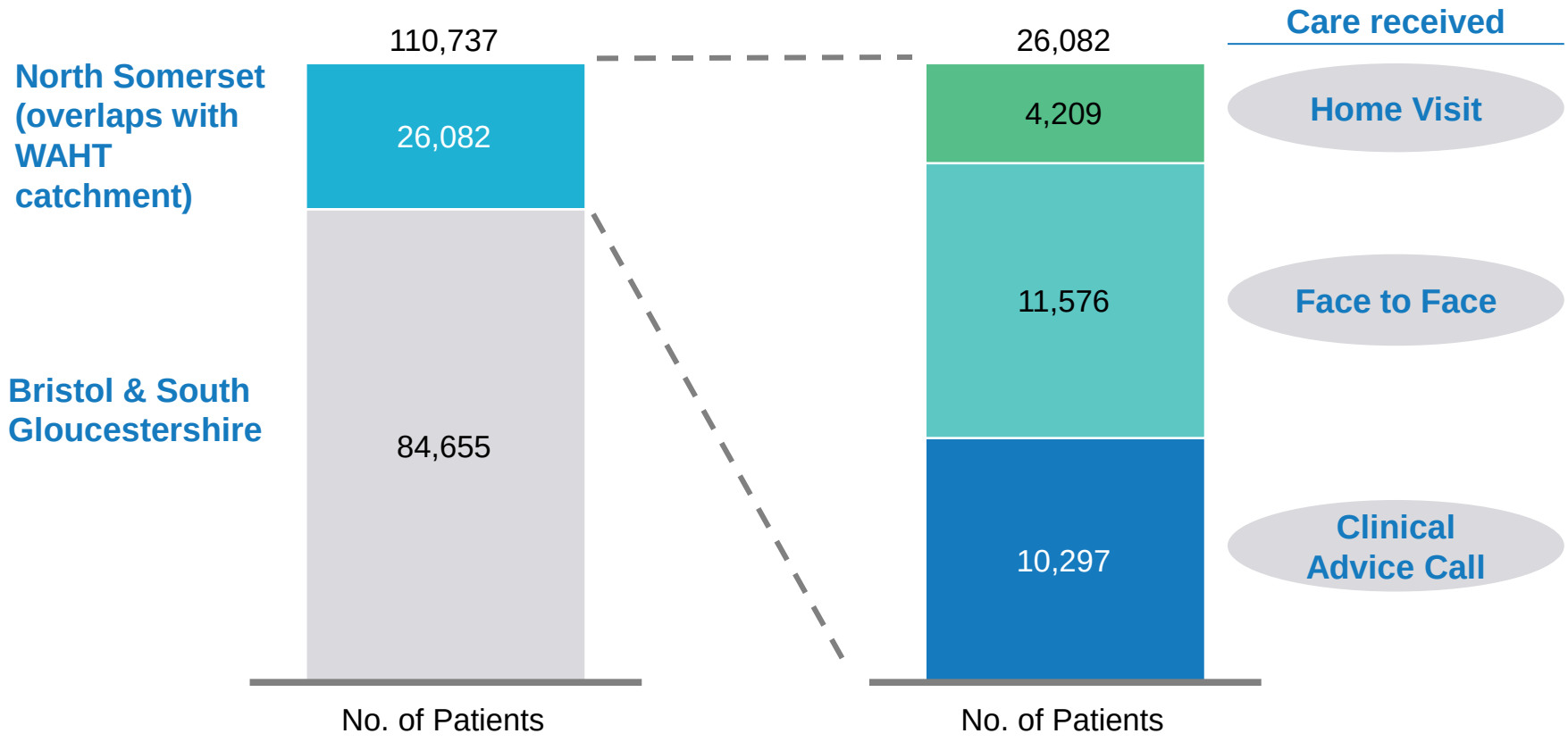


Source: HES 2016/17

Primary care – summary of North Somerset OOH provision

Activity levels in North Somerset

- Approximately **24% of patients** cared for by the BNSSG CCG **live in North Somerset**
- Patients level of interaction **varies across North Somerset**: **44%** will have a **face to face appointment**, **16%** will receive a **home visit**, and **39%** will receive a **clinical advice call** (per 2016/17 data)
- **96.6% of urgent patients** have an appointment booked and are in a base **within 2 hours of referral** by 111



SOURCE: Health Weston Commissioning Context 2017

Primary Care – Summary of Practice Performance (1/2)

☆ Outstanding: Service is performing exceptionally well

● Good: Service is performing well and meeting our expectations

● Requires improvement: Service isn't performing as well as it should be

● Inadequate: Service is performing badly; enforcement action has been taken against it

GP Practice	CQC Categories					
	Overall	Safe	Effective	Caring	Respon-sive	Well-led
Mendip Vale Medical Practice	●	●	●	●	●	●
The Cedars Surgery	●	●	●	●	●	●
New Court Surgery	●	●	●	●	●	●
Stafford Medical Group	●	●	●	●	●	●
Tudor Lodge Surgery	●	●	●	●	●	●
Riverbank Medical Centre	●	●	●	●	●	●
Winscombe Surgery	●	●	●	●	●	●
The Milton Surgery	●	●	●	●	●	●
Graham Road Surgery[1]	●	●	●	●	●	●
Axbridge Surgery	●	●	●	●	●	●
Cheddar Medical Centre	●	●	●	●	●	●
Longton Grove Surgery	●	●	●	●	●	●
Locality Health Centre	●	●	●	●	●	●
Clarence Park Surgery[1]	●	●	●	●	●	●
Brent Area Medical Centre	●	●	●	●	☆	●
St Georges Surgery[1]	●	●	●	●	●	●

1 CQC ratings were completed prior to recent change in ownership

SOURCE: Care Quality Commission website

Primary Care – Summary of Practice Performance (2/2)

HEALTHY WESTON

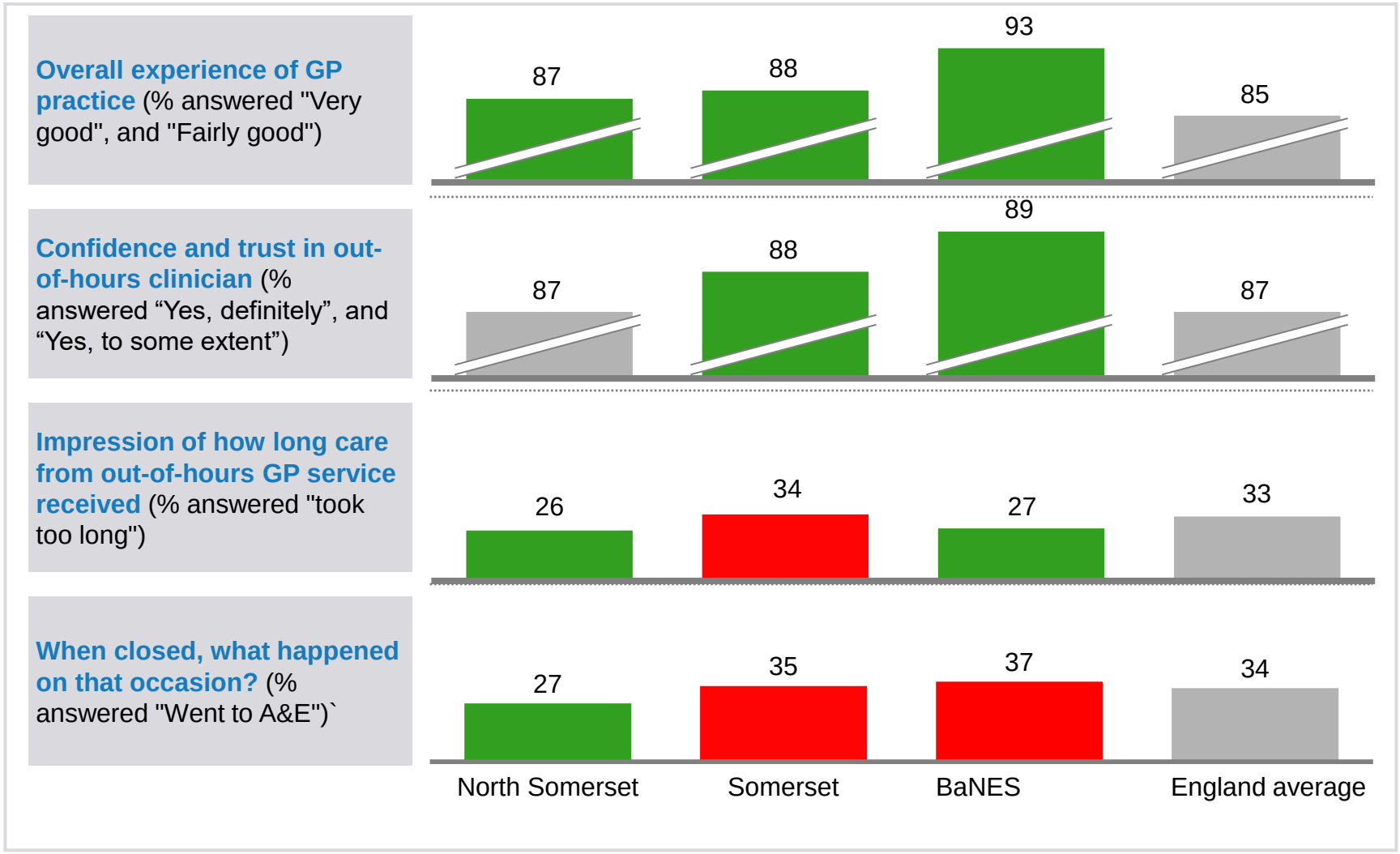
XX Above national average XX In line with national average XX Below national average

	Patient Surveys				
GP Practice	% who describe overall experience as good	% who would recommend	% who were able to get an appointment last time they tried	% who describe their experience of making an appointment as good	% who feel they don't normally have to wait too long to be seen
Mendip Vale Medical Practice	No rating	No rating	No rating	No rating	No rating
The Cedars Surgery	85%	80%	89%	78%	62%
New Court Surgery	82%	83%	91%	71%	65%
Stafford Medical Group	72%	55%	77%	57%	45%
Tudor Lodge Surgery	71%	60%	67%	50%	41%
Riverbank Medical Centre	81%	70%	86%	62%	42%
Winscombe Surgery	94%	91%	96%	89%	60%
The Milton Surgery	93%	84%	93%	83%	52%
Graham Road Surgery	79%	59%	90%	62%	43%
Axbridge Surgery	87%	82%	81%	70%	64%
Cheddar Medical Centre	91%	88%	87%	92%	70%
Longton Grove Surgery	97%	96%	94%	92%	64%
Locality Health Centre	75%	60%	77%	64%	43%
Clarence Park Surgery	85%	78%	90%	74%	47%
Brent Area Medical Centre	92%	89%	97%	94%	76%
St Georges Surgery	80%	77%	91%	74%	60%
Local Average	84%	77%	87%	74%	56%
National Average	85%	77%	84%	73%	58%

SOURCE: GP Patient Survey website

Healthier Together

Patient satisfaction with GP OOHs care is generally above the England average



Source: GP Patient Survey CCG report (July 2017 publication)

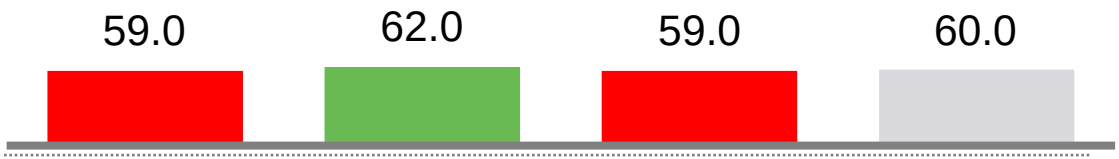
Cancer management – stage of diagnosis, survival and standard of care

Performance below England average

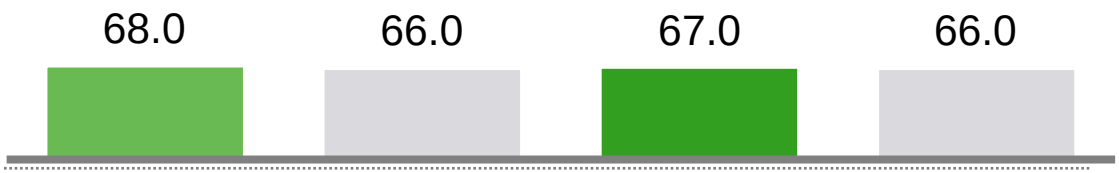
Performance above England average

Performance in line with England average

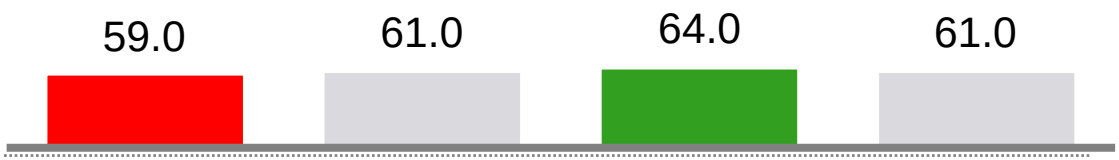
New cases of cancer diagnosed at stage 1 and 2 as a proportion of all new cases of cancer diagnosed, %



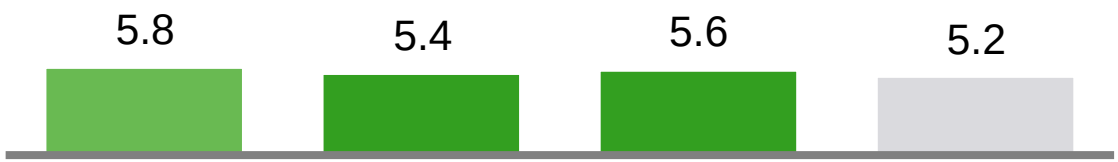
People with urgent GP referral having first definitive treatment for cancer within 62 days of referral, %



Number of adults diagnosed with any type of cancer in a year who are still alive one year after diagnosis, %



Average response to "overall, how would you rate your care?" on a scale of 1-10 (10 being best)



North Somerset | Somerset | Bath & NE Somerset | England average

Source: NHSE CCG Improvement and Assessment indicators 2015/16

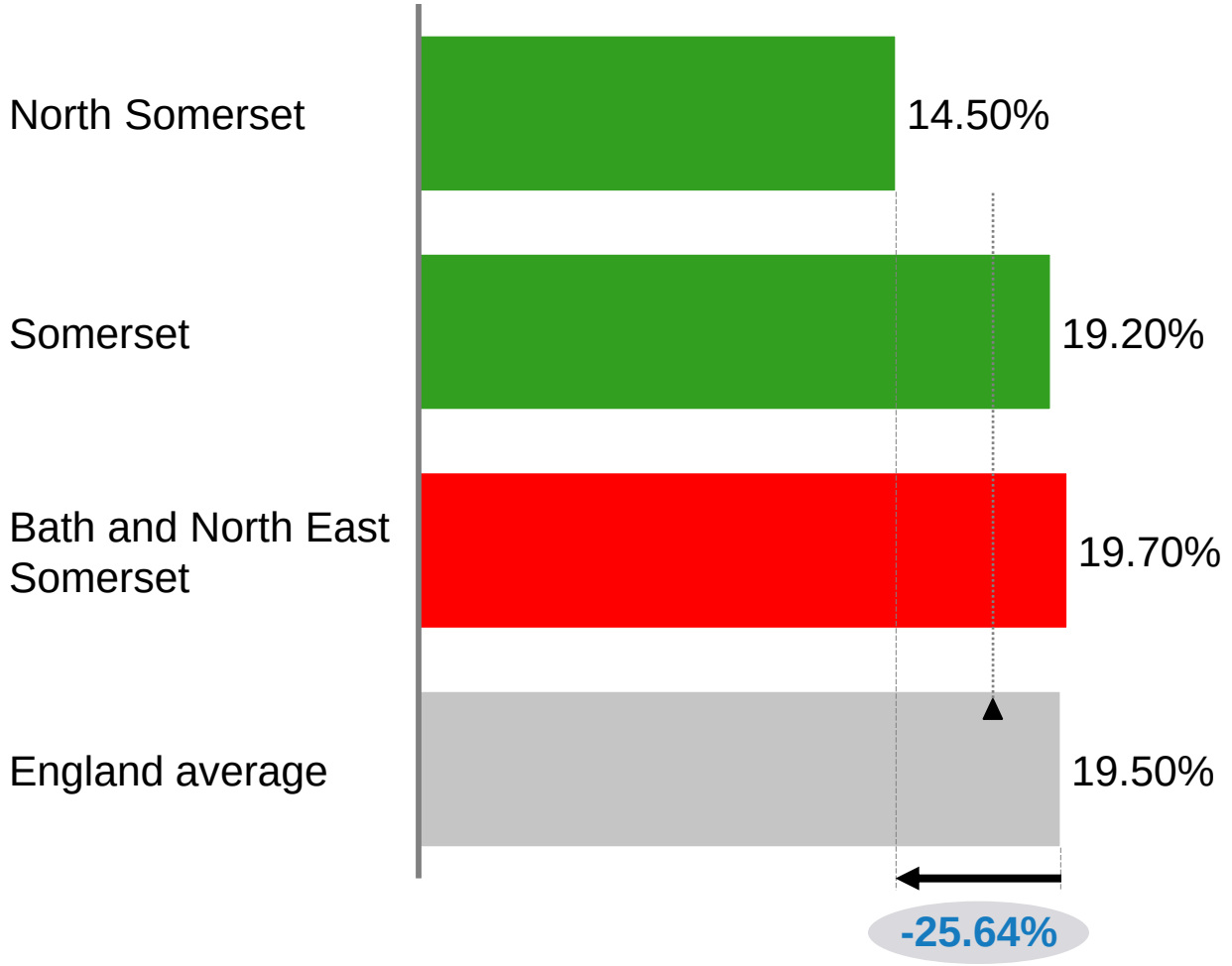
Cancer presentation and diagnosis in A&E

Performance below England average

Performance above England average

% of population[1], 2016/17

Incidence of malignancy diagnosis in A&E– Local population vs. England average



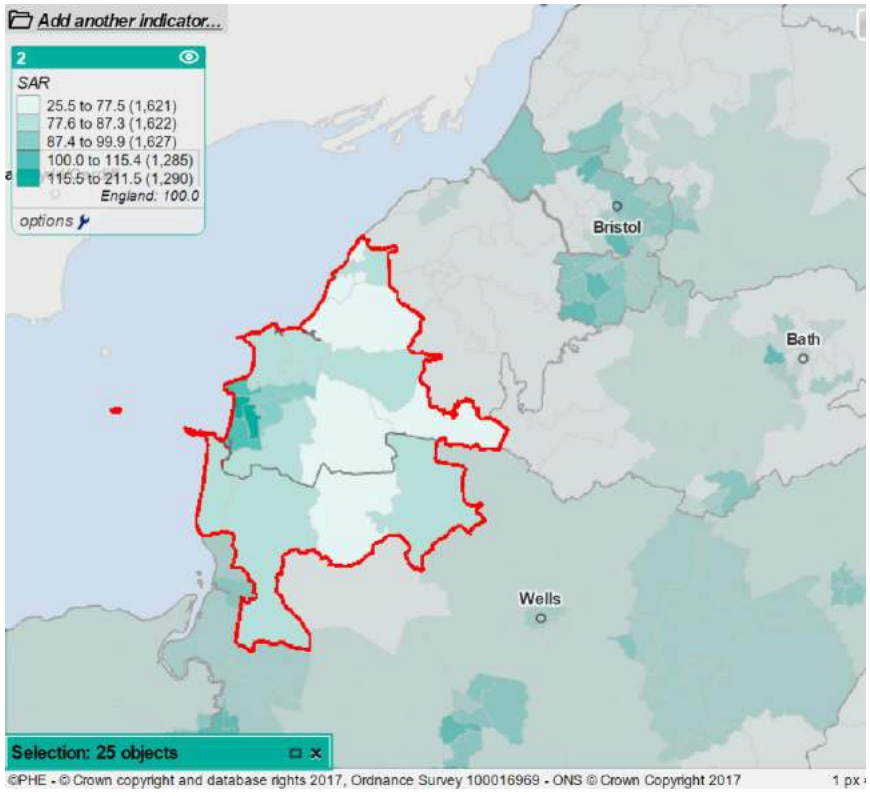
- Represents the proportion of the population who have their initial diagnosis of cancer made in the emergency department
- Seen as an indicator of suboptimal care as patients diagnosed in A&E have later stage at diagnosis, worse prognoses (and cost the system considerably more)

1 Percentage of 2016/17 CCG population

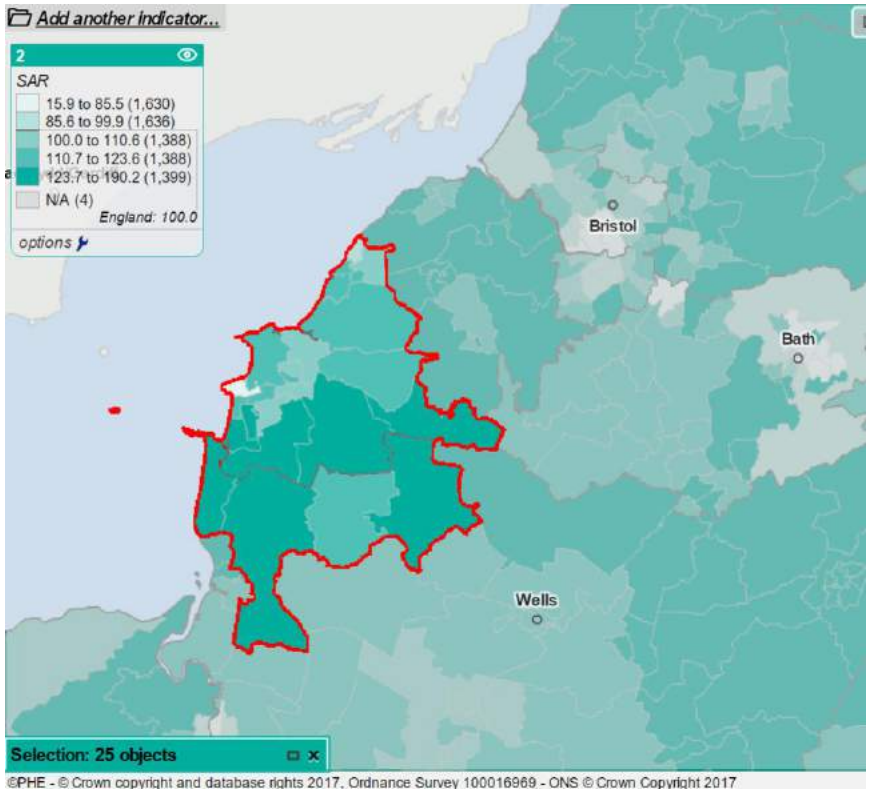
Source: National cancer registration and analysis service (NCRAS) cancer outcome metrics 2016/17

Emergency hospital admissions are concentrated around providers, whereas elective admissions are more evenly spread

Emergency hospital admissions, all causes (standardised admission ratio) *(darker areas indicate more admissions)*



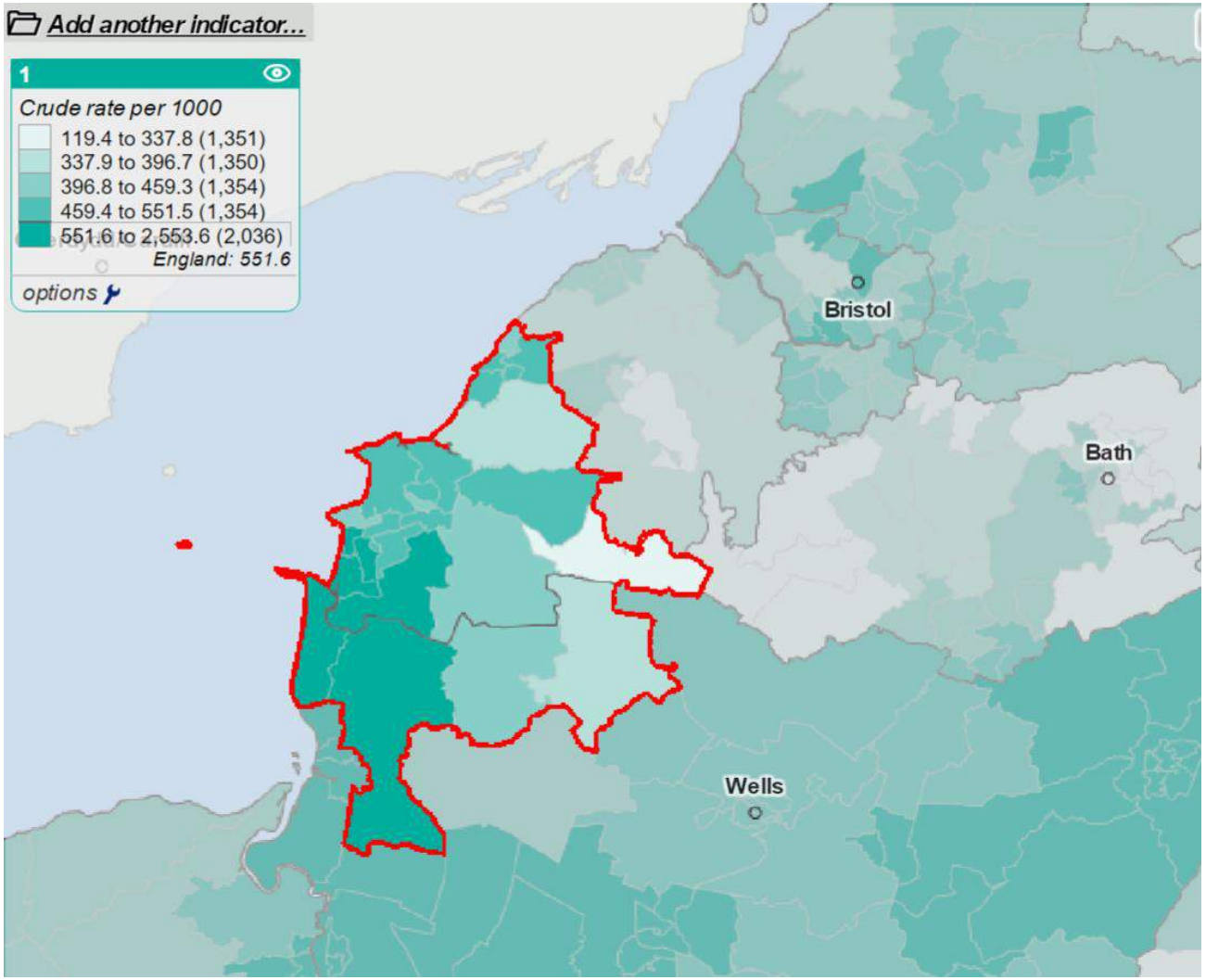
Elective hospital admissions for hip replacement (standardised admission ratio) *(darker areas indicate more admissions)*



Source: PHE local health tool, accessed online in July 2018 [http://www.localhealth.org.uk]

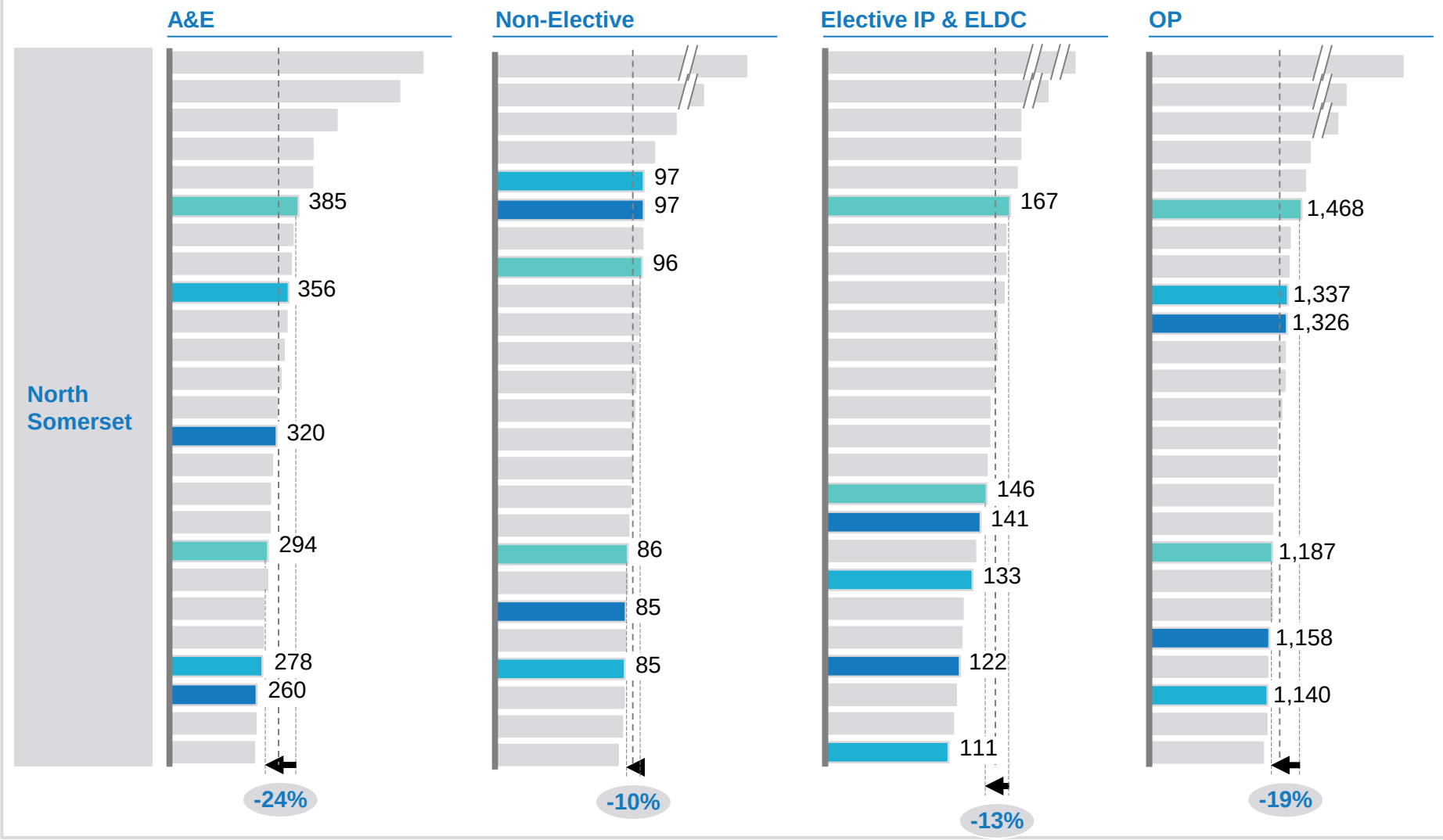
A&E attendances in under-5s are particularly high in the South of the WAHT catchment area

A&E attendances in <5s *(darker areas associated with more attendances)*



Source: PHE local health tool, accessed online in July 2018 [http://www.localhealth.org.uk]

North Somerset activity by GP practice varies most notably for A&E attendances



Source: HES A&E, IP 2016/17; HES OP 2015/16; Weighted population 2015/16 NHS England

Bristol activity by GP practice varies most notably for A&E attendances

Difference from top and bottom quartiles

CCG Median

CCG quartiles

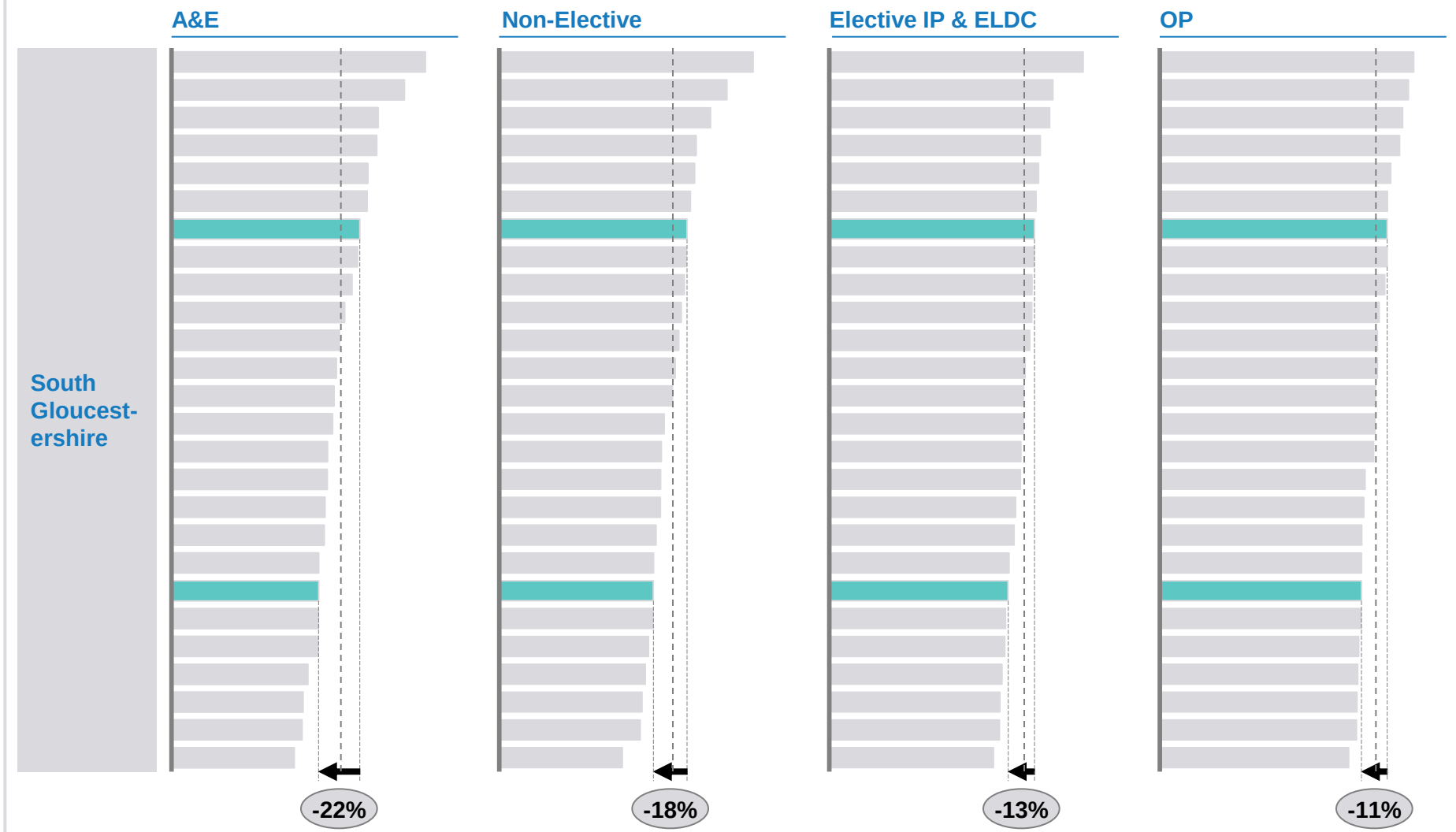
HEALTHY WESTON

Activity by GP practice per 1,000 weighted population

Source: A&E, Elective and Non-elective data from SUS 2016/17, Outpatient from SUS 2015/16; General and Acute weighted population from NHS England 14/15 and 15/16 CCG allocations. Excludes specialist activity

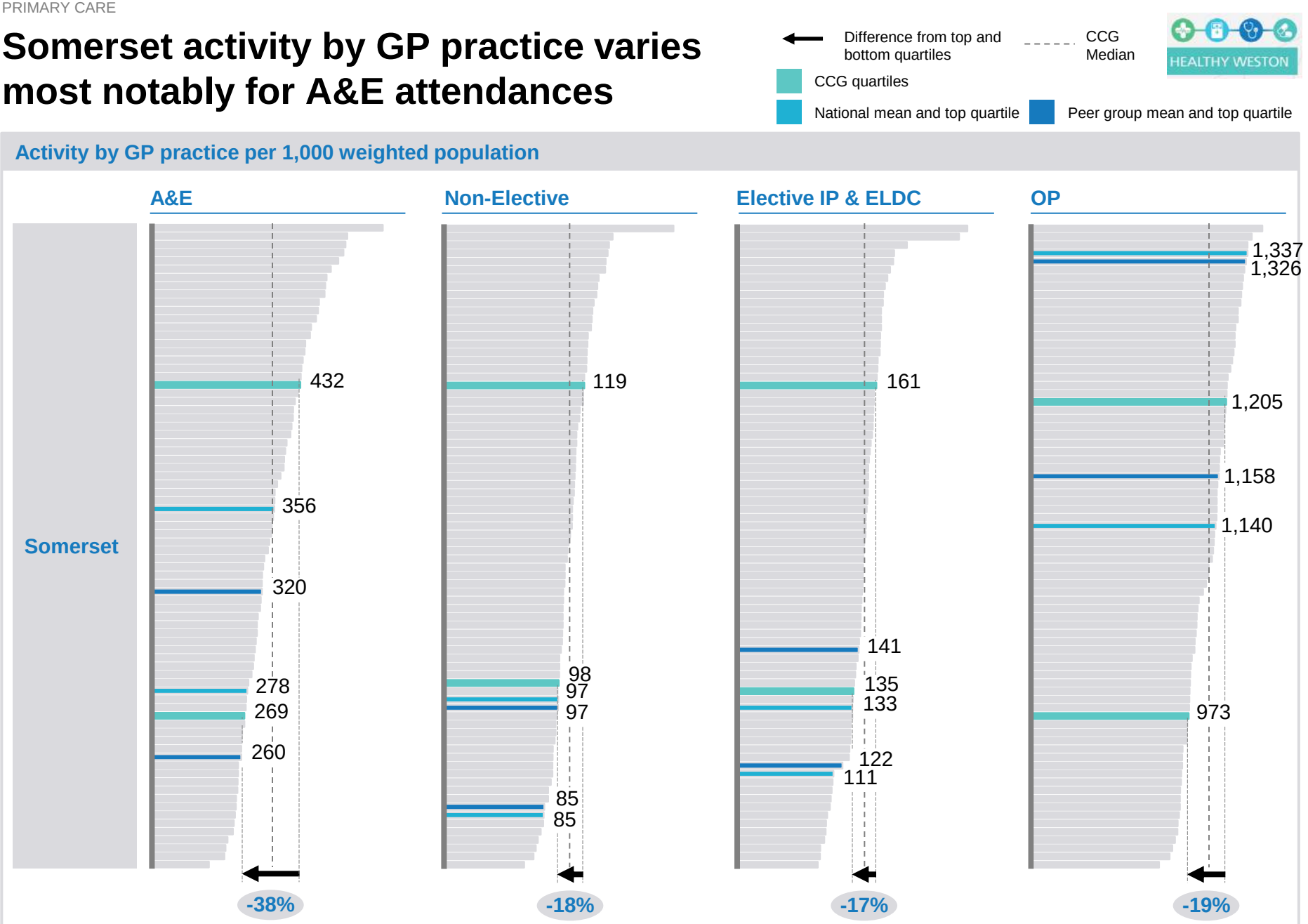
Healthier Together

South Gloucestershire activity by GP practice varies most notably for A&E



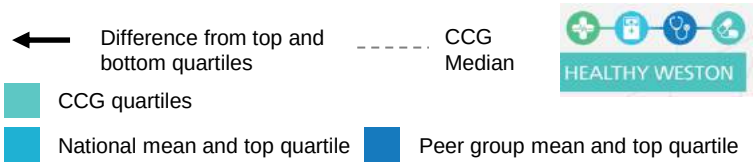
Source: A&E, Elective and Non-elective data from SUS 2016/17, Outpatient from SUS 2015/16; General and Acute weighted population from NHS England 14/15 and 15/16 CCG allocations. Excludes specialist activity

Somerset activity by GP practice varies most notably for A&E attendances

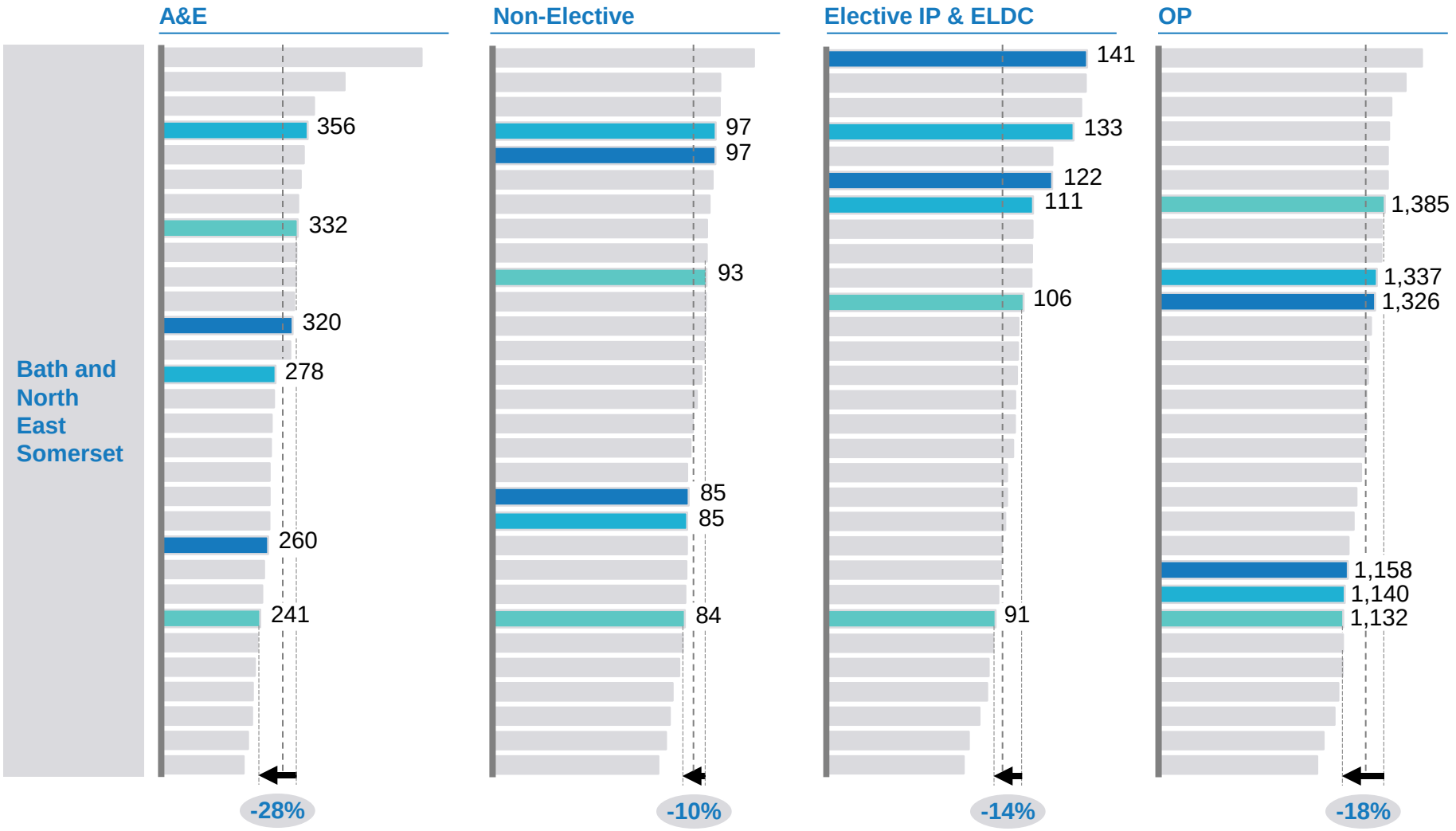


Source: HES A&E, IP 2016/17; HES OP 2015/16; Weighted population 2015/16 NHS England

BaNES activity by GP practice varies most notably for A&E attendances



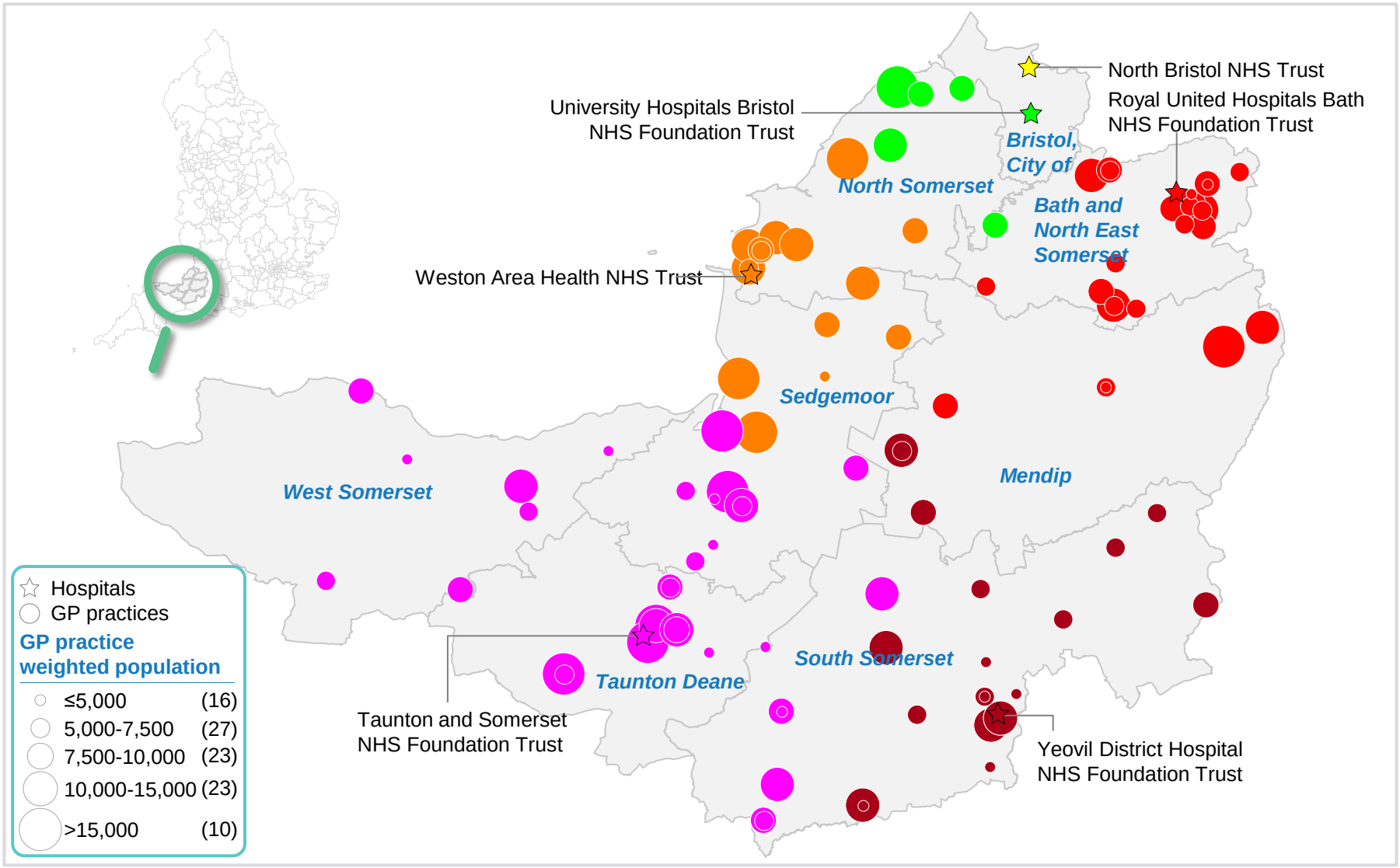
Activity by GP practice per 1,000 weighted population



Source: HES A&E, IP 2016/17; HES OP 2015/16; Weighted population 2015/16 NHS England

Attendance patterns for A&E services are largely geography based across the region

GP practices colour coded by the A&E where majority of patients are referred to



Attendances for A&E services for WAHT catchment area GPs

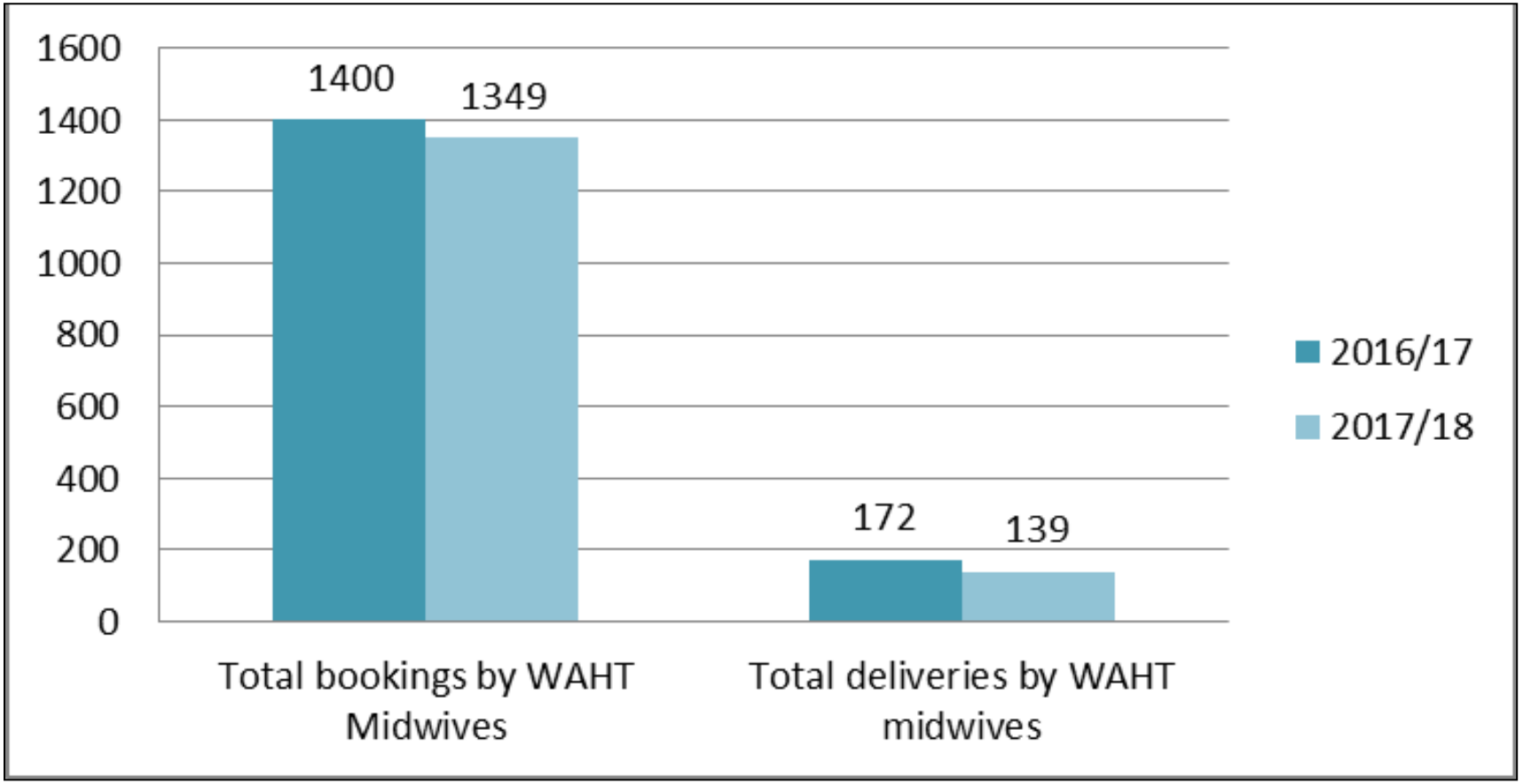
Number of A&E attendances per 1000 weighted list

	WAHT	NBT	UHB	T&S	Other
Locality Health Centre	364	7	37	3	17
Stafford Medical Group	343	6	45	1	32
Tudor Lodge Surgery	310	4	34	2	35
Graham Road Surgery	282	4	26	2	19
Riverbank Medical Centre	269	6	42	2	31
Longton Grove Surgery	267	5	29	1	20
The Cedars Surgery	259	4	35	1	24
New Court Surgery	251	5	28	2	20
Clarence Park Surgery	251	4	23	2	21
The Milton Surgery	239	4	31	1	17
Winscombe Surgery	203	5	42	2	29
Brent Area Medical Centre	197	0	18	18	105
Cheddar Medical Centre	172	5	26	13	100
Axbridge Surgery	149	3	22	24	125
St Georges Surgery[1]	n/a	0	n/a	n/a	n/a
Mendip Vale Medical Practice[1]	n/a	n/a	n/a	n/a	n/a

1 Mendip Vale Medical Practice has merged with several other sites (including St George's surgery) in the time period and comparable data is not yet available

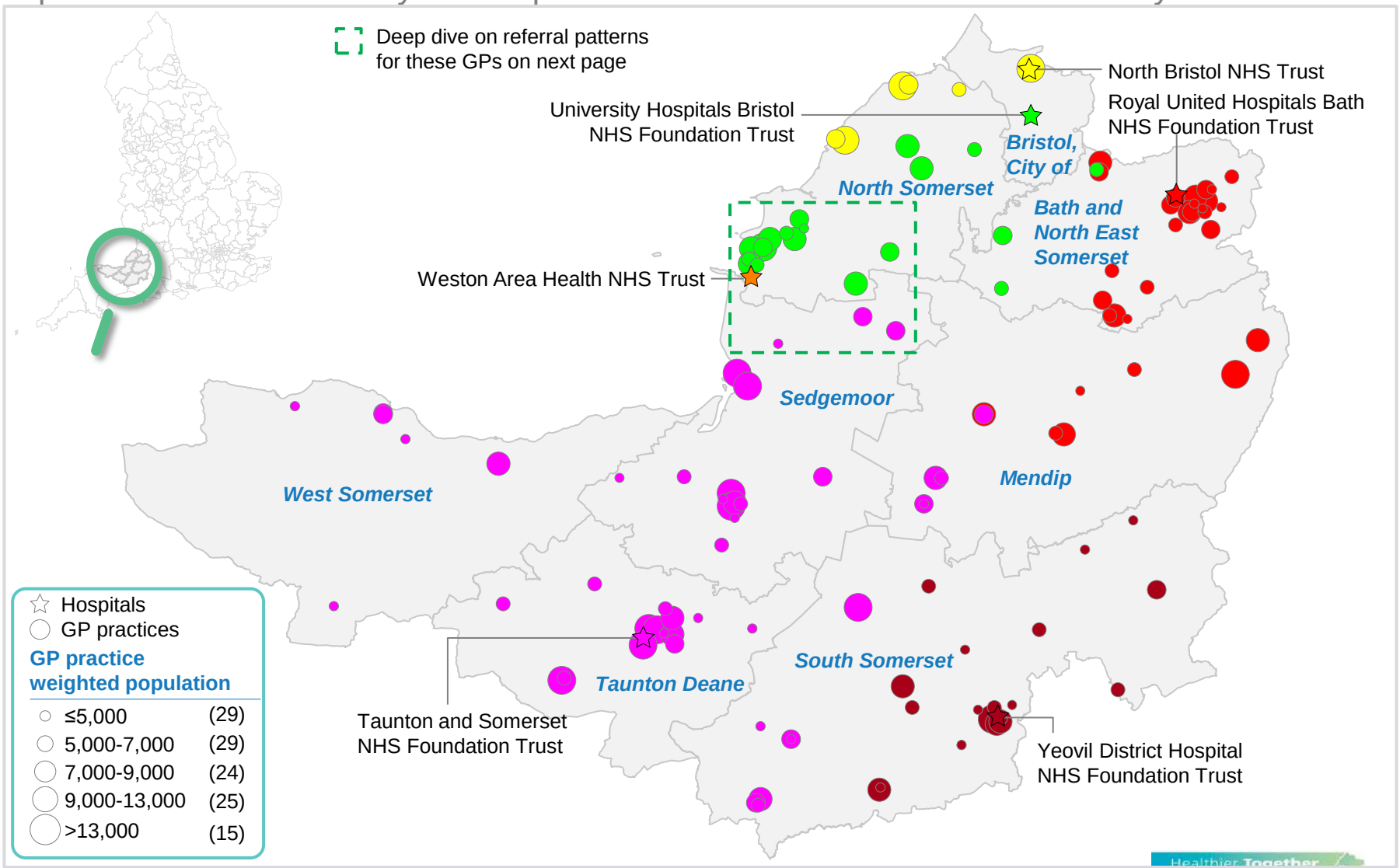
Source: HES 2016/17 APC M13 c/o NHS Digital

Antenatal and post natal care is provided for the majority of women in Weston



(Self)-referral patterns for place of delivery are largely geography based – this does not reflect wider antenatal and post natal provision

GP practices colour coded by the hospital where women choose for their delivery

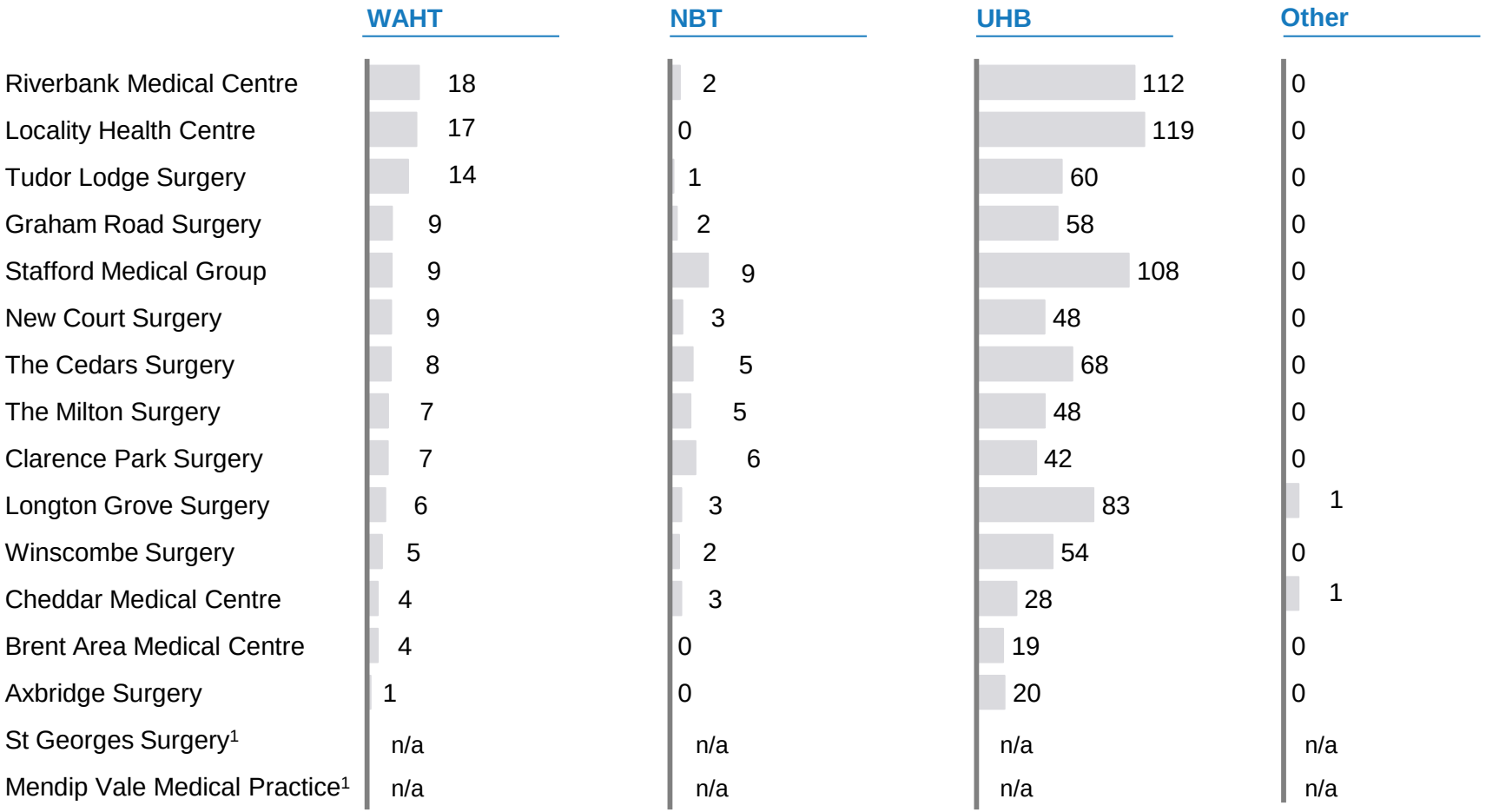


Source: HES 2016/17

(Self)-referral patterns for delivery for WAHT catchment area GPs

Note: Antenatal and post natal care provided for majority of women in Weston.

Number of births by trust per 10,000 weighted list

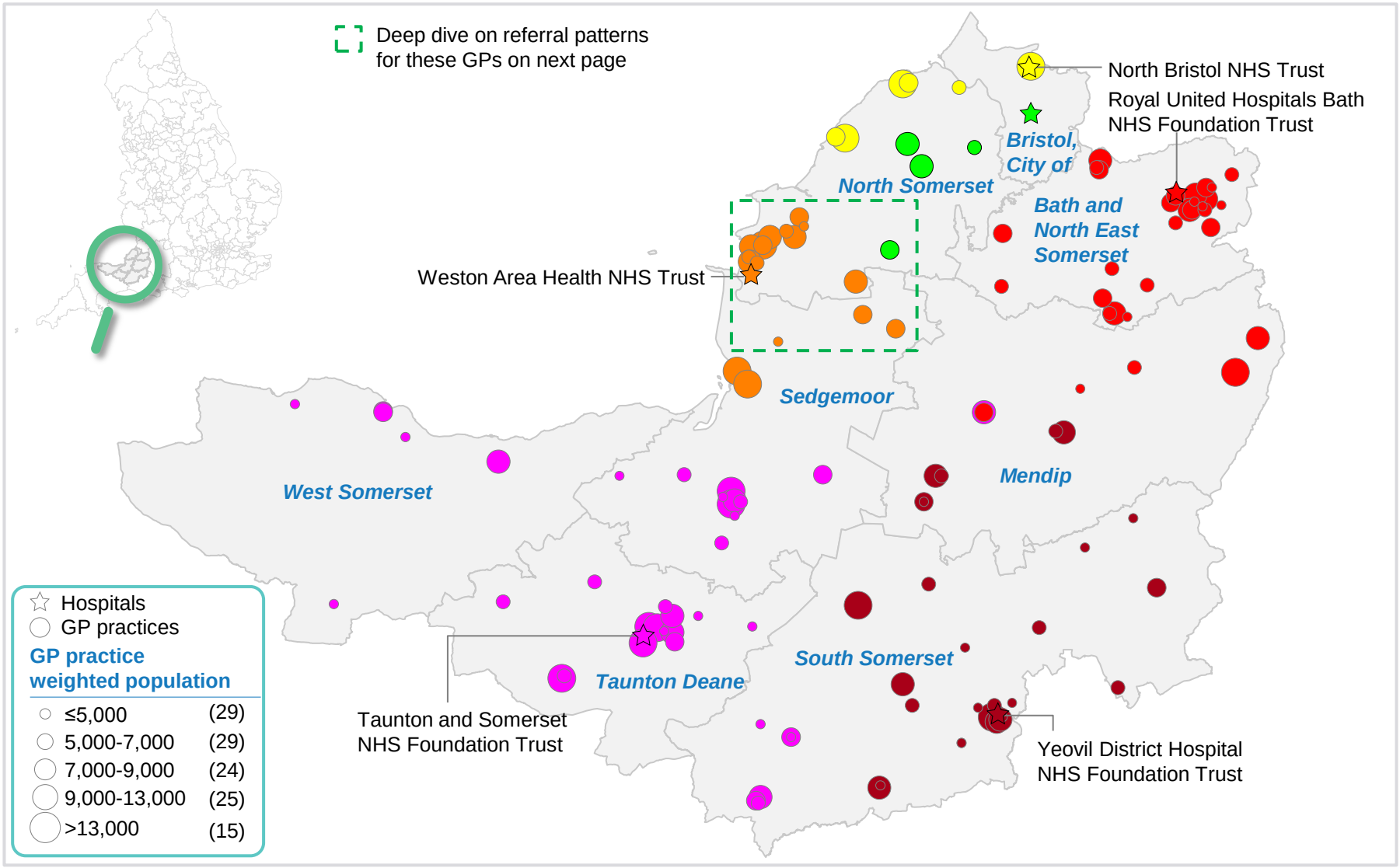


1 Mendip Vale Medical Practice has merged with several other sites (including St George's surgery) in the time period and comparable data is not yet available

Source: HES 2016/17 APC M13 c/o NHS Digital

Referral patterns for elective GI surgery services are largely geography based across the region

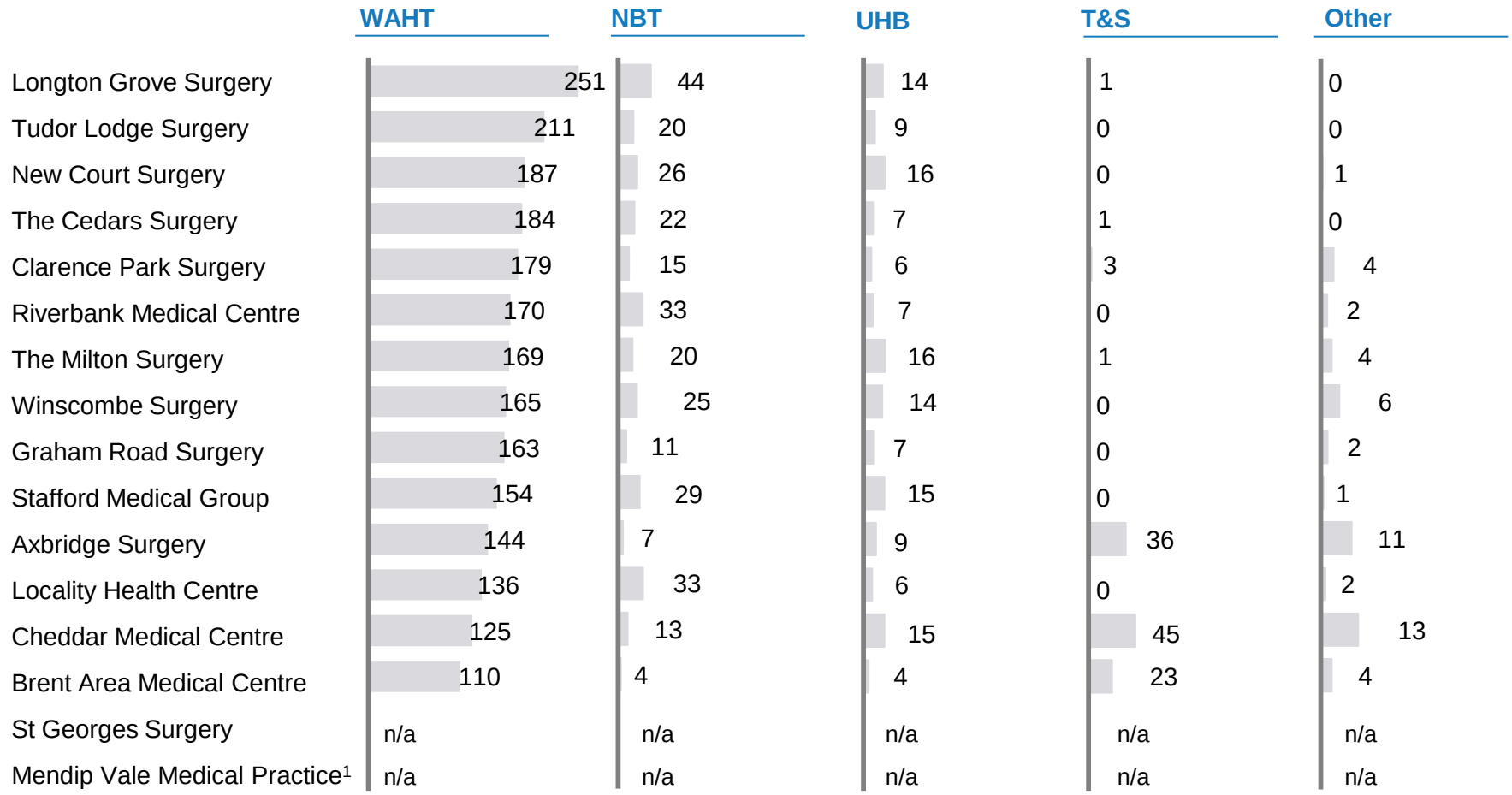
GP practices colour coded by the hospital where most general surgery patients are referred to



Source: HES 2016/17

Referral Patterns for elective GI surgery services for WAHT catchment area GPs

Number of elective abdominal and GI surgery admissions per 10,000 weighted list size[2]



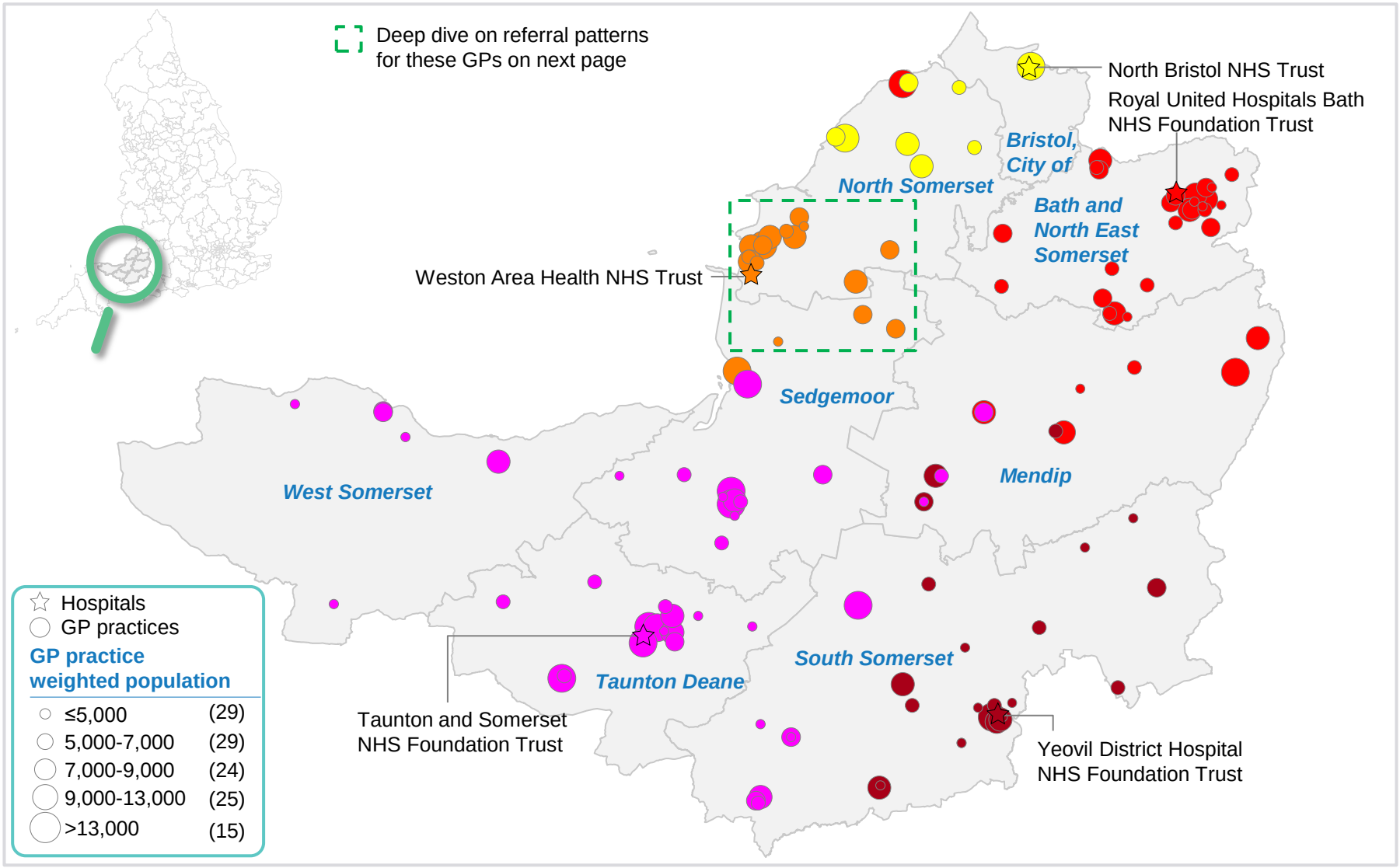
	WAHT	NBT	UHB	T&S	Other
Longton Grove Surgery	251	44	14	1	0
Tudor Lodge Surgery	211	20	9	0	0
New Court Surgery	187	26	16	0	1
The Cedars Surgery	184	22	7	1	0
Clarence Park Surgery	179	15	6	3	4
Riverbank Medical Centre	170	33	7	0	2
The Milton Surgery	169	20	16	1	4
Winscombe Surgery	165	25	14	0	6
Graham Road Surgery	163	11	7	0	2
Stafford Medical Group	154	29	15	0	1
Axbridge Surgery	144	7	9	36	11
Locality Health Centre	136	33	6	0	2
Cheddar Medical Centre	125	13	15	45	13
Brent Area Medical Centre	110	4	4	23	4
St Georges Surgery	n/a	n/a	n/a	n/a	n/a
Mendip Vale Medical Practice[1]	n/a	n/a	n/a	n/a	n/a

1 Mendip Vale Medical Practice has merged with several other sites (including St George's surgery) in the time period and comparable data is not yet available
2 Includes patients assigned to general surgery, hepatobiliary and pancreatic surgery, Upper GI, and colorectal surgery treatment functions

Source: HES 2016/17 APC M13 c/o NHS Digital

Referral patterns for elective orthopaedics services are largely geography based across the region

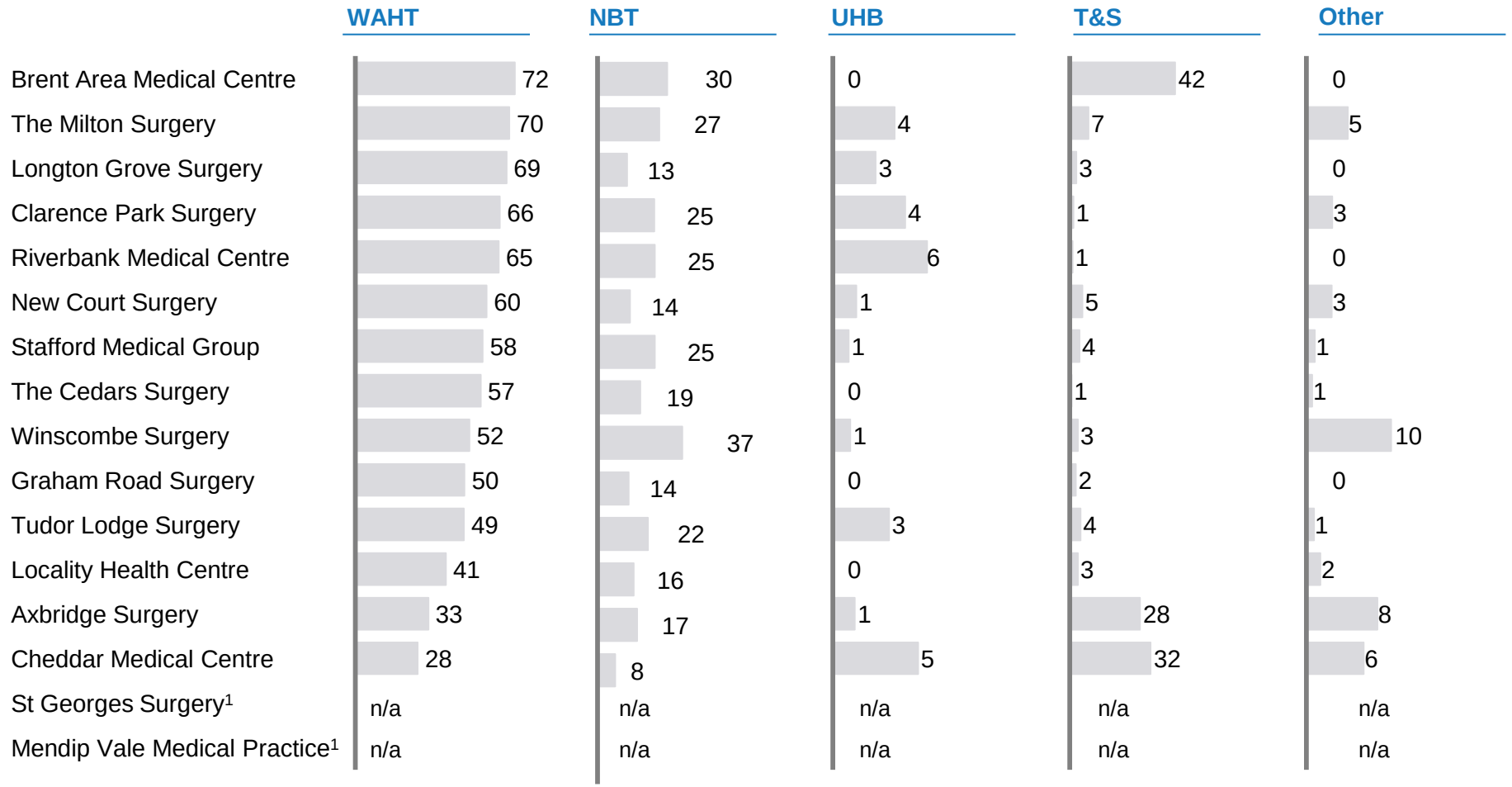
GP practices colour coded by the hospital where most trauma & ortho patients are referred to



Source: HES 2016/17

Referral Patterns for elective orthopaedics services for WAHT catchment area GPs

Number of elective orthopaedic admissions per 1000 weighted list size



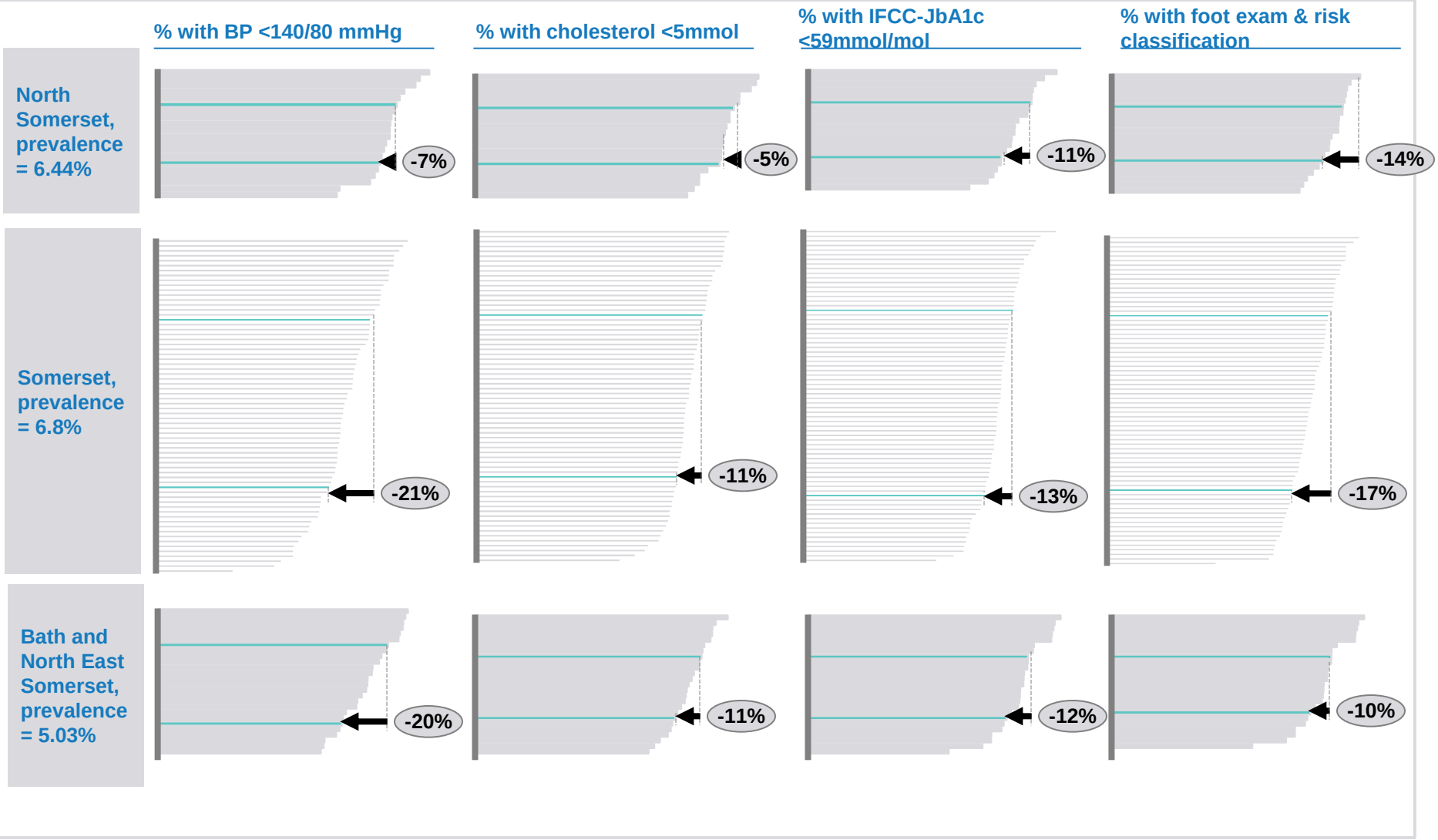
1 Mendip Vale Medical Practice has merged with several other sites (including St George's surgery) in the time period and comparable data is not yet available

Source: HES 2016/17 APC M13 c/o NHS Digital

Best practice indicators for diabetes therapy, by GP practice compared with peer CCG areas

← Difference from top and bottom quartiles

Activity by GP practice per 1,000 weighted population

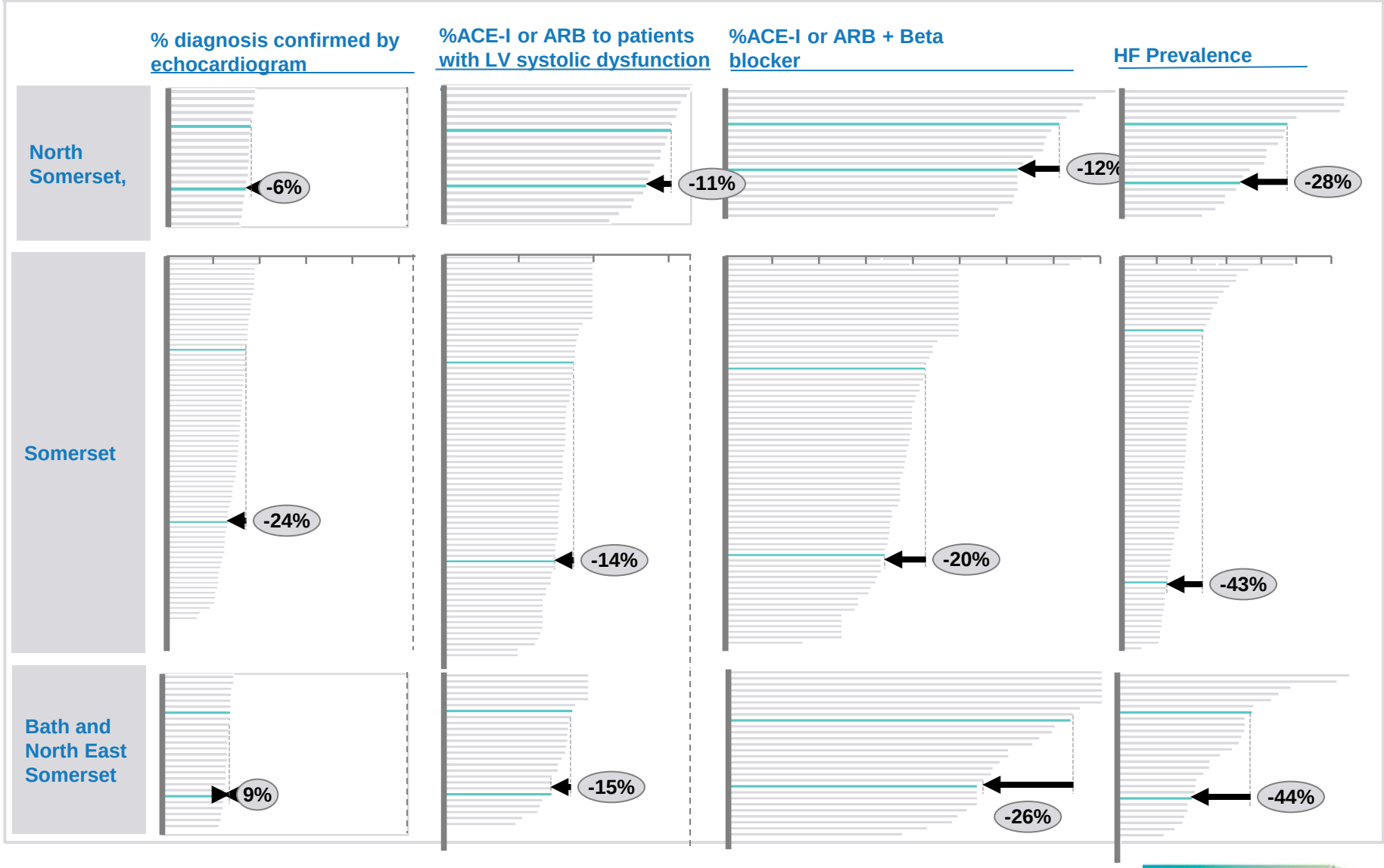


Source: QOF 2016/17

Best practice indicators for heart failure, by GP practice compared with peer CCG areas

← Difference from top and bottom quartiles

Activity by GP practice per 1,000 weighted population

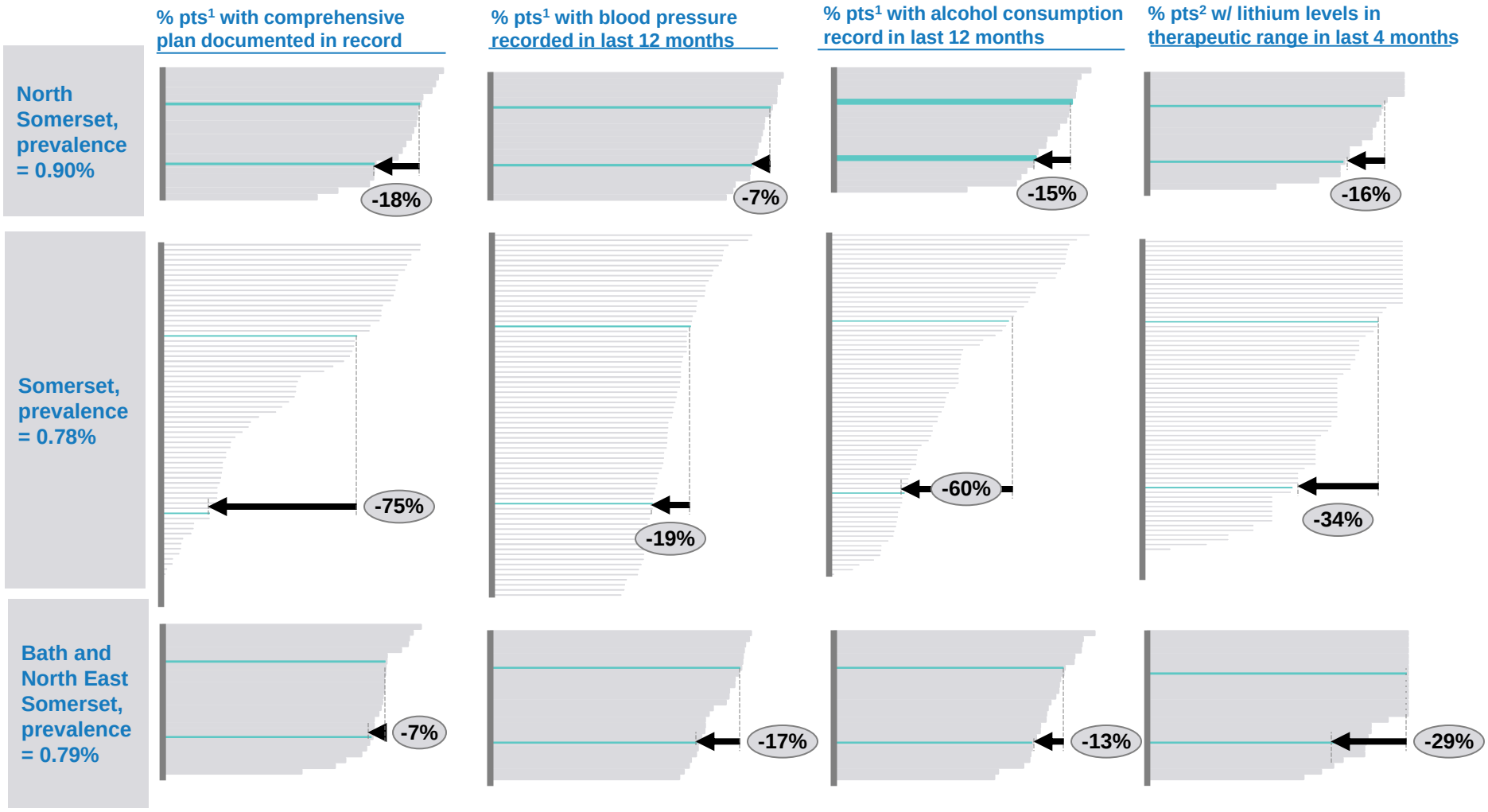


Source: QOF 2016/17

Best practice indicators for mental health therapy, by GP practice compared with peer CCG areas

← Difference from top and bottom quartiles

Activity by GP practice per 1,000 weighted population



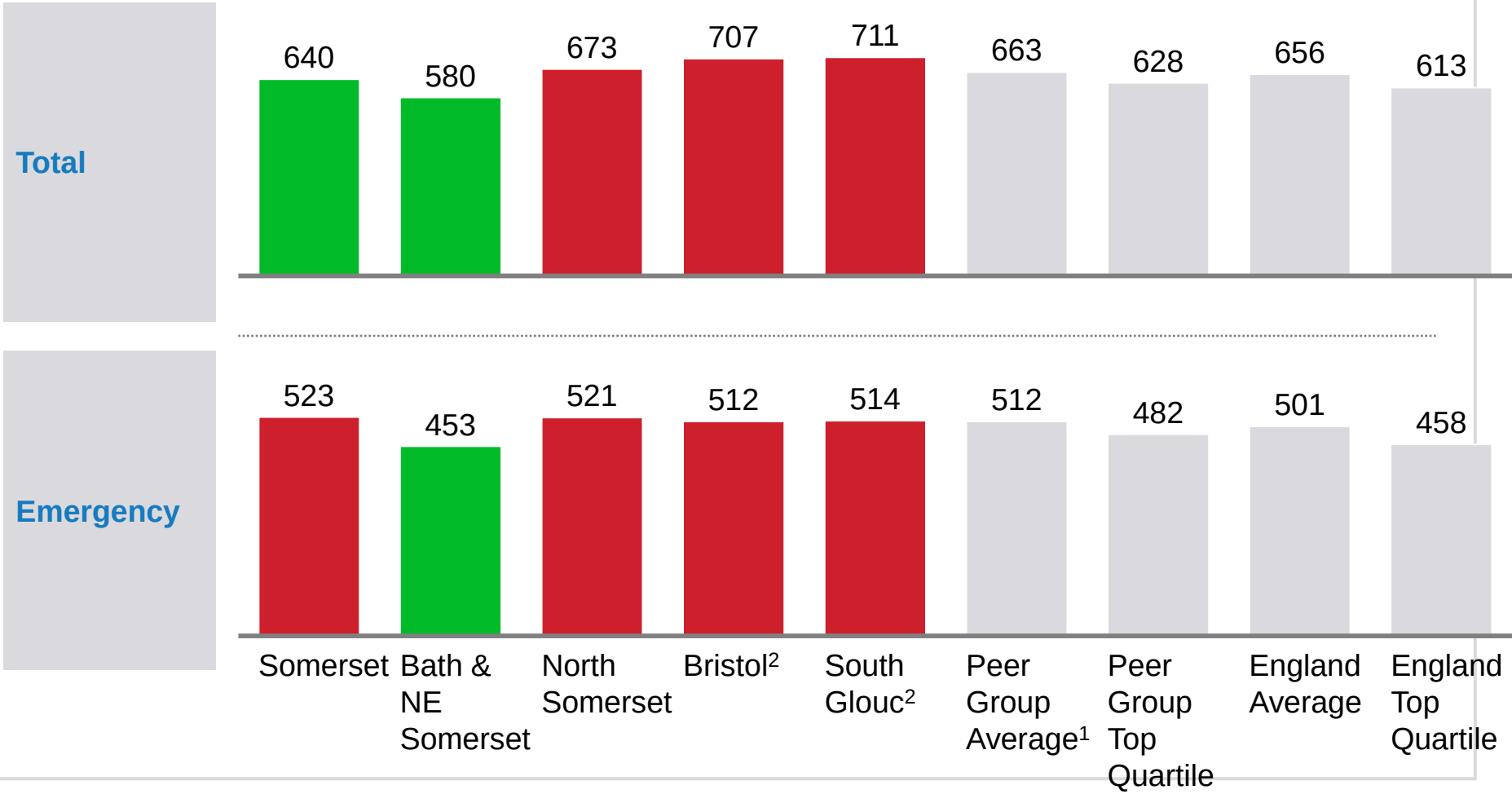
1 Patients with schizophrenia, bipolar affective disorder, or other psychoses
2 Patients on lithium therapy
Source: QOF 2016/17

North Somerset has greater inpatient bed days per weighted population than peers, however lower than Bristol and South Gloucestershire.

Performance above England average

Performance below England average

Inpatient bed days per 1,000 WP



1 Peer group: Prospering UK CCGs 2 SUS data 2016/17, General and Acute weighted population from NHS England 14/15 and 15/16 CCG allocations

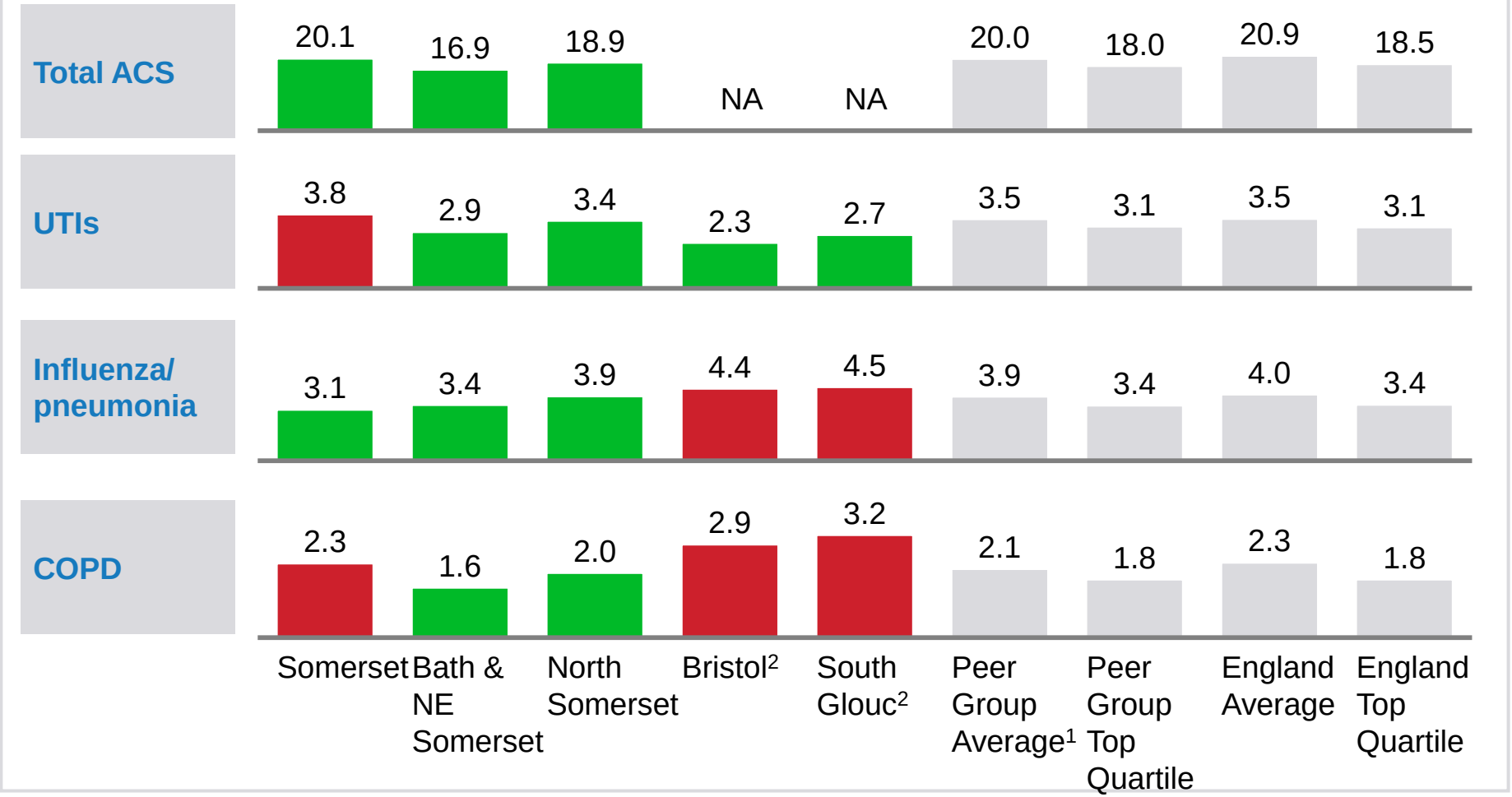
Source: HES 2016/17 M13 APC, C/o NHS Digital. Excludes regular attenders

Ambulatory Care Sensitive admissions are lower in North Somerset than the national average

Performance above England average

Performance below England average

Admissions for ambulatory sensitive conditions per 1000 WP

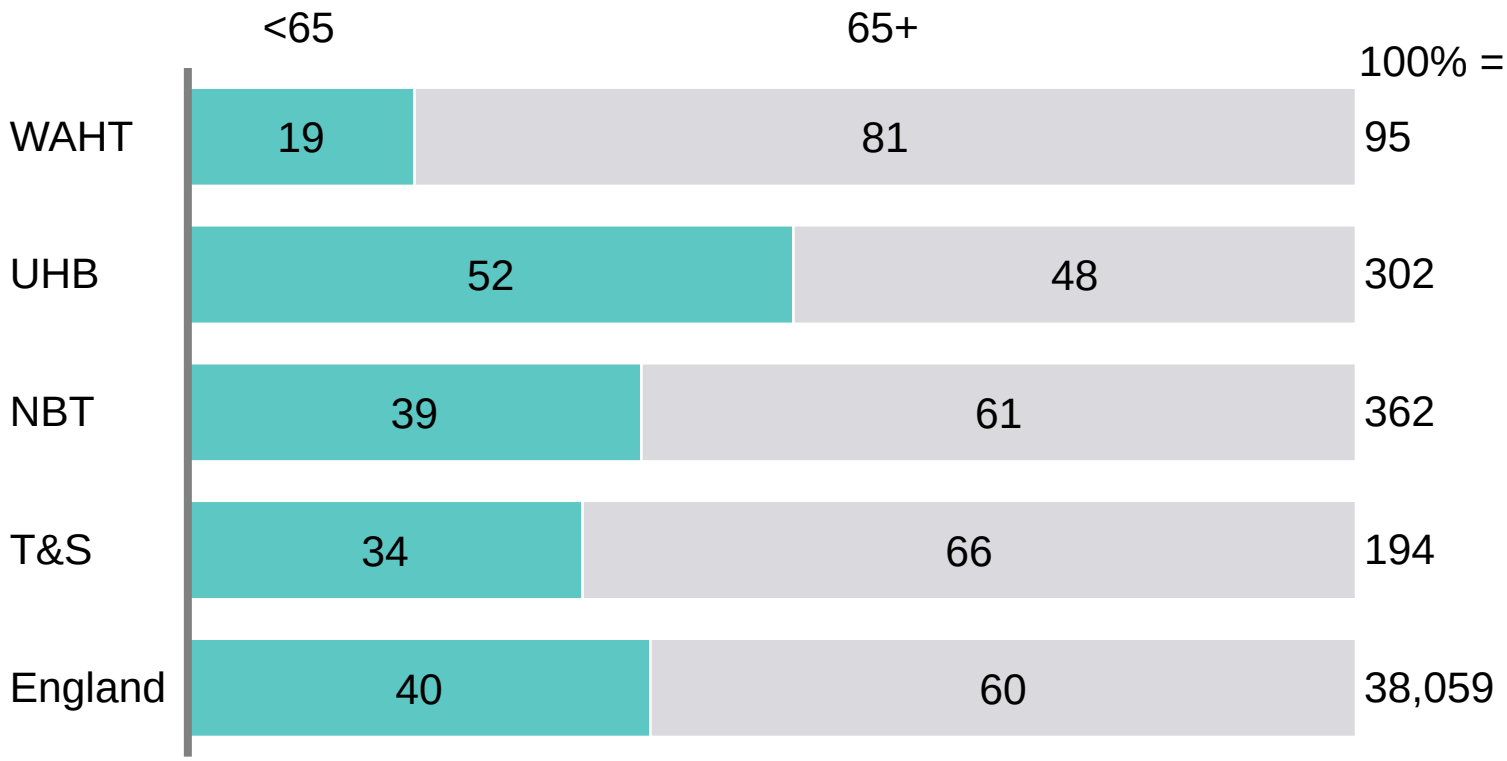


1 Peer group: Prospering UK CCGs 2 SUS data 2016/17, General and Acute weighted population from NHS England 14/15 and 15/16 CCG allocations

Source: HES 2016/17 M13 APC, C/o NHS Digital. Excludes regular attenders

WAHT, NBT and T&S all have large proportion of bed days due to people aged 65+

Hospital bed days in over 65s as a percentage of all bed days, 2016/17, % (total in 'k)



Not case mix adjusted.

SOURCE: HES 2016/17

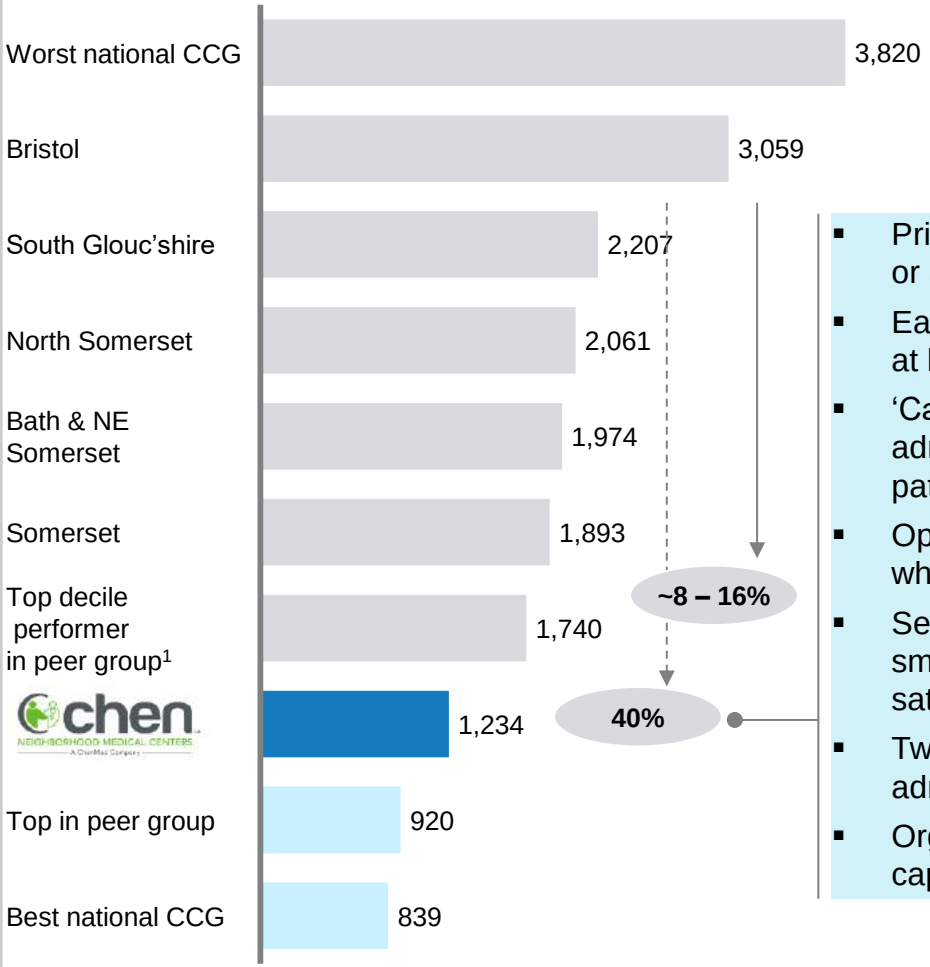
Share of hospital bed days accounted for by patients aged 65+ by GP practice (2016/17)

GP Practice[1]	Weston Area Health Percent	North Bristol Percent	Taunton & Somerset Percent	University Hospitals Bristol Percent
Axbridge Surgery[1]	83	48	57	27
Backwell Medical Centre	86	67	58	72
Brent Area Medical Centre[1]	68	30	66	40
Cheddar Medical Centre[1]	84	52	65	36
Clarence Park Surgery	88	62	0	24
Clevedon Medical Centre	87	56	50	63
Graham Road Surgery	70	45	38	28
Harbourside Family Practice	89	62	0	59
Heywood Family Practice	53	75	33	76
Locality Health Centre	53	34	0	3
Long Ashton Surgery	67	69	50	64
Longton Grove Surgery	86	55	0	20
Nailsea Family Practice	77	76	82	81
New Court Surgery	78	43	20	40
Portishead Medical Group	82	77	22	66
Riverbank Medical Centre	70	30	0	23
St Georges Surgery	77	50	20	9
Stafford Medical Group	76	43	1	16
Sunnyside Surgery	93	65	71	72
The Cedars Surgery	81	56	0	23
The Milton Surgery	81	38	17	23
The Village Surgery	n/a	n/a	25	n/a
Tudor Lodge Surgery	81	58	38	30
Winscombe Surgery	87	64	33	27
Worle Medical Practice	n/a	n/a	0	23
Mendip Vale Practice	81	63	55	38
Yeo Vale Medical Practice	n/a	0	0	5

1 All North Somerset practices includes as well as 3 Sedgemoor practices in the WAHT catchment area: Axbridge, Brent Area and Cheddar Medical Centre
SOURCE: HES 2016/17

Bed days per 1,000 population over 65 yrs by local area in England and internationally

Hospital bed days per 1,000 over 65 population, 2016/17



- Primary care organisation in USA only serving people aged 65 or above, most of whom have LTCs
- Each GP has a list of 450 patients, with patients each having at least monthly 20 minute appointments
- 'Care Team' supporting each GP able to manage their administration, basic clinical tasks (e.g., basic history) and patient care coordination
- Operate in dedicated elderly care neighbourhood centres, which include free transport, X-Ray and on-site specialists
- Senior Medical Director performance manages GPs against small metric list, including hospital utilisation and patient satisfaction
- Twice weekly meetings involving all GPs to discuss all hospital admissions
- Organisation payment based on total cost of care full risk capitation to primary care

1 Peer group defined as Prospering UK ONS Cluster. Top decile East Leicestershire and Rutland; Top peer CCG Nottingham West; Best national CCG NHS Lancashire North CCG

SOURCE: HES 2016/17 APC M13, c/o NHS Digital; Chen Med

Case for Change

- Local population and their health and care needs
- Acute care
- Out of hospital: Primary care
- **Out of hospital: Community, mental health and social care**
- Out of hospital: Ambulance services
- Financial position

Community care services

☆ Outstanding ● Good ● Requires improvement ● Inadequate

- **North Somerset Community Partnership** (NSCP) is a Community Interest Company (CIC) that **provides healthcare services** on behalf of the CCG to the people of North Somerset
- Organisation is **staff owned** and was founded in 2011, **employing over 750 staff**
- Contract value is in excess **of £28.5m per year**
- Majority of services that NSCP provides are **adult community focused** and are usually **delivered in the patient's usual place of residence**, with a number of clinics based across the area
- Services include: district nursing, rapid response, therapies and a range of specialist services.
- NSCP run **the minor injuries unit (MIU) at North Somerset Community Hospital** in Clevedon and provides a number of children's services including school nursing and health visitors
- **Community paediatric** services are provided by **Weston Area Health Trust**

North Somerset Community Partnership, March 2017

Overview and CQC inspections

Overall good

Safe	●
Effective	●
Caring	●
Responsive	●
Well-led	●

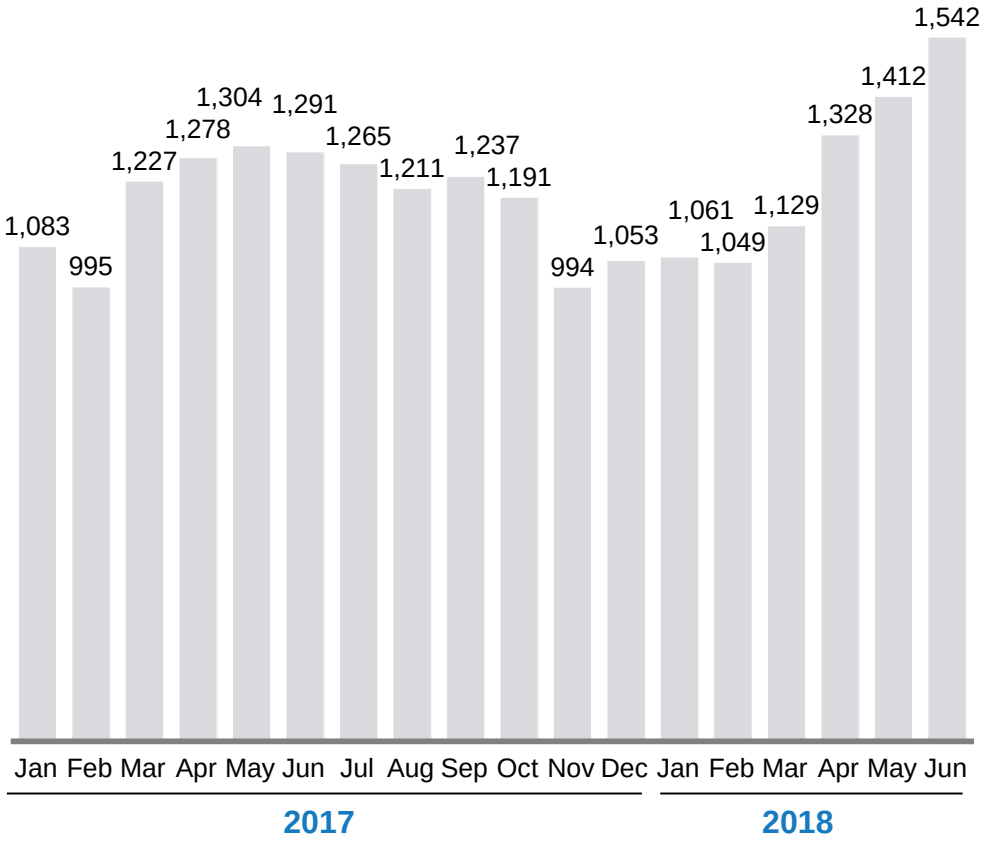
CQC inspections and ratings of specific services

Community health services for adults	●
Community health services for children, young people and families	●
Community mental health services for people with learning disabilities or autism	●
Urgent care services	●
End of life care	●

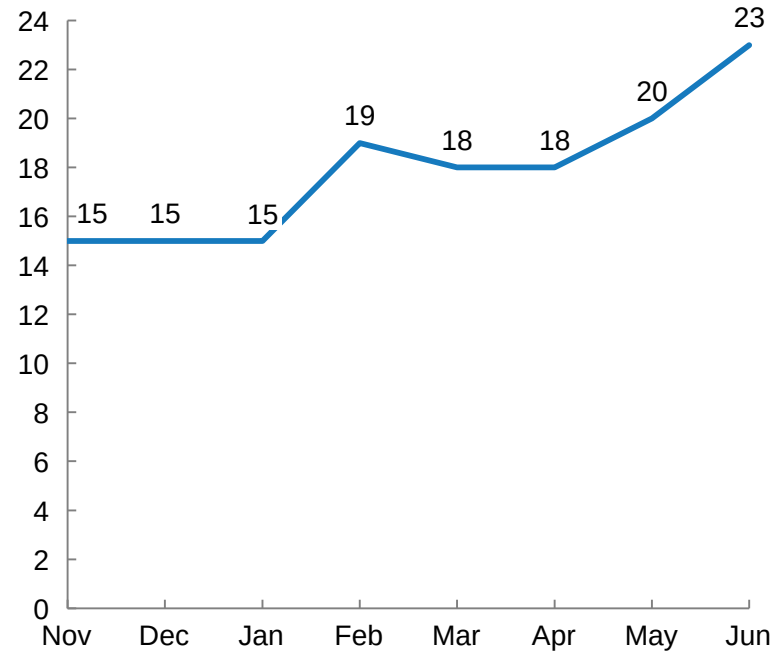
Source: Health Weston Commissioning Context 2017; CQC website

NSCP Minor Injury Unit Attendance Data

Patient attendance data 2017 / 18



Average Waiting Time – 2017 / 18 minutes

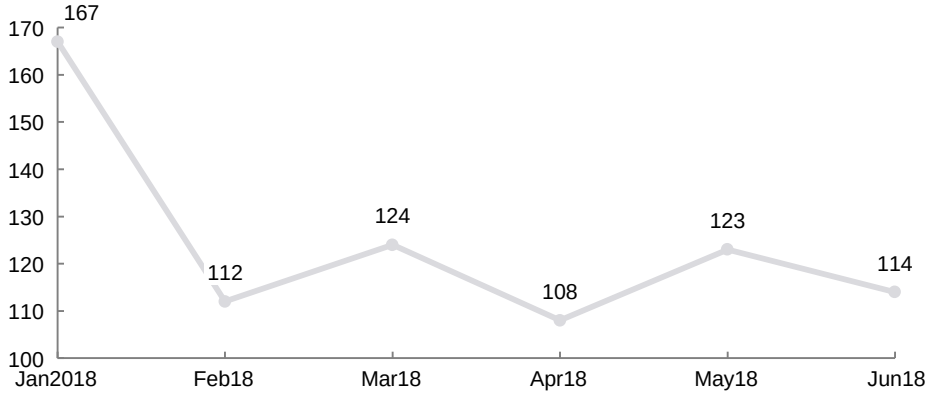


SOURCE: NSCP IQPM Performance Reports (Dec 2017, Jan 2018, July 2018)

Discharge to assess and community delays in Q1 2018

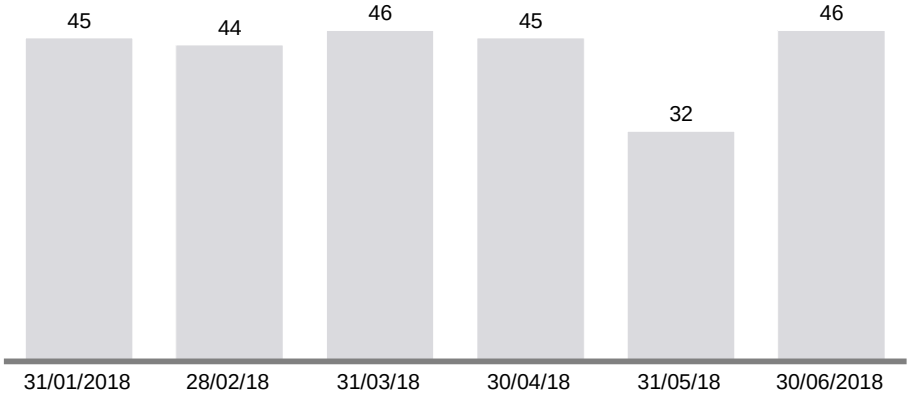
Discharge to Assess Referrals

Number of Referrals



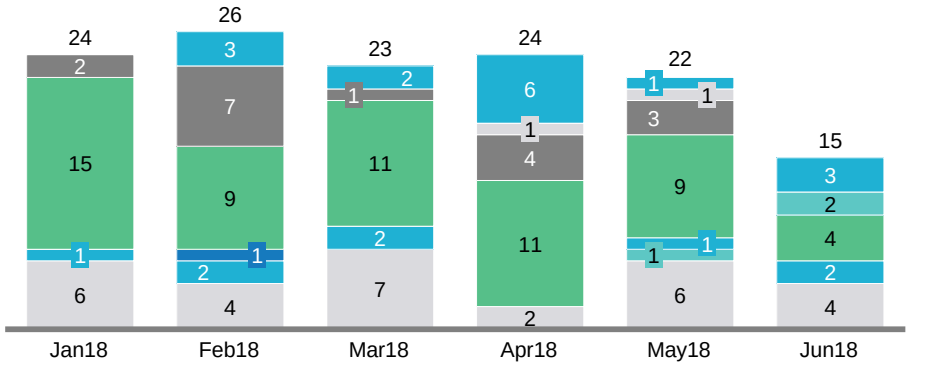
Discharge to Assess Caseload

Number of Patients



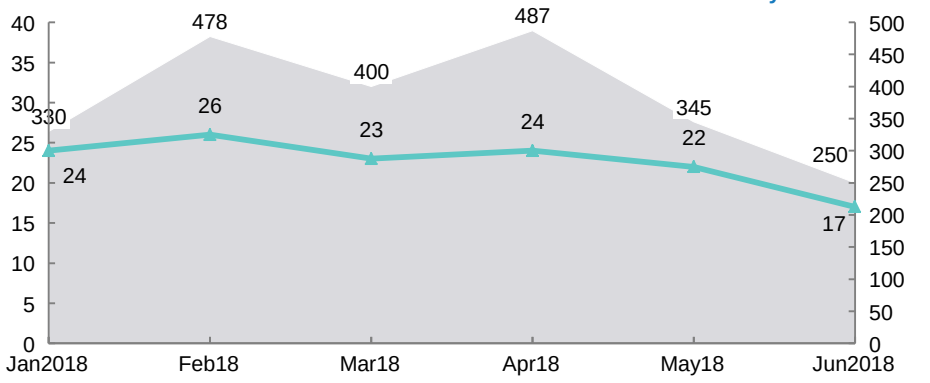
Community Delays: Reasons

Number of Patients



Community Delays: Impact

Number of Patients — Total G2G days this month



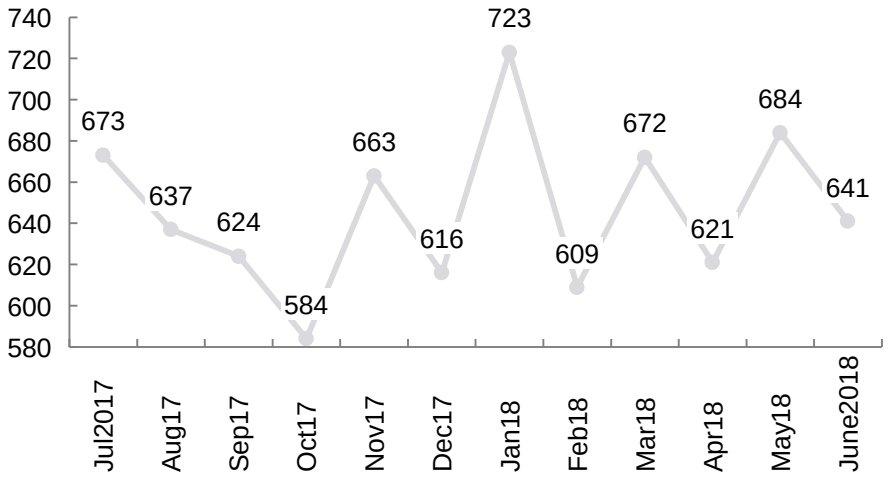
- N/A healthcare need
- 7.1 Patient or family choice
- 1.10.1 Awaiting MDT assessment
- 5.1.2 Awaititing POC-non funded
- 5.1.1 awaititng POC-funded
- 4.2 Awaiting placement - non-funded
- 4.1 Awaiting placement
- 1.5 Awaiting Acute OT assessment
- 1.4.2 Awaiting Social care assessment
- Total green to go (G2G) days this month
- Number of patients

SOURCE: NSCP IQPM Performance Reports (Dec 2017, Jan 2018, July 2018)

District/community nursing referrals and contacts

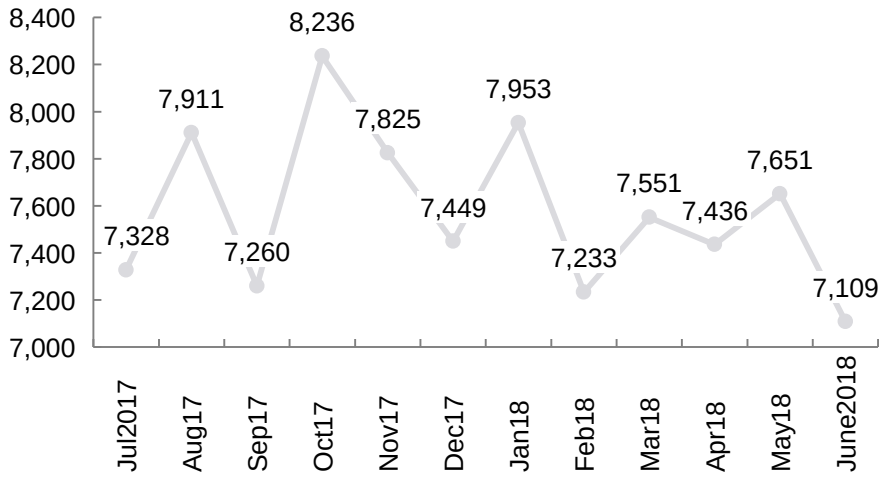
Referrals

Number of referrals[1]



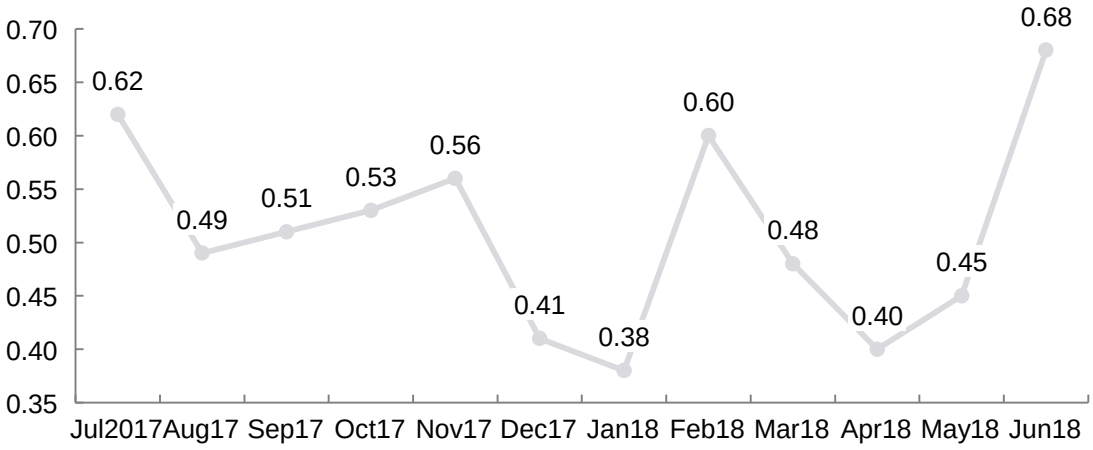
Face to face Contacts

Number of face to face contacts



DNAs & failed Visits

DNA rate %

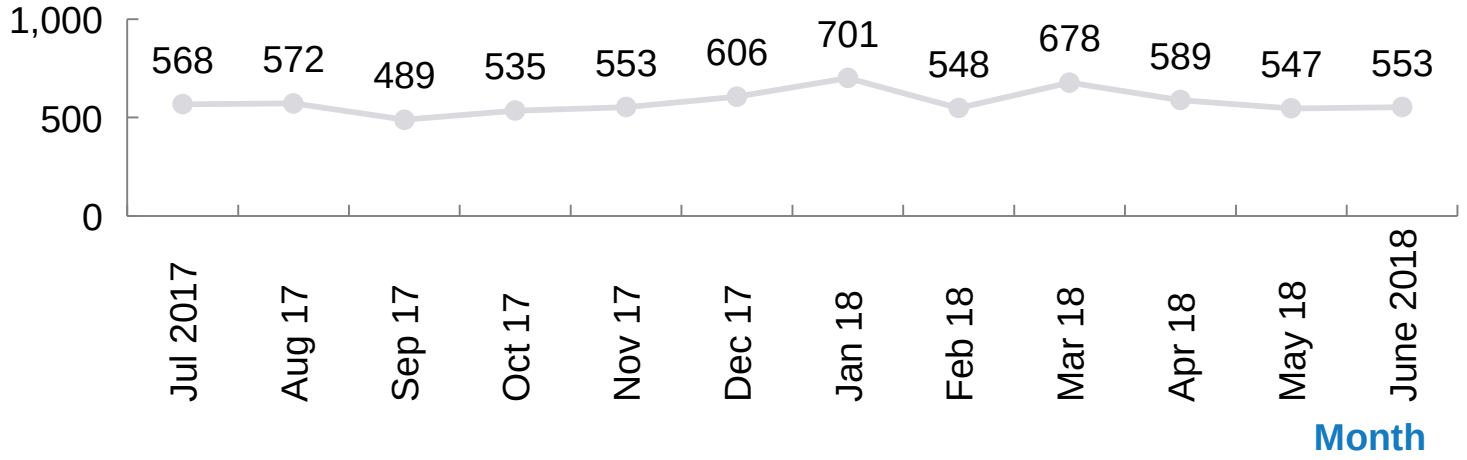


1 Not adjusted for days per month

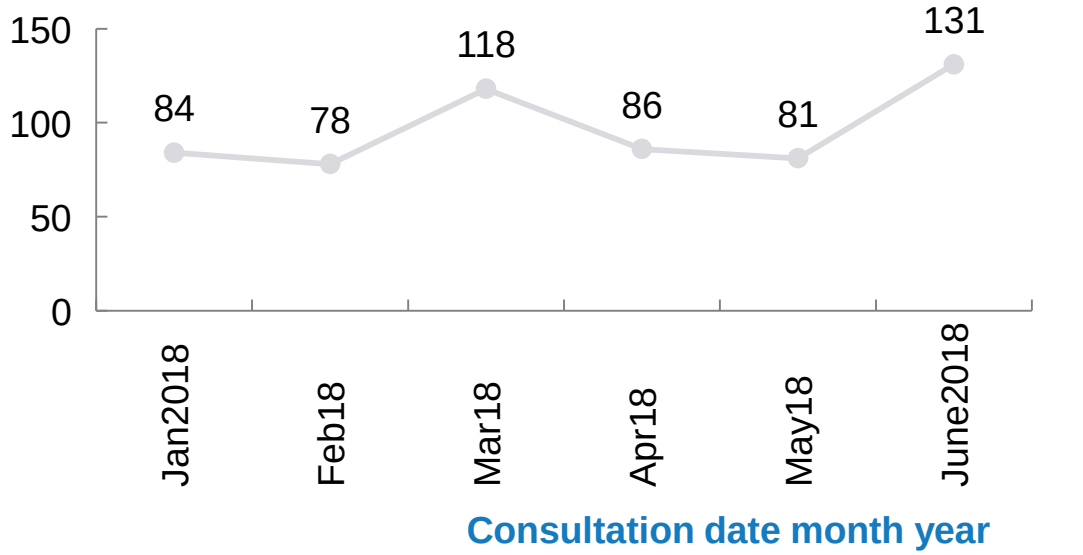
SOURCE: NSCP IQPM Performance Reports (Dec 2017, Jan 2018, July 2018)

Rapid response referrals and admission prevention

Referrals (Clinical Hub)

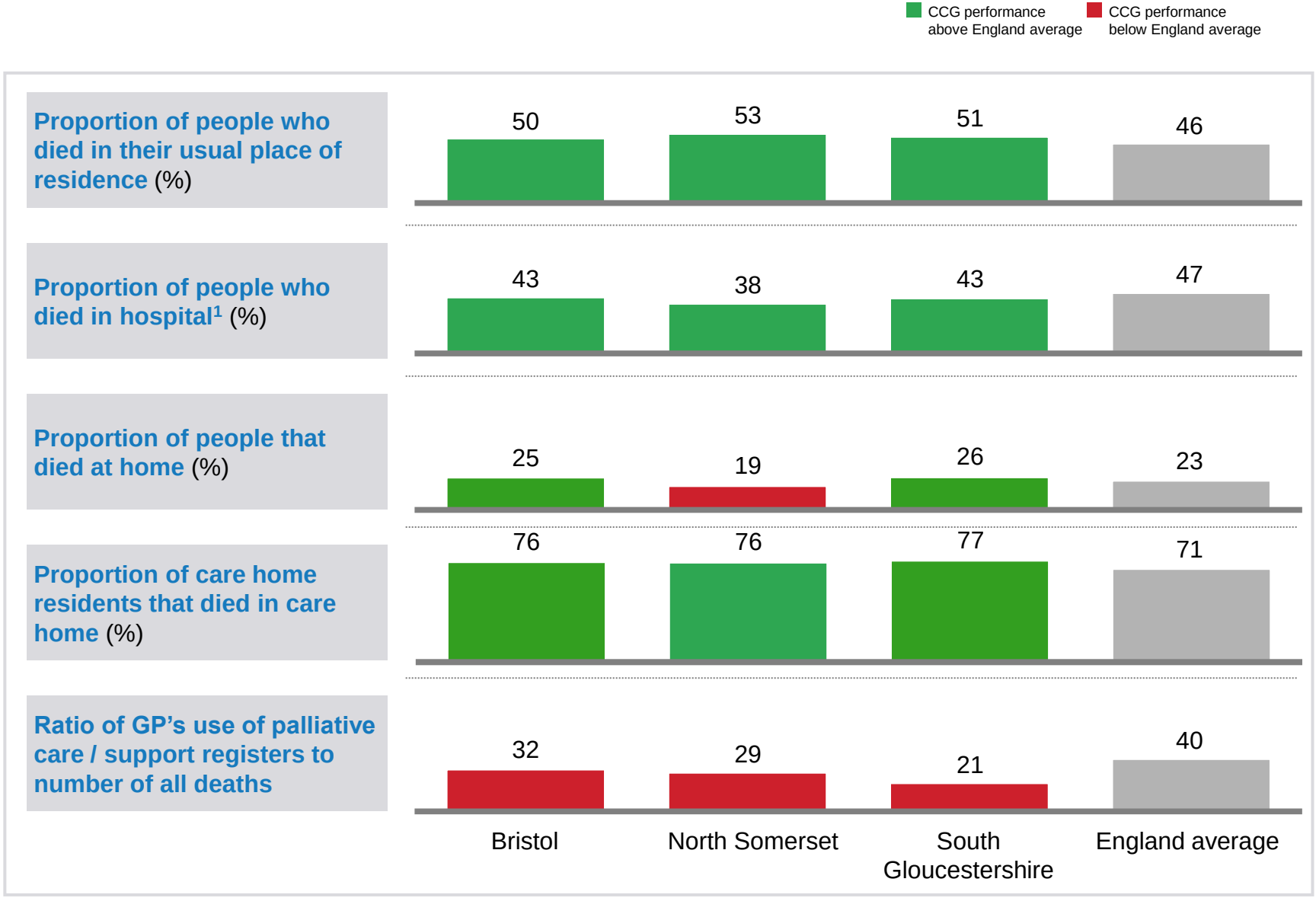


Admission prevention



SOURCE: NSCP IQPM Performance Reports (Dec 2017, Jan 2018, July 2018)

End of life care for Bristol, North Somerset, and South Gloucestershire CCGs



1 Lower percentage considered better performance for this metric

Source: National End of Life Care Intelligence Network – End of Life Care STP Tool, 2015

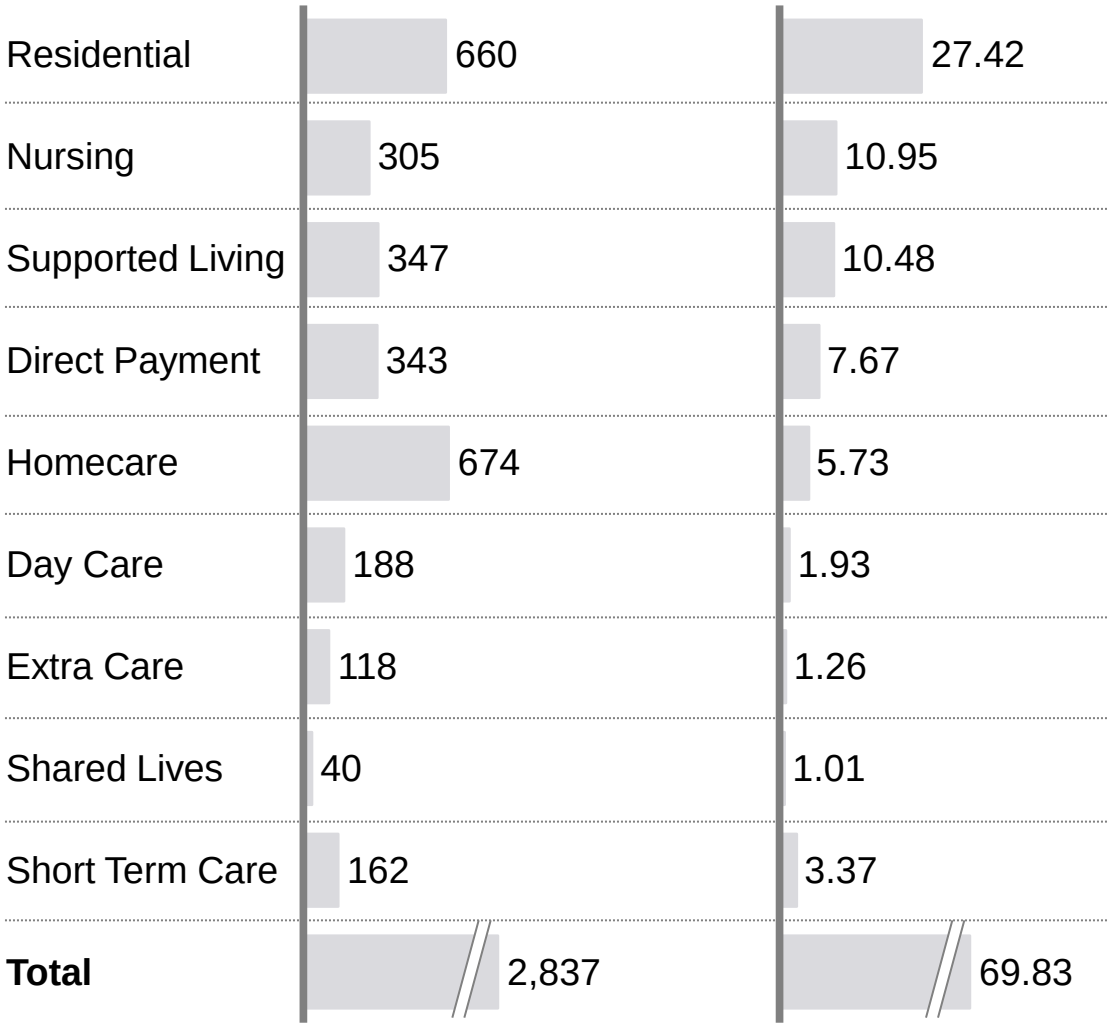
Social care services

- **North Somerset Council** (NSC) commission and provide a **wide range of services** that are extremely relevant to the issues that this document seeks to address

- **Services managed by NSC** include:
  - Dementia
  - Learning disabilities
  - Mental health conditions
  - Personal care
  - Physical disabilities
  - Sensory impairments
  - Substance misuse problems
  - Caring for adults <65 years
  - Caring for adults >65 years
  - Children's services
  - Safeguarding adults & children

- There are **225 CQC listed care homes across North Somerset**

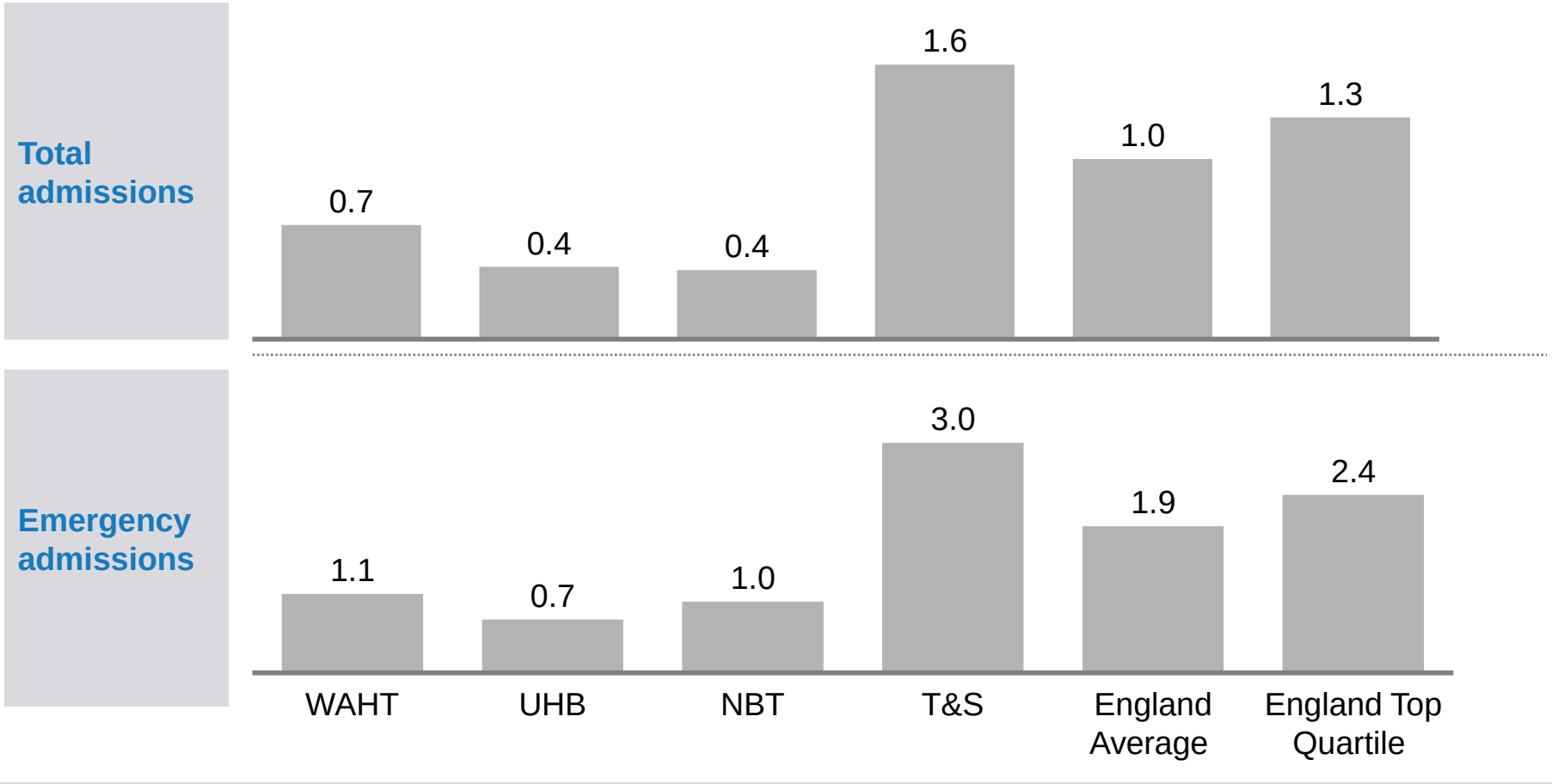
All figures for 2017/18



Source: Healthy Weston Commissioning Context 2017; North Somerset Council annual report 2017/18

Weston Area Trust sees fewer discharges of elderly patients to new residential care settings than average

% Discharges in people aged 75 to care homes or hospices[1]



1 Excludes people who died in hospital and those whose living in a care home prior to admission

Source: HES 2016/17 M13 APC, C/o NHS Digital. Excludes regular attenders

Adult Mental health services are provided by Avon and Wiltshire Mental Health Partnership Trust for North Somerset

Summary of services provided by AWP

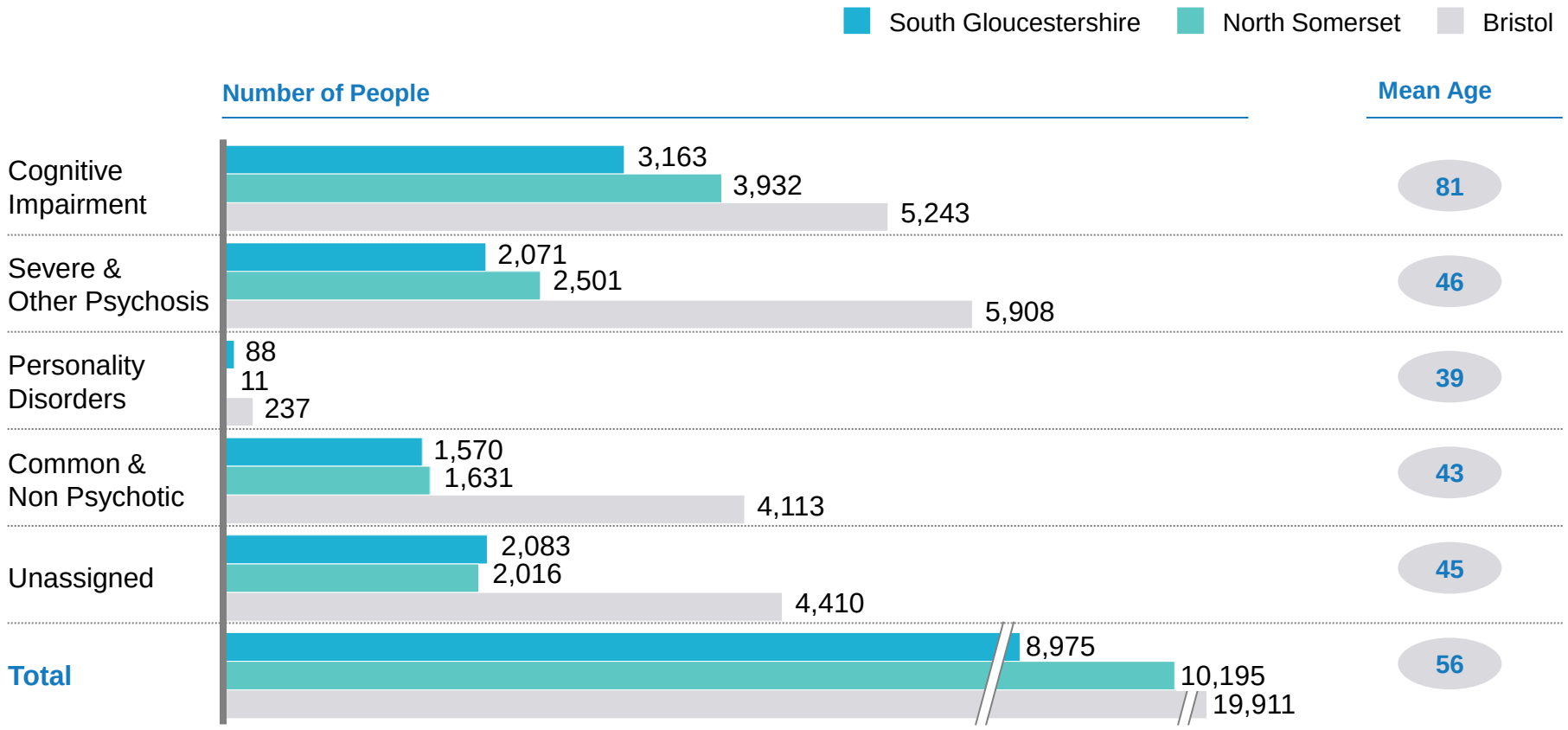
- Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) is a significant provider of mental health services commissioned by a number of CCGS in a catchment area covering Bath and North-East Somerset (B&NES), Bristol, North Somerset, South Gloucestershire (BNSSG), Swindon and Wiltshire. The North Somerset contract with AWP is in excess of £16m per year.
- AWP provides a range of mental health services for the adult population of North Somerset. Figure below summarizes the range of services provided and their key locations:

Inpatient services	
Juniper Ward, Long Fox Unit, (Weston General Hospital)	▪ Adult Mental Health Inpatient Beds X 18
Cove and Dune Wards, Long Fox Unit, (Weston General Hospital)	▪ Later Life Mental Health Inpatient Beds X 25 (Cove =15 & Dune=10)
Elmham Way, Wone	▪ Community-based in-patient rehab beds x 7
Community services	
The Coast Resource Centre	▪ Recovery Team ▪ Early Intervention in Psychosis ▪ IAPT I Positive Step ▪ Psychological Therapies Service ▪ Assessment Team (incorporating ex- PCLS functions)
Long Fox Unit, Weston General Hospital.	▪ Intensive Team ▪ NSC AMHP Service ▪ A&E Hospital Liaison
Windmill House	▪ Complex Interventions Team ▪ DEST ▪ Memory Team ▪ Later Life Therapies
Weston Super Mare Town Hall	▪ Mental Health Triage Service (incorporating ex-PCLS functions)
Other LDU services	
Portishead Police HQ	▪ MH Control Room and street Triage Service
Carlton Centre, Weston	▪ Vocational Services

Source: Health Weston Commissioning Context 2017

Approximately 40k citizens in BNNSG have been in contact with mental health specialists

- The BNSSG STP Mental Health Cohort represents **5% of the population**

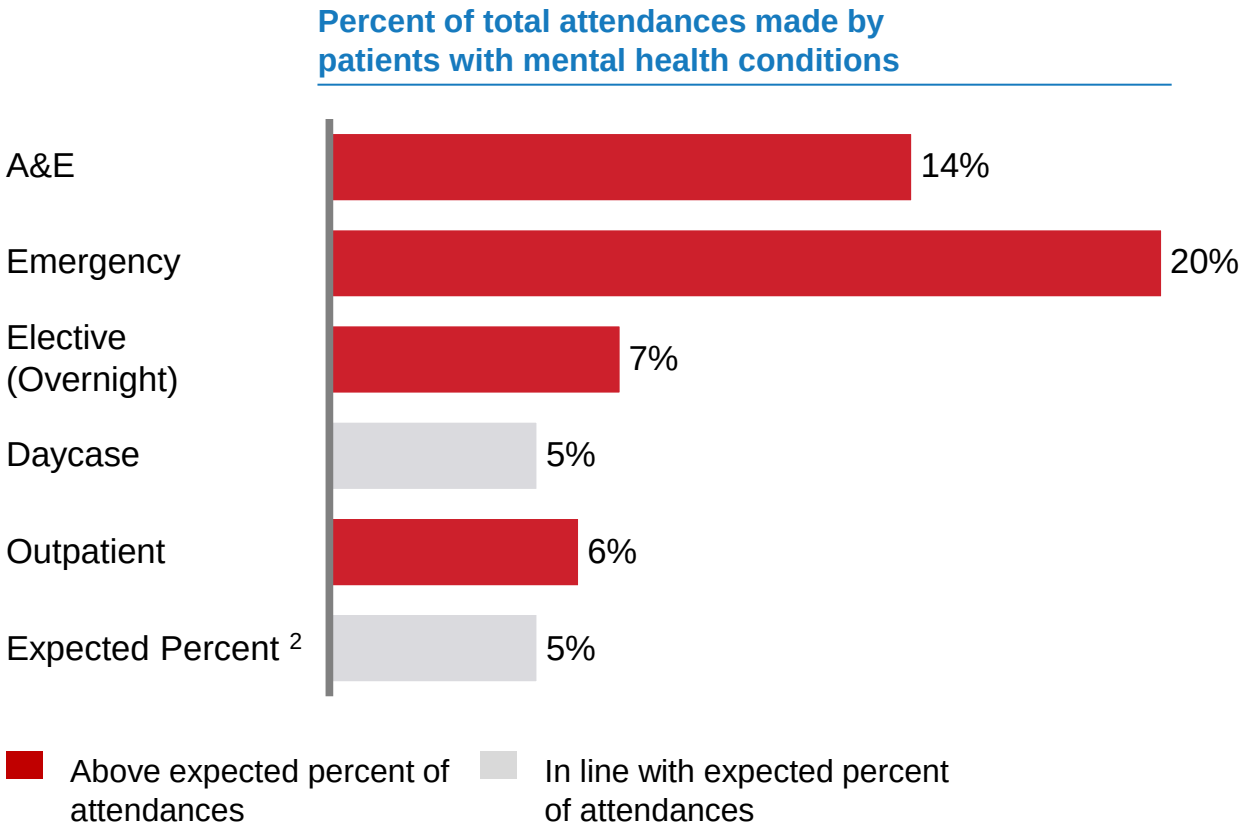


Source: "Making the case for integrating mental and physical health care" yellow paper, May 2017

Citizens with mental health conditions utilise the acute care system at a much higher rate

Patient Rate of Use

- Despite making up **only 5% of the population**, patients with mental health conditions **represent a much higher percentage of attendances** at facilities across the CCG



According to a yellow paper commissioned by the BNSSG STP, **over £20M could be saved across the system** by reducing mental health patients use of the acute care system **to a level closer to that of their peers** nation-wide[1]

1 Only includes subgroups which may be amenable to change, based on published research, grey literature and modelling exercises; costs estimated using national tariff or reference costs and number of visits reduced
2 Based on the fact that population is only 5% of total group

Source: "Making the case for integrating mental and physical health care" yellow paper, May 2017

Case for Change

- Local population and their health and care needs
- Acute care
- Out of hospital: Primary care
- Out of hospital: Community, mental health and social care
- **Out of hospital: Ambulance services**
- Financial position

Performance of ambulance services

Overview of current quality and performance against targets

The latest CQC inspection of South Western Ambulance Services NHS Foundation Trust SWASFT overall as “Good” along with the domains of Effective, Responsive and Well-led. The Trust was assessed as “Outstanding” for Caring and “Requires Improvement” for Safe.

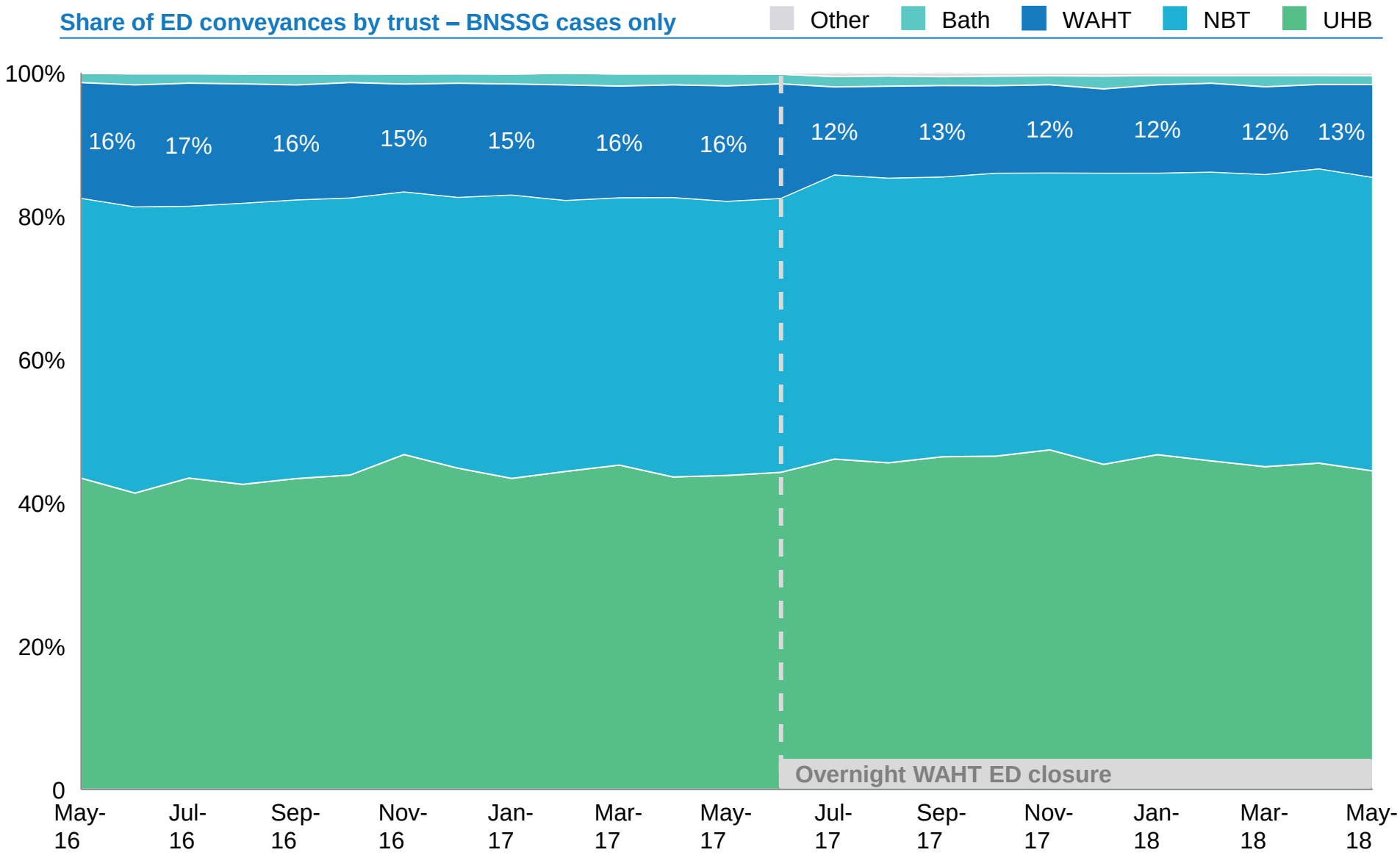
SWASFT has been participating in a national pilot called the Ambulance Response Programme which measures performance differently from current national standards.

- Response times for Category 1 calls (life threatening injuries or illnesses) for SWASFT in August 2018 were better than national standards, however, some unpredictable spikes in demand continue.
- Time to call answer — ambulance services are expected to answer 95% of all 999 calls within 5 seconds. In August 2018 SWASFT reported a Mean call answering time of 5 seconds, 95th centile of 20 seconds and 99th centile of 60 seconds. All three metrics are better than the national average.
- Hospital handover delays continue to impact on available resource. In July 2018 there were 252 handovers involving North Somerset patients which took longer than 15 minutes equating to around 35 hours of lost time.
- Number of incidents per head of population for North Somerset is 38.59 per 1000 population, which is average against the other SWASFT areas.

* CCG performance data

SOURCE: Health Weston Commissioning Context 2017

Overnight ED closure resulted in ~4% points reduction in share of BNSSG ED conveyance



Source: SWAFT Ambulance Conveyance BNSSG Conveyance Summary June 2018

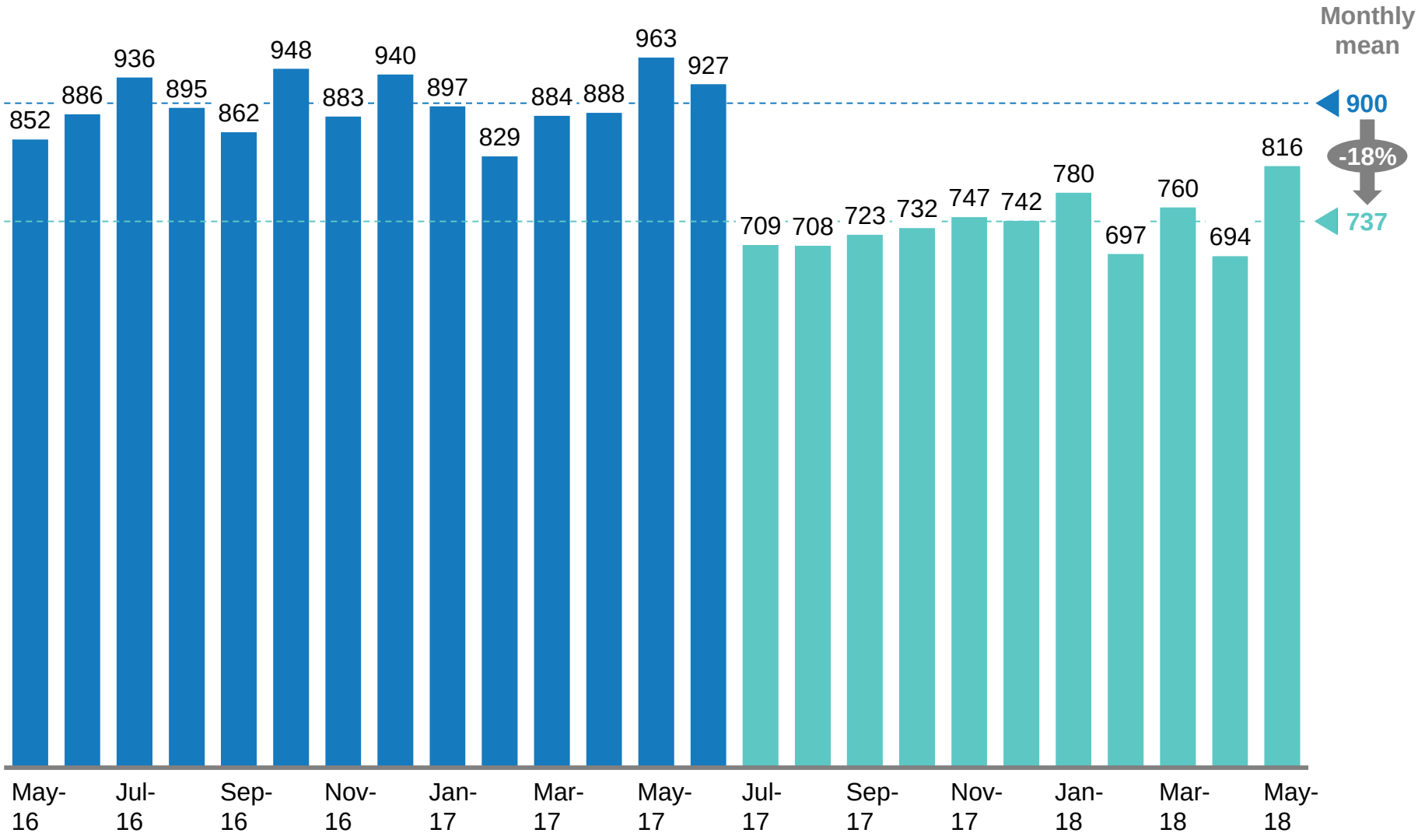
Closure of overnight ED at WAHT resulted in 18% reduction in average monthly WAHT conveyances from BNSSG

HEALTHY WESTON

24/7 ED

14/7 ED

Number of WAHT ED conveyances – BNSSG cases only



Source: SWAFT Ambulance Conveyance BNSSG Conveyance Summary June 2018

Healthier Together

SWASFT emergency responses times against targets

Overview of emergency response duration (min) / count (incidences)

2018/19 YTD, by category, BNSSG

Target met
Target not met

	Mean	Target	90th percentile	Target	Count
Category 1	7.0	7.0	12.2	15.0	3,974
Category 2	24.0	18.0	51.6	40.0	24,664
Category 3	65.7	60.0	163.8	120.0	11,955
Category 4[1]	164.2	N/A	337.5	180.0	465

1 999 call

Source: SWAFT A&E Monthly Commissioners Report July 2018

Performance of NHS 111 services for BNSSG CCG

Performance against target for Jul 2018

Metric	Performance – Jul 2018	Standard	Commentary
Calls answered in 60 seconds	96.6%	≥95%	Strong improvement trend with target met for two consecutive months
Call abandonment	0.5%	≤5%	First time target met this year, recent performance of 8-10% calls dropped
Combined clinical contact (warm transfers plus call backs in 10 min)[1]	60%	≥70%	Recent deterioration from above target results in the previous years
Referrals to Emergency Departments	10.9%	≤5%	Target has never been achieved. Causal factors include staffing pressures
Referrals to the ambulance service	15.7%	≤10%	Mixed performance traditionally, with strong growth trend; target not met this year

1 As a share of calls transfered to clinical advisor

SOURCE: NHS 111 Minimum Data Set August 2018

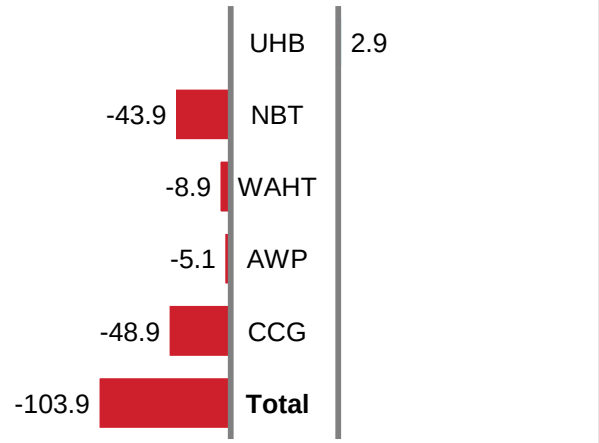
Case for Change

- Local population and their health and care needs
- Acute care
- Out of hospital: Primary care
- Out of hospital: Community, mental health and social care
- Out of hospital: Ambulance services
- **Financial position**

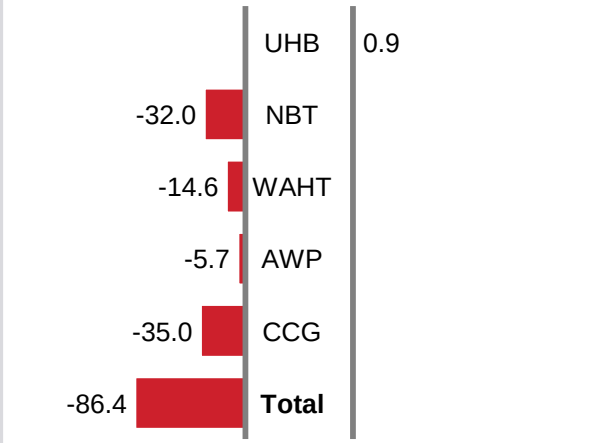
System financial position including STF funding

Deficit | Surplus

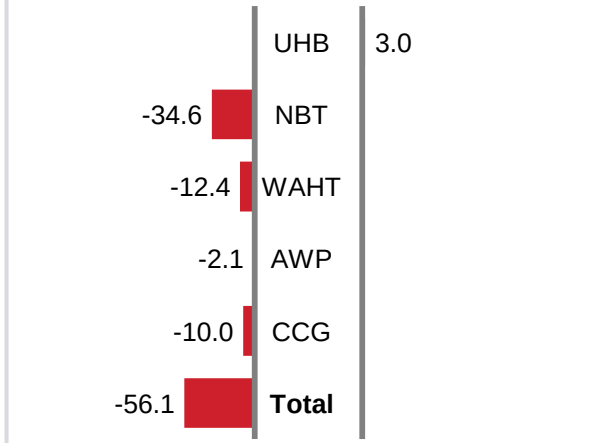
2016/17 Financial Position
£m



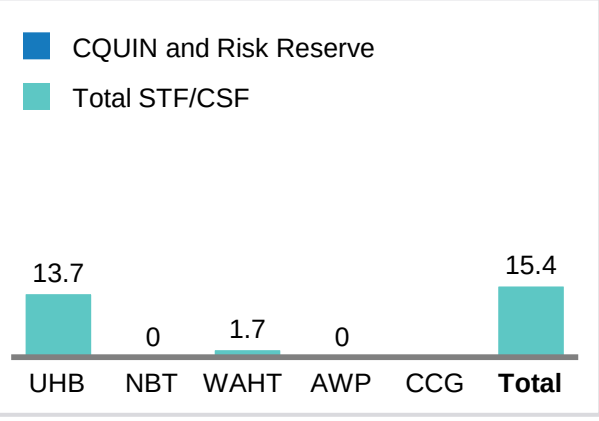
2017/18 Financial Position
£m



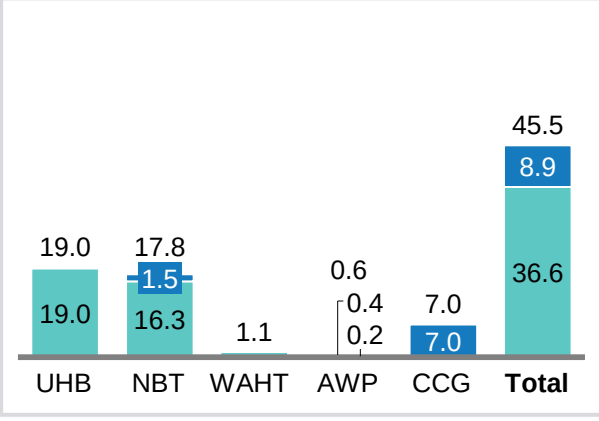
2018/19 Financial Position (Planned)
£m



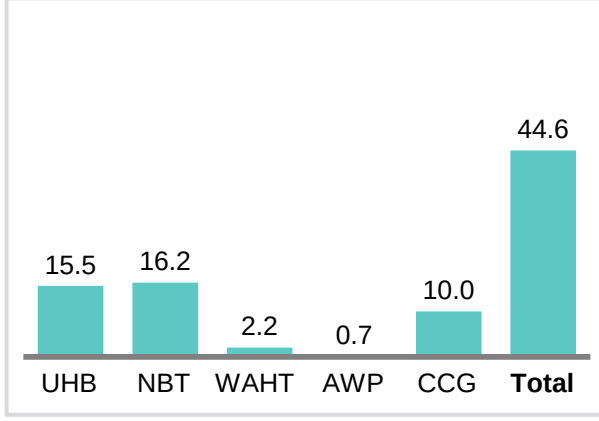
2016/17 STF Funding
£m



2017/18 STF Funding
£m



2018/19 STF Funding (Planned)
£m

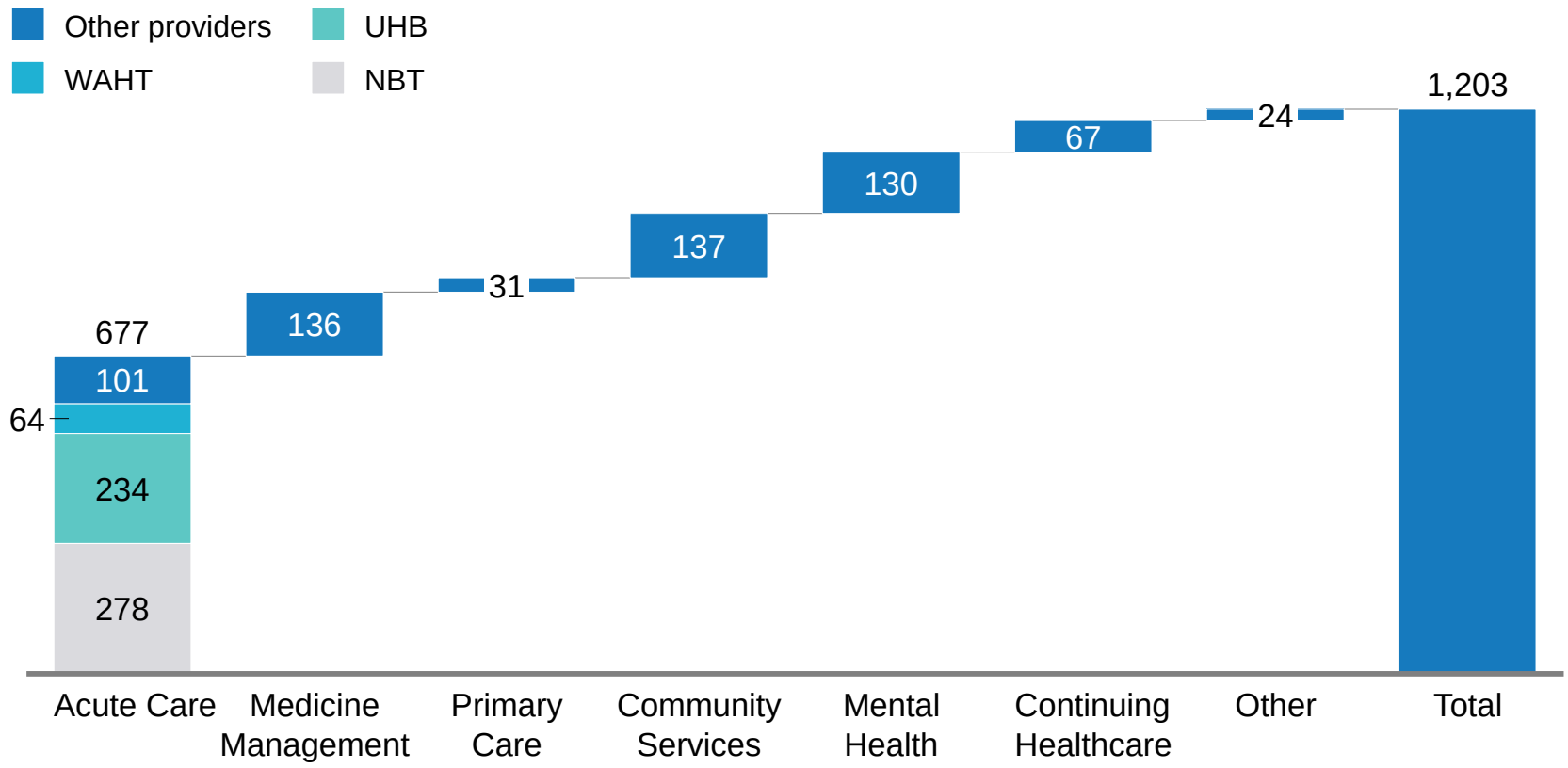


Source: BNSSG Overall Plan summary

BNSSG CCG Cost Statement – 2017 / 18

Total Commission Cost, 2017 / 18

£m



Acute care costs make up **56.3% of total CCG costs**

Source: BNSSG CCG 2017-18 Programme Spend

Even assuming no demand management WAHT deficit will increase to £22.2m by 2024

HEALTHY WESTON

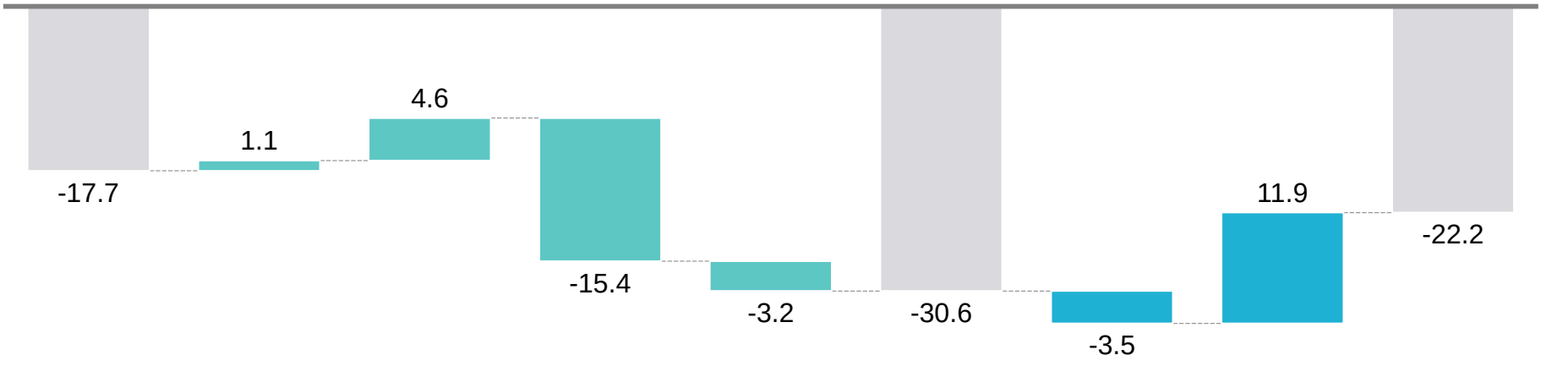
PRELIMINARY

Demand management **0% p.a.**[2]

External factors on "do nothing"

Impact of Trust "must dos" on "do nothing"

Baseline I&E projection for Weston NHS Trust from 2019 to 2024, £m



- Demographic and non-demographic growth 2% p.a.

- CIP assumed at 2% p.a.[5]
- CF analysis assumed no delivery of CIP

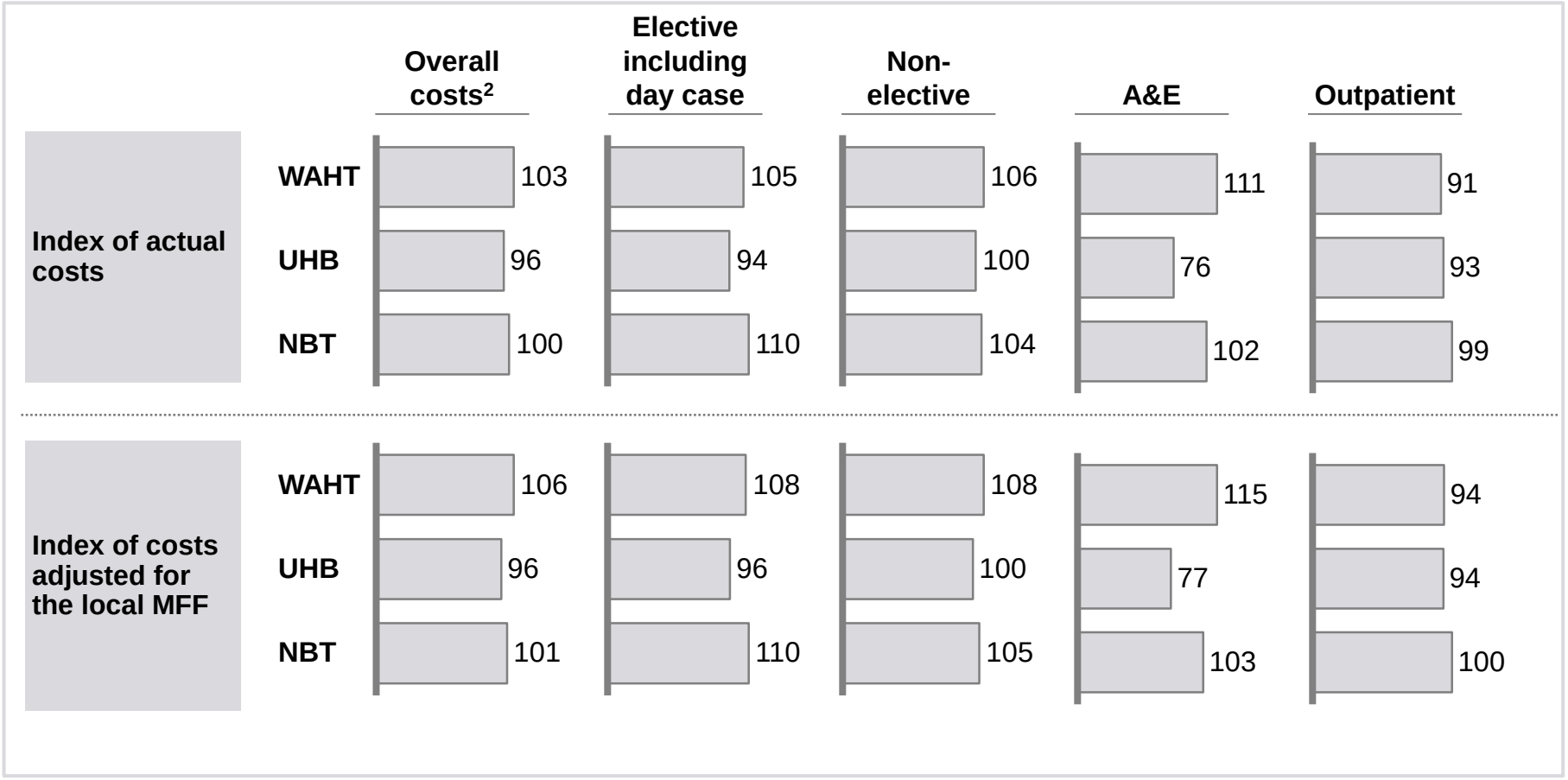
1 Assumptions from historical activity, ONS population projections and CCG assumptions, with new activity adding cost using a varying scaling factor;
2 CCG currently has no view on its planned QIPP; historically achieved 1.8% in 2017/18 without provider support but will require additional support going forward to achieve new targets;
3 Assumption from NHSI economic planning guidance;
4 Assumed growth of 1% per year on permanent staff costs as per national assumptions – no current CCG assumptions;
5 No current CCG assumptions

SOURCE: Weston Trust I&E Plan 2018/19, Financial Baseline Forecasting Model

Healthier Together

Services at Weston were higher cost than elsewhere in 2016/17, especially when adjusted for Market Forces Factors

Reference costs indexed to national costs (national average indexed at 100)[1]



1 National costs adjusted to the case mix of each hospital
2 Excluding excess bed days

SOURCE: NHS Reference Costs Index 2016/17

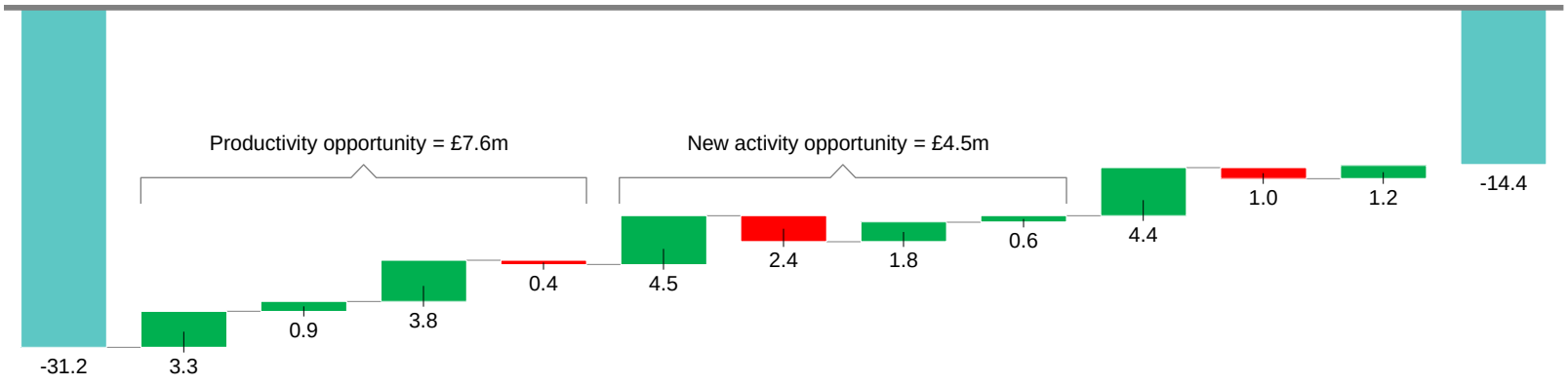
CF analysis: Repatriation of activity and consolidation of elective care could result in additional ~£9.5m of income for WAHT

		Spells	Theatre sessions	Beds	Upper bound contribution: Full transfer £ Millions	lower bound contribution: Franchise model £ Millions
Repatriation of existing services	Non-elective activity	2,078	204	25	2.2	-
	Elective activity	894	307	7	2.0	-
	Daycase activity	2,233	909	-	1.5	-
Elective inpatient consoli-dation	Non-complex orthopaedics	3,321	1,107	21	-	1.8
	Non-complex urology	1,750	357	9	-	0.6
Repatriation of new services	Repatriation of additional daycase activity	3,489	488	-	1.4	-
Healthy Weston	Healthy Weston: 24/7 A&E	-	-	-	-0.7	-0.7
	Healthy Weston: 14/7 A&E	-	-	-	-0.4	-0.4

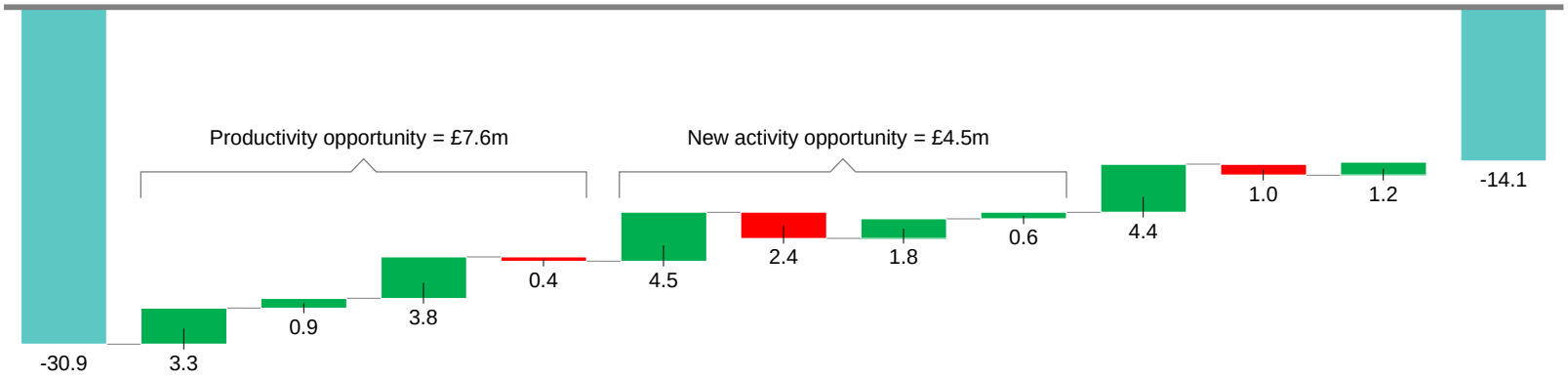
Source: Carnell Farrar analysis

CF analysis: Taking all productivity and repatriation opportunities, modelling has suggested a gap of over £14m vs. do nothing by 2022/23

Scenario 1a: Financial impact of the productivity scenario with a 24/7 A&E (£m)



Scenario 1b: Financial impact of the productivity scenario with a 14/7 A&E (£m)



Do nothing 22/23	Agency + job planning	Theater produc-ti vity	LOS produc-ti vity	Income loss excess bed days	NEL repatria-tion income	NEL repatria-tion cost	Fran-chise fee ortho-paedics	Fran-chis e fee urology	2% CIP delivered	Nursing invest-m ent	Avoided inflation	Rema-ining gap 22/33

Source: Carnell Farrar analysis

Healthy Weston Pre-Consultation Business Case

Appendix 15: Public Case for Change document

NHS

Bristol, North Somerset and South Gloucestershire

Clinical Commissioning Group

HEALTHY WESTON

Why our local health services need to change

Who we are

This document has been prepared by the Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group. We are the NHS organisation responsible for buying, organising and making sure there are good health services in Weston-super-Mare, Worle, Winscombe and the surrounding area.

We work closely with our colleagues in Somerset Clinical Commissioning Group who are responsible for health services for areas that include north Sedgemoor. This is important because while around 80% of patients who use Weston General Hospital are from North Somerset, around 20% come from the north Sedgemoor area. On page 3 you will see the range of other organisations we work with to deliver services to local people.

Healthy Weston is the name of the work we are doing together with a range of health and care organisations to change and improve local services. It is part of Healthier Together – our Bristol, North Somerset and South Gloucestershire Sustainability and Transformation Partnership.

> "A changing population and changing needs"

About this booklet

This booklet explains why we need to change how we organise and provide health care across primary and community services as well as at Weston General Hospital. It sets out four key challenges that we need to address as a priority – a changing population and changing needs; variation in the quality of and access to primary (GP) and community services; staffing vacancies and low patient numbers for some services at Weston Hospital; and the need to get the best value from every pound we spend.

This booklet uses facts and figures from a range of data sources, including NHS services and the Office of National Statistics. Further information about the data is available in *Data to support the Case for Change for services provided at Weston General Hospital* available at: https://bnssghealthiertogether.org.uk/healthyweston/

Our local health and care services

There is a wide range of health and care services for the 212,000 people who live in the North Somerset area covered by the Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group. These services include:

GP and primary care services provided by:
- 16 GP practices within the Weston General Hospital catchment area, covering North Somerset and north Sedgemoor
- Brisdoc who provide GP out of hours services

Community and mental health care services provided by:
- North Somerset Community Partnership
- Somerset Partnership NHS Foundation Trust
- Avon and Wiltshire Mental Health Partnership NHS Trust

Hospital based services provided by:
- Weston Area Health NHS Trust
- University Hospitals Bristol NHS Foundation Trust
- North Bristol NHS Trust
- Taunton and Somerset NHS Foundation Trust

Weston General Hospital provides services to approximately 150,000 people including some patients from north Sedgemoor.

Services provided by:
- South Western Ambulance Service NHS Foundation Trust

Social care services provided by:
- North Somerset Council and Somerset Council

Independent nursing and residential care homes

Care provided by:
- A wide range of voluntary, community and social enterprise sector organisations

Foreword

Every day across the NHS in Weston-super-Mare and the surrounding area our dedicated staff work hard to care for local people. Much of the health care we provide is good, but we face significant challenges.

Our population is increasing and getting older. As we age we are more likely to develop one or more long-term physical health condition. We also have more people living with drug and alcohol dependency and mental health issues than the average for other areas in England. There are marked differences in life expectancy between the most and least deprived areas of North Somerset.

There is variation amongst the care given by our GP practices and community services. Some people have their conditions monitored and managed better than others; some find it difficult to access the services they need, such as getting a GP appointment when they need one, and some experience disjointed care across different services.

The future of Weston General Hospital is an important local issue. For several years we have been discussing with staff and local people how to make sure the hospital can continue to play a vital and sustainable role in delivering health care to our local communities. The current uncertainty is adding to our staffing challenges and is a cause of worry for local people. The temporary overnight closure of Weston General Hospital's A&E department is just one example of the challenges Weston General faces and why we need to make changes. The temporary closure is in place because despite considerable effort the hospital is not able to recruit enough permanent staff to fill a rota to run a safe service 24 hours a day, seven days a week.

As a smaller hospital it doesn't provide the same range of specialist services as some of our bigger neighbouring hospitals, and it faces challenges in some areas. There is great opportunity to reform the scope of services it does provide. We welcome the recent Nuffield Trust report *Rethinking acute medical care in smaller hospitals* (October 2018), as a stimulus for local innovation in response to the challenges faced by smaller hospitals. Like this case for change, that report recognises the urgent need to create sustainable models for smaller hospitals and to develop solutions that allow them to thrive whilst meeting the needs of their local communities.

"We have a clear and compelling vision for the future of health and care services"

This booklet sets out our case for change for the health and care system in our area but recognises that Weston General Hospital faces particular, and urgent pressures to change, especially in light of the temporary overnight closure of its A&E service.

We must act now to make sure Weston General Hospital remains a strong, focused hospital at the centre of our community for years to come. We want Weston General Hospital to be held up nationally as a best practice example of a smaller hospital delivering good quality, sustainable services meeting changing needs. Achieving this ambition is currently the focus of a significant programme of work.

The challenges we face are not unique - other areas in our region and around the country must also adapt and in some cases make difficult decisions to secure a positive future.

As the commissioners responsible for buying and organising health care for the people of Bristol, North Somerset and South Gloucestershire, and the doctors, nurses and other health professionals who work in hospitals, GP surgeries and all other parts of the health system, we have a responsibility to ensure we respond to the challenges we face. Doing nothing is not an option.

Building on the evidence in this case for change, what local people have told us (see page 22), and the ambition we have set out in *Joining up services for better care in the Weston area*, we are now developing detailed proposals for how we believe services should change. We need to make sure all of us who live and work in and visit this area can access safe, effective, good quality care that meets our individual needs, in the right place at the right time. This applies as much to GP, primary care and community services as it does to identifying a clear, strong and focused role for Weston General Hospital in the future.

We are testing our thinking on how we can change and improve services with a wide range of people and will be asking local people for their views on our proposals in our public consultation in 2019. We hope you will get involved.

Dr Jonathan Hayes
Clinical Chair

Julia Ross
Chief Executive

NHS Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group

The challenges we face

We face four key challenges:

Our changing health needs

Our population is growing, getting older, living with more long-term conditions and there are significant inequalities in health.

Variations in care and access in primary and community care

There are differences in the quality and way care is currently provided; some patients also find accessing care more difficult than others.

Meeting national clinical quality standards

Some services at Weston General Hospital don't have sufficient volumes of certain cases and there is a shortage of doctors, nurses and other staff.

Getting value for money

We must live within our financial means and make sure we use our available resources most effectively to meet the needs of all local people.

Challenge 1
Our changing health needs

Our population is growing, getting older, living with more long-term conditions and there are significant inequalities in health. There is an increasing, but changing, demand on health and care services. We need our services to grow and adapt to meet local people's needs now and in the future.

Key facts

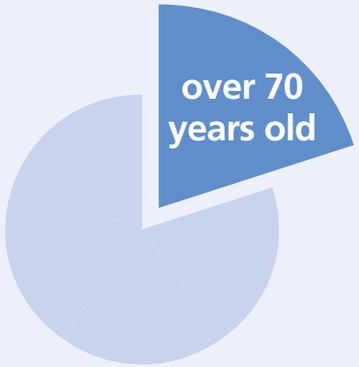
Population growth

Overall the population in the catchment area for Weston General Hospital is set to increase only by around **1% each year**, from 152,000 people to 161,000 by 2025.

161,000 people

25,000 homes

New housing developments are expected to create an additional **25,000 homes** by **2036,** with most of these planned to be in the Weston and Worle areas.



However, a fifth of the growth is predicted to be in people **over 70 years old.**

Older people are moving into North Somerset from other areas, including into sheltered flats and care homes.

The local birth rate is expected to reduce by **0.2% each year** until **2025.**

Increasing demand for health care

64%
of people have long term conditions

Nearly **two-thirds (64%)** of people registered with a GP in Weston Town practices report having a long-term health condition.

6,000
diabetes

6,000 more will have diabetes and a similar number will be living with a serious lung condition known as COPD.

10,000
high blood pressure

By 2030 we can expect over **10,000** more local people will be living with high blood pressure.

10,000
mental health problems

Around **10,000** patients each year in North Somerset receive mental health support, and we expect to see significant increases over the coming years.

Health inequalities

Overall people living in North Somerset have a long life expectancy and good health, however when we look more closely there are big differences between the health of people living in the most well-off areas and the health of those in the poorest.

Our most deprived areas are associated with high rates of **obesity** and harm from **drugs and alcohol.**

10 year
difference in life expectancy

A baby boy born today in the most deprived area in North Somerset would be expected to die in older age **10 years** sooner than a baby boy born in the most well-off area. He would also be expected to live with **22 years** of poor health before he died, compared to **14 years** in the most well-off area.

A baby girl born in the most deprived area would be expected to die in older age around **10 years** sooner and have **26 years** of poorer health before she died, than a girl born in the most well-off area.

42%
smoking rate

We also have some areas with high rates of smoking (as much as **42%** in one of the most deprived areas versus a national average of **15%**).

Addressing the challenge

We need to refocus our services so they meet the changing needs of our local population – that is more older people, more people living with long-term conditions, and more young families. These groups typically need more community-based services that can help them stay well, prevent ill-health and meet day-to-day health and care needs. We also need to make sure people can access urgent and emergency care and high-quality specialist services when they are needed.

Challenge 2
Variations in care and access in primary and community care

In our area there is variation in the size of our GP practices and the numbers of patients per GP. This can impact on patient care. Smaller practices may not be able to offer a wider range of services, such as specialist clinics for conditions like high blood pressure or diabetes, and they can find it harder to cope if staff are away or unwell.

Our community services are often not joined up with each other, and health professionals are not able to share information easily, meaning people must repeat their details and stories multiple times. This lack of join-up leads to both duplication and gaps in care.

People with complex needs or long-term conditions can end up in A&E, and being admitted to hospital, because they weren't able to see a GP, or other health or care professional, at the right time. Sometimes older and frail people are being admitted to hospital for non-medical reasons – such as if their usual carer is unable to look after them. Unplanned emergency admissions are not always good for patients. For example, frail older patients experience 5% muscle wastage for every day spent in a hospital bed, meaning they can find it hard to get back to their previous level of independence.

> "Services are not as joined up as they could be"

What are community services?

When we talk about community-based services, in addition to GP services, district and community nursing, health visitors, physiotherapy and occupational therapy, we are also referring to services such as NHS 111, some midwife care, community-based mental health services, social care, care and nursing homes, and services provided by the community, faith and voluntary sector.

Key facts

Variations in access to care

There is a large variation in the **number of A&E visits** made by patients from different GP practices. Some of this is because patients choose to go to A&E rather than their GP.

Large variation in A&E visits

Some is because some GP practices are more successful than others at **monitoring and managing** their most unwell patients in the community, helping avoid A&E visits from a sudden downturn in their condition.

Successful monitoring avoids A&E visits

People who have a **mental health condition** in our area are three times more likely to go to A&E and four times more likely to have an **emergency admission** to hospital than people without a mental health condition.

4 x more likely

Variation in use of hospital services

There is significant variation across North Somerset in relation to **unplanned admissions** to hospital.

81%
of beds occupied by over 65 year olds

In any one day **81%** of people in hospital beds at Weston General Hospital are over **65 years old**, significantly above the national average.

If we organised the way we work differently we could keep more older people out of hospital and keep them well and independent for longer by providing more **proactive care and support** before they get acutely unwell.

Workforce issues

We have a large proportion of our GPs coming up to retirement age, with **35% aged over 55**, and not enough new GPs training to replace them.

35% GPs
over 55 years old

The gap between the number of community nurses, therapists and care assistants we have and the **number we need is growing.**

Addressing the challenge

We know that where people have access to the best quality GP, primary care and community-based services they will have better health than in areas where services aren't so good. We need to make sure that everyone has good access to these local services so that no-one's health is disadvantaged because of where they live.

Some of our practices are already working more closely with each other so all patients can have access to the same range of services, whatever the size of their practice. One example of this is Pier Health Group, a new arrangement with GPs working together to deliver services in one of the most deprived areas of Weston. Other GP practices are starting to work together too, so they can increasingly offer more appointments to patients, and a wider range of services, such as physiotherapy or counselling services.

With better joined-up community-based services in place to proactively treat and care for frail older people before they need an emergency hospital admission there could be 25 per cent fewer A&E attendances, and half the number of hospital admissions for these patients. We are determined that in future no person will be in a hospital bed just because they are frail. There are better ways we can look after this vulnerable group of people.

By reorganising our services, we will also be able to better meet the needs of children, young people and pregnant women. We will be able to offer more joined-up care to other vulnerable groups such as those with mental health and drug and alcohol dependency.

We are already making important changes so that GP, community and mental health care, hospital services, social care and voluntary organisations are starting to work in a more joined-up way. We are developing mixed teams of specialists that will work more closely together.

Challenge 3
Meeting national clinical quality standards and addressing staffing shortages in our hospital

Weston General Hospital is one of the smallest hospitals in the country in terms of the population it serves. Compared with Southmead Hospital, University Hospitals Bristol and Musgrove Park Hospital it has the lowest, and falling, share of patients across a range of services including outpatient appointments, emergency inpatients and total inpatient admissions.

National quality guidelines set out the minimum recommended population required to deliver certain services. This is to ensure staff see enough, and a range of, patient cases to maintain and build their skills. National guidelines say A&Es like that at Weston General Hospital should serve a minimum population of 500,000 people. This is significantly more than the 152,000 people it currently serves.

Not only do small patient numbers have the potential to impact on quality of care, they can also make it difficult to attract and retain staff. Many doctors and nurses typically want to work, and especially train, in bigger hospitals that have centres of excellence for specialist services.

A Care Quality Commission inspection of Weston General Hospital in June 2017 showed that there are many areas of good care and practice, and that staff work hard and provide compassionate care to their patients. However, concerns about urgent and emergency services, and responsiveness, and requirements to improve some aspects of safety, effectiveness and leadership, meant that overall the trust was rated as requiring improvement. The inspection reflected many of the challenges we know the hospital is facing.

Key facts

Number of patients

Not all the patients who currently go to A&E need to be treated there, around **35%** could be better assessed and treated by a different service (for example a pharmacist, NHS 111 or GP). This is a pattern reflected in other hospitals nearby and across the country too.

35%
of A&E patients could be better seen at another service

Weston has lower than the national average numbers of planned admissions and outpatient appointments in other clinical areas, including cancer services and orthopaedics.

Key facts

Workforce issues

Consultant vacancy rate	23%
Nurse vacancy rate	24%

In March 2018 there was a **23%** consultant vacancy rate, with particular challenges staffing the Emergency Department and General Medicine, which means there is a reliance on locum staff. There is also a nursing vacancy rate of around **24%**.

800
nursing shifts covered by agency staff

In January **2018** alone, over **800** nursing shifts were covered by agency nursing staff, with **60%** of these due to job vacancies (as opposed to staff holidays or illness).

£9.9 million (8.6%) of the overall budget in 2017/18 was spent on agency staff, a greater proportion than at any other hospital in the country. This also affects the continuity of care patients receive.

£9.9m
spent on agency staff

Junior doctors don't always get the level of supervision they need, and they report lower levels of **job satisfaction** than at most other hospitals.

Emergency care at other hospitals

For a number of years people from Weston-super-Mare, Worle and the surrounding area with the most serious emergency conditions have been taken straight to hospitals in Bristol and Taunton by the ambulance service, and this will continue.

The A&E at Weston General Hospital has been temporarily shut from 10pm to 8am since July 2017, after a Care Quality Commission inspection report. As a result, an average of an additional eight patients a night are now being treated elsewhere. The A&E department is open as normal between 8am and 10pm, which is when the majority of patients seen there (80%) have always used it.

Addressing the challenge

The urgent and emergency care services provided at Weston General Hospital need to be reformed as soon as possible so there is certainty for staff, and so patients know how, when and where to access urgent care.

We want Weston General Hospital to become a place where you can receive great care in the areas that our population really need, for example, services for frail and older people (see page 13), mental health, some children's services and outpatient cancer treatment. We also want local people to continue to access high quality specialist services – the sort that most people don't need very often – in neighbouring hospitals when they need to.

There is also room to increase planned surgery, such as hip and knee replacement operations or cataract surgery at Weston General Hospital. We know that dedicated surgical units reduce waiting times and cancellations because they don't take unplanned emergency admissions, making it easier to know how many beds, staff, theatres and other resources will be available to deliver care.

We have a great opportunity to use Weston General Hospital more effectively and efficiently. We are committed to securing a vibrant and dynamic future for it at the heart of the local health and care system, but we need to make changes to better meet the most common needs of our local population.

Challenge 4
Getting value for money

Whilst the government has allocated additional money for the NHS and this will include more funds for North Somerset services, it is still not enough to close the gap between our costs and our available funding. As commissioners of NHS services - the people who plan and buy care for our local population - we are always conscious that we are spending taxpayer's money. We have a duty to do that responsibly and make sure every pound is spent for the greatest benefit. We must do more with what we have and make sure we can offer everyone the care they need.

The Bristol, North Somerset and South Gloucestershire health system spent £86 million more than it had in available funding in 2017/18. This means we don't have enough to spend on those services that we want to improve, such as primary and community care.

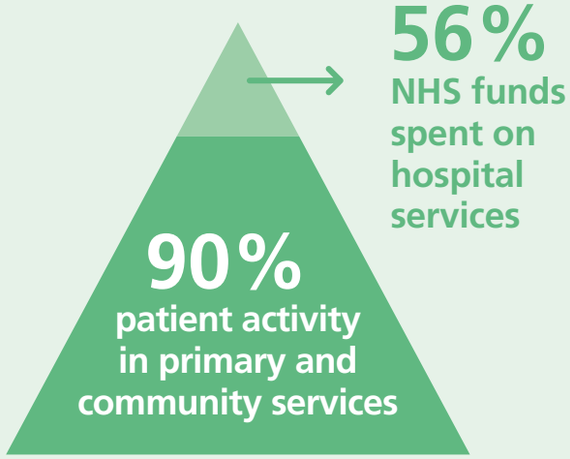
Whilst this situation is not unique to Weston and the surrounding area, the gap between our costs and our funding is significantly higher and more difficult to close because of the smaller scale of Weston General Hospital.

> **We have a duty to spend every pound for the greatest public benefit**

Commissioners are currently paying Weston General Hospital more than the 'going rate' for some hospital services to keep them going. This works as a short-term measure but isn't a long-term solution as it means we can't use this money to invest in other services that better meet the health and care needs of local people across the whole of our population.

Key facts

56% of all NHS funds available for the local population are spent on acute hospital services, but **90%** of patient activity takes place in primary and community services.



Even if Weston General Hospital performed in line with the most efficient hospitals in the country in every department and maximised the number of patients it saw in every service, there would still be a **£14 million** shortfall between available funding and costs.

Weston General Hospital would overspend by **£22 million by 2024** if nothing different is done.

This is because services are not being delivered as efficiently as they could be, there is too much money spent on **agency staff** and the **number of patient cases** is falling so the hospital's income also reduces.

Addressing the challenge

We have made progress to reduce the shortfall, but we still need to do more. We need to use our staff, buildings and equipment in the most efficient ways possible and we need to provide the right care for people in the right place. This includes providing day-to-day services locally and working with our neighbouring hospitals to provide more specialist services when they are needed.

We want to invest more money in the areas that people have told us are important to them – such as better access to GP, primary care and community-based services, mental health and prevention of ill-health. We need to find ways to make all services accessible to people who need them, but make sure we provide them in the most effective and efficient way across the whole population.

We are committed to a strong and vibrant future for Weston General Hospital. This means we need to refocus services to make sure they meet the changing needs of our population and that we use the staff, estate, buildings and equipment to their maximum capacity, making it much more efficient to run.

What you've told us about the changes you think are needed

As we have been thinking about how we could change local services to meet local needs over recent years we have listened to what our staff, local communities and patient groups would like to see happen.

Here are things you've told us that are most important to you:

Day-to-day health care services should be available as close to home as possible and the different parts of the NHS and social care need to be more joined up, working more closely with the voluntary, community and social enterprise sector.

There needs to be better access to GPs, primary and community services.

Local people want to know there is a positive future for Weston General Hospital and that other bigger hospitals nearby are supporting Weston Area Health NHS Trust to deliver sustainable services.

We need to make sure there is access to urgent and emergency services 24 hours a day, seven days a week, and make sure there are enough resources for South Western Ambulance Service.

Too many people are being treated in hospital for conditions that could be managed at, or closer to, home. If a person is admitted, they should be better supported to come home as soon as possible.

To help us attract and retain the best staff we need to find ways to make jobs interesting and exciting and offer staff the chance to work in new and different ways.

Travel times are an important consideration, particularly for people who live in deprived and/or rural areas or who need to use public transport.

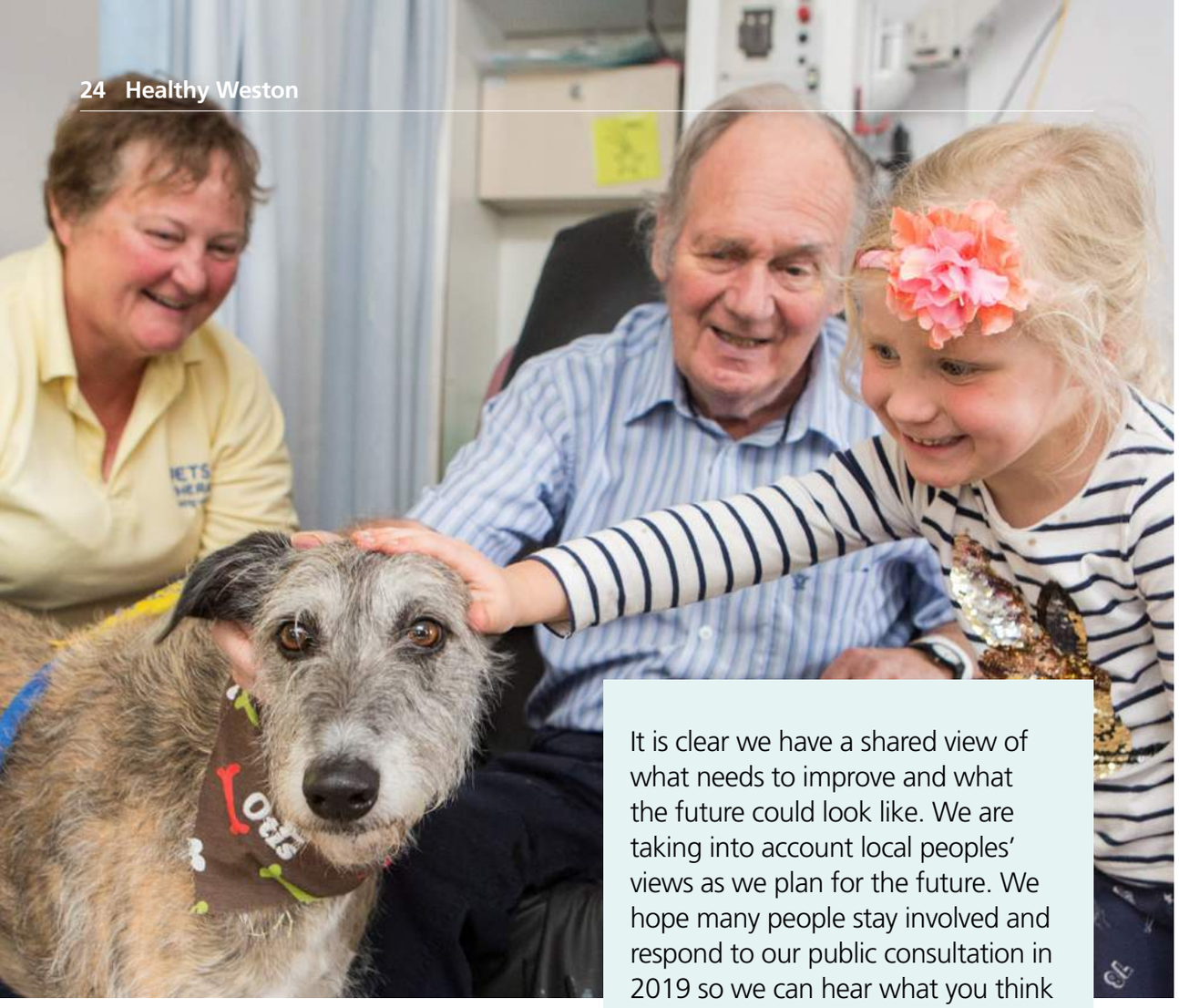
We need to reduce variation in the care people receive by making sure best practice is in place across the whole area.

Health care professionals and organisations should be better at sharing information using IT systems and shared medical records, with permission and respecting patient confidentiality.

Patients want all their needs to be considered together, rather than being seen as a set of individual conditions. They don't want to have to repeat the same information to multiple professionals or have their needs reassessed multiple times.

People want help to understand and navigate the health and care 'system' and be kept informed about what is happening with their or their loved ones' care.

Before any significant decisions or changes are made, local people must be fully involved.



It is clear we have a shared view of what needs to improve and what the future could look like. We are taking into account local peoples' views as we plan for the future. We hope many people stay involved and respond to our public consultation in 2019 so we can hear what you think about our proposals to address the challenges we are facing.

Local people's views

Further information about what our staff, local communities and patient groups have told us is available in these two reports:

1. Weston General Hospital at the heart of the community: public and staff engagement. A report from Healthwatch North Somerset (June 2017) on the results of public and staff feedback gathered from February to April 2017. https://bnssgccg.nhs.uk/library/healthwatch-engagement-report-weston-general-hospital/

2. *Healthy Weston public dialogue and co-design themes: independent summary.* A report from The Evidence Centre on the views received from thousands of people via an online survey, public meetings and workshops, emails, letters and social media posts from October 2017 to March 2018. https://bnssghealthiertogether.org.uk/documents/healthy-weston-public-dialogue-and-co-design-themes-independent-summary/

Progress we're already making

We have been discussing these challenges amongst local NHS and social care organisations and with our staff and local communities for some time.

In conversation with local people about our vision, three areas of work were identified:

Changes that can be put in place immediately. For example: better support to care homes and improved assessments of frail and older people.

Changes that can be made imminently but need some work. For example: developing a mental health crisis and recovery centre in Weston and better integrating children's services.

Changes to ensure a strong, focused Weston General Hospital for the long-term. This requires new thinking on how services could be delivered in the future.

Improvements we have begun to make to local health and care services

GP practices are already working more closely together in some of our most deprived areas.

We have secured additional national funding for child and adolescent mental health services.

We have secured funding for a scheme to support home visits to patients by paramedics linked to GP surgeries, freeing up more GP time for other patients.

There are different specialist health and care professionals working closely together to provide an improved frailty service at Weston General Hospital and in the community. This will be developed further as part of the Healthy Weston Programme.

We have also been thinking differently about the way we deliver some of the services in Weston General Hospital, to make sure it continues to have a strong and dynamic role providing health services in our local community, as described earlier in this document.

Next steps

Over the summer of 2018 doctors and health professionals have been looking at evidence and examples of best practice and thinking about what we can learn from them to improve care for our local population. We are still looking at a range of different potential options and no decisions have yet been made about the future shape of services.

During the rest of 2018 we will be continuing our conversations with health and care partners and local people, testing our thinking and gathering feedback and views. We then expect to develop a shortlist of potential options for change that we will formally consult on with the public early in 2019, before making a decision later that year.

The challenges and opportunities, and our ambition for local services, are set out in *Joining up services for better care in the Weston area.* https://bnssghealthiertogether.org.uk/documents/healthy-weston-joining-up-services-for-better-care-in-the-weston-area/

We want to continue to hear your views about health and care services in Weston and the surrounding area. There will be many more opportunities over the coming months to tell us what you think about this case for change, and our emerging plans to improve services.

To make sure you get all the latest news and dates for your diary please sign-up to receive our updates. www.bnssghealthiertogether.org.uk/healthyweston

Tell us what you think...

You can email, write to us or telephone. You can also keep in touch on social media. Our details are on the back cover.

If you would like this booklet in an alternative format or language please contact us.

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Twitter: @BNSSG_CCG, @WestonNHS #HealthyWeston
Facebook: www.facebook.com/BNSSGCCG/

Healthy Weston Pre-Consultation Business Case

Appendix 16: Case for Change Easy-Read version

HEALTHY WESTON

NHS
Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Group

Why our local health services need to change

Easy read booklet

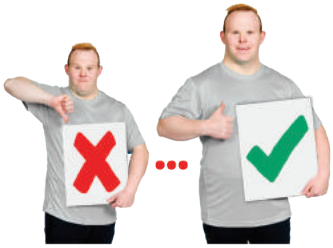
Who we are and what we do

We are **Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group**.

We run your health care services and look after your doctors and nurses.

HEALTHY WESTON

We make changes to local services to make them better. We call this work **Healthy Weston**.



We need to make changes so that we can give better health care services. This booklet is about the 4 main problems we have.

Our local health and care services

We run different health and care services for people who live in Somerset, Bristol and South Gloucestershire.

This means services like

- your GP practice
- community and mental health care

- hospitals
- ambulance services

- social care, like support workers
- nursing and care homes.

Weston General Hospital

Weston General Hospital is having some problems.

We don't have enough staff to keep the **A&E department** open so we've had to close it for a while.

The **A&E department** is where you go if you have had an accident or an emergency.

We have to work quickly to make sure Weston General is a good hospital.

The 4 main problems we have

Problem 1
Peoples health needs are changing.

Problem 2
Some people are getting worse care than others.

Problem 3
We don't have enough staff and we want the best people to work for us.

Problem 4
We need to spend our money in the best way.

Problem 1
Peoples health needs are changing

More people live here. The people who live here are older and are living for longer with **long-term health conditions**.

A long-term health condition is when you are ill for a long time.

Our health and care services are needed more and in new ways. So we need to get bigger and change.

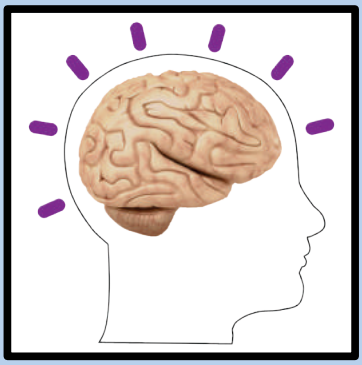
New Home

The facts

- More people are living here.
- New houses are being built so more people will move here.
- More older people move here so there will be more older people living here in the future.
- Less local people are having children.

More people need to use our heath care services for long-term health conditions like

- diabetes
- lung problems
- high blood pressure
- **mental health problems**



Mental health problems affect your mood, thinking and behaviour.

People in North Somerset live long and healthy lives. But people living in richer parts live longer.

Thinking about how to solve this

We need to change so we take better care of older people and young families.

People need local services to help them stop getting unwell.

If people have an emergency they need the best specialist services.

Problem 2
Some people are getting worse care than others

In our area there are lots of different sized GP practices.

Smaller GP practices can't offer lots of different services. They can find it hard to run services if staff are away or unwell.

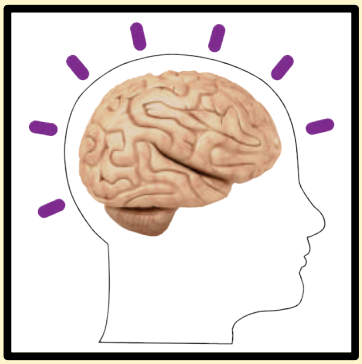
Our community services and staff do not share information very well. So you might have to explain things more than once.

Some older people might be in hospital even if they are not unwell. It is hard for older people to leave hospital once they are there.

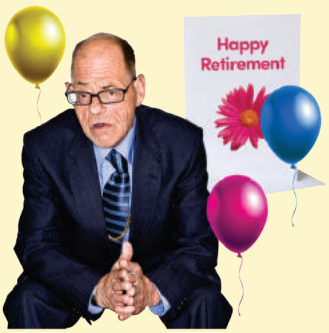
The facts

- Some people choose to go to A&E rather than see their doctor.

- Some GP practices are good at watching their patients and helping them before they need to go to A&E.



- People with mental health problems are more likely to go to A&E.

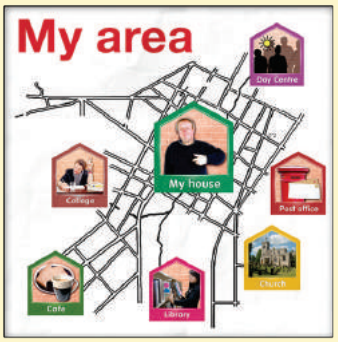


- Older people are much more likely to be in our hospital beds than other people.

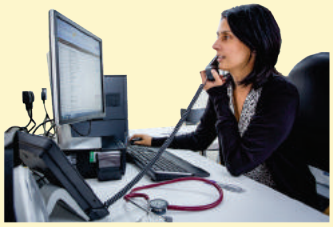
- Lots of our older GPs will stop working soon. We do not have enough young GPs to do their jobs.

- We need more community nurses, therapists and care assistants.

Thinking about how to solve this

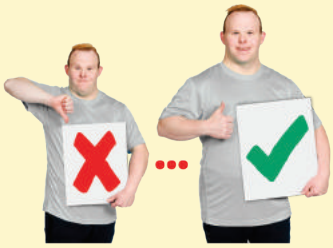


Better healthcare means heathier people. No one should get worse health care because of where they live.



Our GP practices and services should talk to each other more.

We should help older people before they get unwell so they don't have to go to hospital.



We are already working better together to make sure that everyone gets the same good service at their GP practice.

Problem 3
We don't have enough staff and we want the best people to work for us

Weston General is one of the smallest hospitals in the country because not many people live close to it.

The amount of people who can use the hospital is much lower than is recommended by **national guidelines**.

A **national guideline** is a target that helps us give the right care.

Lots of doctors and nurses want to work in bigger hospitals as they would see more patients and learn more.

The facts

- Not all patients who go to A&E need to go there. They could be helped by other services.

- We don't have enough doctors and nurses and its hard to get more.

- We spend a lot more money than other hospitals on **temporary staff**.

Temporary staff are staff we get from somewhere else to work for a short time.

- New doctors don't always get the best training and this can make them unhappy.

- We've had to close A&E at night because we don't have enough staff to work for us.

- Some patients who live close are being taken to other hospitals in Bristol instead of Western General Hospital.

Thinking about how to solve this

We need to make changes quickly at Weston General Hospital so that it is better for staff and patients.

We want less people to have to go somewhere else for their care.

We can do more operations at Weston General Hospital so that people do not have to wait as long.

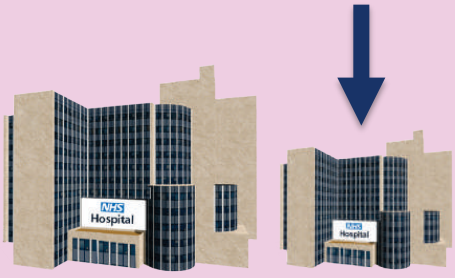
It is important that we make Western General Hospital better for everyone.

Challenge 4
We need to spend our money in the best way

We are getting more money from the government but we are still spending to much.

Its important we spend all the money we get in the right way.

Because we spend more money than we get we can't spend money on making our services better or getting new services.



Western General is a small hospital. This makes it harder to spend less money.

The facts

- We spend more money on services that people don't use as much.

- Even if we spent our money as well as the best hospitals we would still spend to much.

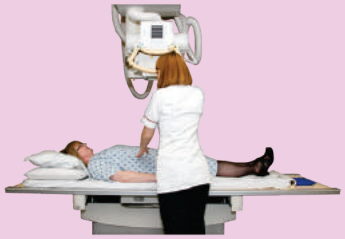
- We need to make changes soon otherwise our overspending will get bigger in the future.

- We spend too much money on temporary staff.

- The hospital has less patients each year so we are given less money.

Thinking about how to solve this

We are getting better at spending less money but we need to get even better.



We need to use our staff, buildings and equipment better.

We want to spend more money on the services that are most important to you.

We will work hard to make sure Weston General Hospital has the best services for you in the future.

What you've told us about the changes you think are needed

We have listened to our staff, patients and local people.

We have 2 written reports you can read to find out more about the changes people want.

Here are the things you told us are most important to you

- Day-to-day care needs to be closer.

- Local people want to know that the future for Western General Hospital is good.

- If someone has an accident or emergency they need to be able to use our services anytime.

- Too many people are in hospital when they could be treated somewhere else.

- We need to offer staff interesting and exciting jobs so we get the best people to work for us.

- Everyone should get the same great care no matter they live.

- We should think about how far people have to travel.

- Services should talk to each other better so that people don't have to say the same things over again.

- People want to know what is happening when they or their loved ones are being cared for.

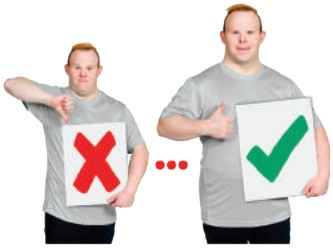
- Local people need to be told about any big changes and have a chance to have their say.

How we will make changes

We found 3 types of changes we can make.

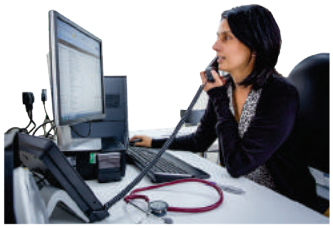
1. Changes that can be made right now. Like better tests for older people.

2. Changes that can be made right now but need some work. Like a better mental health center.



3. Changes that will take longer to make but will make us better in the future.

How we have started to make changes



GP practices are already working more closely together in some of our poorest areas.

We have more money for mental health services for children.

We have changed how we look after older people. We will continue to keep looking at this to make it even better.

We have been thinking hard about the services we provide and how to make Weston General Hospital as good as it can be.

What happens next

We have been thinking hard about how to be better but no final decisions have been made.

- We will talk to people and ask them what they think.
- We will make a list of the changes we think will work best.
- We will ask you what you think about our changes in early 2019.

There will be lots of chances for you to tell us what you think over the next few months.

You can see all the latest news on this website.

www.bnssghealthiertogether.org.uk/healthyweston

What to do if you have any questions

Send an email to this address
bnssg.healthyweston.enquiries@nhs.net

Call this telephone number
0117 900 2198

Write to us at this address
Healthy Weston
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Bristol, BS1 3NX

Find out more on these websites
www.bnssghealthiertogether.org.uk/healthyweston
www.facebook.com/BNSSGCCG/

Healthier Together

Improving health and care in Bristol,
North Somerset and South Gloucestershire

HEALTHY WESTON

Healthy Weston PCBC

Appendix 17: Potential clinical models and overview of process to agree differentiated options to assess

2nd November 2018

Common enablers to all models

- Standardized care pathways
- Common approaches (integration) across whole system
- Easy access to senior decision makers – on site or remotely
- Remote advice to specialist opinion
- Mental health crisis teams available, ideally in ED/UTC
- Stabilisation and rapid transfer for patients needing escalation
- Transfer back from specialist centres to local units
- Easy step-down or transfer to community / social settings
- Greater use of hot clinics
- Enhanced use of IT and technology
- Staff rotations

Potential clinical service models for A&E (1/2)

Additional models for major trauma centre and major emergency hospital (with higher consultant presence) are not shown

	Model A A&E + UTC (24/7)	Model A A&E + UTC (Restricted hours)	Model B A&E + UTC ("Medical")
Staffing	▪ ED consultant available 24/7[1] ▪ Additional complement of Tier 1 and 2 practitioners (incl. Mental Health) ▪ Diagnosticians ▪ Multidisciplinary team to support frailty unit	▪ ED consultant in person until 2 hours after A&E closes ▪ Junior doctor cover until 2-4 hours after close of A&E ▪ Complement of Tier 1 and 2 practitioners (incl. Mental Health) during opening hours ▪ Multidisciplinary team to support frailty unit	▪ ED/acute medicine consultant on site until 2 hours post ED closure ▪ Stabilise & transfer team (anaesthetist + critical care nurse) on site during opening hours ▪ Mental Health practitioner available ▪ Multidisciplinary team to support frailty unit ▪ Remote access to A&E consultant
Other service requirements	▪ Level 3 critical care ▪ NCEPOD staffed theatre 24x7 ▪ 24x7 interventional radiology and endoscopy available ▪ Ambulatory unit and clinical decisions unit ▪ Frailty unit ▪ Primary care front door	▪ Level 3 critical care ▪ NCEPOD staffed theatre 24x7 ▪ Interventional radiology and endoscopy available ▪ Ambulatory unit and clinical decisions unit ▪ Frailty unit ▪ Primary care front door	▪ Level 2 or 3 critical care ▪ Transfer for services not on site including interventional support ▪ MAU and frailty unit on site ▪ Primary care front door
Conditions covered	▪ All A&E attendances and GP referrals ▪ GP out of hours services at UTC	▪ All A&E attendances and GP referrals during opening hours ▪ GP out of hours services at UTC	▪ Medical ED attendances, minor illnesses and injuries, GP referrals ▪ Stabilise and transfer others ▪ GP out of hours services at UTC
Conditions not covered	▪ Major complex conditions needing treatment at specialist centres (e.g. polytrauma, hyperacute stroke) ▪ Stabilise and transfer patients needing tertiary (specialist) care	▪ Major complex conditions needing treatment at specialist centres (e.g. polytrauma, hyperacute stroke) ▪ Stabilise and transfer patients needing tertiary (specialist) care	▪ Surgical ED attendances e.g. patients requiring laparotomy ▪ Other complex needs (any life or limb threatening conditions); conditions requiring critical care

1 For small DGH the assumption is that this would require 8- 10 WTE consultants

Potential clinical service models for A&E (2/2)

	Model C A&E (Urgent treatment centre)	Minor injury
Staffing	▪ GPs ▪ Advanced Nurse Practitioner (ANP) support ▪ HCAs ▪ Multidisciplinary team of GPs, geriatricians, ANPs to support frailty unit ▪ Mental Health practitioner available ▪ Remote access to A&E consultant	▪ ENPs ▪ HCAs
Other service requirements	▪ Capacity to stabilize and transfer ▪ Possibly ambulatory care observation and assessment ▪ Possibly frailty unit	▪ Capacity to stabilize and transfer
Conditions covered	▪ All minor illnesses and injury ▪ Stabilise and transfer others ▪ GP out of hours services	▪ Minor injuries e.g. lacerations
Conditions not covered	▪ Suspected complex fractures; other complex needs (any life or limb threatening conditions); conditions requiring critical care	▪ All patients needing medical input

Potential clinical service models for Acute Medicine (1/2)

	24/7 acute medical take (with a Medical Assessment Unit)	Selective acute take (with a Medical Assessment Unit)	Medical Assessment Unit (MAU) only
Staffing	▪ Acute medicine consultant on site during opening hours of 'front door' ▪ 24 x 7 medical reg on site	▪ Acute medicine consultant on site during opening hours of "front door" ▪ 24 x 7 medical reg on site	▪ Acute medicine consultant on site during opening hours of "front door" ▪ Medical registrar on call
Other service requirements	▪ Level 3 critical care ▪ Interventional radiology and acute bleed service available ▪ Frailty unit and AAU ▪ Diagnostics ▪ Standardized care pathways with GP admits direct to AAU/frailty unit	▪ Level 1 or 2 critical care (with ability to step up to transfer) ▪ Acute assessment unit ▪ Frailty unit ▪ Diagnostics ▪ Standardized care pathways with GP admits direct to AAU/frailty unit	▪ Level 1 or 2 critical care (with ability to step up to transfer) ▪ Acute assessment unit ▪ Frailty unit ▪ Diagnostics ▪ Standardized care pathways with GP admits direct to AAU/frailty unit
Conditions covered	▪ All acute medical admissions except for hyper-acute stroke and cardiac care	▪ All non- high acuity	▪ Non-high acuity patients requiring up to 48-72 hours stay
Conditions not covered	▪ Hyper acute stroke patients requiring thrombectomy ▪ Hyper acute cardiac care ▪ Hepatology	▪ Stroke patients, hyper acute cardiac care, subset of patients requiring level 3 critical care ▪ Acute bleeds ▪ Hepatology	▪ High acuity patients ▪ Patients needing longer inpatient care

Potential clinical service models for Acute Medicine (2/2)

	Ambulatory Care Unit with no beds	Step up / step down or discharge to assess (D2A) beds but no medical take
Staffing	▪ Acute medicine consultant or registrar on site during opening hours of "front door“	▪ Multi disciplinary team with GPs, care of the elderly consultants, ANPs, AHPs, social care
Other service requirements	▪ Frailty unit ▪ Diagnostics ▪ Standardized care pathways with GP admits direct to ACU/frailty unit	▪ Access to specialist opinion ▪ Access to hot clinics ▪ Diagnostics ▪ Capacity to stabilize and transfer ▪ Standardized care pathways
Conditions covered	▪ Patients requiring short term observation and assessment within 24 hours	▪ Patients needing short term assessment
Conditions not covered	▪ Patients needing inpatient care	▪ Acutely unwell patients who warrant care in a more specialist centre

Potential clinical service models for Emergency Surgery

	24 / 7 emergency general surgery	On-call general surgery with no registrar OOH	Ambulatory emergency surgery	Surgery hot clinics (SAU + recovery beds)	Minor injury only
Staffing	▪ 24 / 7 gen. surg. consultant for emergency surgery cover ▪ Surgical registrar OOH and consultant on-call ▪ Anesthetists available ▪ Stabilise & transfer team (anesthetist + critical care nurse) on call	▪ 12 / 7 “in hours" general surgery consultant cover ▪ Consultant surgeon at night (emergencies only) on call ▪ Stabilise & transfer team (anesthetist + critical care nurse) on call	▪ Surgical consultant cover on standby to offer opinion ▪ No on-call rota	▪ Daytime consultant cover for hot clinic ▪ No emergency surgery on-call rota OOH	▪ No "in hours" cover from general surgery team (all care provided by elective surgery teams) ▪ No emergency surgery on-call rota OOH
Other service requirements	▪ Level 3 critical care ▪ NCEPOD staffed theatre 24x7 ▪ Interventional radiology available	▪ Level 3 critical care ▪ NCEPOD staffed theatre 12x7 ▪ Interventional radiology available	▪ Capacity to stabilize and transfer	▪ Capacity to stabilize and transfer	▪ Capacity to stabilize and transfer
Conditions covered	▪ All emergency procedures for patients up to ASA 4 ▪ All #NOF patients admitted directly from SWASFTs as well as those coming through A&E requiring shared care with medics as well as surgeons	▪ All emergency procedures for patients up to ASA 4 ▪ All #NOF patients admitted directly from SWASFT as well as those coming through A&E requiring shared care with medics as well as surgeons	▪ Ambulatory surgical activity e.g., abscess drainage, gall bladders, piles (add to DC lists) ▪ All emergency pro-cedures not required within 12 hours ▪ Well #NOF patients	▪ No emergency surgery ▪ Hot clinic outreach (GP direct access) ▪ All emergency procedures not required within 12 hours ▪ Well #NOF patients	▪ Minor injury e.g. laceration
Conditions not covered	▪ Specialist surgical procedures that require transfer to a specialist centre (e.g., vascular, head injury)	▪ All high risk patients and high complexity procedures	▪ All high risk patients and high complexity procedures ▪ Emerg. laparotomy + all non-medical abdominal pain ▪ Comorbid #NOF patients	▪ All high risk patients and high complexity procedures ▪ Emerg. laparotomy + all non-medical abdominal pain ▪ Comorbid #NOF patients	▪ All patients needing medical input ▪ All #NOF patients, including otherwise well #NOF patients

Potential service models for critical care

	Critical care L3, shared rota +/- eICU*	Critical care L2 +/- eICU*	L1 Ward based care	No enhanced care
Staffing	▪ 24x7 Critical care consultant cover ▪ If eICU - consultant 14x7 / on-call OOH, eConsultant 24x7 ▪ 1:1 RN	▪ 24/7 acute medicine **or** anaesthetic consultant cover ▪ Transfer team for step up and stabilize if required ▪ 1:2 RN	▪ More intensive monitoring, e.g., cardiac monitoring supported by transfer team ▪ Transfer team for step up and stabilize if required ▪ 1:4 RN	▪ No transfer team or support for intensive monitoring
Conditions covered	▪ Level 3 patients - requiring two or more organ support (or needing mechanical ventilation alone)	▪ Level 2 patients - single organ support (excluding mechanical ventilation) such as ionotropes and invasive BP monitoring	▪ Level 1 patients only – no organ support required ▪ CPAP	▪ Normal ward care
Conditions not covered	▪ None	▪ Patients requiring multiple organ support	▪ Patients requiring organ support (including vasopressor support)	▪ Patients requiring organ support or intensive monitoring

***eICU refers to an electronic intensive care unit platform which intensive care consultants can access remotely**

Potential clinical service models for Elective Care

	All elective surgery w/ emergency theatre	Non-complex elective surgery w/ enhanced day care unit (ASA 3 or less)	Non-complex elective surgery with enhanced day care unit (ASA 2 or less)	Day cases only (stand alone or satellite)
Staffing	▪ Full surgical team + 24 / 7 emergency surgical team ▪ OOH cover provided by surgical specialities; on-call anaesthetic consultant ▪ Specialist level in-hours + OOH cover at junior level ▪ Local consultant, local consultant OOH cover	▪ Junior team (specialist level) in-hours, resident anaesthetist, access to medical opinion ▪ Surgery reg or equivalent OOH (specialist level) ▪ Consultant workforce from larger centre or multiple site cover at consultant level	▪ RMO with remote consultant cover ▪ Rotating theatre staff, radiographers; Consultant delivered intervention (extended hours?) & anaesthesia ▪ ECPs for day time care with extended hours	▪ Full surgical team present during (and beyond) opening hours of day surgery unit ▪ Consultant delivered ▪ Radiology + access to radiology ▪ No junior staff
Other service requirements	▪ Level 3 critical care ▪ NCEPOD staffed theatre 24x7 ▪ 24x7 interventional radiology ▪ All elective medicine	▪ Level 2 critical care ▪ NCEPOD staffed theatre 12x7 ▪ 12x7 interventional radiology ▪ All elective medicine	▪ Capacity to stabilize and transfer ▪ All elective medicine	▪ Capacity to stabilize and transfer ▪ All elective medicine
Conditions covered	▪ All complexity general surgical procedures ▪ Elective non-complex T&O day cases ▪ Elective non-complex paediatric surgical cases ▪ Up to & including ASA 4 ▪ Emergency surgery ▪ Interventional Radiology	▪ All mid and low complexity general surgical procedures for medium risk patients ▪ Elective non-complex T&O day cases ▪ Elective non-complex paediatric surgical cases ▪ Up to & including ASA 3 ▪ Endoscopy, Interventional Radiology + other procedures	▪ ASA 2 or less : LOS 1-5 days for IP, day cases (including elective non-complex T&O and paediatric surgical procedures) ▪ Endoscopy + some procedures ▪ Protocols for escalation available	▪ All LA work ▪ Day Case GA ASA 2 or less (including elective non-complex T&O and paediatric surgical procedures)
Conditions not covered	▪ Supra-specialist surgical procedures performed in national centres (e.g., neuro-surgery, oncoplastic recon-struction, vascular surgery)	▪ High complexity and / or high risk patients ▪ ASA 4 + conditions in column 1	▪ Interventional Radiology ▪ No enhanced care ▪ ASA 3 + conditions not covered in other models	▪ No enhanced care

Potential clinical service models for Paediatrics

	Inpatient paediatrics	SSPAU + ambulatory care	SSPAU + ambulatory care (limited hours)	MDT led care at front door (no paediatrician)	Minor injury unit
Staffing	▪ 10 WTE consultant paediatricians to cover 24 / 7 rota	▪ Consultant paediatrician on site when ED is open ▪ Shared staff with A&E with paediatric expert / GPwSI in paeds covering OOH ▪ Facilities for children available 7 days through SSPAU and ED/UTC	▪ Consultant paediatrician on site for limited hours when SSPAU is open ▪ OOH cross cover from A&E consultants (trained in paediatric Early Warning Score Assessment), GPs, senior paediatric nurse practitioner	▪ Paediatric expertise at the "front door" provided by MDT including A&E consultants, GPs, senior paediatric nurse practitioner +/ paediatric doctors	▪ No paediatrics expertise at the “front door”
Conditions covered	▪ All acute general paediatric illnesses requiring admission ▪ Common care pathways across patch	▪ Minor acute illnesses, minor trauma, burns and infections, IV antibiotics ▪ Acutely unwell children transferred ▪ Repatriate cases from Bristol ED if appropriate ▪ Common care pathways across patch ▪ Scheduled care provision	▪ Minor acute illnesses, minor trauma, burns and infections, IV antibiotics ▪ Acutely unwell children transferred ▪ Common care pathways across patch ▪ Repatriate cases from major ED if appropriate ▪ Scheduled care provision	▪ Minor acute illnesses ▪ Acutely unwell children transferred	▪ Minor injury only
Conditions not covered	▪ Tertiary (specialist) paediatric care	▪ Illness requiring >8 hours observation ▪ Children requiring admissions ▪ Neonates requiring NICU	▪ Illness requiring >8 hours observation ▪ Children requiring admissions ▪ Neonates requiring NICU	▪ Children with more serious conditions who need consultant paediatric care	▪ All children needing medical or surgical input

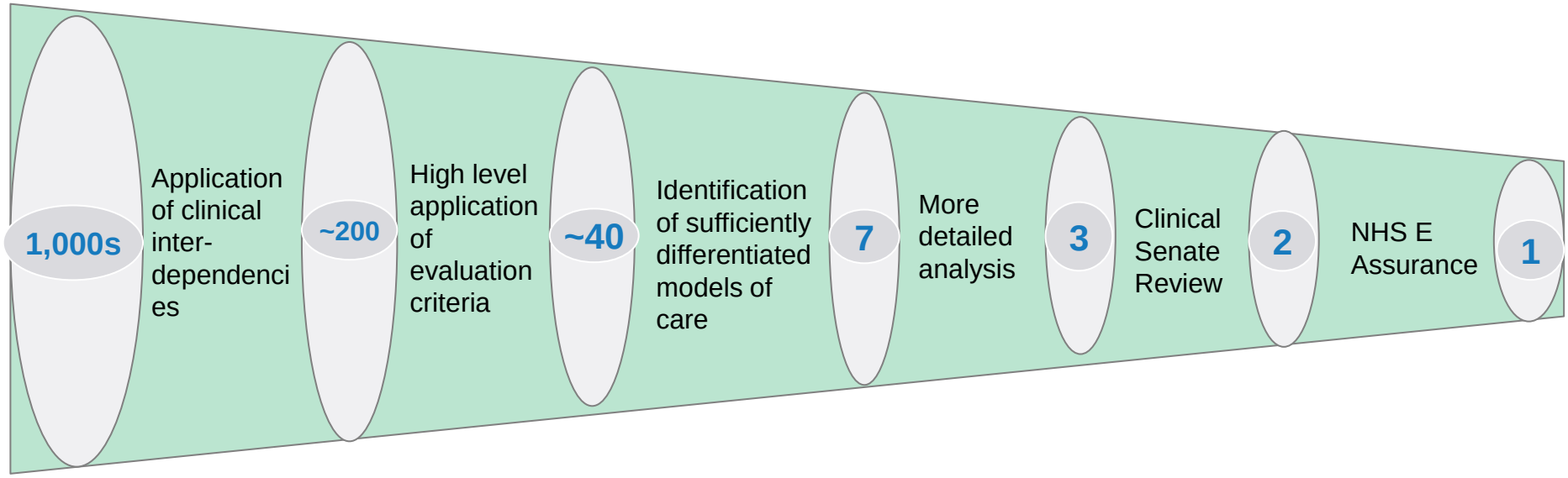
Potential clinical service models for Maternity

	Full obstetric service	Lower risk obstetric service with Level 1 neonates	24 / 7 midwife-led unit
Staffing	▪ 24 / 7 consultant obstetrician on labour unit – possible some cover could be provided by shared rota with nearby trusts ▪ 24 / 7 paediatric cover	▪ 12x7 consultant presence on labour unit ▪ SCBU staffed with registrar paediatrician and / or nurse practitioner (no NICU)	▪ 24 / 7 midwife available on site or on call ▪ Support staff ▪ Primary care hubs for midwife clinics
Other service requirements	▪ Level 3 critical care ▪ Emergency surgery	▪ Level 2 critical care	▪ Capacity to stabilize and transfer
Conditions covered	▪ All births ▪ Emergency gynaecology ▪ Antenatal care / in day assessment unit or in community ▪ Postnatal care in hospital if complex or community (short stay in-unit after birth)	▪ Moderate risk births, may require aesthetic and paediatric support ▪ Births which may require SCBU ▪ Antenatal care / in day assessment unit or in community ▪ Postnatal care in hospital if moderate risk or community (short stay in-unit after birth)	▪ Low risk births, 37 - 42 weeks of gestation ▪ Antenatal care / in day assessment unit or in community ▪ Postnatal care in community (short stay in-unit after birth)
Conditions not covered		▪ Births at risk of requiring NICU ▪ Births under 34 weeks ▪ Women with more complex co-morbidities	▪ Women requiring obstetric care, high-risk pregnancies, maternal-fetal medicine, epidurals, C-sections

Details of proposed service model for frailty/LTCs

	Frailty Unit in front door (no beds)	Frailty Hub	Locality frailty teams	Locality teams for people with different LTCs
Staffing	▪ Emergency medicine / Acute medicine / Frailty consultant ▪ GPs ▪ Specialist nurses ▪ Therapists ▪ Social care ▪ Medicines Management ▪ Wellness navigators	▪ GPs ▪ Specialist nurses ▪ Therapists ▪ Social care ▪ Mental Health Pract. ▪ Medicines Management ▪ Wellness navigators	▪ GPs ▪ Specialist nurses ▪ Therapists ▪ Social care ▪ Mental Health Pract. ▪ Medicines Management ▪ Wellness navigators	▪ GPs ▪ Specialist consultant input ▪ Specialist nurses ▪ Therapists ▪ Social care ▪ Medicines Management ▪ Wellness navigators
Other service requirements	▪ Diagnostics – X ray, U/S, MRI, CT, phlebotomy and (ideally) a lab	▪ X-ray, Phlebotomy	▪ Phlebotomy	▪ Phlebotomy
Conditions covered	▪ Acute medical admissions ▪ Anyone with a care plan for them to be treated/care for locally	▪ Anyone with a care plan for them to be treated/care for locally ▪ Rapid assessment	▪ All older people to be assessed for frailty/wider health needs	▪ All people with a long term condition
Conditions not covered	▪ Highly complex medical or surgical conditions for treatment as per national guidance (e.g. hyper acute stroke)	▪ Acutely unwell patients	▪ Any patient needing rapid assessment/rapid response care which cannot be managed locally	▪ Patients requiring inpatient care specialist input

Further defining of preferred option for Weston General Hospital



The clinical group described best practice care pathways and clinical models to enable delivery of best practice care

By applying clinical interdependencies between different services, the potential models of care were narrowed down to ~200

High level evaluation excluded some models as being suitable for Weston on the basis of clinical quality, workforce criteria and/or access to care

Clinicians identified 7 sufficiently differentiated options to analyse

Detailed evaluation resulted in three viable options for change to be identified

Focus on 2 models following Clinical senate feedback

Move to one model for consultation following NHS E Assurance feedback

A range of clinical models exist for each urgent and emergency care area

Service offering	Range of models explored				
A&E	**Model A A&E (24/7) + UTC**	**Model A A&E (restricted hours*) + UTC**	**Model B A&E ("Medical") + UTC**	**Model C A&E (UTC)**	**Minor injury**
Acute medicine	**24/7 acute medical take with MAU**	**Selective acute take with MAU**	**Medical Assessment Unit (MAU)**	**Ambulatory care unit (ACU) –** no beds	**D2A pathway beds (Step up/Step down)**
Frailty	**Frailty unit/hub in all models of care**				
Emergency surgery	**24/7 emergency general surgery**	**On-call general surgery** – no registrar OOH	**Ambulatory emergency surgery**	**Surgery hot clinics** (SAU + recovery beds)	**Minor injury**
Critical care	**L3 critical care** +/- eICU	**L2 critical care**+/- eICU	**L1 ward based care**	**No enhanced care**	

Assumes diagnostics, pathology, outpatients, elective medicine and a frailty service exist in all options

Filtering for first round of interdependencies gives 37 potential clinical options for urgent and emergency care at a DGH

HEALTHY WESTON

	Model A A&E (24/7) + UTC	Model A A&E (restricted hours*) + UTC	Model B A&E ("Medical") + UTC	Model C A&E (UTC)	Minor injury unit
Acute medicine	1 24/7 medical take + MAU 2 Selective take + MAU 3 MAU 4 ACU 5 D2A pathway beds	1 24/7 medical take + MAU 2 Selective take + MAU 3 MAU 4 ACU 5 D2A pathway beds	1 24/7 medical take + MAU 2 Selective take + MAU 3 MAU 4 ACU 5 D2A pathway beds	1 24/7 medical take + MAU 2 Selective take + MAU 3 MAU y 4 ACU 5 D2A pathway beds	1 24/7 medical take + MAU 2 Selective take + MAU 3 MAU 4 ACU 5 D2A pathway beds
Emergency surg.	1 24/7 Em. Surg 2 On call gen surg (no OOH registrar) 3 Amb emerg surgery 4 Surg. hot clinics 5 Minor injuries	1 24/7 Em. Surg 2 On call gen surg (no OOH registrar) 3 Amb emerg surgery 4 Surg. hot clinics 5 Minor injuries	1 24/7 Em. Surg 2 On call gen surg (no OOH registrar) 3 Amb emerg surgery 4 Surg. hot clinics 5 Minor injuries	1 24/7 Em. Surg 2 On call gen surg (no OOH registrar) 3 Amb emerg surgery 4 Surg. hot clinics 5 Minor injuries	1 24/7 Em. Surg 2 On call gen surg (no OOH registrar) 3 Amb emerg surgery 4 Surg. hot clinics 5 Minor injuries
Critical care	1 Level 3 +/- eICU 2 Level 2 + HDU 3 Level 1 (Ward) 4 No enhanced care	1 Level 3 +/- eICU 2 Level 2 + HDU 3 Level 1 (Ward) 4 No enhanced care	1 Level 3 +/- eICU 2 Level 2 + HDU 3 Level 1 (Ward) 4 No enhanced care	1 Level 3 +/- eICU 2 Level 2 + HDU 3 Level 1 (Ward) 4 No enhanced care	1 Level 3 +/- eICU 2 Level 2 + HDU 3 Level 1 (Ward) 4 No enhanced care
No. of options	100	100	100	100	100
			500		
Rationale	Assuming no interdependencies				

*assumes other admitting services would be restricted hours also

Assumes diagnostics, pathology, outpatients, elective medicine and a frailty service exist in all options

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Filtering for first round of interdependencies gives 37 potential clinical options for urgent and emergency care at a DGH

	Model A A&E (24/7) + UTC	Model A A&E (restricted hours*) + UTC	Model B A&E ("Medical") + UTC	Model C A&E (UTC)	Minor injury unit
Acute medicine	1 24/7 medical take + MAU 2 ~~Selective take + MAU~~ 3 ~~MAU~~ 4 ~~ACU~~ 5 D2A pathway beds	1 ~~24/7 medical take + MAU~~ 2 Selective take + MAU 3 ~~MAU~~ 4 ~~ACU~~ 5 D2A pathway beds	1 24/7 medical take + MAU 2 Selective take + MAU 3 ~~MAU~~ 4 ~~ACU~~ 5 D2A pathway beds	1 ~~24/7 medical take + MAU~~ 2 Selective take + MAU 3 MAU 4 ACU 5 D2A pathway beds	1 ~~24/7 medical take + MAU~~ 2 ~~Selective take + MAU~~ 3 ~~MAU~~ 4 ~~ACU~~ 5 D2A pathway beds
Emergency surg.	1 24/7 Em. Surg 2 On call gen surg (no OOH reg) 3 Amb emerg surgery 4 ~~Surg. hot clinics~~ 5 ~~Minor injuries~~	1 ~~24/7 Em. Surg~~ 2 On call gen surg (no OOH reg) 3 Amb emerg surgery 4 ~~Surg. hot clinics~~ 5 ~~Minor injuries~~	1 ~~24/7 Em. Surg~~ 2 On call gen surg (no OOH reg) 3 Amb emerg surgery 4 Surg. hot clinics 5 Minor injuries	1 ~~24/7 Em. Surg~~ 2 ~~On call gen surg (no OOH reg)~~ 3 Amb emerg surgery 4 Surg. hot clinics 5 Minor injuries	1 ~~24/7 Em. Surg~~ 2 ~~On call gen surg (no OOH reg)~~ 3 Amb emerg surgery 4 Surg. hot clinics 5 Minor injuries
Critical care	1 Level 3 +/- eICU 2 ~~Level 2 + HDU~~ 3 ~~Level 1 (Ward)~~ 4 ~~No enhanced care~~	1 Level 3 +/- eICU 2 ~~Level 2 + HDU~~ 3 ~~Level 1 (Ward)~~ 4 ~~No enhanced care~~	1 ~~Level 3 +/- eICU~~ 2 Level 2 + HDU 3 ~~Level 1 (Ward)~~ 4 ~~No enhanced care~~	1 ~~Level 3 +/- eICU~~ 2 ~~Level 2 + HDU~~ 3 Level 1 (Ward) 4 No enhanced care	1 ~~Level 3 +/- eICU~~ 2 ~~Level 2 + HDU~~ 3 ~~Level 1 (Ward)~~ 4 No enhanced care
No. of models	2	1	8	24	2

37

Assumes diagnostics, pathology, outpatients, elective medicine and a frailty service exist in all options

*assumes other admitting services would be restricted hours also

After further filtering for interdependencies and applying high level criteria, there are 21 potential options for Weston

	Option 1	Option 2	Option 3	Option 4	Option 5	Option 6	Option 7	Option 8	Option 9	Option 10	Option 11	Option 12	Option 13	Option 14	Option 15	Option 16	Option 17	Option 18	Option 19
A&E	Model A A&E (24/7)	Model A A&E (24/7)	Model A A&E (restr. hours)	Model B A&E	Model B A&E	Model B A&E	Model B A&E	Model B A&E	Model B A&E	Model B A&E	Model B A&E	Model C A&E	Model C A&E	Model C A&E	Model C A&E	Model C A&E	Model C A&E	Model C A&E	Model C A&E
Acute Med	24/7 medical take + MAU	24/7 medical take + MAU	Selective take + MAU	24/7 medical take + MAU	24/7 medical take + MAU	24/7 medical take + MAU	24/7 medical take + MAU	Selective take + MAU	Selective take + MAU	Selective take + MAU	Selective take + MAU	Selective take & MAU	Selective take & MAU	Selective take & MAU	Selective take & MAU	Selective take & MAU	Selective take & MAU	MAU	MAU
Emerg. Surg.	On call gen surg (no reg OOH)	24/7 emerg surgery	On call gen surg (no reg OOH)	On call gen surg (no reg OOH)	Amb emerg surgery	Surgical hot clinics	Minor injuries	On call gen surg (no reg OOH)	Amb emerg surgery	Surgical hot clinics	Minor injuries	Amb emerg surgery	Amb emerg surgery	Surgical hot clinics	Surgical hot clinics	Minor injuries	Minor injuries	Amb emerg surg	Amb emerg surg
Critical Care	Level 3	Level 3	Level 3	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 1 (Ward)	No enhanced care	Level 1 (Ward)	No enhanced care	Level 1 (Ward)	No enhanced care	Level 1 (Ward)	No enhanced care

	Option 20	Option 21	Option 22	Option 23	Option 24	Option 25	Option 26	Option 27	Option 28	Option 29	Option 30	Option 31	Option 32	Option 33	Option 34	Option 35	Option 36	Option 37
A&E	Model C A&E	Model C A&E	Model C A&E	Model C A&E	Model C A&E	Model C A&E	Model C A&E	Model C A&E	Model C A&E	Model C A&E	Model C A&E	Model C A&E	Model C A&E	Model C A&E	Model C A&E	Model C A&E	Model C A&E	MIU
Acute Med	MAU	MAU	MAU	MAU	ACU	ACU	ACU	ACU	ACU	ACU	D2A pathway beds	D2A pathway beds	D2A pathway beds	D2A pathway beds	D2A pathway beds	D2A pathway beds	D2A pathway beds	D2A pathway beds
Emerg. Surg.	Surgical hot clinics	Surgical hot clinics	Minor injuries	Minor injuries	Amb emerg surgery	Amb emerg surgery	Surgical hot clinics	Surgical hot clinics	Minor injuries	Minor injuries	Amb emerg surgery	Amb emerg surgery	Surgical hot clinics	Surgical hot clinics	Minor injuries	Minor injuries	Surgical hot clinics	Minor injuries
Critical Care	Level 1 (Ward)	No enhanced care	Level 1 (Ward)	No enhanced care	Level 1 (Ward)	No enhanced care	Level 1 (Ward)	No enhanced care	Level 1 (Ward)	No enhanced care	Level 1 (Ward)	No enhanced care	Level 1 (Ward)	No enhanced care	Level 1 (Ward)	No enhanced care	No enhanced care	No enhanced care

Assumes diagnostics, pathology, outpatients, elective medicine and a frailty service exist in all options

A range of clinical models exist for elective care, paediatrics and maternity

Service offering	Range of models explored				
Elective care	All elective surgery	Non-complex surgery for ASA 3 and below	Non complex surgery for ASA 2 and below	Day cases	
Paediatrics	Inpatient	SSPAU	SSPAU with limited hours	MDT led care (no paeds consultant)	MIU
Maternity	Full obstetric service	Lower risk obstetric service with limited neonates (L1)	24/7 midwife-led unit		

High level evaluation criteria exclude a range of models in elective surgery, paediatrics and maternity

Service offering	Range of models explored				
Elective care	~~All elective surgery~~	Non-complex surgery (ASA 3 or less)	Non complex surgery (ASA 2 and less)	Day cases	
Paediatrics	~~Inpatient~~	SSPAU	SSPAU with limited hours	MDT led care (no paeds consultant)	MIU
Maternity	~~Full obstetric service~~	~~Lower risk obstetric service with limited neonates (L1)~~	24/7 midwife-led unit		

Of these, there are ~ six meaningfully distinctive UEC options

Meaningfully different options

	Option 1	Option 3	Option 4	Option 5	Option 6	Option 7	Option 8	Option 9	Option 10	Option 11	Option 12
A&E	Model A A&E (24/7)	Model A A&E (restr. hours)	Model B A&E	Model B A&E	Model B A&E	Model B A&E	Model B A&E	Model B A&E	Model B A&E	Model B A&E	Model C A&E
Acute Med	24/7 medical take + MAU	Selective take + MAU	24/7 medical take + MAU	24/7 medical take + MAU	24/7 medical take + MAU	24/7 medical take + MAU	Selective take + MAU	Selective take + MAU	Selective take + MAU	Selective take + MAU	Selective take & MAU
Emerg. Surg.	On call gen surg, no reg OOH	On call gen surg (no reg OOH)	On call gen surg (no reg OOH)	Amb emerg surgery	Surgical hot clinics	Minor injuries	On call gen surg (no reg OOH)	Amb emerg surgery	Surgical hot clinics	Minor injuries	Amb emerg surg
Critical Care	Level 3	Level 3	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 1 (Ward)

	Option 14	Option 16	Option 25	Option 27	Option 29	Option 31	Option 33	Option 35	Option 36	Option 37
A&E	Model C A&E	Model C A&E	Model C A&E	Model C A&E	Model C A&E	Model C A&E	Model C A&E	Model C A&E	MIU	MIU
Acute Med	Selective take & MAU	Selective take & MAU	ACU	ACU	ACU	D2A pathway beds	D2A pathway beds	D2A pathway beds	D2A pathway beds	D2A pathway beds
Emerg. Surg.	Surgical hot clinics	Minor injuries	Amb emerg surgery	Surgical hot clinics	Minor injuries	Amb emerg surgery	Surgical hot clinics	Minor injuries	Surgical hot clinics	Minor injuries
Critical Care	Level 1 (Ward)	Level 1 (Ward)	No enhanced care	No enhanced care	No enhanced care	No enhanced care	No enhanced care	No enhanced care	No enhanced care	No enhanced care

Assumes diagnostics, pathology, outpatients, elective medicine and a frailty service exist in all options

Different models of UEC can be combined with inter-dependent elective models

Highest level of elective surgery that can be provided

	Option 1	Option 3	Option 9	Option 12	Option 27	Option 37
A&E	Model A A&E (24/7)	Model A A&E (restricted hours)	Model B A&E	Model C A&E	Model C A&E	MIU
Acute Medicine	24/7 medical take + MAU	Selective take + MAU	Selective take + MAU	Selective take + MAU	ACU	D2A pathway beds
Emergency Surgery	On call gen surg (no registrar OOH)	On call gen surg (no registrar OOH)	Amb emerg surgery	Amb emerg surgery	Surgical hot clinics	Minor injuries
Critical Care	Level 3	Level 3	Level 2	Level 1 (Ward)	No enhanced care	No enhanced care
Combined with one of elective care options available:						
a **Non-complex surgery (ASA 3 or less)**	✓	✓	✓	✓	X	X
b **Non-complex surgery (ASA 2 or less)**	✓	✓	✓	✓	✓	✓
c **Day cases**	✓	✓	✓	✓	✓	✓

Assumes diagnostics, pathology, outpatients, elective medicine and a frailty service exist in all options

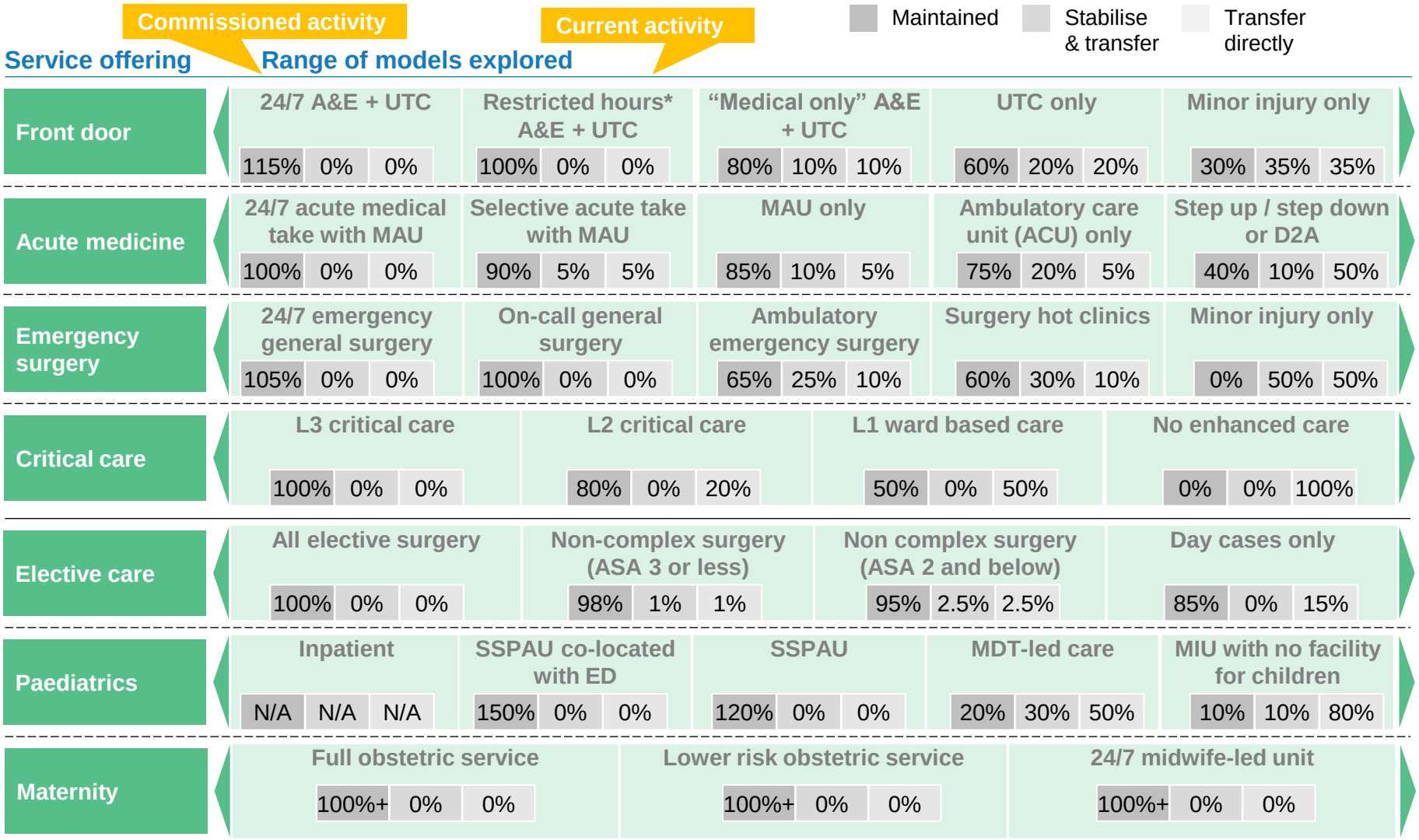
Five options were shortlisted for further evaluation

	Option 1a	Option 3a	Option 9a	Option 12a	Option 27b
A&E	24x7 A&E + UTC	A&E (restricted hours) + UTC	Model B A&E + UTC	UTC only	UTC only
Acute Medicine	24/7 medical take + MAU	Selective take + MAU	Selective take + MAU	Selective take + MAU	ACU only
Emergency Surgery	On call general surgery*	On call general surgery*	Ambulatory emergency surgery	Ambulatory emergency surgery	Surgical hot clinics
Critical Care	Level 3	Level 3	Level 2	Level 1 / 2	No enhanced care
Elective care	Non-complex surgery (ASA 3 or less)	Non-complex surgery (ASA 3 or less)	Non-complex surgery (ASA 3 or less)	Non-complex surgery (ASA 3 or less)	Non-complex surgery (ASA 2 or less)
Paediatrics	SSPAU	SSPAU	SSPAU	SSPAU	SSPAU
Maternity	24/7 midwife led unit	24/7 midwife led unit	24/7 midwife led unit	24/7 midwife led unit	24/7 midwife led unit

* No registrar out of hours

Assumes diagnostics, pathology, outpatients, elective medicine and a frailty service exist in all options

Percentage of WAHT 2017/18 activity (with the temporary A&E closure) maintained and transferred



Assumes diagnostic imaging, pathology services and a frailty service exist in all options

*assumes other admitting services would be restricted hours also

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HEALTHY WESTON

Healthy Weston PCBC

Appendix 18: Model Descriptors for shortlisted models

Updated12th December with revised Model 27b following CSDDG after Clinical Senate
Updated 9th Jan 2019 following CSDDG scrutiny of 9a after NHS E Assurance

7 potential acute service models for Weston General Hospital, which all incorporate vital clinical care pathways

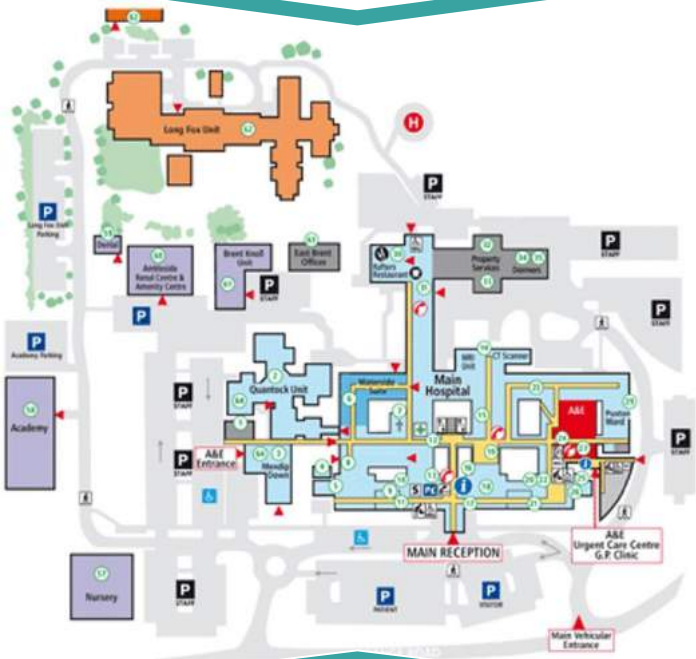
HEALTHY WESTON

Enablers common to all models
Frailty unit + hub
Primary care at the front door
Easy stabilisation & transfer of pts as req
Enhanced use of IT and technology

1a – Model A A&E (24/7) + UTC with 24/7 medical take + on-call general surgery
24/7 A&E + UTC
24/7 medical take + MAU
On-call general surgery
Level 3 critical care

3a – Model A A&E (restricted hrs) + UTC with selective take + on-call gen surgery
Restricted hours A&E + UTC
Selective medical take + MAU
On-call general surgery
Level 3 critical care

9a – Model B A&E + UTC + selective medical take + amb. emergency surgery
Medical only A&E+ UTC
Selective medical take+ MAU
Ambulatory emergency surgery
Level 2 critical care



Clinical pathways featuring in all models
Non-complex elective surgery (ASA ≤ 2/3)
SSPAU (located with ED where possible)
Outpatients and Elective medicine
On-call midwife-led unit
Diagnostics and Pathology services

12a – Model C A&E, selective take, with additional non-complex elective surgery
UTC
Selective medical take + MAU
Ambulatory emergency surgery
Level 1 / 2 critical care

12b – Model C A&E with selective medical take, ASA ≤2 elective surgery
UTC
Selective medical take + MAU
Ambulatory emergency surgery
Level 1 (ward-based care)

27b – Model C A&E with ACU + surgical hot clinics
UTC only
ACU (ambulatory care unit)
Surgical hot clinics
No critical care / enhanced care

37b – MIU only with D2A pathway beds + minor injuries
MIU (minor injury unit)
D2A (discharge to assess) pathway beds
Minor injuries
No enhanced care

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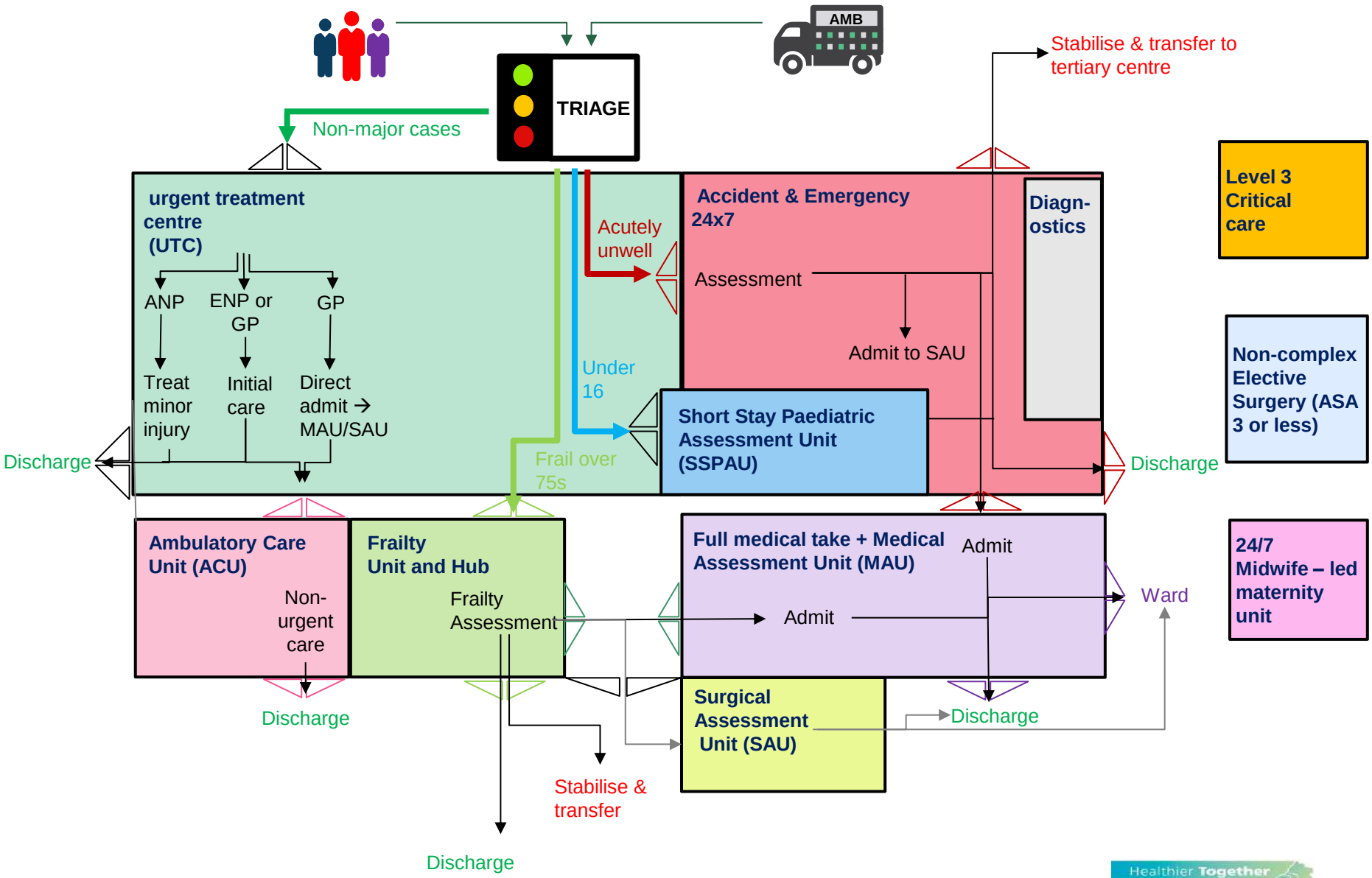
Option 1a –A&E (24/7) + UTC, full medical take, on call surgery



*NB – direct referrals from community GPs to MAU & SAU not included

Option 1a - A&E (24/7) + UTC, full medical take, on call surgery

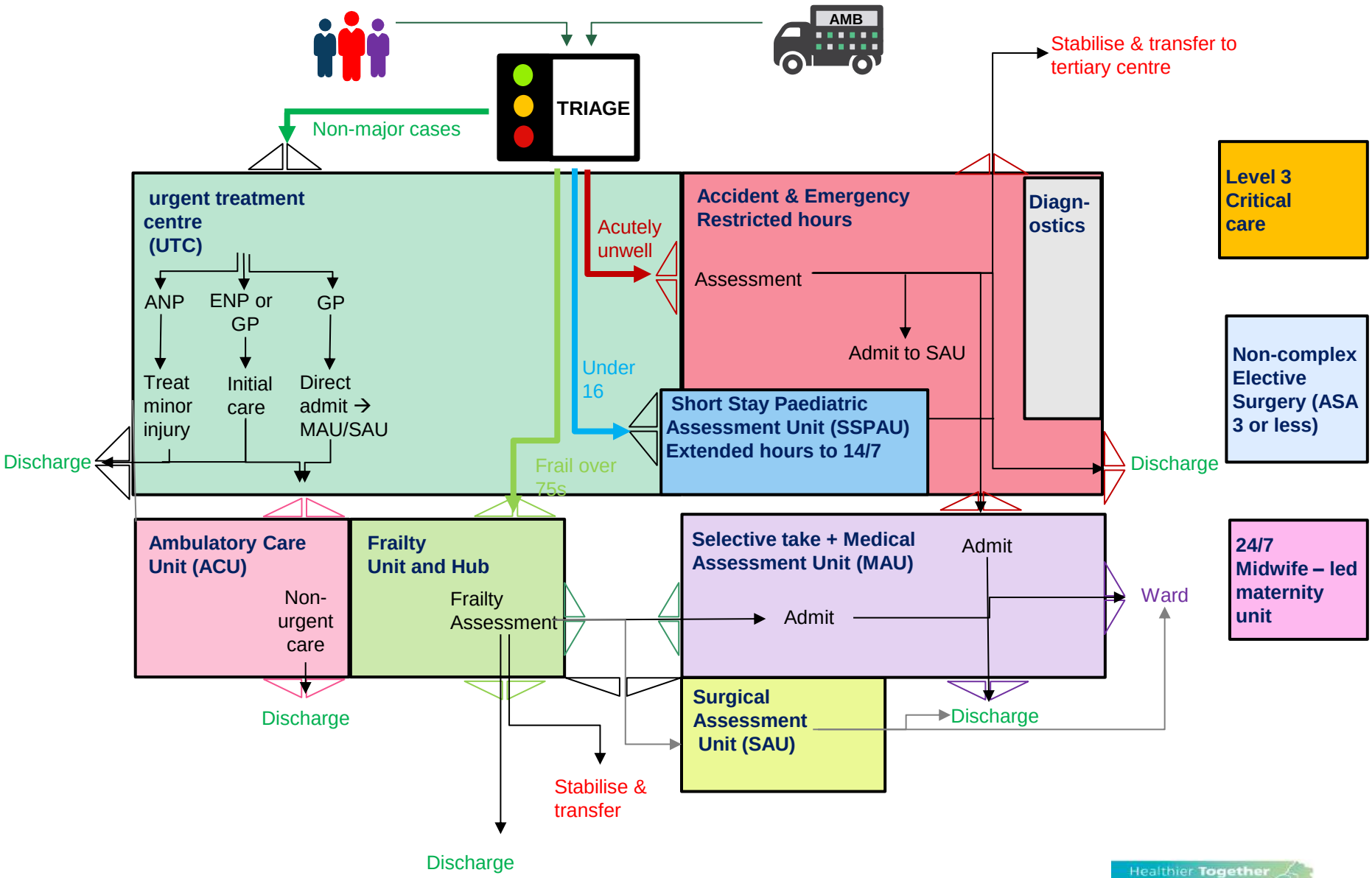
	Staffing	Other services required	Conditions Covered	Conditions not covered
Model A A&E (24/7)	▪ ED cons. in person 24/7[1] ▪ Additional complement of Tier 1 and 2 practitioners (incl. Mental Health) ▪ Diagnosticians ▪ Multidisciplinary team to support frailty unit	▪ Level 3 critical care ▪ NCEPOD staffed theatre 24x7 ▪ 24/7 IR and endoscopy available ▪ Amb. unit and clinical decisions unit ▪ Frailty unit ▪ Primary care front door	▪ All A&E attendances and GP referrals ▪ GP out of hours services at UTC	▪ Major complex conditions needing treatment at specialist centres (e.g. polytrauma, hyper acute stroke) ▪ Stabilise and transfer patients needing tertiary (specialist) care
24/7 medical take + MAU	▪ Acute medicine cons. on site during opening hours of 'front door' ▪ 24 x 7 medical reg on site	▪ Level 3 critical care ▪ IR and acute bleed service available ▪ Frailty unit and AAU ▪ Diagnostics ▪ Standardized care pathways with GP admits direct to AAU/frailty unit	▪ All acute medical admissions except for hyper-acute stroke and cardiac care	▪ Hyper acute stroke patients requiring thrombectomy ▪ Hyper acute cardiac care ▪ Hepatology
On call gen surg (no registrar OOH)	▪ 12 / 7 “in hours" gen. surgery consultant cover ▪ Cons. surgeon at night (emergencies only) on call ▪ Stabilise & transfer team (anesthetist + critical care nurse) on call	▪ Level 3 critical care ▪ NCEPOD staffed theatre 12x7 ▪ IR available	▪ All emergency procedures for patients up to ASA 4 ▪ Includes #NOF direct admits as well as stabilising and admitting comorbid patients.	▪ All high risk patients and high complexity procedures
Level 3 Critical Care	▪ 24/7 Critical care cons. Cover ▪ If eICU – cons. 14/7 oncall OOH, econs. 24/7		▪ Level 3 patients - requiring two or more organ support (or needing mechanical ventilation alone)	▪ None
Non-complex elective surgery (ASA ≤3)	▪ Junior team (specialist level) in-hours, resident anaesthetist, access to medical opinion ▪ Surgery reg or equivalent OOH (specialist level) ▪ Cons. workforce from larger centre or multiple site cover at cons. level	▪ Level 2+ critical care ▪ NCEPOD staffed theatre 12x7 ▪ 12x7 IR available	▪ All mid and low complexity procedures for medium risk patients (ASA 3 ≤) ▪ Endoscopy, IR + other procedures ▪ On-call emergency surgery	▪ High complexity and / or high risk patients ▪ ASA 4 + conditions in column 1
SSPAU + ambulat-ory care	▪ Cons. paediatrician on site when ED is open ▪ Shared staff with A&E with paediatric expert / GPwSI in paeds covering OOH ▪ Facilities for children available 7 days through SSPAU and ED/UTC		▪ Minor acute illnesses, minor trauma, burns and infections, IV antibiotics ▪ Acutely unwell children transferred ▪ Repatriate cases from Bristol ED if appropriate ▪ Common care pathways across patch	▪ Illness requiring >8 hours observation ▪ Children requiring admissions ▪ Neonates requiring NICU
24/7 Midwife led unit	▪ Midwife available on call ▪ Support staff ▪ Primary care hubs for midwife clinics	▪ Capacity to stabilize and transfer	▪ Low risk births, 37 - 42 weeks of gestation, ▪ Antenatal care / in day assessment unit or in community ▪ Postnatal care in community (short stay in-unit after birth)	▪ Women requiring obstetric care, high-risk pregnancies, maternal-foetal medicine, epidurals, C-sections

1 For small DGH the assumption is that this would require 8- 10 WTE consultants

* Note the commissioned model is a 24x7 A&E

Assumes diagnostics, pathology, outpatients, elective medicine and a frailty service exist in all options

Option 3a –A&E (restricted hours) + UTC, selective take, on call surgery



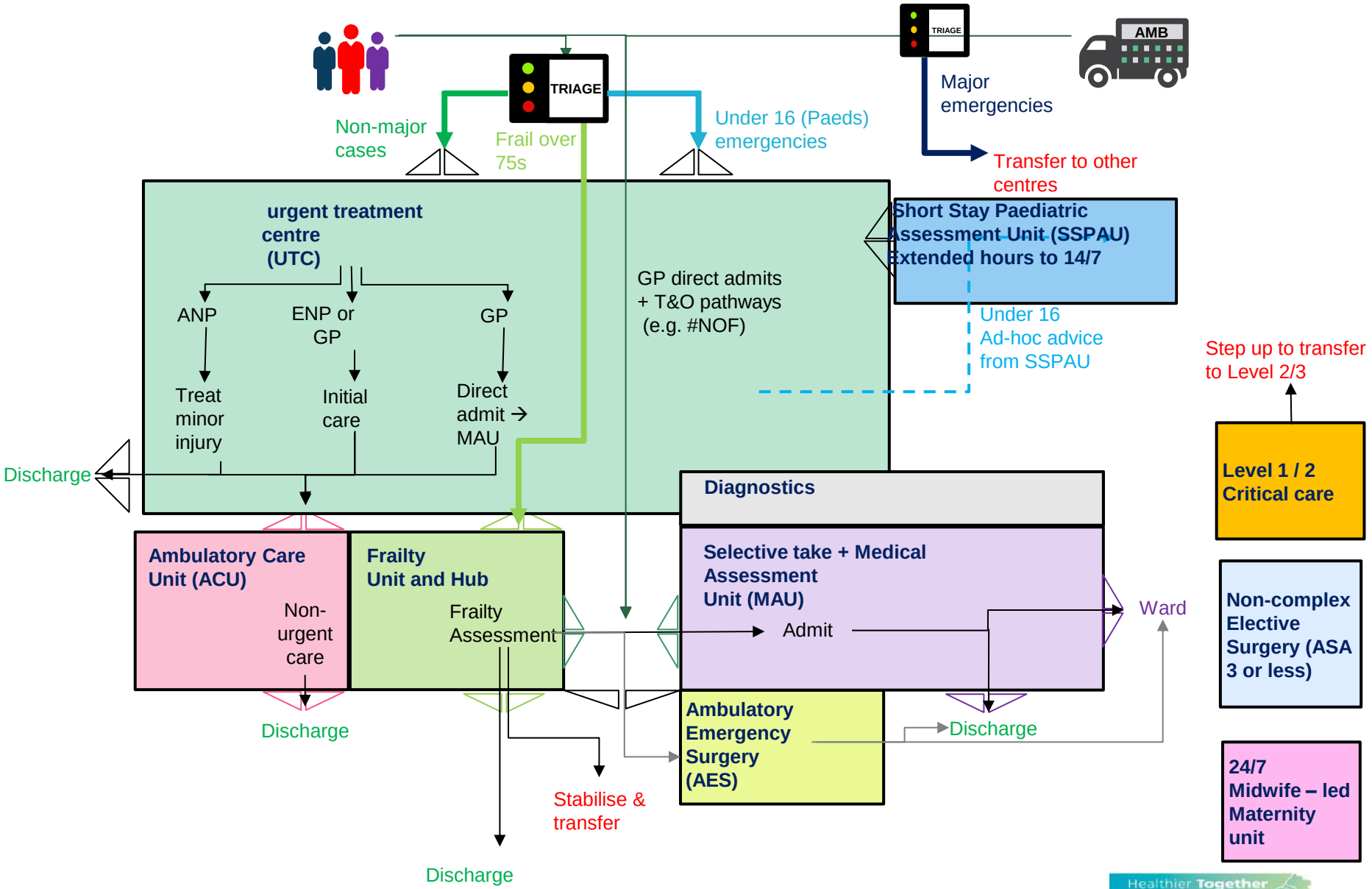
*NB – direct referrals from community GPs to MAU & SAU not included in this

Option 3a – A&E (restricted hours) + UTC, selective take, on call surgery

	Staffing	Other services required	Conditions Covered	Conditions not covered
Model A A&E (restricted hours)	▪ ED consultant in person until 2 hours after A&E closes ▪ Junior doctor cover until 2-4 hours after close of A&E ▪ Complement of Tier 1 and 2 practitioners (incl. Mental Health) during opening hours ▪ Multidisciplinary team to support frailty unit	▪ Level 3 critical care ▪ NCEPOD staffed theatre 24x7 ▪ Interventional radiology and endoscopy available ▪ Ambulatory unit and clinical decisions unit ▪ Frailty unit ▪ Primary care front door	▪ All A&E attendances and GP referrals during opening hours ▪ GP out of hours services at UTC	▪ Major complex conditions needing treatment at specialist centres (e.g. polytrauma, hyperacute stroke) ▪ Stabilise and transfer patients needing tertiary (specialist) care
Selective take + MAU	▪ Acute medicine cons. on site during opening hours of 'front door' ▪ 24 x 7 medical registrar on site	▪ Level 1 or 2 critical care (with ability to step up to transfer) ▪ Acute assessment unit ▪ Frailty unit ▪ Diagnostics ▪ Standardized care pathways with GP admits direct to AAU/frailty unit	▪ All non- high acuity	▪ Stroke patients, hyper acute cardiac care, subset of patients requiring level 3 critical care ▪ Acute bleeds ▪ Hepatology
On call gen. surg (no registrar OOH)	▪ 12 / 7 “in hours" general surgery consultant cover ▪ Cons. surgeon at night (emergencies only) on call ▪ Stabilise & transfer team (anesthetist + critical care nurse) on call	▪ Level 3 critical care ▪ NCEPOD staffed theatre 12x7 ▪ IR available	▪ All emergency procedures for patients up to ASA 4 ▪ Includes #NOF direct admits as well as stabilising and admitting comorbid patients.	▪ All high risk patients and high complexity procedures
Level 3 Critical Care	▪ 24x7 Critical care consultant cover ▪ If eICU – cons. 14x7 / on-call OOH, eConsultant 24x7 ▪ 1:1 RN		▪ Level 3 patients - requiring two or more organ support (or needing mechanical ventilation alone)	▪ None
Non-complex elective surgery (ASA ≤3)	▪ Junior team (specialist level) in-hours, resident anaesthetist, access to medical opinion ▪ Surgery reg or equivalent OOH (specialist level) ▪ Cons. workforce from larger centre or multiple site cover at cons. level	▪ Level 2+ critical care ▪ NCEPOD staffed theatre 12x7 ▪ 12x7 interventional radiology	▪ All mid and low complexity procedures for medium risk patients (ASA 3 ≤) ▪ Endoscopy, Interventional Radiology + other procedures ▪ On-call emergency surgery	▪ High complexity and / or high risk patients ▪ ASA 4 + conditions in column 1
SSPAU + ambulat-ory care	▪ Cons. paediatrician on site when ED is open ▪ Shared staff with A&E with paediatric expert / GPwSI in paeds covering OOH ▪ Facilities for children available 7 days through SSPAU and ED/UTC		▪ Minor acute illnesses, minor trauma, burns and infections, IV antibiotics ▪ Acutely unwell children transferred ▪ Repatriate cases from Bristol ED if appropriate ▪ Common care pathways across patch	▪ Illness requiring >8 hours observation ▪ Children requiring admissions ▪ Neonates requiring NICU
24/7 Midwife led unit	▪ Midwife available on call ▪ Support staff ▪ Primary care hubs for midwife clinics	▪ Capacity to stabilize and transfer	▪ Low risk births, 37 - 42 weeks of gestation ▪ Antenatal care / in day assessment unit or in community ▪ Postnatal care in community (short stay in-unit after birth)	▪ Women requiring obstetric care, high-risk pregnancies, maternal-foetal medicine, epidurals, C-sections

Assumes diagnostics, pathology, outpatients, elective medicine and a frailty service exist in all options

Option 12a –A&E, selective take and GP direct admits, amb emerg surg with ASA 3 or less + additional elective surgery



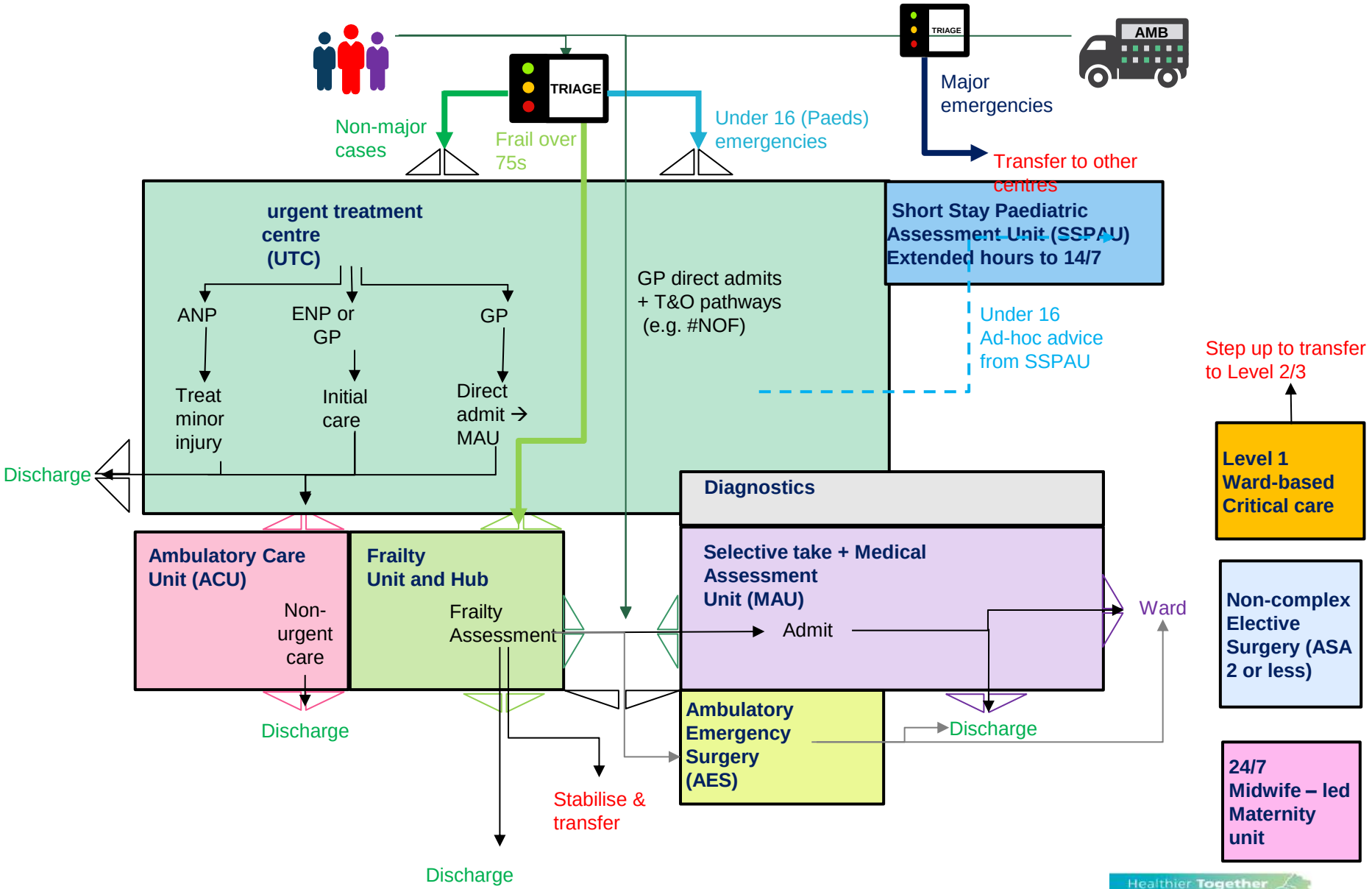
*NB – direct referrals from community GPs to MAU & SAU not included

Option 12a – A&E, selective take and GP direct admits, amb emerg surg with ASA 3 or less + additional elective surgery

	Staffing	Other services required	Conditions Covered	Conditions not covered
Model C A&E	▪ GPs ▪ Advanced Nurse Practitioner (ANP) support ▪ HCAs ▪ Multidisciplinary team of GPs, geriatricians, ANPs to support frailty unit ▪ Mental Health practitioner available ▪ Remote access to A&E consultant	▪ Capacity to stabilize and transfer ▪ Possibly ambulatory care observation and assessment ▪ Possibly frailty unit	▪ All minor illnesses and injury ▪ Stabilise and transfer others ▪ GP out of hours services	▪ Suspected complex fractures; other complex needs (any life or limb threatening conditions); conditions requiring critical care
Selective take + MAU	▪ Acute medicine cons. on site during opening hours of 'front door' ▪ 24 x 7 medical registrar on site	▪ Level 1 or 2 critical care (with ability to step up to transfer) ▪ Acute assessment unit ▪ Frailty unit ▪ Diagnostics ▪ Standardized care pathways with GP admits direct to AAU/frailty unit	▪ All non- high acuity	▪ Stroke patients, hyper acute cardiac care, subset of patients requiring level 3 critical care ▪ Acute bleeds ▪ Hepatology
Amb emerg surgery	▪ Dedicated surgical consultant on a limited rota (e.g. 8/5) and on standby to offer opinion ▪ NCEPOD theatre available for ~4 hours a day	▪ Capacity to stabilize and transfer	▪ Ambulatory surgical activity e.g., abscess drainage, gall bladders, piles (add to DC lists) ▪ All emergency procedures not required within 12 hours, including well #NOF pts	▪ All high risk patients and high complexity procedures ▪ Emergency laparotomy + all non-medical abdominal pain
Level 1 / 2 critical care	▪ 24/7 acute medicine or anaesthetic cons. cover ▪ Transfer team for step up and stabilize if required ▪ 1:2 RN		▪ Level 2 patients - single organ support (excluding mechanical ventilation) such as inotropes and invasive BP monitoring	▪ Patients requiring multiple organ support
Non-complex elective surgery (ASA ≤3)	▪ Junior team (specialist level) in-hours, resident anaesthetist, access to medical opinion ▪ Surgery reg or equivalent OOH (specialist level) ▪ Cons. workforce from larger centre or multiple site cover at cons. level	▪ Capacity to stabilize and transfer	▪ All mid and low complexity procedures for medium risk patients (ASA 3 ≤) ▪ Endoscopy, IR + other procedures ▪ On-call emergency surgery ▪ Additional non-complex cases if possible	▪ High complexity and / or high risk patients ▪ ASA 4 + conditions in column 1 ▪ No enhanced care
SSPAU (limited hours)	▪ Cons. paediatrician on site 11 / 5 ▪ OOH cross cover from GPs		▪ Minor acute illnesses, minor trauma, burns and infections, IV antibiotics ▪ Acutely unwell children transferred ▪ Common care pathways across patch ▪ Scheduled care provision	▪ Illness requiring >8 hours observation ▪ Children requiring admissions ▪ Neonates requiring NICU
24/7 Midwife led unit	▪ Midwife available on call ▪ Support staff ▪ Primary care hubs for midwife clinics	▪ Capacity to stabilize and transfer	▪ Low risk births, 37 - 42 weeks of gestation ▪ Antenatal care / in day assessment unit or in community ▪ Postnatal care in community (short stay in-unit after birth)	▪ Women requiring obstetric care, high-risk pregnancies, maternal-foetal medicine, epidurals, C-sections

Assumes diagnostics, pathology, outpatients, elective medicine and a frailty service exist in all options

Option 12b – A&E, selective take and GP direct admits, amb emerg surg with ASA 2 or less non-complex elective surgery



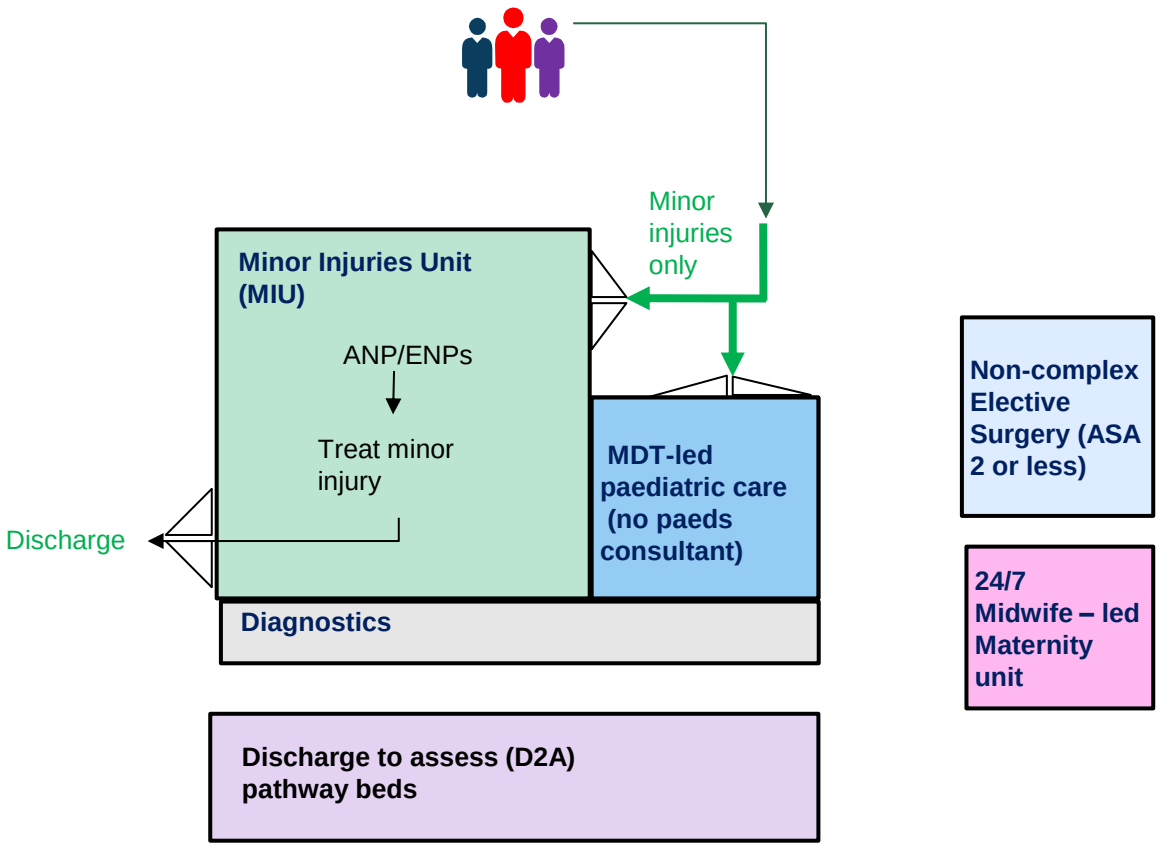
*NB – direct referrals from community GPs to MAU & SAU not included

Option 12b – Model C A&E, selective take and GP direct admits, amb emerg surg with ASA 2 or less non-complex elective surgery

	Staffing	Other services required	Conditions Covered	Conditions not covered
Model C A&E	▪ GPs ▪ Advanced Nurse Practitioner (ANP) support ▪ HCAs ▪ Multidisciplinary team of GPs, geriatricians, ANPs to support frailty unit ▪ Mental Health practitioner available ▪ Remote access to A&E consultant	▪ Capacity to stabilize and transfer ▪ Possibly ambulatory care observation and assessment ▪ Possibly frailty unit	▪ All minor illnesses and injury ▪ Stabilise and transfer others ▪ GP out of hours services	▪ Suspected complex fractures; other complex needs (any life or limb threatening conditions); conditions requiring critical care
Selective take + MAU	▪ Acute medicine cons. on site during opening hours of 'front door' ▪ 24 x 7 medical registrar on site	▪ Level 1 or 2 critical care (with ability to step up to transfer) ▪ Acute assessment unit ▪ Frailty unit ▪ Diagnostics ▪ Standardized care pathways with GP admits direct to AAU/frailty unit	▪ All non- high acuity	▪ Stroke patients, hyper acute cardiac care, subset of patients requiring level 3 critical care ▪ Acute bleeds ▪ Hepatology
Amb emerg surgery	▪ Dedicated surgical consultant on a limited rota (e.g. 8/5) and on standby to offer opinion ▪ NCEPOD theatre available for ~4 hours a day	▪ Capacity to stabilize and transfer	▪ Ambulatory surgical activity e.g., abscess drainage, gall bladders, piles (add to DC lists) ▪ All emergency procedures not required within 12 hours, including well #NOF pts	▪ All high risk patients and high complexity procedures ▪ Emergency laparotomy + all non-medical abdominal pain
Level 1+ ward-based care	▪ More intensive monitoring, e.g., cardiac monitoring supported by transfer team ▪ 1:4 RN		▪ Level 1 patients only – no organ support required ▪ CPAP	▪ Patients requiring organ support (including vasopressor support)
Non-complex elective surgery (ASA ≤2)	▪ RMO with consultant available out of hours ▪ Rotating theatre staff, radiographers; Consultant delivered intervention (extended hours?) & anaesthesia ▪ ECPs for day time care with extended hours	▪ Capacity to stabilize and transfer	▪ ASA 2 ≤: LOS 1-3 days for IP, day cases ▪ Endoscopy + some procedures ▪ Protocols for escalation available	▪ IR ▪ No enhanced care ▪ ASA 3 + conditions not covered in other models
SSPAU (limited hours)	▪ Cons. paediatrician on site 11 / 5 ▪ OOH cross cover from GPs		▪ Minor acute illnesses, minor trauma, burns and infections, IV antibiotics ▪ Acutely unwell children transferred ▪ Common care pathways across patch ▪ Scheduled care provision	▪ Illness requiring >8 hours observation ▪ Children requiring admissions ▪ Neonates requiring NICU
24/7 Midwife led unit	▪ Midwife available on call ▪ Support staff ▪ Primary care hubs for midwife clinics	▪ Capacity to stabilize and transfer	▪ Low risk births, 37 - 42 weeks of gestation ▪ Antenatal care / in day assessment unit or in community ▪ Postnatal care in community (short stay in-unit after birth)	▪ Women requiring obstetric care, high-risk pregnancies, maternal-foetal medicine, epidurals, C-sections

Assumes diagnostics, pathology, outpatients, elective medicine and a frailty service exist in all options

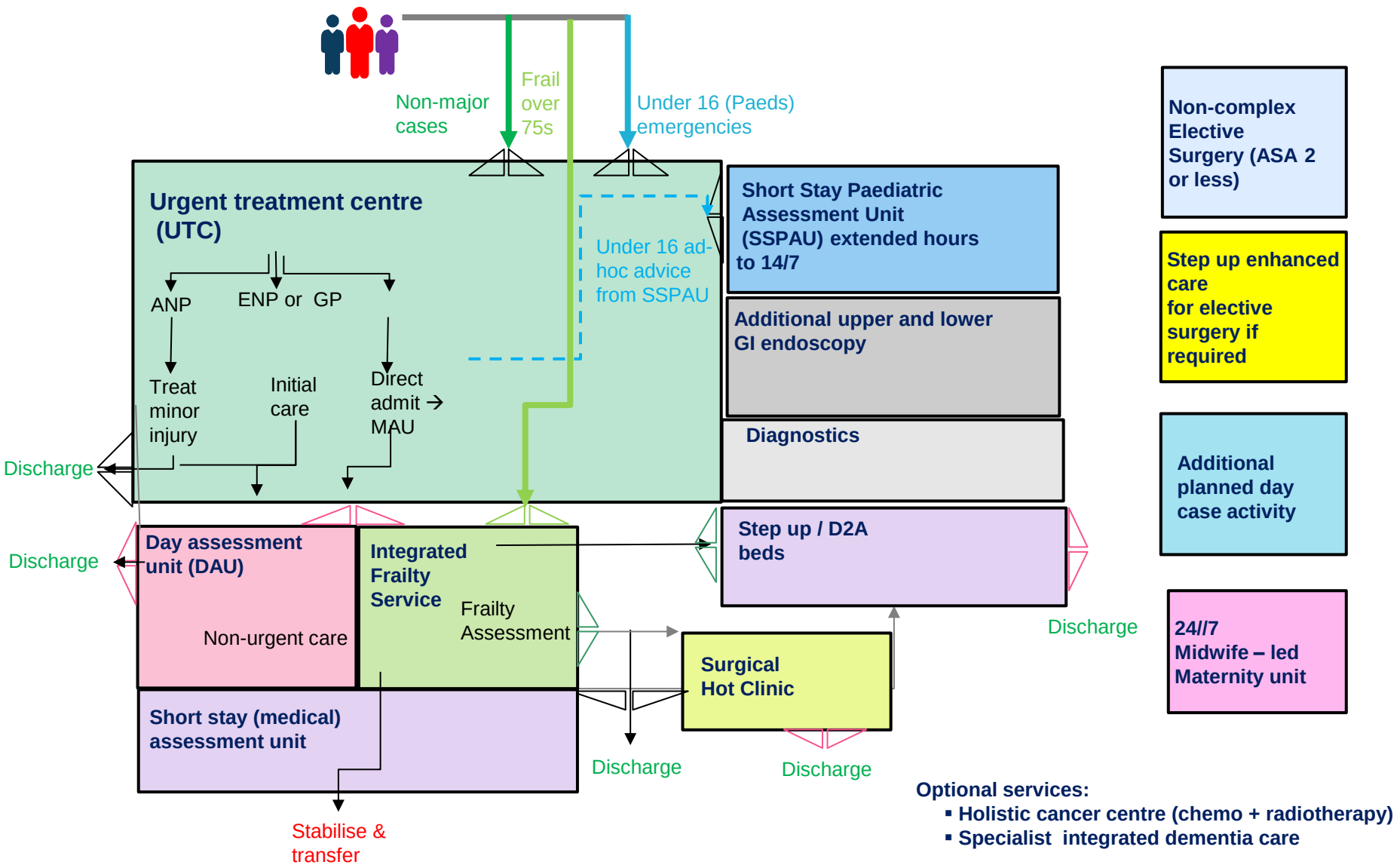
Option 37b– MIU, D2A beds, no enhanced care



Option 37b– MIU only, D2A beds only, no enhanced care

	Staffing	Other services required	Conditions Covered	Conditions not covered
MIU	▪ ENPs ▪ HCAs	▪ Capacity to stabilize and transfer	▪ Minor injuries e.g. lacerations	▪ All patients needing medical input
D2A pathway beds	▪ Multi disciplinary team on GPs, care of the elderly cons., ANPs, AHPs, social care	▪ Access to specialist opinion ▪ Access to hot clinics ▪ Diagnostics ▪ Capacity to stabilize and transfer ▪ Standardized care pathways	▪ Patients needing short term assessment	▪ Acutely unwell patients who warrant care in a more specialist centre
Minor injuries	▪ No "in hours" cover from general surgery team (all care provided by elective surgery teams) ▪ No emergency surgery on-call rota OOH	▪ Capacity to stabilize and transfer	▪ Minor injury e.g. laceration	▪ All patients needing medical input, including well #NOF pts
No enhanced care	▪ No transfer team or support for intensive monitoring		▪ Normal ward care	▪ Patients requiring organ support or intensive monitoring
Non-complex elective surgery (ASA ≤2)	▪ RMO with remote cons. cover ▪ Rotating theatre staff, radiographers; Cons. delivered intervention (extended hours?) & anaesthesia ▪ ECPs for day time care with extended hours	▪ Capacity to stabilize and transfer	▪ ASA 2 ≤: LOS 1-5 days for IP, day cases ▪ Endoscopy + some procedures ▪ Protocols for escalation available	▪ IR ▪ No enhanced care ▪ ASA 3 + conditions not covered in other models
MIU for children	▪ No paediatrics expertise at the "front door"		▪ Minor injury only	▪ All children needing medical or surgical input
24/7 Midwife led unit	▪ Midwife available on call ▪ Support staff ▪ Primary care hubs for midwife clinics	▪ Capacity to stabilize and transfer	▪ Low risk births, 37 - 42 weeks of gestation ▪ Antenatal care / in day assessment unit or in community ▪ Postnatal care in community (short stay in-unit after birth)	▪ Women requiring obstetric care, high-risk pregnancies, maternal-foetal medicine, epidurals, C-sections

Option 27b



Optional services:

- **Holistic cancer centre (chemo + radiotherapy)**
- **Specialist integrated dementia care**

***NB – direct referrals from community GPs to MAU & SAU not included**

Option 27b

	Staffing	Other services required	Conditions Covered	Conditions not covered
Urgent Treatment Centre	▪ GPs ▪ Advanced Nurse Practitioner (ANP) support ▪ HCAs ▪ Multidisciplinary team of GPs, geriatricians, ANPs to support frailty unit ▪ Mental Health practitioner available ▪ Remote access to A&E consultant	▪ Capacity to stabilize and transfer ▪ Possibly ambulatory care observation and assessment ▪ Possibly frailty unit	▪ All minor illnesses and injury ▪ Stabilise and transfer others ▪ GP out of hours services	▪ Suspected complex fractures; other complex needs (any life or limb threatening conditions); conditions requiring critical care
DAU	▪ Acute medicine cons. Or registrar on site during opening hours of "front door" ▪ 12-16 hour, 7 day a week cover required	▪ Frailty unit ▪ Diagnostics ▪ Standardized care pathways with GP admits direct to assessment unit	▪ Patients requiring short term observation and assessment within 24 hours	▪ Patients needing inpatient care
Short stay MAU	▪ 24/7 cover by frailty team, primary care, and acute physicians	▪ Longer stay step up / D2A beds for patients with continuing generalist needs	▪ Patients requiring less than 72 hour stays (e.g. frail patients with UTIs)	▪ Patients needing more than 72 hours care
Surgical hot clinics	▪ Daytime cons. cover for hot clinic ▪ No emergency surgery on-call rota OOH ▪ #NOF patients seen on elective list on the next day if appropriate	▪ Capacity to stabilize and transfer	▪ No emergency surgery ▪ Hot clinic outreach (GP direct access) ▪ All emergency procedures not required within 12 hours, including most #NOF pts	▪ All high risk patients and high complexity procedures ▪ Emergency laparotomy + all non-medical abdominal pain
Enhanced Care	▪ No regular critical care team ▪ Potential for enhanced care setup if appropriate to enable the model (e.g. for #NOF)		▪ Normal ward care ▪ Minimal enhanced care needs in selected cases (e.g. #NOF)	▪ Patients requiring organ support or intensive monitoring
Non-complex elective surgery (ASA ≤2)	▪ RMO with consultant available out of hours ▪ Rotating theatre staff, radiographers; Consultant delivered intervention (extended hours?) & anaesthesia ▪ ECPs for day time care with extended hours	▪ Capacity to stabilize and transfer	▪ ASA 2 ≤: LOS 1-5 days for IP, day cases ▪ Endoscopy + some procedures ▪ Protocols for escalation available	▪ IR ▪ No enhanced care ▪ ASA 3 + conditions not covered in other models
SSPAU	▪ Cons. paediatrician on site when ED is open ▪ Shared staff with A&E with paediatric expert / ▪ Facilities for children available 7 days through SSPAU		▪ Minor acute illnesses, minor trauma, burns and infections, IV antibiotics ▪ Acutely unwell children transferred ▪ Common care pathways across patch ▪ Scheduled care provision	▪ Illness requiring >8 hours observation ▪ Children requiring admissions ▪ Neonates requiring NICU
24/7 Midwife led unit	▪ Midwife available on call ▪ Support staff ▪ Primary care hubs for midwife clinics	▪ Capacity to stabilize and transfer	▪ Low risk births, 37 - 42 weeks of gestation ▪ Antenatal care / in day assessment unit or in community ▪ Postnatal care in community (short stay in-unit after birth)	▪ Women requiring obstetric care, high-risk pregnancies, maternal-foetal medicine, epidurals, C-sections

Assumes diagnostics, pathology, outpatients, elective medicine and a frailty service exist in all options

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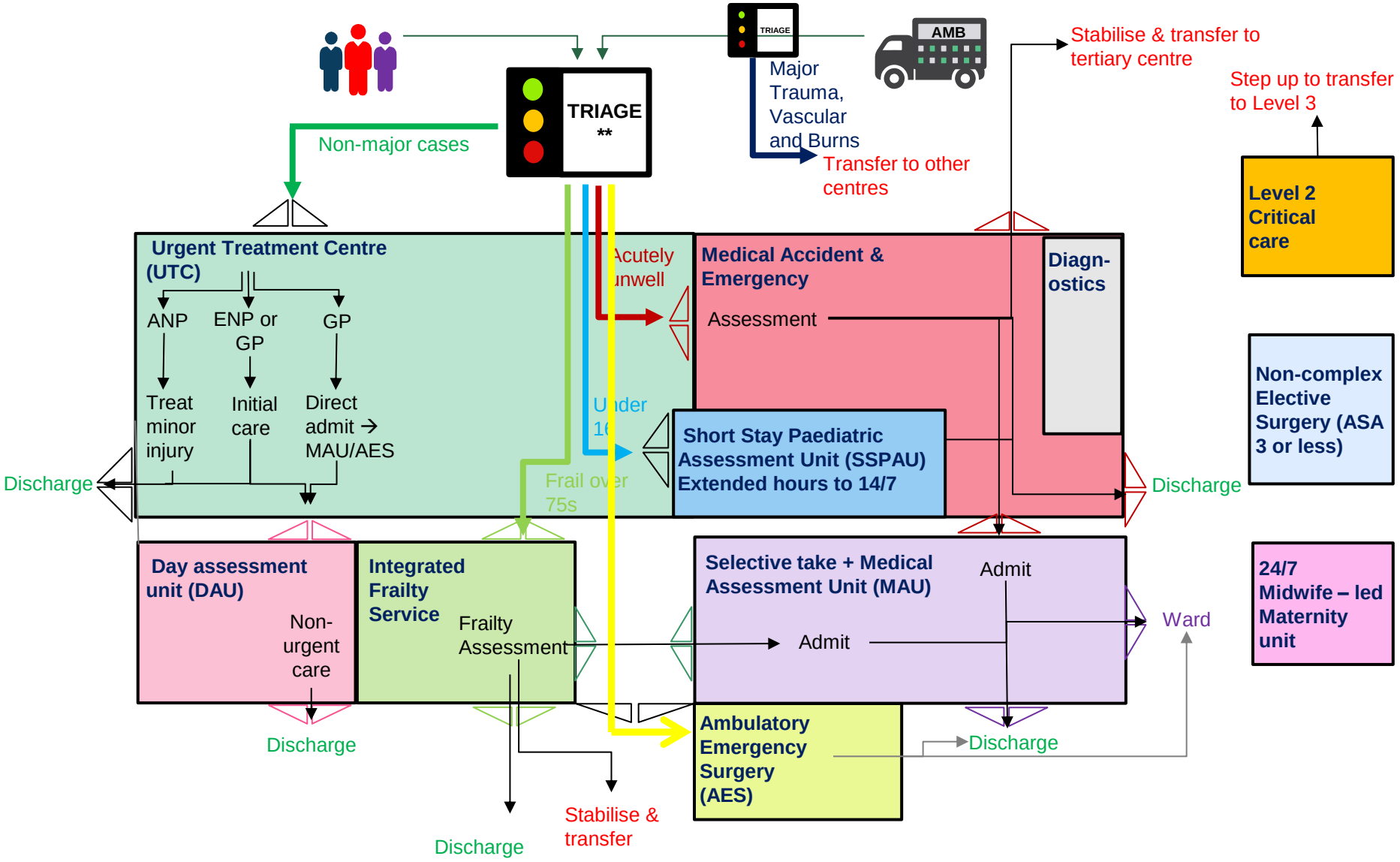
Preferred option (9a amended by CSDDG 17/1/19)

Preferred Option – A&E + UTC, selective take, ambulatory emergency surgery (9a amended & agreed by CSDDG 170119)



*NB – direct referrals from community GPs to MAU & SAU not included

**Skillset required at pre-hospital triage to be defined and to enable 24/7 referral

Preferred Option – A&E + UTC, selective take, ambulatory emergency surgery (9a amended by CSDDG 170119)

	Staffing	Other services required	Conditions Covered	Conditions not covered
Model B A&E	▪ Senior clinical decision maker on site until 2 hours post ED closure ▪ Stabilise & transfer team (anaesthetist + critical care nurse) on site during opening hours ▪ Mental Health practitioner available ▪ Multidisciplinary team to support frailty unit ▪ A&E consultants available on site	▪ Level 2+ critical care ▪ Transfer for services not on site including interventional support ▪ MAU and frailty unit on site ▪ Primary care front door ▪ Triage by senior decision maker (ED/acute cons, GP, middle-grade)	▪ Medical ED attendances, minor illnesses and injuries, GP referrals ▪ Stabilise and transfer others ▪ GP out of hours services at UTC	▪ Surgical ED attendances e.g. patients requiring laparotomy ▪ Other complex needs (any life or limb threatening conditions); conditions requiring critical care
Selective take + MAU	▪ Acute medicine cons. on site during opening hours of 'front door' ▪ 24 x 7 medical registrar on site	▪ Level 2 critical care (with ability to stabilize and transfer) ▪ Day assessment unit ▪ Frailty unit ▪ Diagnostics ▪ Standardized care pathways with GP admits direct to AAU/frailty unit	▪ All non- high acuity	▪ Stroke patients, hyper acute cardiac care, subset of patients requiring level 3 critical care ▪ Acute bleeds ▪ Hepatology
Amb emerg surgery	▪ daytime surgical presence with on call out of hours	▪ Capacity to stabilize and transfer ▪ NCEPOD theatre available for ~4 hours a day (patients can be seen on elective list next day with NCEPOD available for absolute emergencies)	▪ Ambulatory surgical activity e.g., abscess drainage, gall bladders, piles (add to DC lists) ▪ All emergency procedures not required within 12 hours, including most #NOF pts	▪ All high risk patients and high complexity procedures ▪ Emergency laparotomy + all non-medical abdominal pain
Level 2+ Critical Care	▪ 24/7 acute medicine or anesthetic cons. cover ▪ Transfer team for step up and stabilize if required ▪ 1:2 RN		▪ Level 2 patients - single organ support such as inotropes and invasive BP monitoring ▪ Ability to provide level 3 for 12 hours with option to extend on a case by case basis	▪ Patients requiring multiple organ support
Non-complex elective surgery (ASA ≤3)	▪ Junior team (specialist level) in-hours, resident anaesthetist, access to medical opinion ▪ Surgery reg or equivalent OOH (specialist level) ▪ Cons. workforce from larger centre or multiple site cover at cons. level	▪ Level 2+ critical care	▪ All mid and low complexity procedures for medium risk patients (ASA 3 ≤) ▪ Endoscopy, IR + other procedures ▪ On-call emergency surgery	▪ High complexity and / or high risk patients ▪ ASA 4 + conditions in column 1
SSPAU + ambulat-ory care	▪ Paediatric service on site when ED is open ▪ Shared staff with A&E with paediatric expert / GPwSI in paeds covering OOH ▪ Facilities for children available 7 days through SSPAU and ED/UTC		▪ Minor acute illnesses, minor trauma, burns and infections, IV antibiotics ▪ Acutely unwell children transferred ▪ Repatriate cases from Bristol ED if appropriate ▪ Common care pathways across patch	▪ Illness requiring >8 hours observation ▪ Children requiring admissions ▪ Neonates requiring NICU
24/7 Midwife led unit	▪ Midwife available on call ▪ Support staff ▪ Primary care hubs for midwife clinics	▪ Capacity to stabilise and transfer	▪ Low risk births, 37 - 42 weeks of gestation, ▪ Antenatal care / in day assessment unit or in community ▪ Postnatal care in community (short stay in-unit after birth)	▪ Women requiring obstetric care, high-risk pregnancies, maternal-foetal medicine, epidurals, C-sections

Assumes diagnostics, pathology, outpatients, elective medicine and a frailty service exist in all options

Preferred Option – A&E + UTC, selective take, ambulatory emergency surgery (9a amended by CSDDG 170119)

	Staffing	Other services required	Conditions Covered	Conditions not covered
Ortho Trauma	▪ Senior decision maker on site during day time, with 24/7 on call (“as now” anticipated)	▪ Level 2 critical care with step up ▪ Capacity to stabilize and transfer	▪ NOF direct admissions ▪ “Walking wounded”	▪ NOF’s requiring prolonged level 3 ITU care

Assumes diagnostics, pathology, outpatients, elective medicine and a frailty service exist in all options

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Appendix 19: Evaluation of Options

A Summary of Evaluation Completed by the CSDDG and DoFs

2nd November 2018

Agreed evaluation criteria

Evaluation criteria	Defined as
1 **Quality of Care**	1.1 Clinical effectiveness 1.2 Patient and carer experience 1.3 Safety (e.g. workforce rotas)
2 **Access to care**	2.1 Impact on patient choice 2.2 Distance, cost and time to access services 2.3 Service operating hours
3 **Workforce**	3.1 Scale of impact 3.2 Impact on recruitment, retention, skills
4 **Value for money**	4.1 Forecast income and expenditure at system and organisation level 4.2 Capital cost to the system 4.3 Transition costs required 4.4 Net present value (10, 20 and 60 year)
5 **Deliverability**	5.1 Expected time to deliver 5.2 Co-dependencies with other strategies/strategic fit

Source: Public Health Outcomes Framework, 2014/16, Healthcare and Premature Mortality

1 Evaluating options against: Quality of Care (1/4)

++ Significantly better than status quo
+ Slightly better than status quo
● Similar to status quo
- Slightly worse than status quo
-- Significantly worse than status quo

Clinical effectiveness

Evaluation criteria	1a	3a	9a	12a	12b	27b	37b	Rationale behind the scores
▪ Is care in line with national standards or best practice?								Options on the left do not meet national standards for best practice care as catchment population is not in line with Keogh standards, resulting in staff having less experience/skills. Option 3a is similar to status quo because it is provides additional UTC and frailty services but not 24/7 ED
A&E	-	●	+	++	+	++	++	For A&E and emergency surgery, option 1a does not meet national standards with regards to catchment area required for staff to maintain skills and experience, and so scores a negative. In options to the right (27b and 37b), the local catchment population would be receiving care from larger units with higher numbers of consultants on site and delivered by teams with greater experience and skills. For emergency surgery option 12b was rating slightly less positively due to the lower level of critical care combined with acute medical patients
Emergency surgery	-	●	++	++	+	++	++	
Acute medicine	+	+	++	++	+	+	++	For acute medicine, all options would be an improvement on the status quo due to the addition of a frailty service/unit. Options 9a and 12a would see an improvement in quality of care due to dedicated focus of the hospital on acute medicine in combination with frailty. Option 12b was rated marginally less positively due to a lower level of critical care. Options 27b and 37b would have more patients receiving acute medicine care in units which meet national standards.
Critical care	-	●	+	●	●	++	+	For critical care, option 1a does not meet national standards for levels of activity required to maintain skills, and so scores a negative. Options to the right (e.g. 27b) are more positive as patients needing critical care would receive care from units meeting national standards. Option 12b is less positive because patients brought in from a selective take with no Level 2 critical care may not receive the optimal level of care
Paediatrics	+	++	++	++	+	++	++	All options increase quality of care due to the SSPAU having opening hours more in line with patient demand. Options 12b is slightly less positive than 12a due to lack of anaesthetic cover for the small number of paediatric cases requiring intubation (however this is a very small number). Options 27b and 37b would further increase quality of care as more children would be cared for in units meeting national standards.

1 Evaluating options against: Quality of Care (2/4)

++ Significantly better than status quo
+ Slightly better than status quo
● Similar to status quo
- Slightly worse than status quo
-- Significantly worse than status quo

To be discussed

Clinical effectiveness

Evaluation criteria	Options 1a	3a	9a	12a	12b	27b	37b	Rationale behind the scores
▪ Will there be more effective prevention to improve life exp. and reduce health inequalities?	●	●	●	+	+	++	●	While amendments to acute hospital care pathways also support effective prevention, options on the left are associated with more investment in acute services and less investment in primary and community services where most preventative care happens. Increased numbers of GPs per head of population is associated with longer life expectancy nationally, supporting the UTC focused options. Most prevention From 12a, staffing shifts to a fully primary care led model. Option 37b does not support increased local primary care because there is no GP presence in the MIU.
▪ Will this option account for future changes in the population size and demographics?	+	+	●	●	●	●	●	Options on the left with a greater bed base may provide scope for expanding services further to support an increased population. Scaling down the site in the options on the right decreases the potential for providing wider services at some stage in the future. The frailty model across all options improves the care for an increasingly ageing population, although it is less effective in 37b where only 40% of acute medicine activity/support is maintained.

1 Evaluating options against: Quality of Care (3/4)

++ Significantly better than status quo
+ Slightly better than status quo
● Similar to status quo
- Slightly worse than status quo
-- Significantly worse than status quo

To be discussed

Clinical effectiveness

Evaluation criteria	1a	3a	9a	12a	12b	27b	37b	Rationale behind the scores
▪ Will it lead to more people being treated by teams with the right skills and experience in the right place?								All options have appropriate care provided by UTC and Frailty model but options on the left do not support enough activity for many specialists to maintain skills and experience. All models of care that allow for staff rotation can also help meet national guidance for maintaining skills.
A&E	-	-	+	+	+	++	++	For A&E and emergency surgery, options on the right see more people treated in centres with a mix of appropriate staffing and skills. Options 27b and 37b have large numbers of patients cared for in well staffed units. Options 9a, 12a and 27b willl ensure the population is treated in units with enough volume to meet skills requirements. Ambulance protocols should be changed to support different service provision (e.g. in emergency surgery) however this needs to be clearly defined in order to be followed and implemented effectively.
Emergency surgery	-	-	++	++	+	++	++	
Acute medicine	+	+	++	++	+	+	+	For acute medicine, all models provide more appropriate skills through the frailty service. Options 9a and 12a benefit from better integration of frailty services with a multidisciplinary front door. Option 12b was rated marginally less positively due to a lower level of critical care skills. Options 27b and 37b have more patients treated in larger centres, but there is limited acute medicine support for patients seen as part of the frailty service locally.
Critical care	-	-	+	+	●	++	++	For critical care, options on the left have limited activity for maintaining level 3 competencies. Options 9a, and 12a have an appropriate skill mix for the population needs. In options 27b and 37b most of the population will treated in a specialist unit with the right care.
Paediatrics	+	+	+	+	+	+	++	Most options have an appropriately skilled SSPAU, however options 12b and 27b do not have critical care skills for the population cared for locally. For option 37b the population will be managed in a unit with the right skills

1 Evaluating options against: Quality of Care (4/4)

++ Significantly better than status quo | + Slightly better than status quo | ● Similar to status quo | - Slightly worse than status quo | -- Significantly worse than status quo

	Evaluation criteria	1a	3a	9a	12a	12b	27b	37b	Rationale behind the scores
		Options							
Patient and carer experience	▪ Will it improve continuity of care? (e.g. reduce hand offs across teams/organisations, increase frequency of single clinician/team responsible for patient)	-	-	-	+	●	●	●	All options include frailty services to facilitate continuity of care but also involve more handovers between different groups within the organisation (e.g. UTC, A&E, Frailty service). Although continuity of acute carer may lower to the right with more handoffs for the small group of patients that need to be transferred; for the majority of the population continuity of *care* will be improved in options with a front door which is fully led by primary care and providing more integration with the community. For option 37b patients there is less inter-organisation transfer as most patients are treated on one site
	▪ Will it enable greater opportunity to link with voluntary/community/health & wellbeing services?	●	●	+	+	+	+	●	Options 9a, 12a and 27b integrate primary care and frailty more effectively prominently improving links with community and voluntary care for people living with frailty. An integrated model for children across all options also supports these links. High acuity patients being transferred in options 27b and 37b have lower voluntary care needs
	▪ Will it improve the quality of environment in which care is provided?	-	-	+	++	++	++	-	All options should be able to ensure a good environment for delivery of care (e.g. significant investment has been made into improving the local front door environment). It has been recognised that there may be benefit in providing protected environment for planned care that is not impacted by emergency activity. This is easier to do in options to the right but would require consideration at a system level. Option 37b decreases patient experience because a significant amount of care is not provided locally
Patient safety	▪ Will it allow for patient transfer/ emergency intervention in a clinically safe timeframe? Will travel time impact on the patient's outcome?	●	●	●	●	●	●	●	All options enable clinically safe transfers with minimal impact of travel time on patient outcomes. Patients are already transferred safely at night and for emergencies, and so the travel time must be clinically acceptable
	▪ Will there be a reduce level of risk? (e.g. 24/7 staffed rota, provide networked care, standardization)	●	+	+	++	++	++	++	Options to the right result in more patients treated in units with fully staffed rotas. This reduces the risk level for care provided and more efficient services support better networking and standardization of care

2 Evaluating options against: Access to care (1/2)

++ Significantly better than status quo | + Slightly better than status quo | ● Similar to status quo | - Slightly worse than status quo | -- Significantly worse than status quo

	Evaluation criteria	1a	3a	9a	12a	12b	27b	37b	Rationale behind the scores
Impact on patient choice	▪ Is there an increase or decrease in choice for patients?								Choice for most elective services do not change for majority of population. Paediatrics and frailty services also offer more choice for patients for all options. Options to the right may improve choice for primary care due to increased investment. Options with fewer local non-elective services may decrease choice although the choice to be cared at centres which do not perform to national standard (1a & 3a) may be limited.
	Non-elective care	●	-	●	-	-	-	--	
	Elective care	●	●	●	●	●	●	●	
	Primary care	●	●	●	+	+	+	+	
	▪ Is it easier for people to understand which services they can access when and where?	●	-	--	●	-	●	●	Options which have unclear or mixed opening hours (e.g. restricted hours ED, limited hours paediatric assessment unit) are unclear for people. In addition option 9a which provides selective services (i.e. 'medical' A&E) could be unclear for patients. Options 1a, 12a, 27b and 37b provide services which are well-known and easy for the public to understand.
Distance, cost and time	▪ Will it increase or decrease travel time and/or cost for patients to access specific services?	●	-	-	-	-	--	--	Options with fewer services locally increase travel time from an average of 24 minutes (peak) to 41 minutes (peak) for those services. The more services are shifted as options move to the right, the more patients are impacted with increased travel time and travel costs
	▪ Will patients be travelling more/less frequently? Will there be a change in # journeys to access urgent medical intervention?	●	-	-	-	-	--	--	Options to the right with fewer onsite urgent services result in more trips to access the required care. Options which involve care between different organisations (e.g. local community care and non-local acute care) also increase frequency of travel
	▪ Is there an increase or decrease in waiting time to access services?	●	●	●	●	●	●	-	Options on the right may increase waiting times for patients who are seen by other providers if the amount of activity shifted is unsustainable for other Trusts. This may be mitigated locally by repatriated elective activity in some cases but for option 37b significant amounts of activity are shifted.

2 Evaluating options against: Access to care (2/2)

++ Significantly better than status quo | + Slightly better than status quo | ● Similar to status quo | - Slightly worse than status quo | -- Significantly worse than status quo

To be discussed

	Evaluation criteria	1a	3a	9a	12a	12b	27b	37b	Rationale behind the scores
Distance, cost and time	▪ Is there an increase or decrease in travel and/or cost for carers & family?	●	-	-	-	-	--	--	Options which involve increased travel time/frequency and admissions to locations further away will also mean increased travel time and cost for carers. Parking is also more available locally than at some other Trusts so options which shift activity away will increase parking cost and decrease convenience. Services for paediatrics and frail elderly will be increased from current thus reducing travel for some.
	▪ Is new technology used to improve access?	●	●	+	+	+	++	++	All options can implement new technology to improve access but options with less local care provision necessitate better utilization of technology to improve access to care.
Service operating hours	▪ Are operating hours for the service in line with needs of the population?	-	●	+	+	+	+	-	The overnight closure has demonstrated that the clinical needs of the population can be met with alternate models of care outside a 24/7 service (option 1a). Option 37b does not provide the activity levels to sustain a consolidated out of hours GP service. Other options can provide an extended hours service for primary care and paediatrics compared to status quo
	▪ Is risk of unplanned changes reduced, and service resilience improved?	●	+	++	++	++	+	●	Options with well-staffed services (9a, 12a,12b and 27b to a lesser extent) will be able to withstand unplanned changes. Option 3a also benefits from decreased working hours against the commissioned model and so improves resilience. Options where significant activity moves to other Trust may increase the strain on other Trusts and decrease resilience of those services

3 Evaluating options against: Workforce (1/2)

++ Significantly better than status quo | + Slightly better than status quo | ● Similar to status quo | - Slightly worse than status quo | -- Significantly worse than status quo

To be discussed

	Evaluation criteria		Options 1a	3a	9a	12a	12b	27b	37b	Rationale behind the scores
Scale of impact	▪ What proportion of current staff will be impacted adversely by the changes across the system (including travel)?		-	-	-	-	-	--	--	Options to the right which transfer more activity and services will lead to a greater impact on staff (including on staff travel). All options will change the delivery of care with greater focus on frailty and primary care which will affect staff ways of working. Options on the right where staff have to work across multiple sites increase the amount of staff travel required during the day
Recruitment, retention, skills	▪ Is there improved recruitment and retention of permanent staff with the right skills, values and competencies? Are staff enabled to maintain or enhance their skills?	*Primary care*	●	●	+	+	+	+	-	Options 1a and 3a are similar to the current service, which experiences challenges related to recruiting staff in A&E. Options 9a, 12a, 12b and 27b have reduced dependence on A&E workforce and provides better opportunities for staff to work in new roles which improves recruitment/retention rate. Options to the right (e.g. 27b) improve ability to recruit at a system level and in primary care but also have less attractive job opportunities for staff in acute medicine and emergency surgery. Smaller sites (e.g. MIU in option 37b) may struggle to recruit compared to larger sites due to less opportunity for staff to work across different specialties, enhance their skills and progress careers
		A&E	-	-	●	+	+	+	-	
		Acute med / Emergency surgery	●	●	+	●	●	-	-	
	▪ Is the staff relocation or retraining required acceptable?		●	●	-	--	--	--	-	Options on the right with more activity across multiple sites will increase likelihood of relocation for staff. Many doctors live away from Weston while nursing staff live more locally. Option 37b shifts the majority of activity but reduces the travel requirements between sites. Opportunity for retraining exists for all options however the job enhancement opportunities are greater in options on the left which retain more services.

3 Evaluating options against: Workforce (2/2)

++ Significantly better than status quo
+ Slightly better than status quo
● Similar to status quo
- Slightly worse than status quo
-- Significantly worse than status quo

To be discussed

Recruitment, retention, skills

Evaluation criteria	Options 1a	3a	9a	12a	12b	27b	37b	Rationale behind the scores
▪ Is it possible to develop the skills base required in an acceptable time frame?	●	●	●	●	●	●	●	All options can support development of the required skills within a 5 year timeframe - streamlining services can be easily and quickly adopted.
▪ Are the clinical staff utilized and enable to work at the "top of their license"?	●	●	+	+	+	+	+	In options 1a and 3a, medical staff will have insufficient complex work and so will have to work below their license, with knock on impact on other staff. Options 9a, 12a, 27b and 37b include a more integrated and appropriately staffed workforce, which provides the opportunity to best utilize staff.
▪ Will accountability and governance structures be placed to support staff?	●	●	●	●	●	●	●	All options will require appropriate accountability and governance structures to be set up in order to be delivered within 5 years
▪ Will multi-disciplinary / cross-organisation working be increased?	+	+	+	+	+	+	+	All options include the support of primary care at the front door and frailty services which will lead to more multi-disciplinary care and cross-organizational collaboration than the status quo

4 Evaluating options against: Value for Money

++ Significantly better + Slightly better ● Neutral - Slightly worse -- Significantly worse

To be discussed

	Evaluation criteria		1a	3a	9a	12a	12b	27b	37b	Rationale behind the scores
			Options							
Capital costs	▪ What would the capital costs be to the system of each option, including refurbishing or rebuilding capacity in other locations?		●	-	-	-	-	--	--	All options from 3a imply some capital cost outlay with the capital requirement for option 37b (~£60m) being notably significant)
		Additional beds required (beds)	0	19	47	59	60	128	174	
		Implied capital cost required (£m)	0.3	6.9	16.5	20.8	21.0	44.9	61.0	
	▪ Can the required capital be accessed and will the system be able to afford the necessary financing costs?		●	●	●	-	-	--	--	System may struggle with capital cost >£20m (options 12a, 12b and 27b) and would be unlikely to source capital of ~£60m (option 37b).
Forecast I&E at system and Trust level	▪ What are the implications on income and expenditure for each acute Trust within the system?		+	+	++	++	++	++	++	All options improve system I&E position against status quo with a step I&E improvement notable from option 9a onwards
		I & E change vs baseline (£m) – WAHT	4.9	4.2	7.7	7.4	7.2	9.8	9.2	
		I & E change vs baseline (£m) – Other trusts	0.0	(0.1)	0.9	1.4	1.6	2.3	3.9	
		I & E change vs baseline (£m) – System	4.9	4.1	8.5	8.7	8.8	12.1	13.0	
	▪ Does this option reduce the requirement for additional provider subsidy?		+	+	++	++	++	++	++	All options improve the WAHT I&E position by an amount greater than the current subsidy (~£3.5m) – with greatest improvement from option 9a onwards
	▪ What are the implications for total acute spend across the health and care system?		+	+	++	++	++	++	+	Reduced acute spend in most options (increases for options to the right) but significant capacity will need to be built in other acute trusts for scenario 37b
	▪ What are the opportunities for investing in more appropriate / alternative settings of care?		●	●	+	+	+	+	+	Better integration and improved I&E position from option 9a supports opportunities for investment in alternative care settings
Trans-ition costs	▪ What are the transition costs (e.g., relocating staff, training and education costs)?		●	●	-	-	-	--	--	More significant change requires longer higher transition costs due to number of beds to shift
		Transition costs (£m)	0.1	0.5	1.1	1.4	1.4	3.0	4.0	
NPV	▪ What is the 30 and 60 year NPV (net present value) of each option, taking into account capital costs, transition costs and operating costs?		+	+	++	++	++	++	++	30 and 60 year NPV improves with all options compared to baseline – with greater impact (but little distinction) between options 9a and 37b
		30 year option NPV vs baseline (£m)	85.3	61.5	123.3	122.4	122.4	140.2	139.8	

5 Evaluating options against: Deliverability (1/2)

++ Significantly better than status quo
+ Slightly better than status quo
● Similar to status quo
- Slightly worse than status quo
-- Significantly worse than status quo

To be discussed

	Evaluation criteria	1a	3a	9a	12a	12b	27b	37b	Rationale behind the scores
		Options							
Expected time to deliver	▪ Will this service model be deliverable within 5 years?	--	-	+	●	●	-	--	Options which move more acute services to other sites (i.e. 27b, 37b) will more difficult to deliver within 5 years as they require greater transition time, and cause more disruption. Options 1a and 3a may also not be deliverable in line with national standards (e.g. Keogh guidance) as they are closest to the status quo which has been unsustainable for several years. Options 37b is difficult to deliver politically because of public and staff pressure to retain as many services as possible local. National workforce pressures, requirements for cancer care and other macro factors will make all models more difficult to deliver going forward.
	▪ How quickly could the benefits be delivered?	--	-	+	●	●	-	-	Option 1a will not deliver benefits in line with Keogh guidance within the timeframe as the current model has been shown to be unsustainable. Option 3a is likely to start delivering dis-benefits to patients and staff within 5 years. Options 9a, 12a and 12b can deliver benefits in a short timeframe because the changes to the current services are modest. Major changes to services as in options 27b and 37b will not deliver benefits as quickly
Co-dependencies	▪ Is this service model compatible with the Healthier Together STP vision?	-	-	++	++	++	++	-	Options 1a and 3a do not support the best quality care for the local population. Options 9a, 12a, 12b and 27b support the STP and Healthy Weston vision for improving the quality of care for the population. The STP may not support option 37b given political implications and the potential diminishing role of MIUs nationally
	▪ Does it support the Healthy Weston vision?	-	-	++	++	++	++	-	
	▪ Does it enable the system to maximise the role of and adapt to new technology?	-	-	+	+	+	+	+	Options 9a, 12a and 27b have less local care provision and more cross-site collaboration, which will necessitate the maximal use of new technologies. Options 1a and 3a are closest to the status quo and have more standalone services which will therefore have less immediate pressure to adopt technological solutions

5 Evaluating options against: Deliverability (2/2)

++ Significantly better than status quo
+ Slightly better than status quo
● Similar to status quo
- Slightly worse than status quo
-- Significantly worse than status quo

To be discussed

Co-dependencies

Evaluation criteria	1a	3a	9a	12a	12b	27b	37b	Rationale behind the scores
▪ Will it rely on other models of care / provision being put in place, and if so, are these deliverable within the necessary timeframe?	-	●	-	-	-	--	--	Option 1a may be unsustainable in light of the case for change and the potential lack of sufficient funding to invest in a 24/7 ED in parallel with primary and community care changes, whilst option 3a is closest to the current service set up. Options with less urgent care services at the front door and in the hospital will require more provision in the community and in other Trusts (than status quo) to support the activity shift.
▪ Will the wider system be able to deliver on this change, including the community and voluntary sector? Can the additional capacity requirements be delivered? Will it destabilize any other providers in a way that can not be managed?	+	+	++	++	++	+	-	All options include a frailty model which will support the wider system to deliver better care. Option 37b does not integrate as closely with primary care as there are no GPs at the front door, making changes more difficult to deliver in 37b. Capacity requirements (for neighbouring providers) increase with options to the right. In particular, the capacity required from community will take longer and its impact on other providers is more likely to destabilize them
▪ Will the system have access to the infrastructure, capacity and capa-bilities required to successfully implement this service model?	●	●	●	●	●	●	●	For all potential options proposed, the system has the infrastructure available and the will to implement the changes. There is widespread support for changing services to optimally meet the needs of the local population

Agreed evaluation criteria

Evaluation criteria	Defined as
1 **Quality of Care**	1.1 Clinical effectiveness 1.2 Patient and carer experience 1.3 Safety (e.g. workforce rotas)
2 **Access to care**	2.1 Impact on patient choice 2.2 Distance, cost and time to access services 2.3 Service operating hours
3 **Workforce**	3.1 Scale of impact 3.2 Impact on recruitment, retention, skills
4 **Value for money**	4.1 Forecast income and expenditure at system and organisation level 4.2 Capital cost to the system 4.3 Transition costs required 4.4 Net present value (10, 20 and 60 year)
5 **Deliverability**	5.1 Expected time to deliver 5.2 Co-dependencies with other strategies/strategic fit

Source: Public Health Outcomes Framework, 2014/16, Healthcare and Premature Mortality

1 Evaluating options against: Quality of Care (1/4)

++ Significantly better + Slightly better Neutral - Slightly worse -- Significantly worse

HEALTHY WESTON

To be discussed

Clinical effectiveness

Evaluation criteria	Options 3a	9a	12a	27b	Rationale behind the scores
▪ Is care in line with national standards or best practice?					Volume of activity impacts on ability to sustain higher acuity clinical services that adhere to national guidance and standards. For example, options to the left do not meet Keogh guidance on catchment populations for urgent and emergency care, resulting in staff having less experience and skills. Option 3a is similar to status quo because it is provides additional UTC and frailty services but not 24/7 ED. All models of care that allow for staff rotation can also help meet national standards and guidance for maintaining skill levels
A&E	Neutral	+	++	++	Options to the right are more in line with Keogh guidance where more of the local catchment population receive care from larger units with higher volumes, more consultants on site and delivery by teams with greater experience and skills. This is in line with Keogh guidance. GIRFT and national guidance support greater standardization of emergency surgery provision.
Emergency surgery	Neutral	++	++	++	
Acute medicine	+	++	++	+	All options assume the addition of a frailty service/unit. Options 9a and 12a would see an improvement in quality of care due to dedicated focus of the hospital on acute medicine in combination with frailty. Options 27b has more patients being seen in larger centres, however there is no co-location of frailty services with acute medicine
Critical care	Neutral	+	Neutral	++	For critical care, options to the right (e.g. 27b) are more positive as all patients needing critical care would receive care from larger units. Other options where more care is kept locally can be supported by alternative approaches such as e-icu bringing local care more in line with national guidance and best practice. In option 12a, there are a number of patients whose care may remain local for whom critical care provision is less robust
Paediatrics	++	++	++	++	All options increase quality of care due to the SSPAU (which provides consultant led care) having opening hours more in line with patient demand. In options 12a and 27b, some children would be cared for in larger units, however care will not always be directly delivered by a consultant so quality may not improve.

Healthier Together

1 Evaluating options against: Quality of Care (2/4)

++ Significantly better + Slightly better ● Neutral - Slightly worse -- Significantly worse

HEALTHY WESTON

To be discussed

Clinical effectiveness

Evaluation criteria	Options 3a	9a	12a	27b	Rationale behind the scores
▪ Will there be more effective prevention to improve life exp. and reduce health inequalities?	●	●	+	++	While amendments to acute hospital care pathways also support effective prevention, options on the left are associated with more investment in acute services and less investment in primary and community services where most preventative care happens. Increased numbers of GPs per head of population is associated with longer life expectancy nationally, supporting the UTC focused options. From 12a, staffing shifts to a fully primary care led model. Patient groups from disadvantaged backgrounds who are at risk of health inequalities are better managed by primary and community care services in options to the right (27b and to some extent 12a) where there is increased investment
▪ Will this option account for future changes in the population size and demographics?	+	●	●	●	Options on the left with a greater bed base may provide scope for expanding services further to support an increased population. Scaling down the site in the options on the right decreases the potential for providing wider services at some stage in the future. The frailty model across all options improves the care for an increasingly ageing population, while a short stay paediatric unit and centralization of primary care out of hours services supports better care for young children across all options.

Healthier Together

1 Evaluating options against: Quality of Care (3/4)

++ Significantly better + Slightly better Neutral - Slightly worse -- Significantly worse

HEALTHY WESTON

To be discussed

Clinical effectiveness

Evaluation criteria	Options 3a	9a	12a	27b	Rationale behind the scores
▪ Will it lead to more people being treated by teams with the right skills and experience?					All options have appropriate care provided by UTC and Frailty model but options on the left do not support enough activity for many specialists to maintain skills and experience. All models of care that allow for staff rotation can also help meet national standards and guidance for maintaining skill levels
A&E	-	+	+	++	For A&E and emergency surgery, options on the right see more people treated in centres with a mix of appropriate staffing and skills. Option 27b has more patients cared for in well staffed units. Options 9a, 12a and 27b willl ensure the population is treated in units with enough volume to meet skills requirements. Ambulance protocols should be changed to support different service provision (e.g. in emergency surgery) however this needs to be clearly defined in order to be followed and implemented effectively
Emergency surgery	-	++	++	++	
Acute medicine	+	++	++	+	For acute medicine, all models provide more appropriate skills through the frailty service. In options 9a and 12a, patients treated locally benefit from better integration of frailty services with a multidisciplinary front door. Option 27b has more patients treated in larger centres but there is limited acute medicine support for patients seen as part of the frailty service locally; appropriate triaging should ensure that the majority of patients requiring critical care support are not treated locally
Critical care	-	+	+	++	For critical care, option 3a has limited activity for maintaining level 3 competencies. Options 9a, and 12a have an appropriate skill mix for the population needs. In option 27b most of the population are treated in specialist units where staff have the right skills and experience
Paediatrics	+	+	+	+	All options have appropriately skilled staff in an SSPAU with increased activity volumes. Option 27b has limited critical care support which will affect a small number of children (<5 a year) requiring intubation – these children may be transferred to larger centres with staff that have more experience with such procedures

Healthier Together

1 Evaluating options against: Quality of Care (4/4)

HEALTHY WESTON

++ Significantly better + Slightly better ● Neutral - Slightly worse -- Significantly worse

To be discussed

	Evaluation criteria	Options 3a	9a	12a	27b	Rationale behind the scores
Patient and carer experience	▪ Will it improve continuity of care? (e.g. reduce hand offs across teams/organisations, increase frequency of single clinician/team responsible for patient)	-	-	+	●	All options include a frailty service to facilitate continuity of care but also involve more handovers between different groups within the organisation (e.g. UTC, A&E, Frailty service). Although continuity of acute *carer* may lower to the right with more handoffs for the small group of patients that need to be transferred; for the majority of the population continuity of *care* will be improved in options 12a and 27b with a front door which is fully led by primary care and providing more integration with the community. Option 12a provides better continuity of care than 27b due to less acute handoffs for some patients
	▪ Will it enable greater opportunity to link with voluntary/community/health & wellbeing services?	●	+	+	+	Options 9a, 12a and 27b integrate primary care and frailty more effectively prominently improving links with community and voluntary care for people living with frailty. An integrated model for children across all options also supports these links. High acuity patients being transferred in options 27b have lower voluntary care needs.
	▪ Will it improve the quality of environment in which care is provided?	-	+	++	++	All options should be able to ensure a good environment for delivery of care (e.g. significant investment has been made into improving the local front door environment). It has been recognised that there may be benefit in providing protected environment for planned care that is not impacted by emergency activity. This is easier to do in options to the right but would require consideration at a system level.
Patient safety	▪ Will it allow for patient transfer/ emergency intervention in a clinically safe timeframe? Will travel time impact on the patient's outcome?	●	●	●	●	All options enable clinically safe transfers with minimal impact of travel time on patient outcomes. Patients are already transferred safely at night and for emergencies, and so the travel time must be clinically acceptable
	▪ Will there be a reduced level of risk? (e.g. 24/7 staffed rota, provide networked care, standardization)	+	+	++	++	Options to the right result in more patients treated in units with fully staffed rotas. This reduces the risk level for care provided and more efficient services support better networking and standardization of care

2 Evaluating options against: Access to care (1/2)

++ Significantly better + Slightly better ● Neutral - Slightly worse -- Significantly worse

HEALTHY WESTON

To be discussed

	Evaluation criteria	Options 3a	9a	12a	27b	Rationale behind the scores
Impact on patient choice	▪ Is there an increase or decrease in choice for patients?					Choice for most elective services do not change for majority of population – patients can also choose more local elective services if activity is repatriated. Paediatrics and frailty services also offer more choice for patients across most options. Options to the right may improve choice for primary care services due to increased investment. Options with fewer local non-elective services may decrease choice although choice for patients to go or be taken to non-elective centres which do not perform to national standard (option 3a) may be limited
	Elective care	●	●	●	●	
	Primary care	●	●	+	+	
	Non-elective care	-	●	-	-	
	▪ Is it easier for people to understand which services they can access when and where?	-	--	●	●	Options which have unclear or mixed opening hours (e.g. restricted hours ED, limited hours paediatric assessment unit) are unclear for people. In addition, option 9a which provides selective services (i.e. 'medical' A&E) could be unclear for patients. In options 12a and 27b the offering to the public is more clearly described as care that can be provided by a primary care led urgent treatment centre
Distance, cost and time	▪ Will it increase or decrease travel time and/or cost for patients to access specific services?	-	-	-	--	Options with fewer services locally increase travel time from an average of 24 minutes (peak) to 41 minutes (peak) for those services. The more services are shifted as options move to the right, the more patients are impacted with increased travel time and travel costs
	▪ Will patients be travelling more/less frequently? Will there be a change in # journeys to access urgent medical intervention?	-	-	-	--	Options to the right with fewer onsite urgent services result in more trips to access the required care. Options which involve care between different organisations (e.g. local community care and non-local acute care) also increase frequency of travel
	▪ Is there an increase or decrease in waiting time to access services?	●	●	●	●	Options on the right may increase waiting times for patients who are seen by other providers if the amount of activity shifted is unsustainable for other Trusts. This may be mitigated locally by repatriated elective activity in some cases

Healthier Together
Improving health and care in Bristol, North Somerset and South Gloucestershire

2 Evaluating options against: Access to care (2/2)

++ Significantly better + Slightly better Neutral - Slightly worse -- Significantly worse

To be discussed

	Evaluation criteria	Options 3a	9a	12a	27b	Rationale behind the scores
Distance, cost and time	▪ Is there an increase or decrease in travel and/or cost for carers & family?	-	-	-	--	Options which involve increased travel time/frequency and admissions to locations further away will also mean increased travel time and cost for carers. Parking is also more available locally than at some other Trusts so options which shift activity away will increase parking cost and decrease convenience. Services for paediatrics and frail elderly will be increased from current thus reducing travel for some
	▪ Is new technology used to improve access?	Neutral	+	+	++	All options can implement new technology to improve access but options with less local care provision necessitate better utilization of technology to improve access to care
Service operating hours	▪ Are operating hours for the service in line with needs of the population?	Neutral	+	+	+	The current strains on ED demonstrates that the clinical needs of the population can be better met with alternate models of care. Options to the right support an improved ability to staff an extended hours service for primary care and paediatrics
	▪ Is risk of unplanned changes reduced, and service resilience improved?	+	++	++	+	Options with well-staffed services (9a, 12a and 27b) will be able to withstand unplanned changes locally. Option 3a also benefits from decreased working hours against the commissioned model and so improves resilience. Option 27b where more activity moves to other Trust may increase the strain on other Trusts

3 Evaluating options against: Workforce (1/2)

++ Significantly better + Slightly better Neutral - Slightly worse -- Significantly worse

HEALTHY WESTON

To be discussed

	Evaluation criteria		Options 3a	9a	12a	27b	Rationale behind the scores
Scale of impact	▪ What proportion of current staff will be impacted adversely by the changes across the system (including travel)?		-	-	-	--	Options to the right which transfer more activity and services will lead to a greater impact on staff. All options will change the delivery of care with greater focus on frailty and primary care which will affect staff ways of working. Options where staff have to work across multiple sites increase the amount of staff travel required during the day In option 27b, junior trainees may not have sufficient exposure to acute activity in order to receive appropriate training locally
Recruitment, retention, skills	▪ Is there improved recruitment and retention of permanent staff with the right skills, values and com-petencies? Are staff enabled to maintain or enhance their skills?	*Primary care*	Neutral	+	+	+	Options 9a, 12a and 27b have reduced dependence on ED workforce and provide better opportunities for staff to work in new roles which improves recruitment/retention rate. Options to the right (e.g. 27b) improve ability to recruit at a system level and in primary care but also have less attractive job opportunities for staff in acute medicine and emergency surgery. While there are currently challenges with recruitment of GPs, this can be improved by provision of opportunities to work in urgent care across options. Increased partnering between organisations can enable staff rotations across all options.
		ED	-	Neutral	+	+	
		Acute med / Emergency surgery	Neutral	+	Neutral	-	
	▪ Is the staff relocation or retraining required acceptable?		Neutral	-	--	--	Options on the right with more activity across multiple sites will increase likelihood of relocation for staff at Weston General Hospital. Opportunity for retraining exists for all options but the scale required increased in options to the right while job enhancement opportunities are greater in options on the left which retain more services

3 Evaluating options against: Workforce (2/2)

++ Significantly better + Slightly better ● Neutral - Slightly worse -- Significantly worse

HEALTHY WESTON

To be discussed

Recruitment, retention, skills

Evaluation criteria	Options 3a	9a	12a	27b	Rationale behind the scores
▪ Is it possible to develop the skills base required in an acceptable time frame?	●	●	●	●	All options can support development of the required skills within a 5 year timeframe - streamlining services can be easily and quickly adopted.
▪ Are the clinical staff utilized and enable to work at the "top of their license"?	●	+	+	+	Options 9a, 12a and 27b which included a more integrated and appropriately staffed workforce provide the opportunity to best utilize staff. In option 3a, medical staff provision is stretched and so staff will continue to have insufficient complex work and so will have to work on roles below their license with knock on impact on other staff
▪ Will accountability and governance structures be placed to support staff?	●	●	●	●	All options will require appropriate accountability and governance structures to be set up in order to be delivered within 5 years
▪ Will multi-disciplinary / cross-organisational working be increased?	+	+	+	+	All options include the support of primary care at the front door and frailty services which will lead to more multi-disciplinary care and cross-organizational collaboration than the status quo

4 Evaluating options against: Value for Money

++ Significantly better + Slightly better ● Neutral - Slightly worse -- Significantly worse

To be discussed

	Evaluation criteria		3a	9a	12a	27b	Rationale behind the scores
			Options				
Capital costs	▪ What would the capital costs be to the system of each option, including refurbishing or rebuilding capacity in other locations?		-	-	-	--	All options from 3a imply some capital cost outlay with the capital requirement for option 37b (~£60m) being notably significant)
		Additional beds required (beds)	19	47	59	128	
		Implied capital cost required (£m)	6.9	16.5	20.8	44.9	
	▪ Can the required capital be accessed and will the system be able to afford the necessary financing costs?		●	●	-	--	System may struggle with capital cost >£20m (options 12a, and 27b)
Forecast I&E at system and Trust level	▪ What are the implications on income and expenditure for each acute Trust within the system?		+	++	++	++	All options improve system I&E position against status quo with a step I&E improvement notable from option 9a onwards
		I&E change vs baseline (£m) – WAHT	4.2	7.7	7.4	9.8	
		I&E change vs baseline (£m) – Other trusts	(0.1)	0.9	1.4	2.3	
		I&E change vs baseline (£m) – System	4.1	8.5	8.7	12.1	
	▪ Does this option reduce the requirement for additional provider subsidy?		+	++	++	++	All options improve the WAHT I&E position by an amount greater than the current subsidy (~£3.5m) – with greatest improvement from option 9a onwards
	▪ What are the implications for total acute spend across the health and care system?		+	++	++	++	Reduced acute spend in most options (increases for options to the right)
	▪ What are the opportunities for investing in more appropriate / alternative settings of care?		●	+	+	+	Better integration and improved I&E position from option 9a supports opportunities for investment in alternative care settings
Trans-ition costs	▪ What are the transition costs (e.g., relocating staff, training and education costs)?		●	-	-	--	More significant change requires longer higher transition costs due to number of beds to shift
		Transition costs (£m)	0.5	1.1	1.4	3.0	
NPV	▪ What is the 30 and 60 year NPV (net present value) of each option, taking into account capital costs, transition costs and operating costs?		+	++	++	++	30 and 60 year NPV improves with all options compared to baseline – with greater impact (but little distinction) between options 9a and 27b
		30 year option NPV vs baseline (£m)	61.5	123.3	122.4	140.2	

5 Evaluating options against: Deliverability (1/2)

++ Significantly better + Slightly better ● Neutral - Slightly worse -- Significantly worse

To be discussed

	Evaluation criteria	Options 3a	9a	12a	27b	Rationale behind the scores
Expected time to deliver	▪ Will this service model be deliverable within 5 years?	-	+	●	-	Option 27b which moves more acute services to other sites will more difficult to deliver within 5 years because it requires greater transition time, and causes more disruption. Option 3a is closest to the current operating model which continues to be challenging. National workforce pressures, requirements for cancer care and other macrofactors will make all options more difficult to deliver going forward
	▪ How quickly could the benefits be delivered?	-	+	●	-	Option 3a is likely to start delivering dis-benefits to patients and staff within 5 years given that the current state is unsustainable. Option 9a (and to a lesser extent 12a) could deliver benefits in a shorter timeframe because the changes to services are more modest. Major changes to services as in option 27b will not deliver benefits as quickly
Co-dependencies	▪ Is this service model compatible with the Healthier Together STP vision?	-	++	++	++	Option 3a does not support the best quality care for the local population. Options 9a, 12a and 27b support the STP and Healthy Weston vision for improving the quality of care for the population
	▪ Does it support the Healthy Weston vision?	-	++	++	++	
	▪ Does it enable the system to maximise the role of and adapt to new technology?	-	+	+	+	Options 9a, 12a and 27b have less local care provision and more cross-site collaboration which will necessitate the maximal use of new technologies. Option 3a is closest to the status quo and has more standalone services which will be under less pressure to adopt technological solutions.

5 Evaluating options against: Deliverability (2/2)

++ Significantly better + Slightly better Neutral - Slightly worse -- Significantly worse

To be discussed

Co-dependencies

Evaluation criteria	Options 3a	9a	12a	27b	Rationale behind the scores
▪ Will it rely on other models of care / provision being put in place, and if so, are these deliverable within the necessary timeframe?	Neutral	-	-	--	Options to the right with less urgent care services at the front door and in the hospital will require more investment and provision in the community and in other Trusts (than status quo) to support the activity shifted away
▪ Will the wider system be able to deliver on this change, including the community and voluntary sector? Can the additional capacity requirements be delivered? Will it destabilize any other providers in a way that can not be managed?	+	++	++	+	All options include a frailty model which will support the wider system to deliver better care – with links with the community and voluntary sector improving in options to the right. Capacity requirements for neighbouring acute providers and community care increase in option 27b which increases difficulty to deliver
▪ Will the system have access to the infrastructure, capacity and capa-bilities required to successfully implement this service model?	Neutral	Neutral	Neutral	Neutral	For all potential options proposed, the system has the infrastructure available and the will to implement the changes. There is widespread support for changing services to optimally meet the needs of the local population

Healthy Weston Pre-Consultation Business Case

Appendix 20:

Activity and Financial Modelling

1 INTRODUCTION

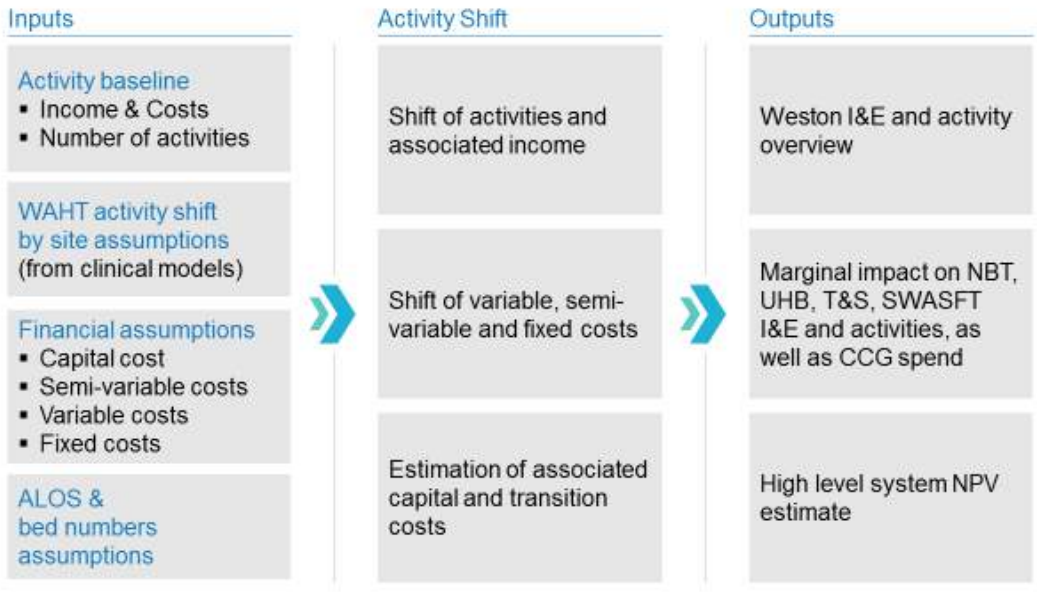
In order to produce the financial analysis required to evaluate options against the agreed evaluation criteria, the STP Directors of Finance (DoF) group; which has been including the Healthy Weston Finance and Enabling Group responsibilities in the remit of its fortnightly meetings since from August 2018, is the oversight group that has developed a methodology, agreed the assumptions and approved outputs for sign off at the Steering Group.

During this time the CSDDG and STP DoF group discussed and modelled different **Options**; during the development of the PCBC and following the Clinical Senate these developed into two **Phases** (9a and revised 27b) which went through further financial analysis as the clinical model was further developed and then these options were further refined into one preferred option (revised 9a). This appendix shows the different stages of financial and activity modelling as the different models of care (options) went from a medium list (7 options) to a small list (2 phases) to the **final preferred option** (revised 9a).

2 METHODOLOGY

The overall modelling approach is outlined in Figure F1 and is detailed below.

FIGURE F1: HIGH-LEVEL MODELLING APPROACH OVERVIEW



The financial baseline was created to project a “do nothing” scenario over the five-year period to 2023/24. This has been used a basis of comparison for all options in particular for the “income and expenditure” and “net present value” sub-criteria.

Starting from a normalised position for 2017/18 with all non-recurrent items removed, the baseline takes into account Commissioner plans, including demand management, and Trust cost improvement or productivity plans to ensure any scenario is in line with wider system expectations and planning assumptions.

Activity change assumptions were agreed to project forward the impact on patient activity in terms of spells, attendances, bed days etc. A list of “service lines” were agreed as a basis for modelling to provide enough detail to accurately estimate the consolidation or fragmentation effects under various potential service configuration options.

This activity projection, enables the total capacity required for the Weston General Hospital to be estimated for each type of service and with additional assumptions based on actual performance, for example average length of stay and activity growth projections, allowing the number of beds required at the Trust to be estimated.

Anticipated future population flows under different potential service configuration options based on the work of the Clinical Services Design and Delivery Group were used as a basis for estimating the numbers of patients using services at each site in the future.

Combining these assumptions and pieces of analysis – the activity projection, population flows and potential activity volumes under each clinical model – activity shifts have been estimated under each of the potential service configuration options on the short list and these are shown at figure F5.

A set of assumptions about how cost would move as activity shifts between sites have been agreed, with capital costs estimated using bed movements and other likely capacity changes, while I&E was estimated by analysing the change in fixed cost and the workforce economies, or dis-economies, of scale likely to be observed under each potential service configuration option. Due to significantly different cost bases in new clinical models, parts of the proposed A&E and frailty clinical models have a bottom-up cost baseline calculated.

Finally, this financial analysis was brought together to quantify the trade-offs between capital build costs and future operating efficiency benefits to calculate the net present value (NPV) at 30 years and 60 years.

Sensitivity was applied under each of the assumptions to show the potential impact of increasing demand management, activity switch proportions and productivity assumptions, as well as showing the impact of repatriating activity to maximise utilisation of fixed assets.

3 CREATING A FINANCIAL AND ACTIVITY BASELINE

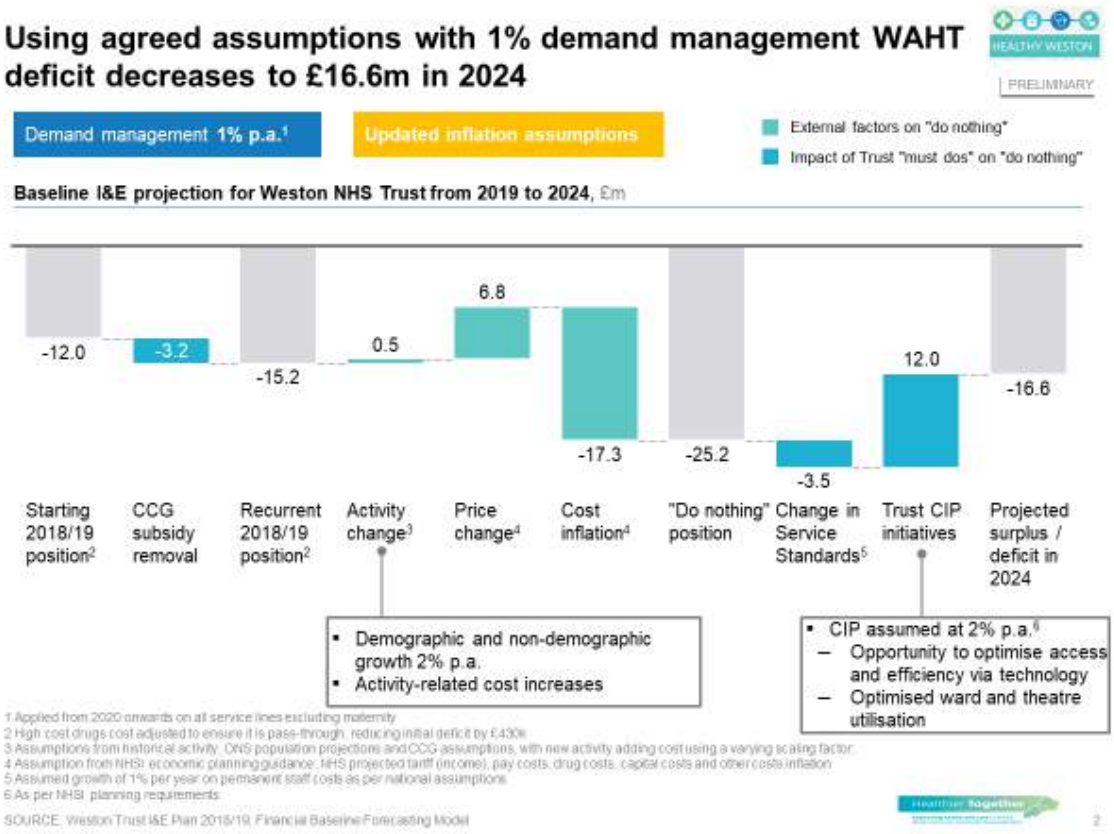
3.1 Creating a financial baseline for Weston General Hospital

A baseline projection was agreed using assumptions to align with WAHT plans, CCG plans, national guidance and locally observed trends. Using these as inputs income, expenditure and retained surplus/deficit was projected over a five-year period to 2023/24.

The WAHT plan for 2018/19 was taken as a starting point and all non-recurrent items were removed to identify the normalised recurrent position. After removing an existing CCG subsidy of £3.2m as a non-recurrent item, this left a planned recurrent deficit of £15.2m.

Projecting this forward by looking at activity growth, price change, cost inflation, future changes in service standards (e.g. move to 7 day working in line with national clinical standards) and required provider cost improvement programmes gives a recurrent deficit of £16.6m by 2024 and £19m by 2030. Figure F2 shows the projected financial position in 2024.

FIGURE F2: PROJECTED WAHT BASELINE "DO NOTHING" POSITION IN 2024



- Activity change was factored in as the combination of demographic growth (the age-weighted growth expected due to a growing and ageing population), non-

demographic growth (the effect of supply-side factors and behavioural change on service usage) and demand management;

- The local population size was projected forward using ONS population projections, which closely match commissioner plans. Historical activity at 5-year age bands was combined with population growth to calculate the impact of demographic growth for each service line. Local Authority house building plans which are detailed in the case for change are not incorporated as their incremental impact on absolute population growth within the next 5-7 years is not clear and is unlikely to be material over these timescales.
- Non-demographic growth was estimated by looking at the residual growth over the past three years, after removing the demographic component and delivered demand management to date, comparing local activity data with national activity data to triangulate to a set of agreed growth numbers.
- Demand management of 1% across BNSSG commissioned services was assumed to apply to both the acute sector and the non-acute sector.
- The agreed BNSSG system inflation assumptions were used, adding ~2.8% of cost pressure each year off set by tariff inflation by 1.3%, resulting in a combined 1.5% pressure each year including the impact of CCG demand management. The impact of improving service standards has been assumed to add 1% to the cost of workforce each year and cost improvement is assumed to be delivered across the entire cost base at 2% per year.

The full set of assumptions agreed for the baseline projection are shown in Figure F3.

FIGURE F3: ASSUMPTIONS FOR BASELINE PROJECTION

Income		5Y CAGR,%	5Y impact,%	10Y CAGR,%	10Y impact,%
Demo-graphic growth	NEL	1.4	7.3	1.4	15.3
	Maternity	0.3	1.5	0.2	2.5
	ELDC	1.4	7	1.2	13
	ELIP	1.3	6.9	1.2	13.2
	A&E	0.9	4.7	1	10.1
	OP	1.3	6.6	1.2	12.7
Non-demo-graphic growth	NEL	0.6	3.2	0.6	6.4
	Maternity	-0.6	-3.2	-0.6	-6.3
	ELDC	0.5	2.4	0.5	4.8
	ELIP	0.8	3.9	0.8	7.9
	A&E	1.3	6.4	1.3	13.3
	OP	1	5.2	1	10.7
Demand mgmt	All	-1	-4.9	-1	-9.5
Price change	All	0.9	4.6	0.9	9.5

Costs		5Y CAGR,%	5Y impact,%	10Y CAGR,%	10Y impact,%
Cost inflation	Perm. staff	2.4	12.5	2.6	29.8
	Non perm. staff	2.4	12.5	2.6	29.8
	Drugs[1]	4	21.7	4	48.7
	Clinical supplies	2	10.4	2	21.9
	PDC costs	3.1	16.7	3.1	36
	Other	2	10.4	2	21.9
CIP	All	2	10.4	2	21.9
CISS[2]	Perm. staff	1	5.1	1	10.5

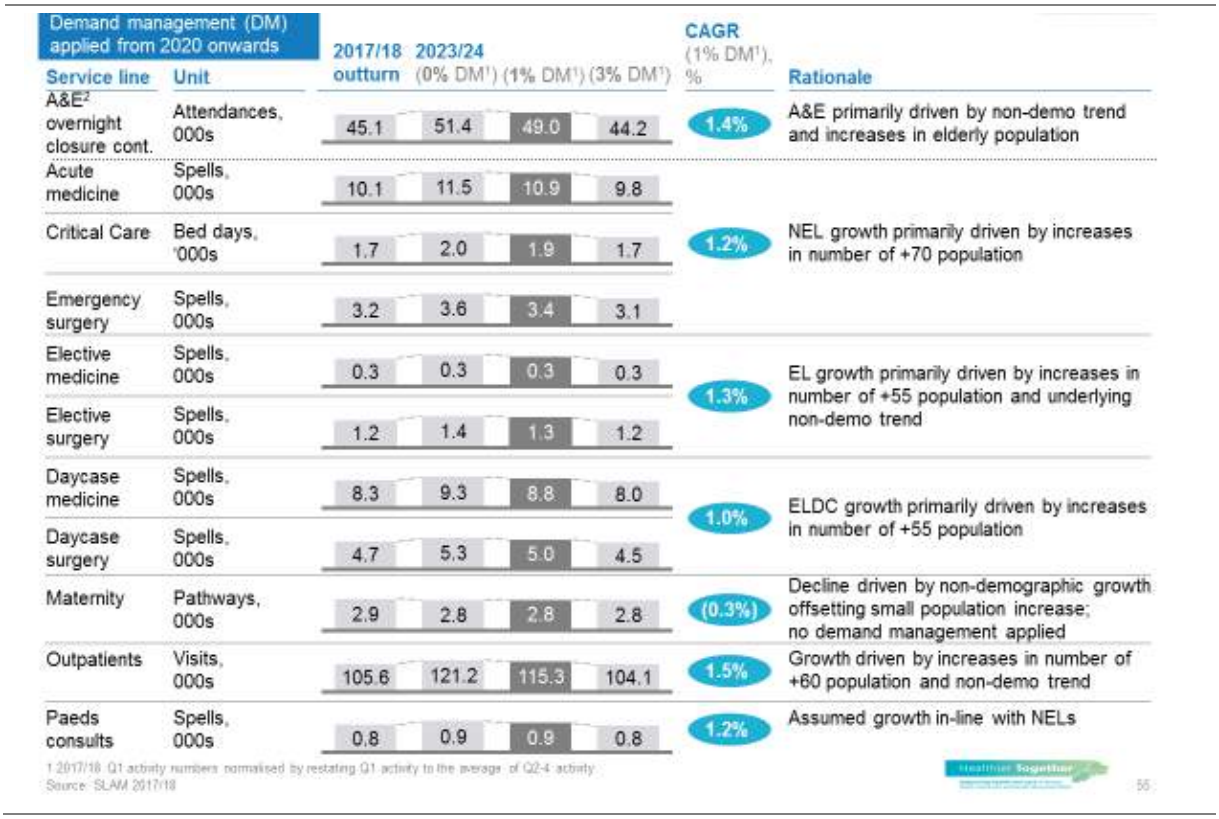
Base case if for 1% demand management excluding maternity; -3% demand management sensitivity is also tested

3.2 Creating an activity baseline

WAHT service line reporting data (SLAM) for the period April 2017 – March 2018 was used as a baseline for activity. This was recognised as distinct from the commissioned model (i.e. before the temporary overnight closure which has been in effect since July 2017). The activity baseline was adjusted to provide a full 12 month picture of the temporary overnight closure. The same activity growth and demand management assumptions used in the financial baseline were used for projecting forward activity.

The list of service lines to be used for reconfiguration modelling was agreed and activity projections at this level of detail are shown in Figure F4.

FIGURE F4: WAHT ACTIVITY BASELINES PROJECTION AGAINST THE SERVICE LINES



Demand management (DM) applied from 2020 onwards

Service line	Unit	2017/18 outturn	2023/24 (0% DM[1])	(1% DM[1])	(3% DM[1])	CAGR (1% DM[1]), %	Rationale
A&E[2] overnight closure cont.	Attendances, 000s	45.1	51.4	49.0	44.2	1.4%	A&E primarily driven by non-demo trend and increases in elderly population
Acute medicine	Spells, 000s	10.1	11.5	10.9	9.8		
Critical Care	Bed days, '000s	1.7	2.0	1.9	1.7	1.2%	NEL growth primarily driven by increases in number of +70 population
Emergency surgery	Spells, 000s	3.2	3.6	3.4	3.1		
Elective medicine	Spells, 000s	0.3	0.3	0.3	0.3	1.3%	EL growth primarily driven by increases in number of +55 population and underlying non-demo trend
Elective surgery	Spells, 000s	1.2	1.4	1.3	1.2		
Daycase medicine	Spells, 000s	8.3	9.3	8.8	8.0	1.0%	ELDC growth primarily driven by increases in number of +55 population
Daycase surgery	Spells, 000s	4.7	5.3	5.0	4.5		
Maternity	Pathways, 000s	2.9	2.8	2.8	2.8	(0.3%)	Decline driven by non-demographic growth offsetting small population increase; no demand management applied
Outpatients	Visits, 000s	105.6	121.2	115.3	104.1	1.5%	Growth driven by increases in number of +60 population and non-demo trend
Paeds consults	Spells, 000s	0.8	0.9	0.9	0.8	1.2%	Assumed growth in-line with NELs

1 2017/18 Q1 activity numbers normalised by restating Q1 activity to the average of Q2-4 activity
Source: SLAM 2017/18

3.3 Bottom-up activity baseline

A baseline forecast of bottom-up costing for service lines which change significantly such as the Urgent Treatment Centre (UTC) and Integrated Frailty service was created.

Staff costing was applied, with pathways of activities determining staff type and visit time per activity. Standard NHS salary costs and working hours were applied. Variable cost was assumed to be 15% of income and a fixed activity case-mix was assumed for income calculations. Fixed costs were assumed to remain constant as the UTC and Acute Frailty Unit are expected to sit in the existing estates alongside A&E.

Integrated Frailty Service Impact

An integrated frailty service is recognised as a fundamental part of all new models of care. There are two main elements of the integrated frailty service, firstly the Acute Frailty Unit (AFU) which will sit alongside the Hospital Emergency Department (ED) and will be funded under tariff as an alternative to normal ED attendances. The second element is a more pro-active management of frail patients in primary and community care which is referred to as the frailty hub. The investment for this service will be funded by through reduced presentations of frail patents being managed through the frailty hub and reduced admission for frail patients seen in the frailty unit. It is believed that there is the opportunity to reduce frail patients presenting at ED by 25% from current levels based on the experience of other health systems where this has been implemented and then further to avoid admissions by 50% based on a observed reductions for this cohort of patients achieved in several pilots run at WGH from January to August 2018 as well models implemented elsewhere.

Currently 65% of relevant patients have been assessed by primary care against the Rockwood Frailty Criteria[1] and received frailty scores. This is to be rolled out across the remaining patients to produce a risk stratified cohort of patients. The numbers involved and the levels of stratification are shown on Frailty Appendix 7 of PCBC.

Based on experience of similar models of care implemented elsewhere; it is expected that 25% of the ED attendances of this cohort of patients can be avoided by this model of care. While much of the workforce required to support the integrated frailty model will be drawn from existing resource some additional investment is assumed within the costings.

4 FINANCIAL AND ACTIVITY ANALYSIS OF ORIGINAL 7 SHORTLISTED OPTIONS

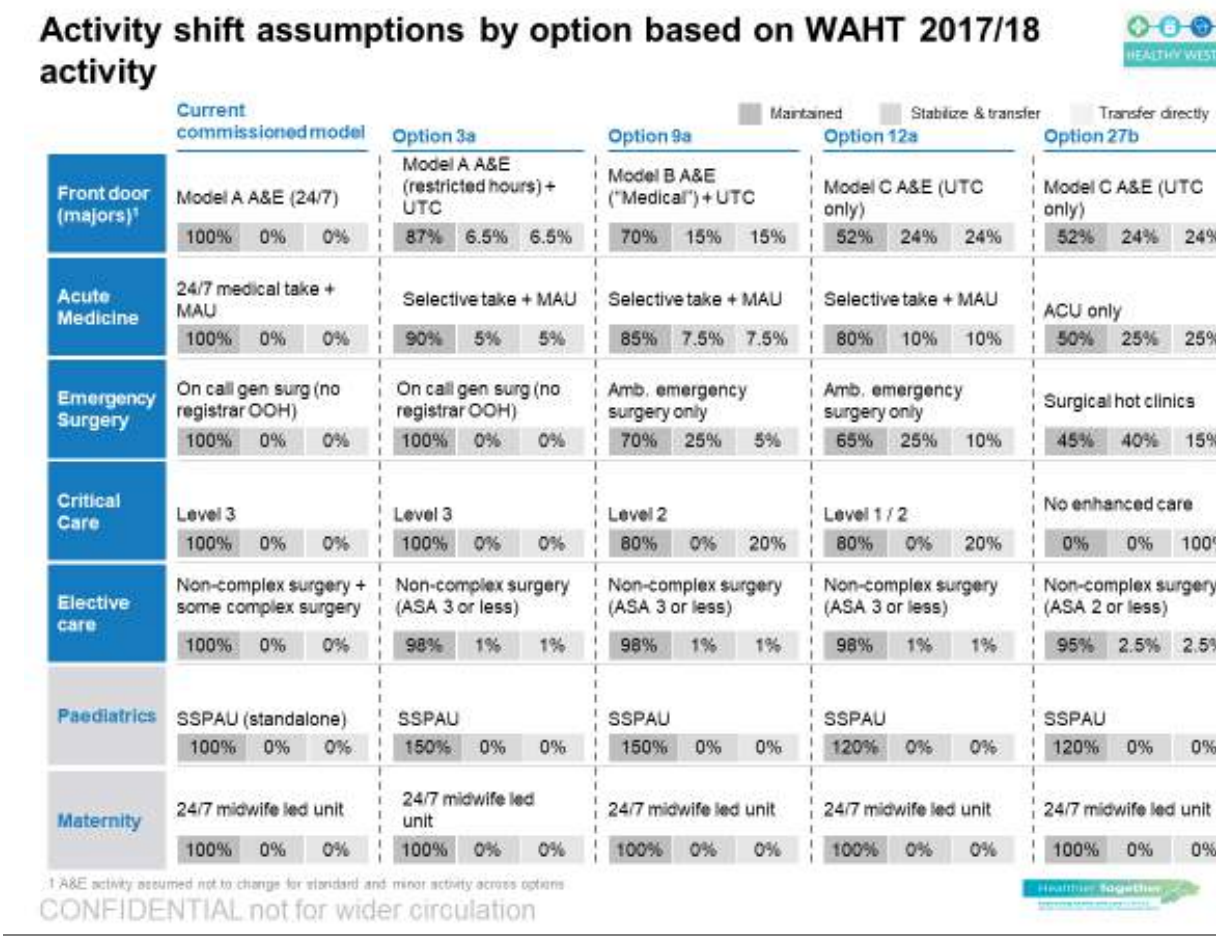
This section of the appendix shows all the financial and activity analysis on the original 7 shortlisted clinical models that were subjected to financial evaluation for the version of the PCBC that was considered by the Clinical Senate in November 2017. This has been overtaken by more recent work but is included here for completeness.

4.1 Activity Shifts Between Sites for 7 options

The proportion of patients that would continue to be managed at WGH under each of the options was debated and formally signed off by the Clinical Design and Delivery Group and is summarised in Figure 5 below.

Rockwood et al., 2005, *A global clinical measure of fitness and frailty in elderly people.* CMAJ, 173(5): 489-495

FIGURE F5: ACTIVITY SPLIT FOR THE PROPOSED MODELS (PERCENTAGE OF WAHT 2017/18 ACTIVITY)



To validate these assumptions, local GPs completed clinical audits of two weeks of attendances at Weston General Hospital A&E.

The impact of the above adjustments to A&E majors on the overall A&E proportions is shown below:

Table F1: Estimated level of activity 2019/20

	2018/19	9a		12a		27b	
	(*)	Activity	%	Activity	%	Activity	%
A&E major	7,700	5,789	75.2%	4,342	56.4%	4,342	56.4%
A&E standard	21,923	21,127	96.4%	21,127	96.4%	21,127	96.4%
A&E minor	16,439	16,166	98.3%	16,166	98.3%	16,166	98.3%
A&E Total	**46,062**	**43,082**	**93.5%**	**41,635**	**90.4%**	**41,635**	**90.4%**

The initial results, when adjusted for the expected impact of the Integrated Frailty Service show that for Option 9a and 12a the figures that will remain at WGH are

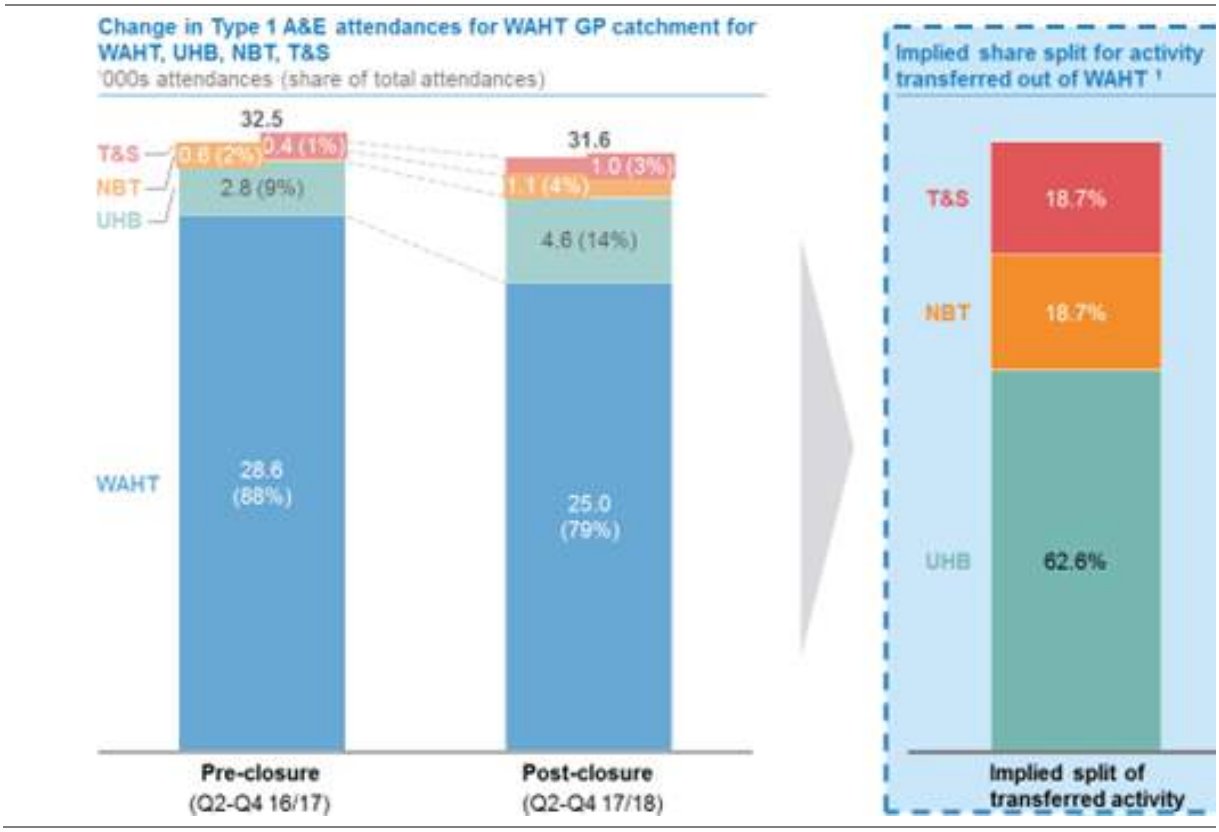
between 93.0% - 98% and 83.2% - 90.6% which very much in line with the estimates. For Option 27b the range is 66.9% - 72.2% which is some distance from the modelling assumptions. This is being taken back through the CSDDG to understand the basis for the differences. Please note that these A&E activity shifts do not drive bed numbers in receiving sites which are modelled from the activity shift of Acute Medicine and Emergency Surgery.

Table F2 % A&E attendance retained at WGH

	9a	12a	27b
Top Down	93.5%	90.4%	90.4%
GP Jan (adj)	93.0%	83.2%	66.9%
GP Aug (adj)	98.1%	90.6%	72.2%

Activity flow has been modelled in line with patient flows observed after the overnight closure of the A&E at WAHT. This is based on the observation that travel times are highly sensitive to small changes – with UHB and NBT having very similar times for the catchment population. See Figure F6 below:

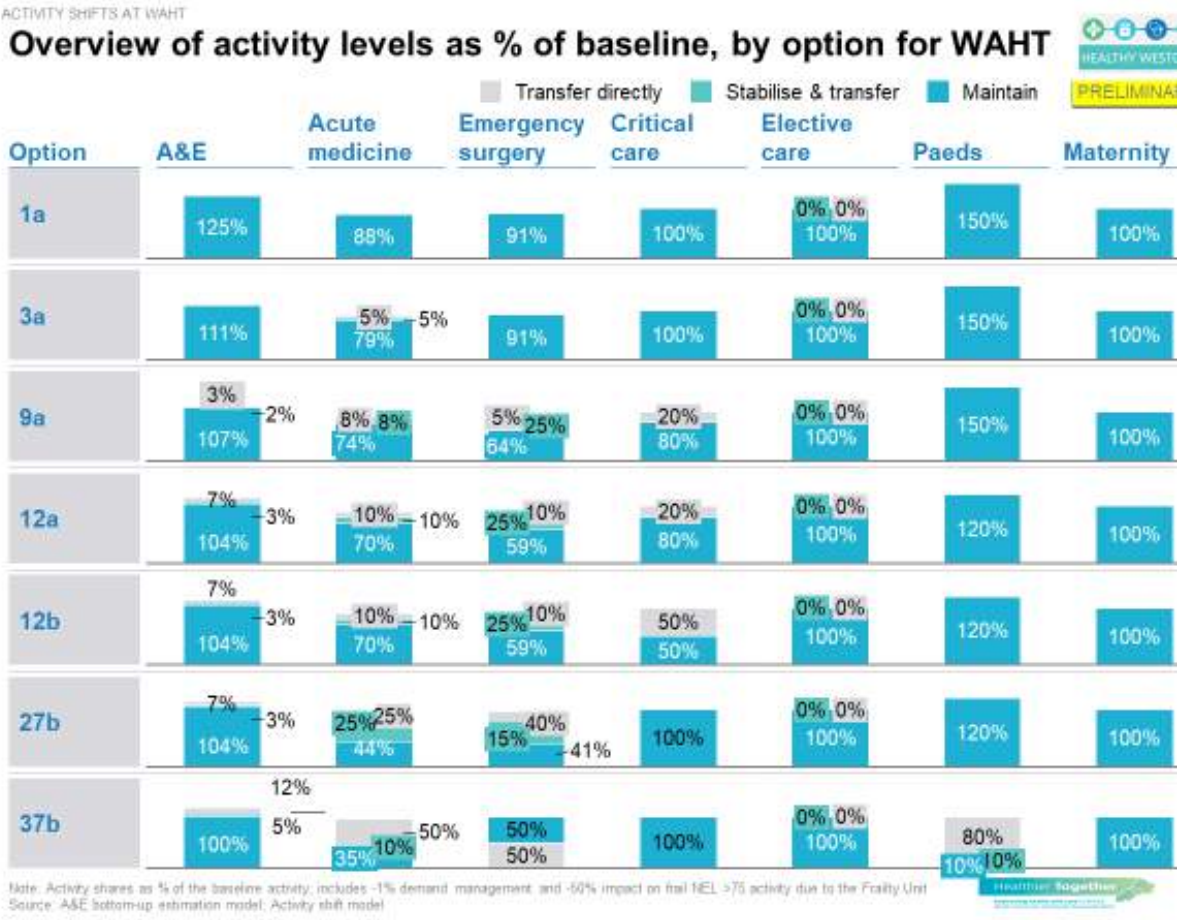
FIGURE F6: ACTIVITY SHIFT SPLIT BY TRUST WAS MODELLED USING THE IMPACT OF THE OVERNIGHT CLOSURE ON A&E FLOWS



Applying the population flows, together with the assumed split of activity under each clinical model in Figure F5, to the activity baseline projection and the impact of the

new frailty service as described above, gives the activity profiles for each potential service configuration option shown in F7.

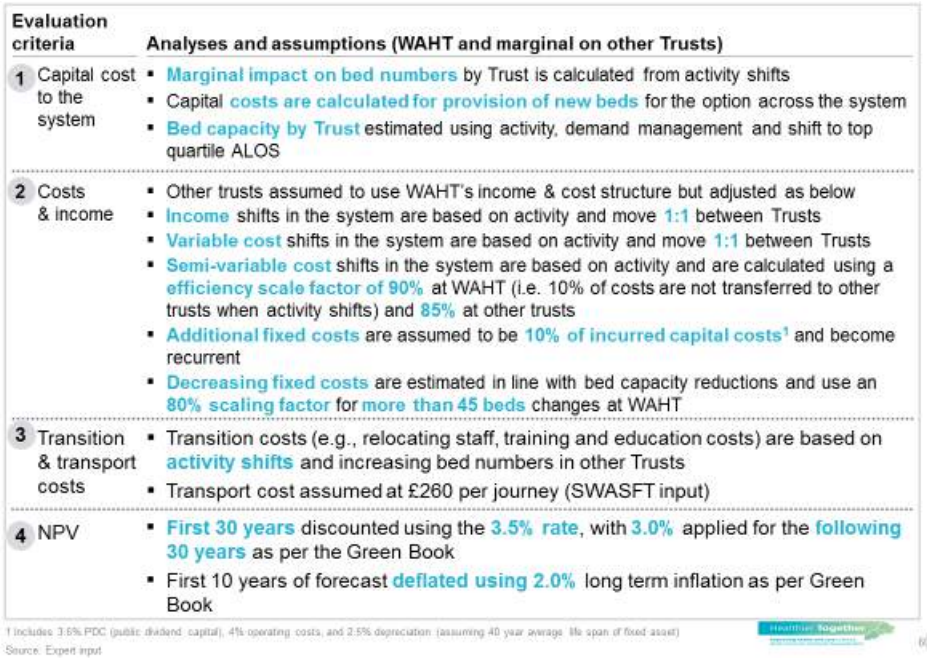
FIGURE F7: OVERVIEW OF ACTIVITY LEVELS AS % OF BASELINE, BY OPTION FOR WAHT



4.2 Components of the financial evaluation of 7 options

Financial assumptions used in the modelling work are listed in Figure F8.

FIGURE F8: KEY ASSUMPTIONS FOR FINANCE MODELLING



Evaluation criteria	Analyses and assumptions (WAHT and marginal on other Trusts)
1 Capital cost to the system	▪ Marginal impact on bed numbers by Trust is calculated from activity shifts ▪ Capital costs are calculated for provision of new beds for the option across the system ▪ Bed capacity by Trust estimated using activity, demand management and shift to top quartile ALOS
2 Costs & income	▪ Other trusts assumed to use WAHT's income & cost structure but adjusted as below ▪ Income shifts in the system are based on activity and move 1:1 between Trusts ▪ Variable cost shifts in the system are based on activity and move 1:1 between Trusts ▪ Semi-variable cost shifts in the system are based on activity and are calculated using a efficiency scale factor of 90% at WAHT (i.e. 10% of costs are not transferred to other trusts when activity shifts) and 85% at other trusts ▪ Additional fixed costs are assumed to be 10% of incurred capital costs[1] and become recurrent ▪ Decreasing fixed costs are estimated in line with bed capacity reductions and use an 80% scaling factor for more than 45 beds changes at WAHT
3 Transition & transport costs	▪ Transition costs (e.g., relocating staff, training and education costs) are based on activity shifts and increasing bed numbers in other Trusts ▪ Transport cost assumed at £260 per journey (SWASFT input)
4 NPV	▪ First 30 years discounted using the 3.5% rate, with 3.0% applied for the following 30 years as per the Green Book ▪ First 10 years of forecast deflated using 2.0% long term inflation as per Green Book

1 Includes 3.5% PDC (public dividend capital), 4% operating costs, and 2.5% depreciation (assuming 40 year average life span of fixed asset)
Source: Expert input

4.3 Capital costs associated with 7 original options

Capital costs have been estimated by looking at the cost of building new hospital capacity, using the number of new inpatient beds to estimate this, both within WAHT and at neighbouring Trusts. This has been modelled on £350,000 per new bed built (or £7,000,000 for a 20 bedded ward) with no threshold / step function included. No assumptions have been included for any net land receipts generated from releasing capital for capacity no longer required.

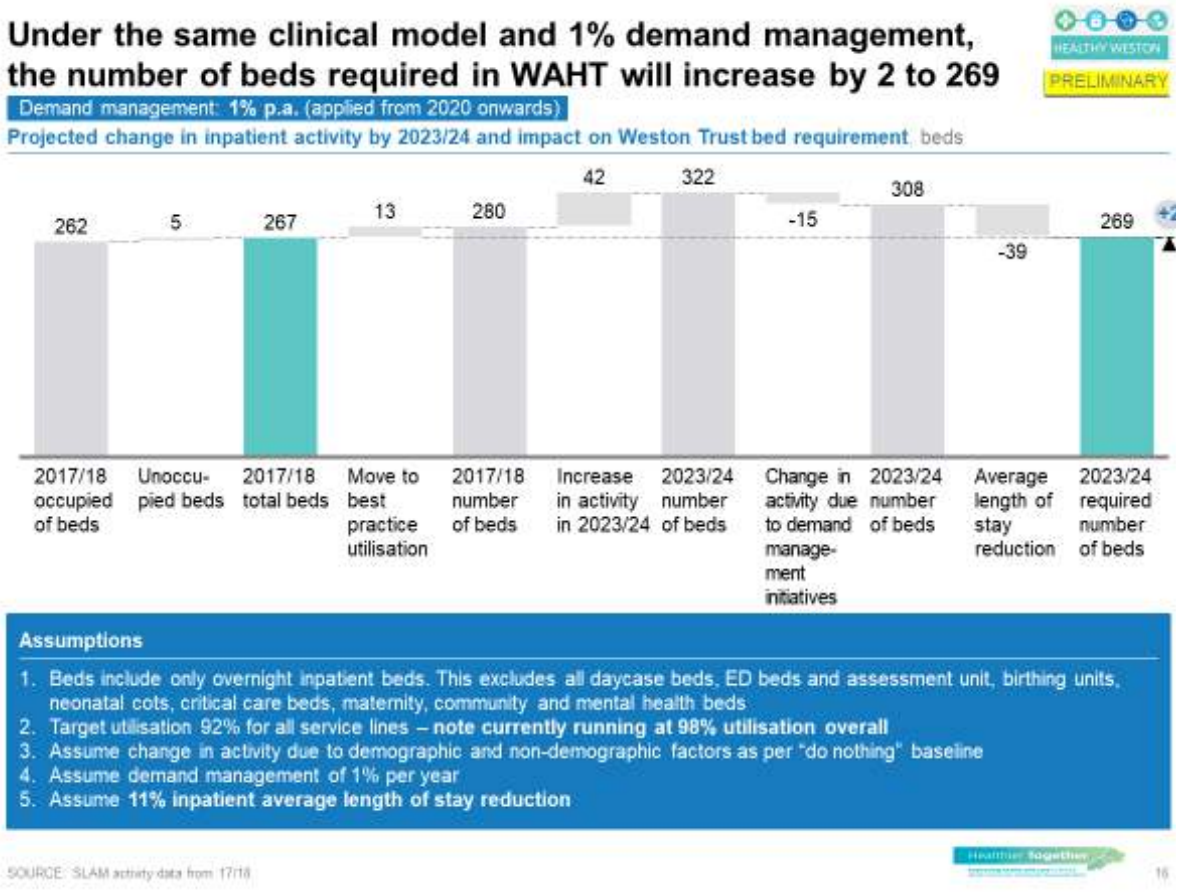
Sensitivity has been applied to this assumption to show the potential impact of different bed build costs on system capital costs (including a step change where lower costs are incurred per bed built below a set threshold). No assumptions on one-time cost requirements for releasing fixed costs (e.g. demolition of buildings) have been included.

Additionally, no capital allowance has been made in this PCBC for any additional ambulance capacity needed as a result of increasing the numbers of conveyances (see section Finance Appendix section 4.3 on Transport assumptions).

In terms of bed numbers at Weston General Hospital no significant change in bed numbers would be forecast if current services continued based on the following assumptions which are illustrated in Figure F9

- an 11% reduction in length of stay to reach top quartile performance;
- Activity changes in response to population growth
- target utilisation for beds of 92%
- Demand management of 1%

FIGURE F9: PROJECTED CHANGE IN INPATIENT ACTIVITY BY 2023/24 AND IMPACT ON WESTON TRUST BED REQUIREMENT BEDS



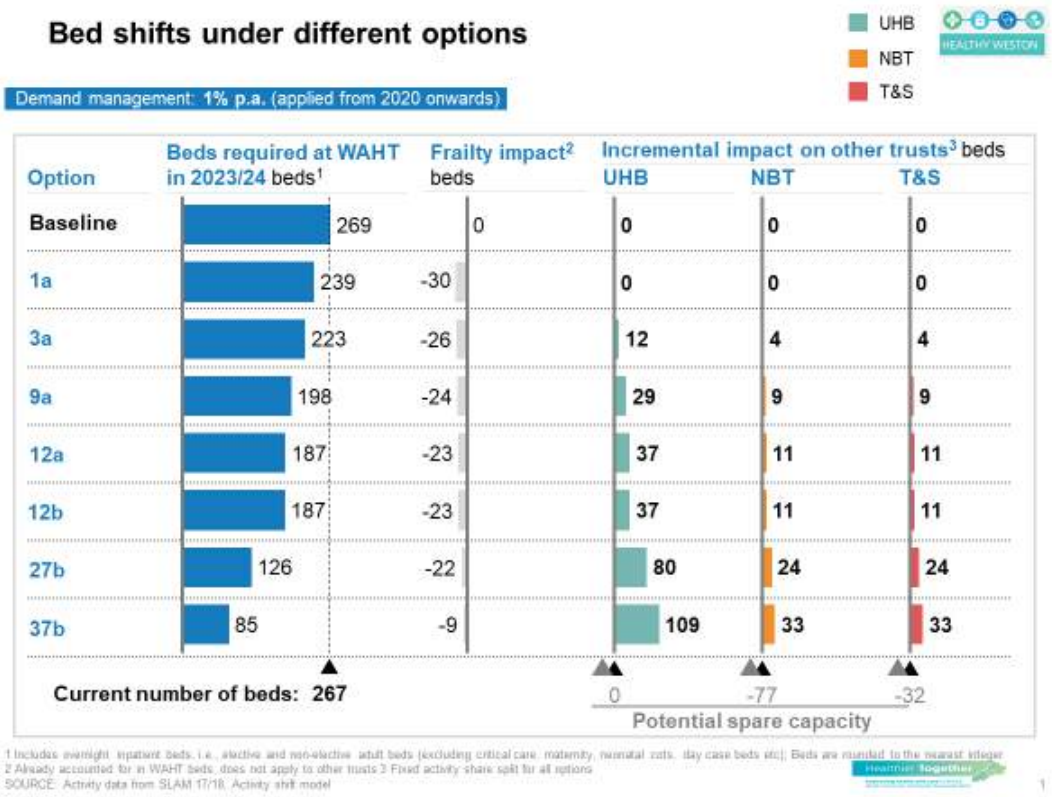
With the same assumptions around demand management and length of stay as in the "do nothing" scenario, applying the activity shifts results in bed requirements for each option as shown in Figure F10. The impact of length of stay is tested in the sensitivity analyses.

Please note that at present these bed numbers at receiving sites do not reflect the expected impact of mitigating actions such as:

- The impact of a BNSSG wide Integrated Frailty Service
- Further improvements in productivity (beyond the upper quartile of top 50 Trusts)
- The impact of moving elective activity to WGH.

The CCG would seek significant mitigations before planning significant capital to facilitate these proposals which would be laid out in the DMBC.

FIGURE F10: BED SHIFTS UNDER 7 ORIGINAL SHORTLISTED OPTIONS



Assuming no net land receipts the capital cost of adding capacity to the system by provider was calculated and is shown in Figure F11.

FIGURE F11: IMPLIED CAPITAL COSTS TO THE SYSTEM UNDER DIFFERENT OPTIONS

4.4 Income and expenditure

Income and expenditure (I&E) is the net of all recurrent income and all recurrent expenditure. It is an important measure of financial performance recognising that an NHS Trust is not financially viable unless it is able to generate a surplus. While the financial baseline projection expects WAHT to run a deficit position, any option must improve on this in order to justify any capital expenditure.

In order to compare each of the options, a methodology for reconfiguration modelling income and expenditure has been estimated for each service line with expenditure broken down into variable cost, semi-variable cost and fixed cost.

- Variable cost represents all cost that will scale in line with clinical activity, for example, food, laundry services, and consumables such as drugs.
- Semi-variable cost represents the cost of staff, both permanent and temporary, and will change with activity albeit not in a linear fashion as economies or diseconomies of scale are realised – a 15% consolidation benefit [for receiving organisations] and a 10% diseconomies loss factor [for WAHT] is assumed. Furthermore, the premium on staff, due to use of non-permanent ED staff, was assumed to taper as activity is shifted away (up to 75% reduction in option 37b).
- Fixed cost is the cost of buildings and equipment and overheads and will not scale with activity unless an active decision that impacts this directly, such as increasing or decreasing capacity, is taken.

The full set of assumptions used in the I&E modelling is shown in Figure F8 above and the WAHT baseline is shown in Figure F12 below.

FIGURE F12: WAHT INCOME AND COST (INCLUDING COST BREAKDOWN) BY SERVICE LINE

Modelling the impact of changes to I&E under different potential service configuration options follows the inclusion of bottom up costings and has been progressed in three stages which are summarised below:

- First, the impact of activity leaving WAHT is estimated by assuming all activity arriving at neighbouring Trusts will generate fragmentation effects within WAHT. More specifically, this means 100% of income associated with reduced activity will leave WAHT while less than 100% of expenditure associated with this activity leaves. 100% of variable cost will leave but only 90% of semi-variable cost will leave. Fixed costs will not be impacted at this stage – changes in fixed costs are modelled separately. Additionally, activity is moved to the receiving hospital assuming WAHT Average Length of Stay (aLoS) to reflect the case mix of the transferring activity and not the current case mix of the receiving hospital.
- Second, the impact of consolidation is estimated. For service lines that are seeing more activity provided by larger sites, financial consolidation benefits in terms of semi-variable costs will be observed, while for service lines that are being provided by WAHT, a small trust, fragmentation effects have been assumed. This is estimated by modelling 90% of semi-variable cost being released with decreasing activity and 85% of the **sending site semi-variable cost** added to the receiving site, as all are significantly larger than WAHT. As WAHT is making a loss on most activities this should be a conservative approach as the larger receiving hospitals should be more cost effective than this.
- Third, the change in fixed cost due to reconfiguring capacity is estimated. Fixed cost is added for increasing capacity at 10% of capital expenditure, while fixed cost to be removed in line with closed capacity is modelled in terms of inpatient beds reduction with 80% scaling factor. For example, if 10% of inpatient beds are released, 8% of fixed cost can be released at that site once a threshold of at least 45 beds has been reached – this effectively assumes that reducing beds by up to 45 does not allow the release of any fixed costs.

The result of this is that:

- options with sub-threshold activity reductions (the threshold for releasing fixed cost was agreed to be 45 beds) perform less favourably in terms of WAHT I&E than the others due to stranded fixed costs.
- options with more new bed build requirements at other Trusts perform less favourably in terms of system I&E because the consolidation benefits are unable to offset the impact of high capital costs on the fixed cost base.

Figure F13 shows the breakdown of WAHT I&E for each potential service configuration option while Figure F14 show the breakdown of system I&E by Trust.

FIGURE F13: CHANGE IN 2023/24 WAHT I&E ACROSS ALL OPTIONS

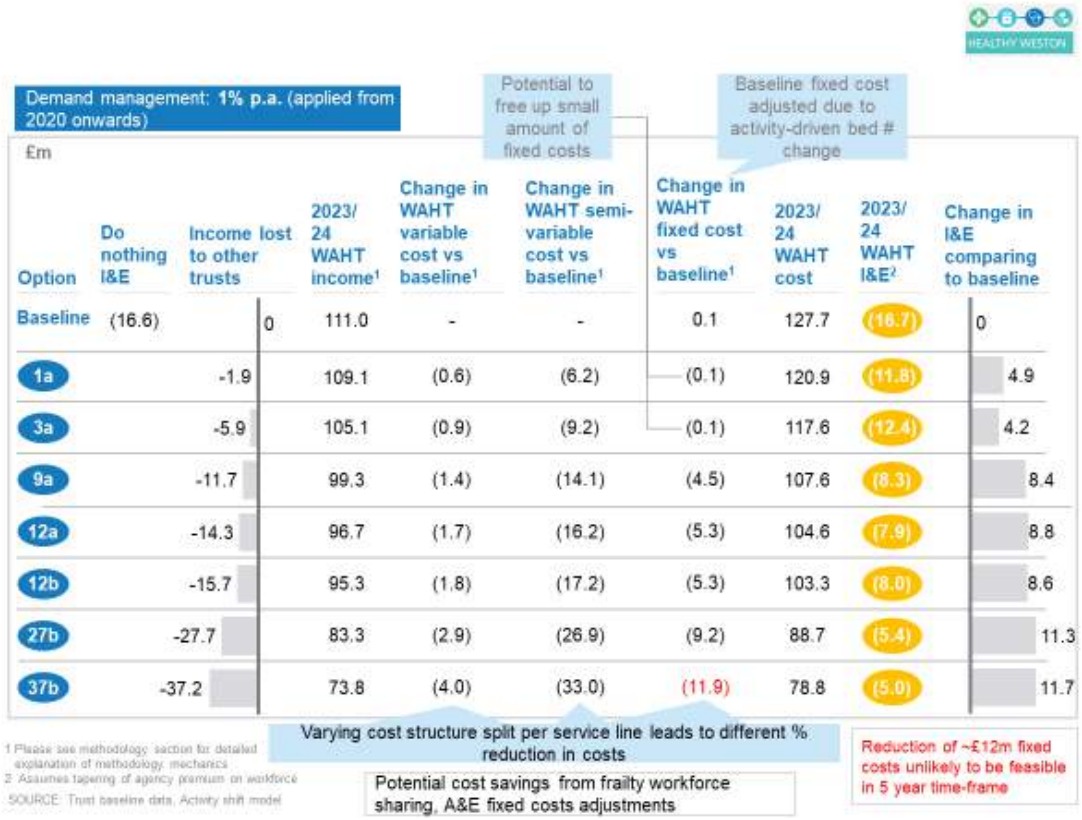


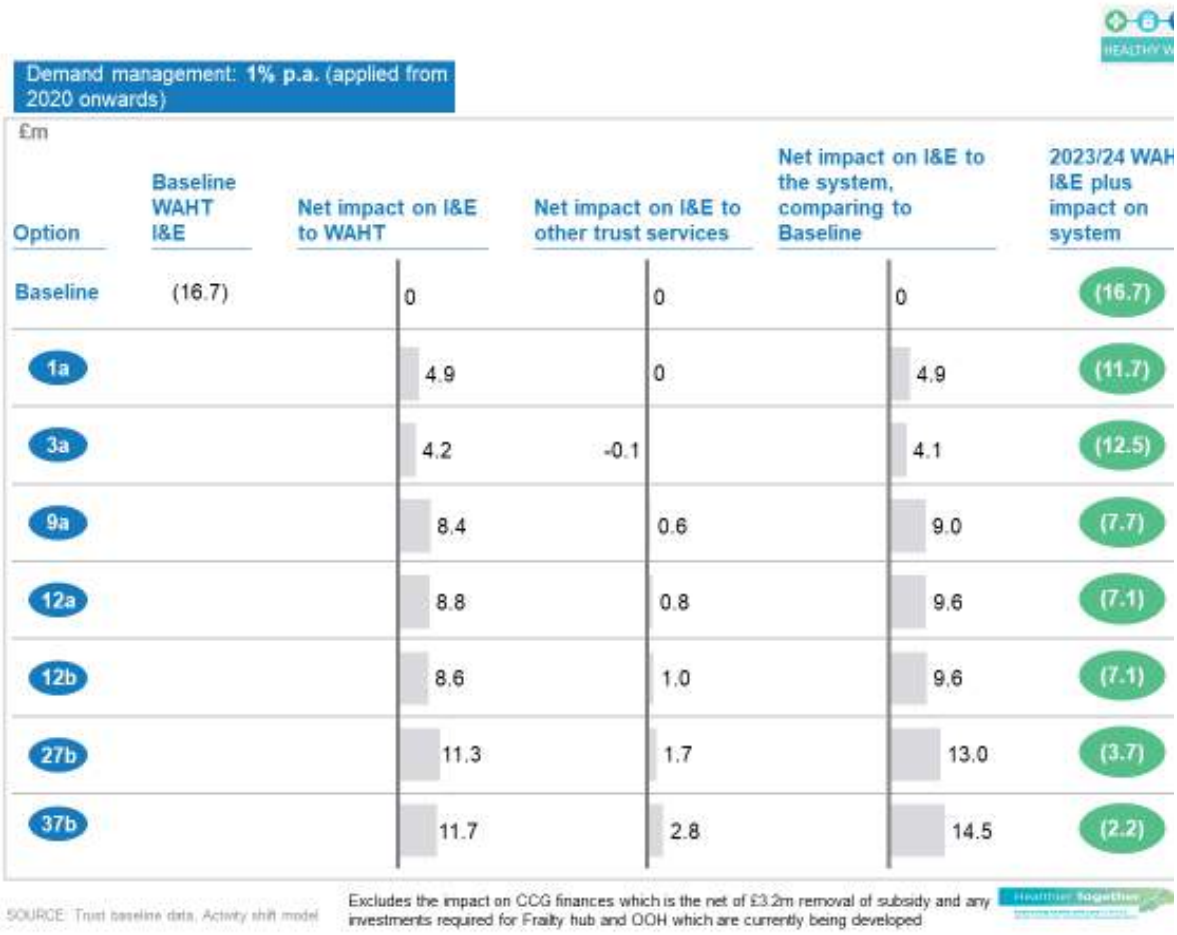
FIGURE F14: NET CHANGE TO I&E FOR OTHER TRUSTS

All reconfiguration options see neighbouring Trusts benefit in terms of I&E and as such the system as a whole benefits for all options.

- while the most favourable option in terms of headline I&E is option 37b due to maximum cost release from fixed costs, there is also a significant capital cost requirement and a significant amount of fixed cost release (~60% of total fixed costs) assumed.
- Options 27b and 37b see the most system benefit because more activity is shifted to the larger neighbouring Trusts which operate with greater efficiency than WAHT.

Figure F15 shows the impact on I&E on neighbouring Trusts and the system as a whole. It should be noted that the impact on the CCG is assumed neutral with it receiving the benefit of not paying the premium to WAHT and the saving on reduced admissions through the Integrated Frailty Service but also assuming that these savings are invested in the strengthening community services to support the new models.

FIGURE F15: NET CHANGE TO I&E FOR THE SYSTEM



4.5 Transition Costs And Transport Costs for 7 original shortlisted options

Transition costs are the additional costs beyond the capital build requirement that would be incurred due to the disruption caused through any changes made to the configuration of services, in particular any double running of services. This has been estimated to be incurred in line with bed movements (i.e., new bed capacity), at a cost of £250 per bed day of disruption both within WAHT and at neighbouring Trusts. Disruption is assumed to last for 90 days for each bed movement. An additional £100k is added for PMO overhead across all options. The differential transition cost per option is shown in Figure F16.

FIGURE F16: TRANSITION COSTS ASSOCIATED WITH BED MOVEMENT

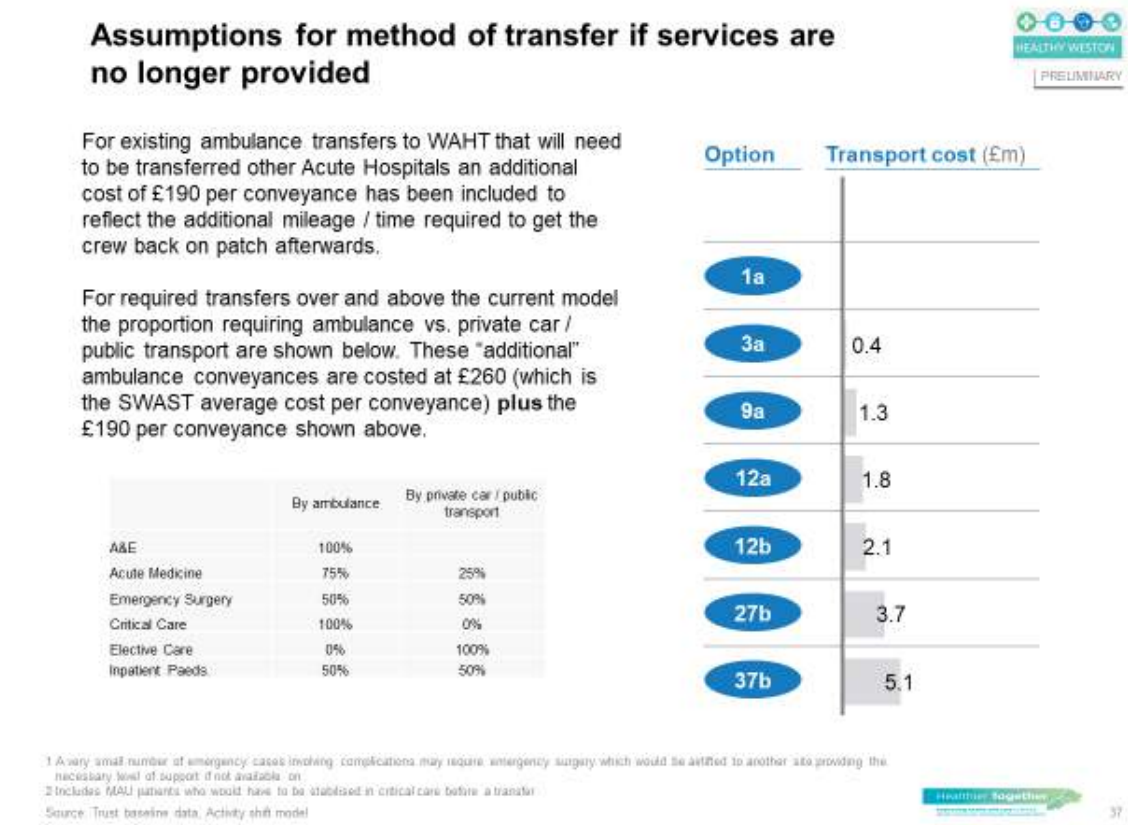
For existing ambulance transfers to WAHT that will need to be transferred other Acute Hospitals an additional cost of £190 per conveyance has been included to reflect the additional mileage / time required.

For required transfers over and above the current model the proportion requiring ambulance vs. private car / public transport are shown below. These “additional” ambulance conveyances are costed at £260 (which is the SWAST average cost per conveyance) **plus** the £190 per conveyance shown above to cover:

No capital has been included for additional ambulance capacity, detailed modelling will be undertaken as a preferred option starts to emerge which will feed into the full business case. This detailed modelling will include estimating the impact of evidence that changes to A&E opening times or range of services offered can result in up to a 13.9% increase in ambulance calls in the locality.

Figure F17 shows the estimated additional ambulance cost for each option.

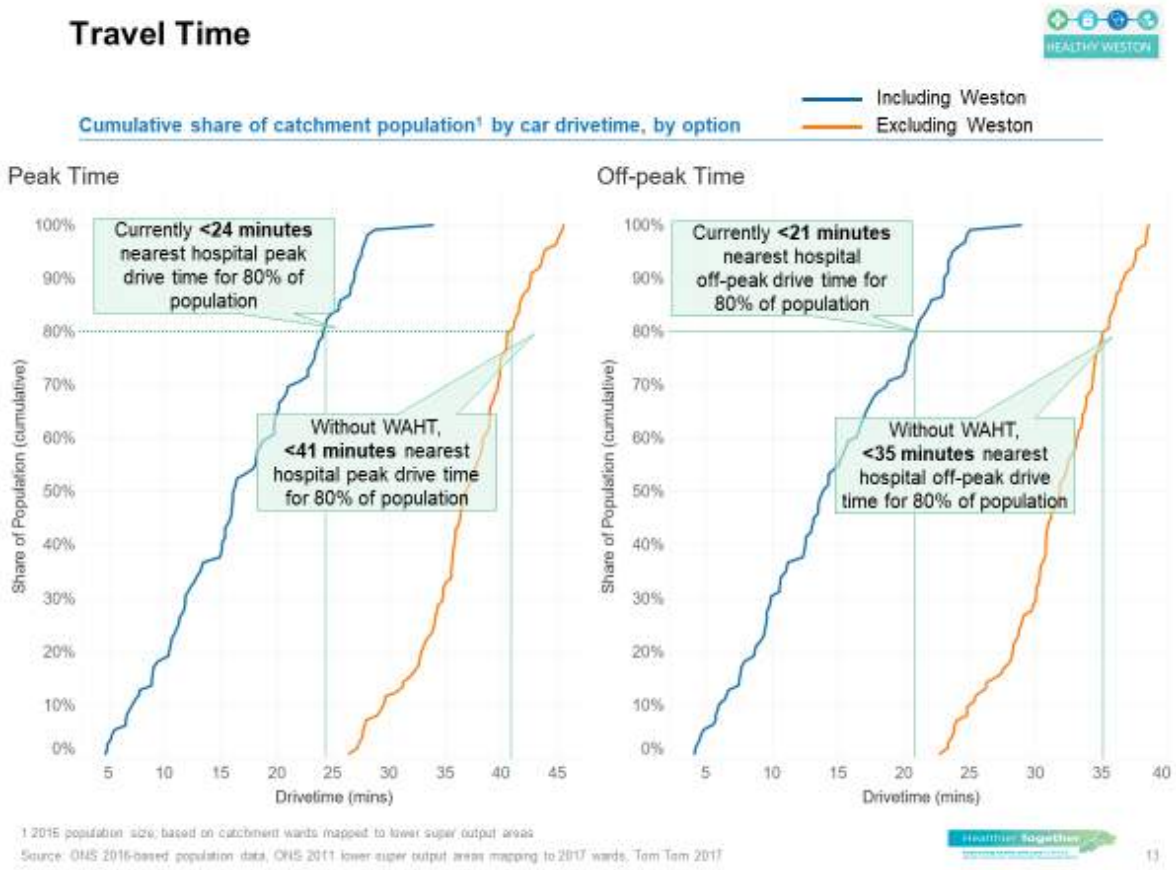
FIGURE F17: ASSUMPTIONS FOR METHOD OF TRANSFER IF SERVICES ARE NO LONGER PROVIDED



4.6 Travel Time Analysis

Analysis was carried out showing the time taken for the catchment population to access an Acute Hospital at both peak and off-peak times. This was then recalculated if people had to travel to a different hospital for those services. This showed at the 80th centile of population that during peak times people would need to travel for an additional 17 minutes and off peak for an extra 14 minutes.

FIGURE F18: TRAVEL TIME ANALYSIS



4.7 Net present value

HM Treasury guidance in The Green Book states that public sector capital projects should be appraised in terms of value for money using a net present value (NPV) measure. This measure represents the return on investment: i.e., to what extent will the initial capital cost of new infrastructure be offset by future cash generated as a result of this investment? In an NHS context, cash is likely to be generated through productivity savings and consolidation benefits. Options have been evaluated based on a 30-year NPV, with a 60-year NPV also calculated for sensitivity as NHS England guidance states return on investment should be analysed over a 60 year period.

NPV is calculated as net capital expenditure plus the projected surplus or deficit I&E position each year discounted by the agreed discount rate. The terminal value of any assets is not included in this calculation at the end of the 30 or 60 year time period.

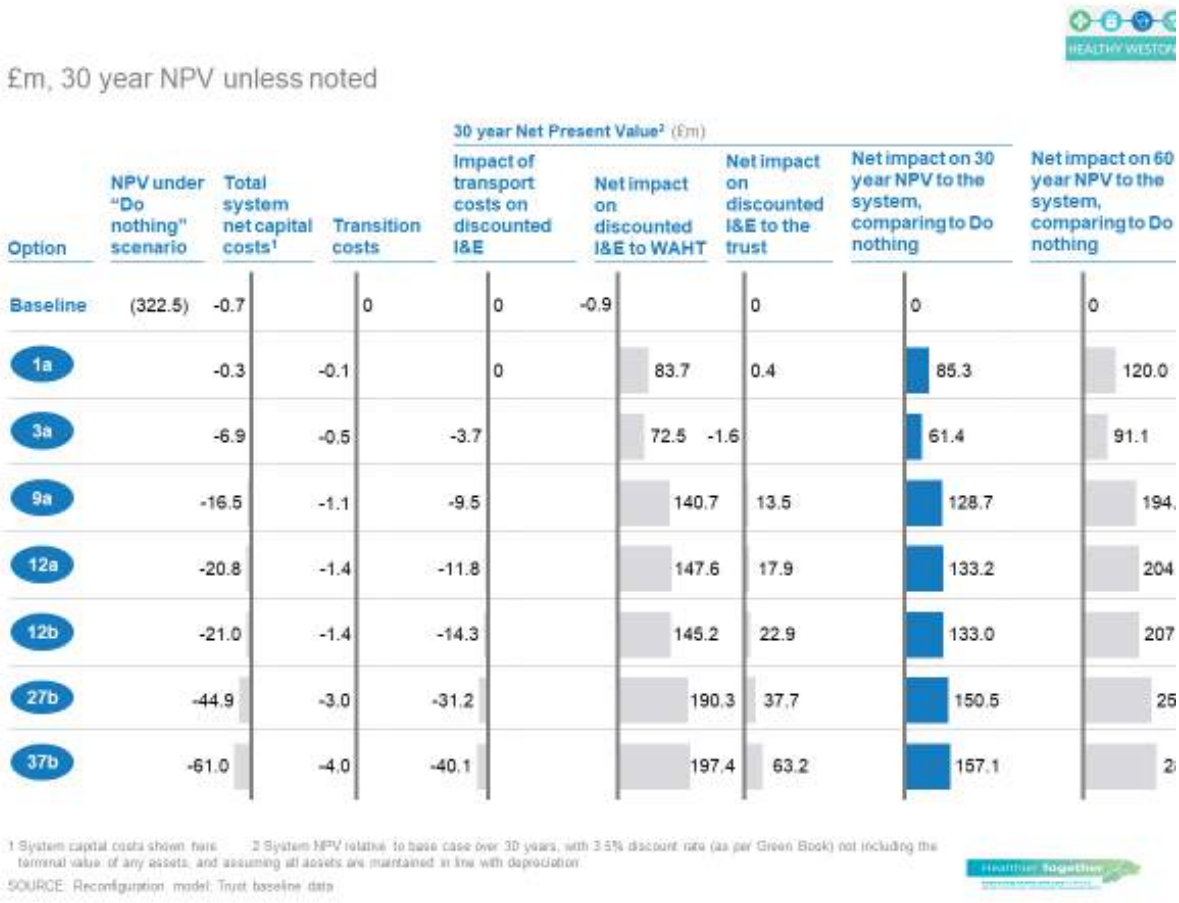
As in guidance in The Green Book, forecasts have been brought into real cash terms by discounting them with the long-term inflation rate of 2%. A discount rate of 3.5% is used for years 1-30 and 3% thereafter, also in line with The Green Book guidance. Future cash flows are discounted to correct for the belief that £100 is deemed to be worth more today than it will be in subsequent years, due to the

opportunity cost of not being able to deploy the £100 in a value creating investment or put to other beneficial use were it not to be available today.

NPV is calculated within WAHT, and within the wider health system, including all neighbouring Trusts, to provide a comprehensive metric for comparison against the "do nothing" scenario.

The breakdown of NPV over a 30 year and 60 year time period is shown in Figure F19.

FIGURE F19: SYSTEM NPV ANALYSIS WITH CURRENT ASSUMPTIONS



4.8 Sensitivity analyses

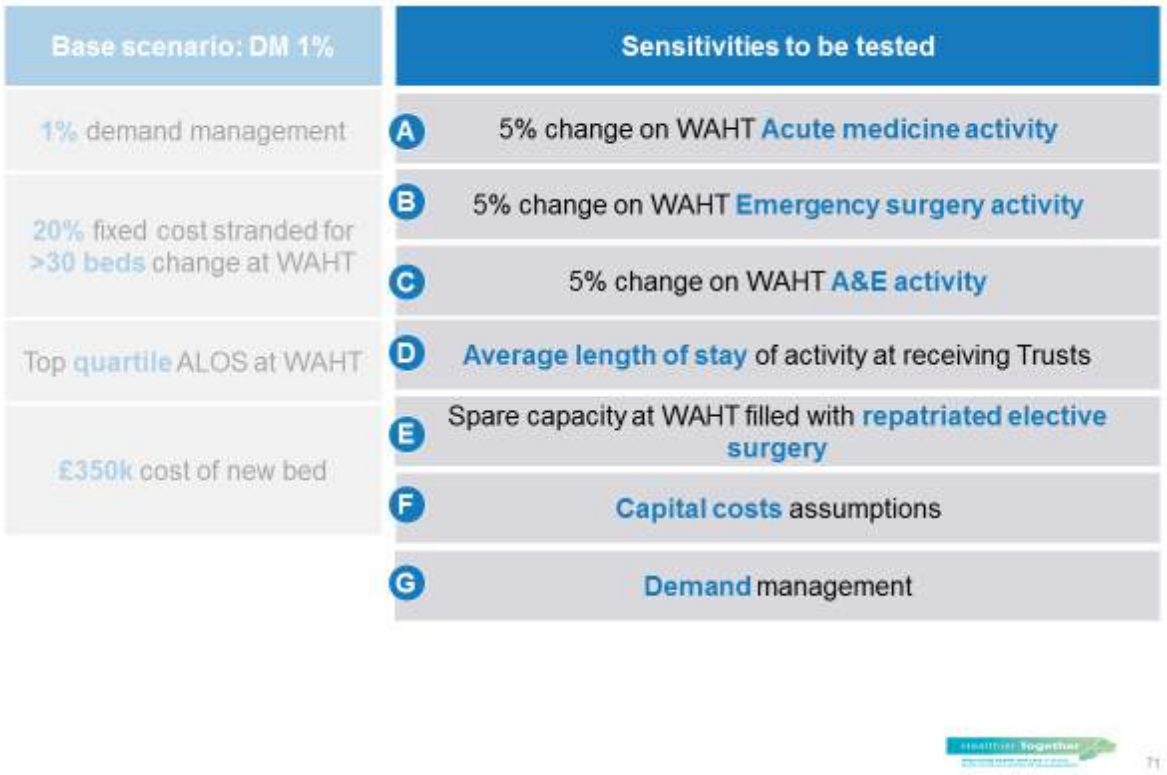
Sensitivity analyses were performed to understand the major drivers of I&E impact and capital shifts.

These analyses were agreed and reviewed by the STP DoFs and then subsequently reviewed by the Steering Group.

The key sensitivities tested are shown in Figure F20 and described below.

Sensitivities A-E are shown on Figure F21, sensitivity F is shown on Figure 22 and sensitivity G is shown on Figures F23 and F24.

FIGURE 20: SENSITIVITIES TESTED



A. **Proportion of acute medicine activity maintained at WAHT** was tested with the impact of a 5% increase or decrease shown. The system wide I&E impact (against baseline) for option 12a was used as a proxy output. A 5% increase in activity maintained at WAHT led to £300,000 worsening of the net system I&E for option 12a. The opposite and equivalent impact was seen for a 5% decrease in activity maintained. This impact is because acute medicine activity has a strong negative margin and therefore removing activity is beneficial to overall WAHT I&E. In turn other Trusts receive the activity at less than 100% of the cost due to scaling efficiencies.

B. **Proportion of emergency surgery activity maintained at WAHT** was tested with the impact of a 5% increase or decrease shown. The system wide I&E impact (against baseline) for option 12a was used as a proxy output. A 5% increase in activity maintained at WAHT led to £110,000 worsening of the net system I&E for option 12a. The opposite and equivalent impact was seen for a 5% decrease in activity maintained. This impact is because emergency surgery activity has a negative margin and therefore removing activity is beneficial to overall WAHT I&E. In turn other Trusts receive the activity at less than 100% of the cost due to scaling efficiencies.

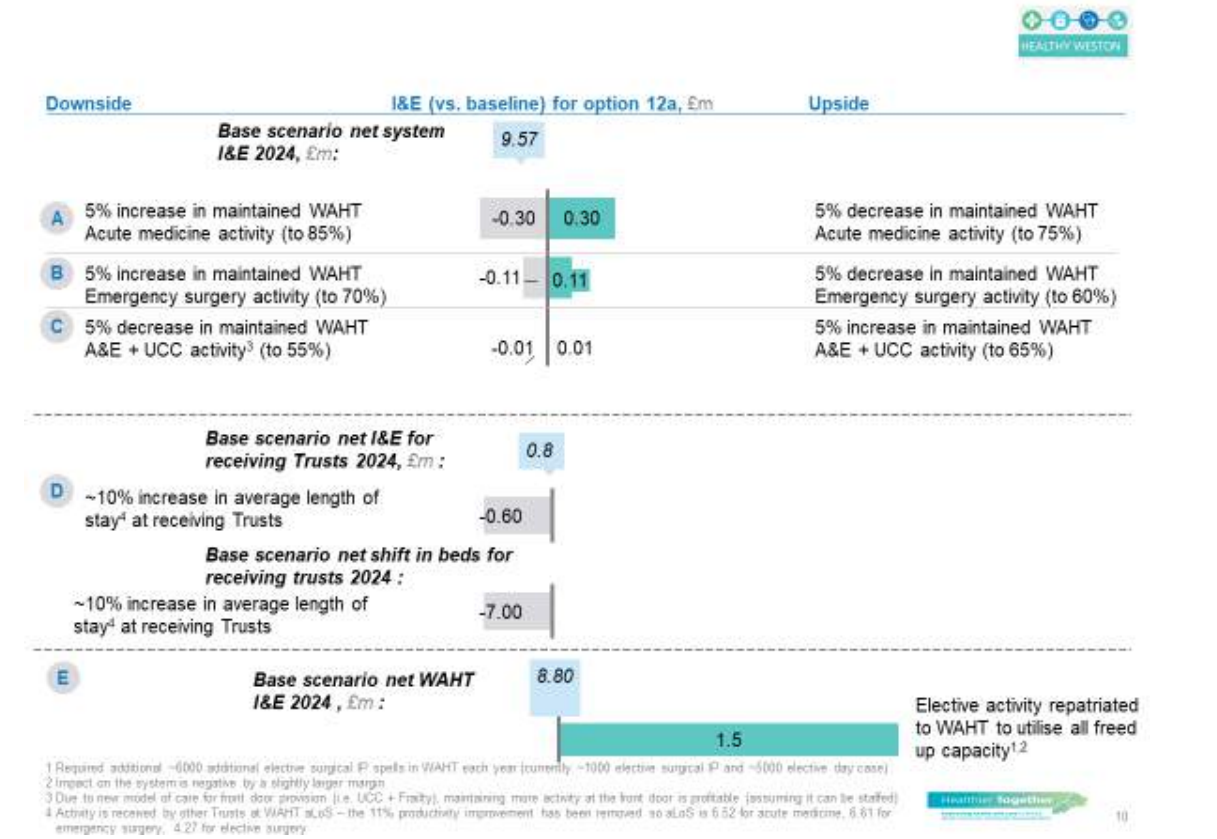
C. **Proportion of A&E activity maintained at WAHT** was tested with the impact of a 5% increase or decrease shown. The system wide I&E impact (against baseline) for option 12a was used as a proxy output. A 5% increase in activity maintained at WAHT led to £160,000 improvement in the net system I&E for option 12a. The opposite and equivalent impact was seen for a 5% decrease in activity maintained. This impact is due to the improved cost

position of A&E activity (with a UTC, and reduced cost premiums on ED staffing) which means incremental A&E activity has a positive overall margin.

D. **Average length of stay (aLoS) of activity shifted to other Trusts** was increased by ~10%. The average length of stay of shifted activity was assumed to be the same as the WAHT aLoS for the relevant service line with an 11% improvement to reach top quartile by 2024. This sensitivity removed the 11% improvement so that activity shifted to other Trusts at WAHT's aLoS The net I&E impact on receiving Trusts (against baseline) for option 12a was used as a proxy output. Removing the 11% improvement led to a worsening of the net I&E impact for receiving Trusts by £260,000. This impact is explained by increased costs due to longer stays for patients. The impact of this change on the numbers of beds needed in the receiving Trusts and showed that removing the 11% improvement in aLoS increased the numbers of beds required by 7.

E. **Repatriation of elective surgical activity to fill freed up capacity** was tested, with ~600% increase in elective (inpatient) surgical activity required in option 12a to fill bed capacity freed up by other activity shifts. This is equivalent to an additional ~6,000 elective spells. Repatriating this activity improves the net WAHT I&E position by £1,500,000. However it also decreases the I&E position of other Trusts (which lose this activity) by a similar amount.

FIGURE F21: SENSITIVITIES A-E ON I&E FOR CHANGES IN ACTIVITY LEVELS, AVERAGE LENGTH OF STAY AND ELECTIVE ACTIVITY REPATRIATION



F. **Capital costs per bed were tested –** base case assumptions of £350,000 per new bed built (or £7,000,000 for a new ward of 20 beds) were based on expected cost of building on a brand new site with 54m^2 required per bed and as well as additional clinical and non-clinical space. This cost was thought to be potentially too high when compared to costs of previous projects, particularly if the space is already available and only a conversion into clinical space required. In the event that an entirely new building is required in a more expensive area (e.g. Bristol) the costs may potentially be higher. Therefore, sensitivities were added for a higher cost (£500,000 per bed) or a lower cost (£100,000 per bed up to 30 beds and £200,000 per bed after 30 beds). The results of these changes across all options is shown in Figure 55

G. **Demand management** was agreed at 1% in the base case. However further changes in primary and community care may be required to meet the CCG control target and so sensitivities were tested for different levels of demand management. The impact of changing demand management on WAHT I&E and on baseline bed base per Trust are shown in Figures 56 and 57. Increasing demand management to 3% has a £2,400,000 negative impact on the WAHT I&E and a £4,200,000 positive impact on the CCG position. Increasing demand management also supports more freed up capacity in receiving Trusts for activity that is shifted from WAHT.

FIGURE F22: SENSITIVITY F ON CAPITAL COST PER BED

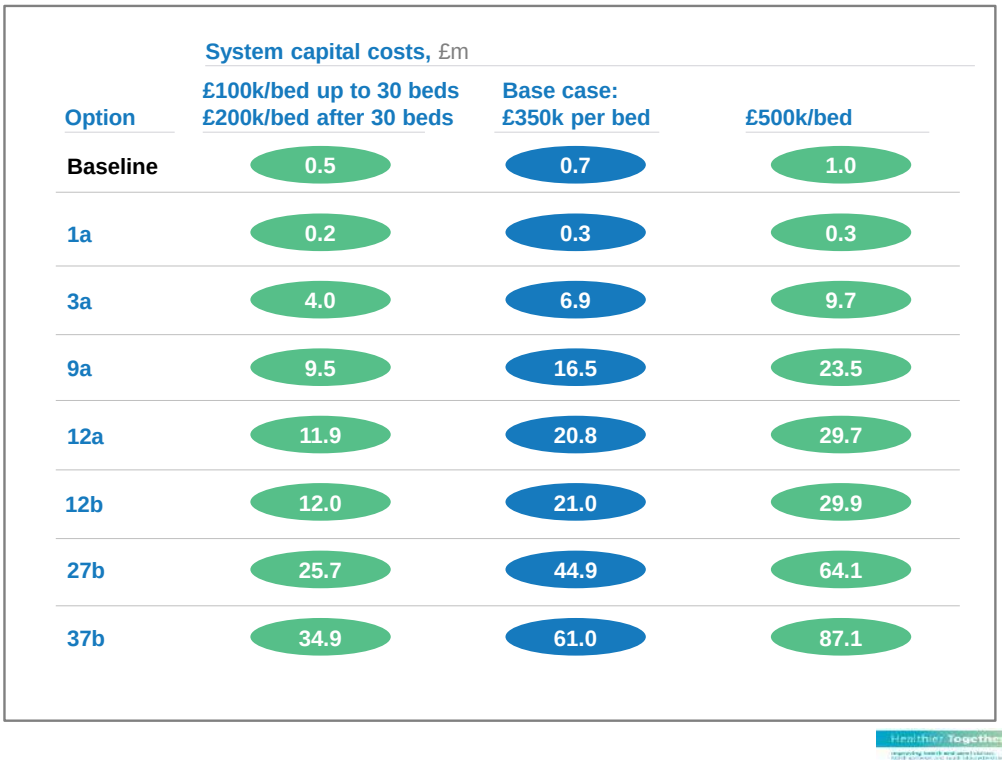


FIGURE F23: SENSITIVITY G ON DEMAND MANAGEMENT IMPACT ON WAHT AND CCG FINANCIAL POSITION

2024 position - sensitivity to CIP and demand management

Annual demand mgmt. on acute services lines only	Annual cost improvement (3.5%)	(3.0%)	(2.5%)	(2.0%)	(1.5%)	(1.0%)	(0.5%)	Change in CCGs' position from demand mgmt. in WAHT only
(4.0%)	(12.3)	(14.8)	(17.5)	(20.1)	(22.9)	(25.7)	(28.5)	6.2
(3.0%)	(11.0)	(13.6)	(16.3)	(19.0)	(21.9)	(24.7)	(27.6)	4.2
(2.0%)	(9.6)	(12.3)	(15.0)	(17.9)	(20.8)	(23.7)	(26.7)	2.1
(1.0%)	(8.1)	(10.9)	(13.7)	(16.6)	(19.6)	(22.6)	(25.7)	0.0 Assumed CCG balance position
0.0%	(6.5)	(9.4)	(12.3)	(15.3)	(18.3)	(21.5)	(24.6)	(2.1)
1.0%	(4.8)	(7.8)	(10.8)	(13.9)	(17.0)	(20.2)	(23.5)	(4.3)
2.0%	(3.0)	(6.1)	(9.2)	(12.4)	(15.6)	(18.9)	(22.3)	(6.5)

SOURCE: Financial Baseline Forecasting Model

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FIGURE F24: SENSITIVITY G ON DEMAND MANAGEMENT IMPACT ON BED CAPACITY AT RECEIVING TRUSTS

Option	Net bed change for option 12a (1% demand management)	Net change in baseline bed capacity by 2024[1] (1% demand management)	Net change in baseline bed capacity by 2024[1] (3% demand management)
WAHT	- 80	+ 2	-13
UHB	+37	0	- 105
NBT	+ 11	+ 77	- 42
T&S	+ 11	+ 32	- 32

1 Assuming top quartile LoS for all Trusts

7

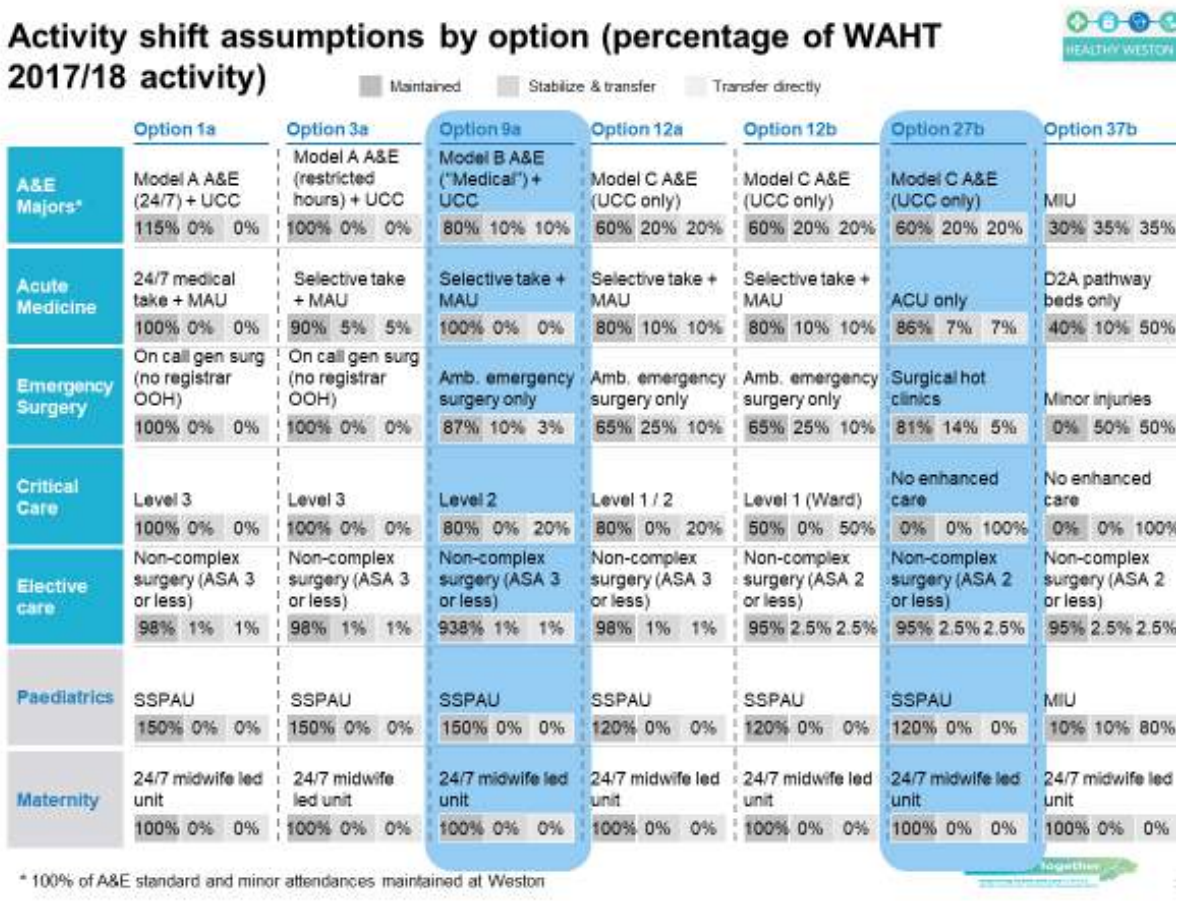
5 ACTIVITY AND FINANCIAL MODELLING OF REVISED MODELS FOLLOWING CLINICAL SENATE

This section of the appendix shows all the financial and activity analysis on the two phases of clinical model that were subjected to financial evaluation for the version of the PCBC that was considered by NHS England in its Stage 2 assurance meeting in December 2017. This has been overtaken by more recent work but is included here for completeness.

5.1 Following Clinical Senate meeting in November further clinical scrutiny of options 9a and a revised and "fleshed out" 27b which included beds and MAU went through financial and activity modelling as outlined in this chapter.

The changes to the proposed clinical models and activity shifts that followed the input from the Clinical senate have been made to Options 9a and 27b in the following slides, the other options were not updated as the clinical senate accepted the assessment against the evaluation criteria which indicated that they should not be developed further.

FIGURE F25: ACTIVITY SPLIT FOR THE 2 PROPOSED REVISED MODELS (PERCENTAGE OF WAHT 2017/18 ACTIVITY)



To validate these assumptions, local GPs completed clinical audits of two weeks of attendances at Weston General Hospital A&E.

The impact of the above adjustments to A&E majors on the overall A&E proportions is shown below:

Table F3: Estimated level of activity 2019/20 revised

	2018/19	9a		27b	
	(*)	Activity	%	Activity	%
A&E major	7,700	5,789	75.2%	4,342	56.4%
A&E standard	21,923	21,127	96.4%	21,127	96.4%
A&E minor	16,439	16,166	98.3%	16,166	98.3%
A&E Total	**46,062**	**43,082**	**93.5%**	**41,635**	**90.4%**

The initial results, when adjusted for the expected impact of the Integrated Frailty Service show that for Option 9a and 12a the figures that will remain at WGH are between 93.0% - 98% and 83.2% - 90.6% which very much in line with the estimates. For Option 27b the range is 66.9% - 72.2% which is some distance from the modelling assumptions. This is being taken back through the CSDDG to understand the basis for the differences which are believed to be caused by the addition of a 72 hour Medical Assessment Unit to Option 27b made after the clinical audit.

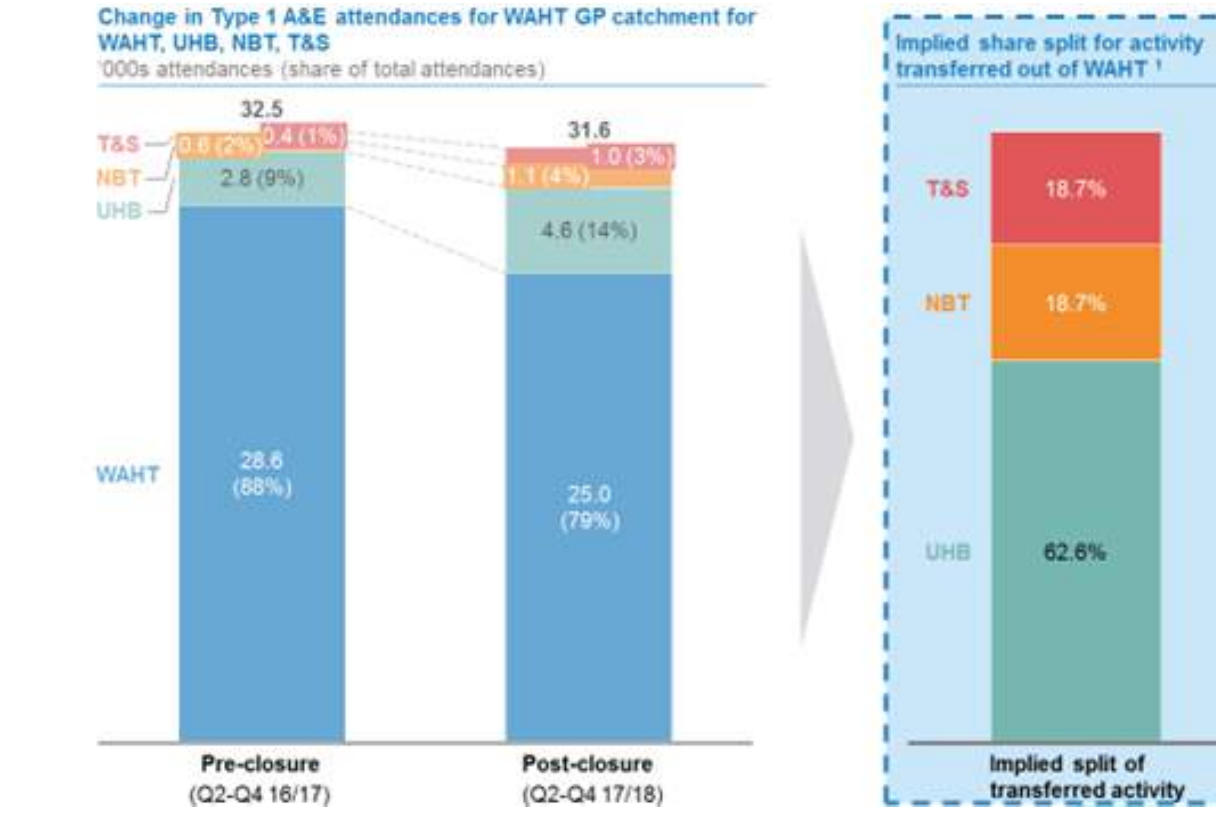
Please note that this A&E does not drive bed numbers in receiving sites which are modelled from the activity shift of Acute Medicine and Emergency Surgery.

Table F4: % A&E attendance retained at WGH revised

	9a	27b
Top Down	93.5%	90.4%
GP Jan (adj)	93.0%	66.9%
GP Aug (adj)	98.1%	72.2%

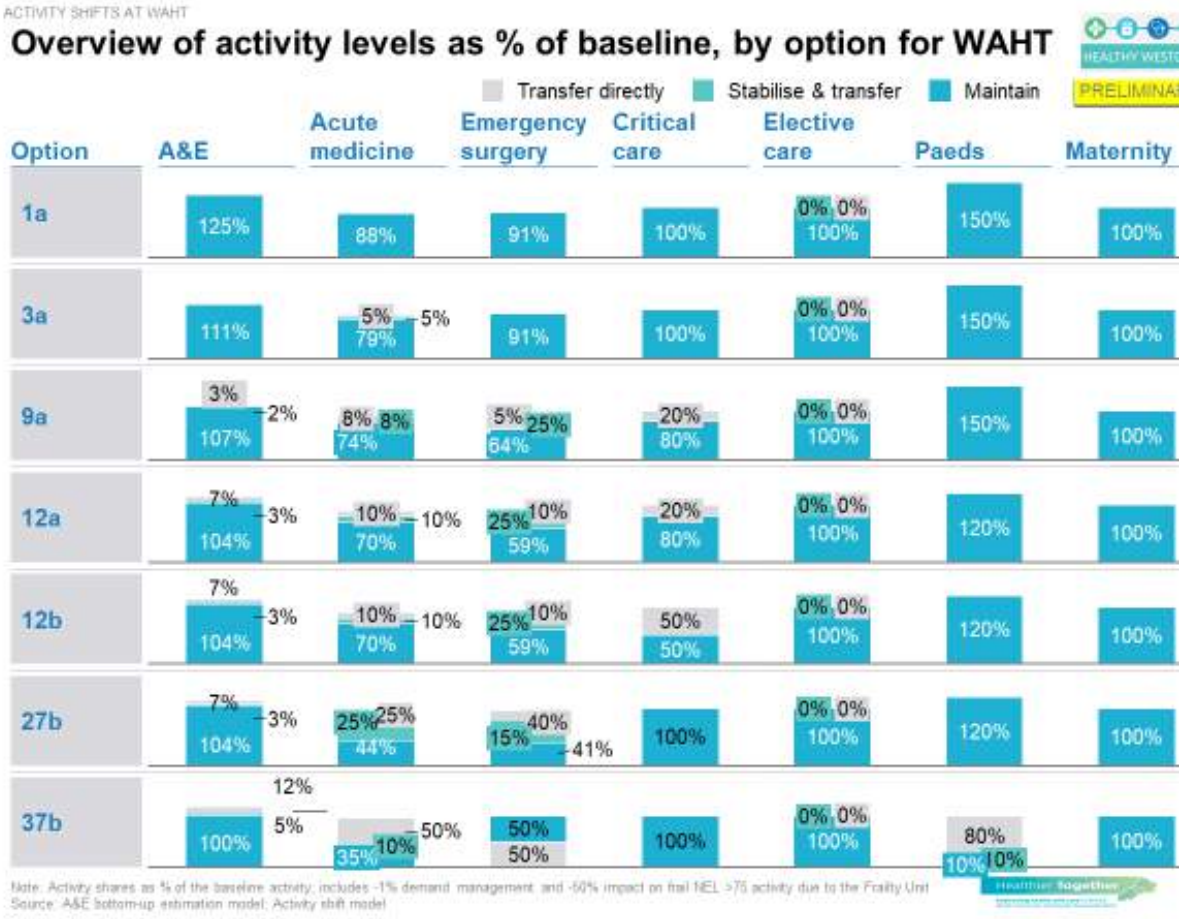
The Healthy Weston Steering Group agreed to use recent patient behaviour as a proxy for expected activity flows as shown in F6. This approach was applied to all service lines except for paediatrics where only UHB and T&S are considered (NBT does not provide a paediatric service).

FIGURE F26: ACTIVITY SHIFT SPLIT BY TRUST WAS MODELLED USING THE IMPACT OF THE OVERNIGHT CLOSURE ON A&E FLOWS



Applying the population flows, together with the assumed split of activity under each clinical model Figure F25, to the activity baseline projection, and the impact of the new frailty service as described above, gives the activity profiles for each potential service configuration option shown in F27.

FIGURE F27: OVERVIEW OF ACTIVITY LEVELS AS % OF BASELINE, BY OPTION FOR WAHT



5.2 Components of the financial evaluation

5.2.a *Capital costs*

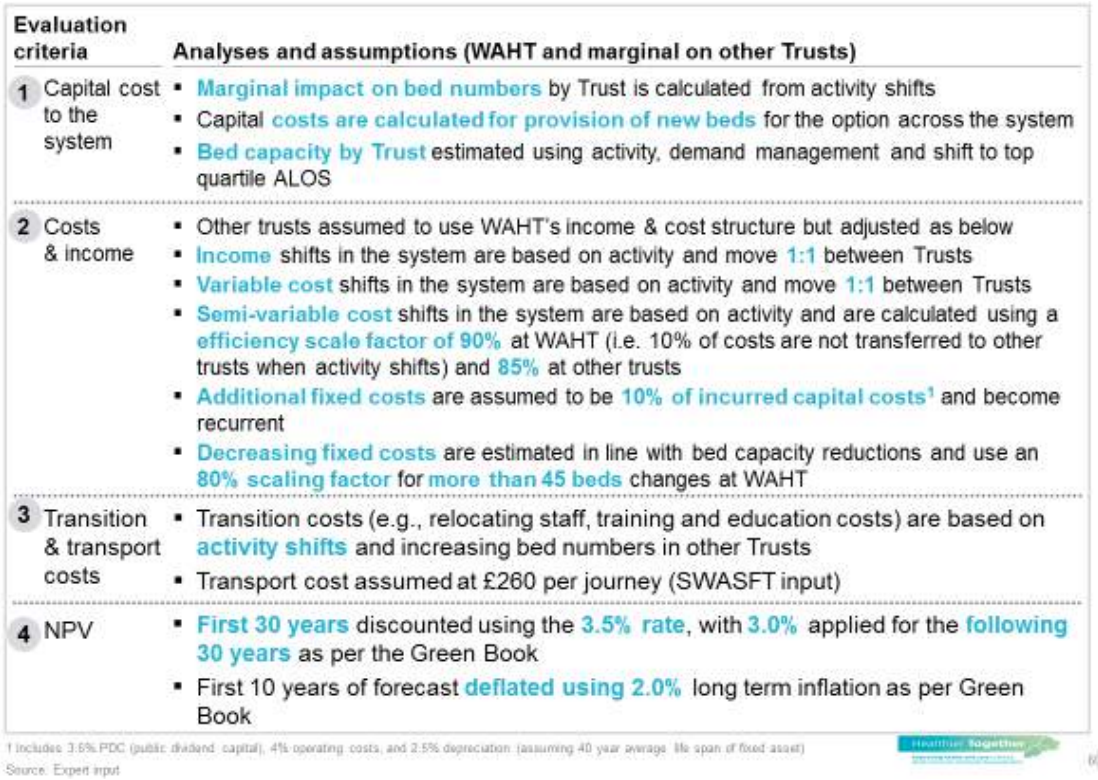
Capital costs have been estimated by looking at the cost of building new hospital capacity, using the number of new inpatient beds to estimate this, both within WAHT and at neighbouring Trusts. This has been modelled on £350,000 per new bed built (or £7,000,000 for a 20 bedded ward) with no threshold / step function included. No assumptions have been included for any net land receipts generated from releasing capital for capacity no longer required.

Sensitivity has been applied to this assumption to show the potential impact of different bed build costs on system capital costs (including a step change where lower costs are incurred per bed built below a set threshold). No assumptions on one-time cost requirements for releasing fixed costs (e.g. demolition of buildings) have been included.

Additionally, following discussion with the ambulance service, a capital allowance has been made in this PCBC for additional ambulance capacity needed as a result of increasing the numbers of conveyances. £0.6m has been allowed for Option 9 and £1.2m for Option 27b.

Financial assumptions used in the modelling work are listed in Figure F28.

FIGURE F28: Key assumptions for finance MODELLING



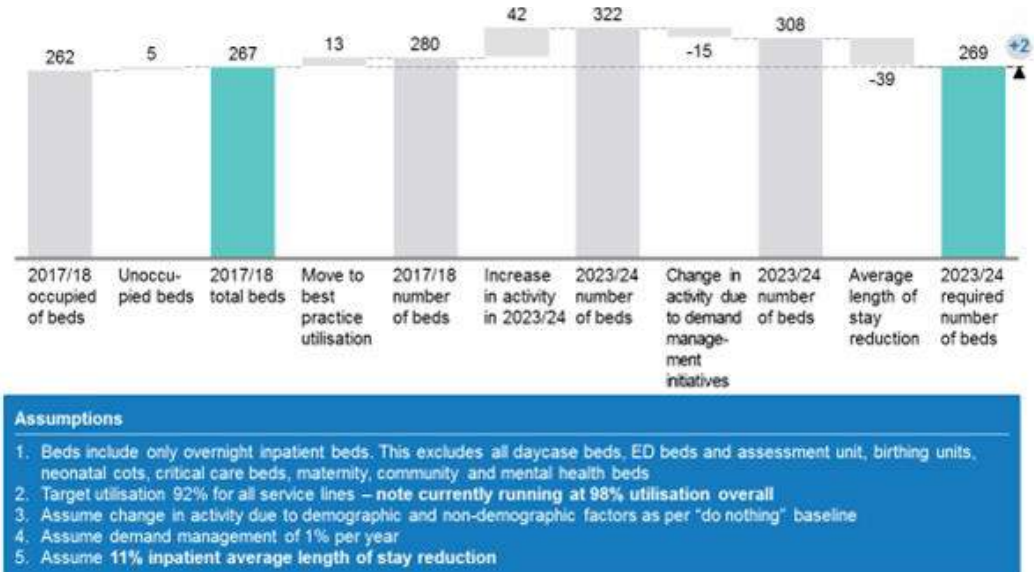
Evaluation criteria	Analyses and assumptions (WAHT and marginal on other Trusts)
1 Capital cost to the system	▪ Marginal impact on bed numbers by Trust is calculated from activity shifts ▪ Capital costs are calculated for provision of new beds for the option across the system ▪ Bed capacity by Trust estimated using activity, demand management and shift to top quartile ALOS
2 Costs & income	▪ Other trusts assumed to use WAHT's income & cost structure but adjusted as below ▪ Income shifts in the system are based on activity and move 1:1 between Trusts ▪ Variable cost shifts in the system are based on activity and move 1:1 between Trusts ▪ Semi-variable cost shifts in the system are based on activity and are calculated using a efficiency scale factor of 90% at WAHT (i.e. 10% of costs are not transferred to other trusts when activity shifts) and 85% at other trusts ▪ Additional fixed costs are assumed to be 10% of incurred capital costs[1] and become recurrent ▪ Decreasing fixed costs are estimated in line with bed capacity reductions and use an 80% scaling factor for more than 45 beds changes at WAHT
3 Transition & transport costs	▪ Transition costs (e.g., relocating staff, training and education costs) are based on activity shifts and increasing bed numbers in other Trusts ▪ Transport cost assumed at £260 per journey (SWASFT input)
4 NPV	▪ First 30 years discounted using the 3.5% rate, with 3.0% applied for the following 30 years as per the Green Book ▪ First 10 years of forecast deflated using 2.0% long term inflation as per Green Book

1 Includes 3.5% PDC (public dividend capital), 4% operating costs, and 2.5% depreciation (assuming 40 year average life span of fixed asset)
Source: Expert input

In terms of bed numbers at Weston General Hospital no significant change in bed numbers would be forecast if current services continued based on the following assumptions which are illustrated in Figure F29

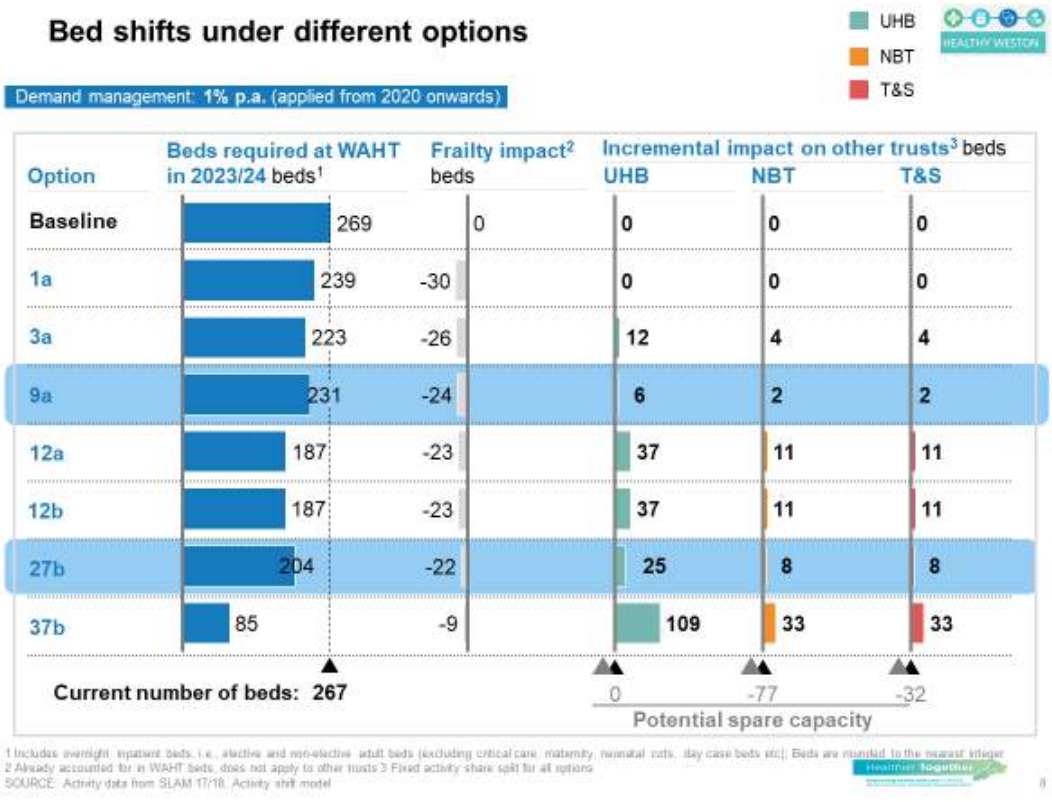
- an 11% reduction in length of stay to reach top quartile performance;
- Activity changes in response to population growth
- target utilisation for beds of 92%
- Demand management of 1%

FIGURE F29: PROJECTED CHANGE IN INPATIENT ACTIVITY BY 2023/24 AND IMPACT ON WESTON TRUST BED REQUIREMENT BEDS



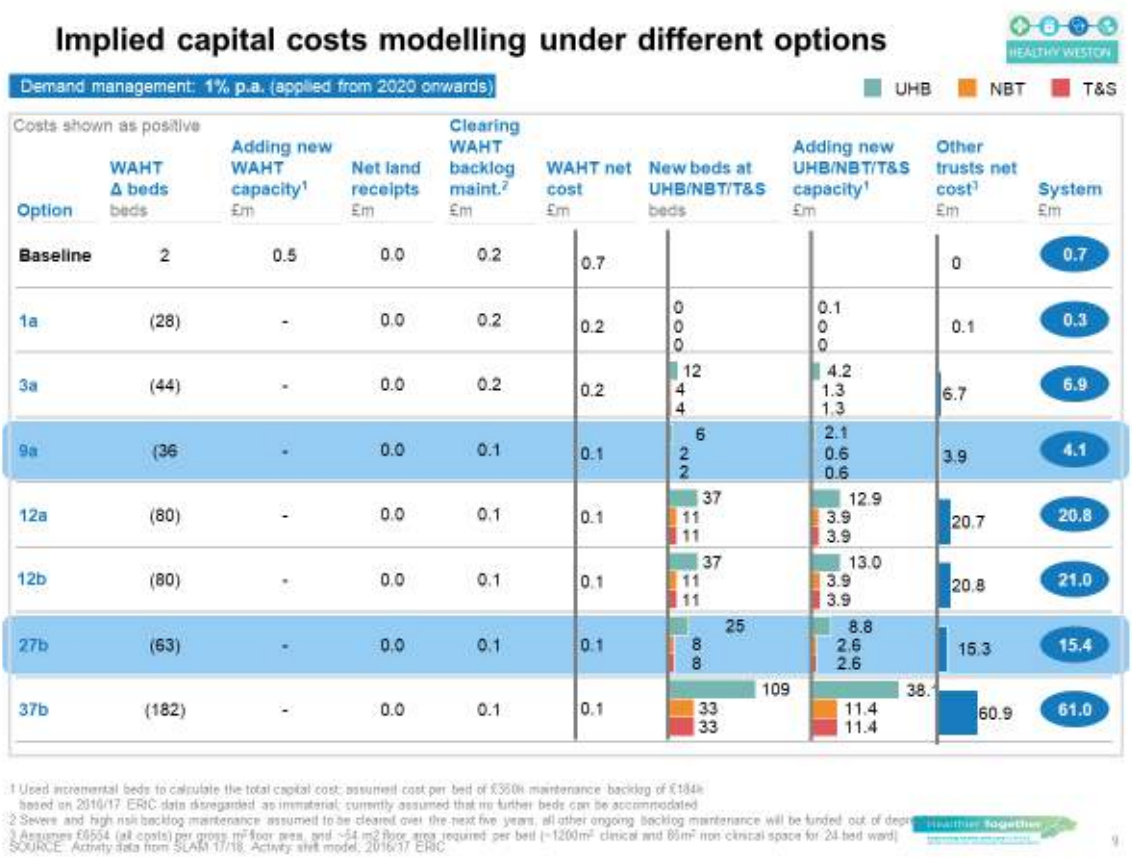
With the same assumptions around demand management and length of stay as in the "do nothing" scenario, applying the activity shifts results in bed requirements for each option as shown in Figure F29. Reducing length of stay further (e.g. to top decile) would reduce the amount of additional capacity required. This is also tested with sensitivity analyses.

FIGURE F30: BED SHIFTS FOR TWO REVISED OPTIONS (HIGHLIGHTED IN BLUE)



For worst case financial modelling we have assumed no net land receipts making the capital cost of adding capacity to the system by provider as shown in Figure F31.

FIGURE F31: IMPLIED CAPITAL COSTS TO THE SYSTEM UNDER REVISED OPTIONS (HIGHLIGHTED IN BLUE)



It should be noted that the BNSSG system will be developing detailed mitigating plans to avoid the need to commit significant capital to creating replacement bed capacity. These mitigations will include:

1. Seeking the productivity opportunities at NBT and TST shown on Figure F10 (shown as potential spare capacity);
2. The option of increasing the Elective Activity that is carried out at WGH and so effectively moving Bed Days from the other hospitals
3. For Option 27b the impact of a BNSSG system wide Integrated Frailty Service which is expected to reduce the baseline activity at the other Acute Trusts
4. Improved use of the discharge to assess (D2A) beds as a result of the procurement of Adult Community Services.

More detailed planning will be carried out to ensure that capital requirements for any reconfiguration are able to be met from individual Trust capital plans and these changes will be high priority STP plans and so will have first call on capital made available through STPs.

5.2.b *Income and expenditure*

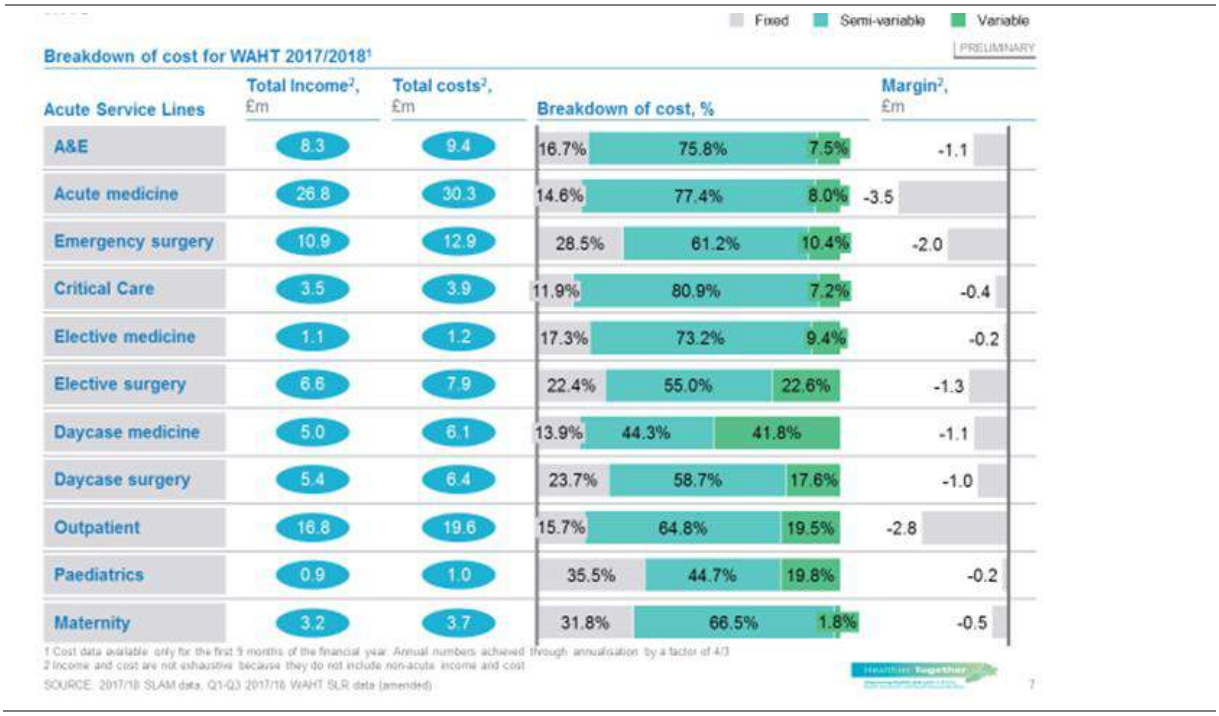
Income and expenditure (I&E) is the net of all recurrent income and all recurrent expenditure. It is an important measure of financial performance recognising that an NHS Trust is not financially viable unless it is able to generate a surplus. While the financial baseline projection expects WAHT to run a deficit position, any option must improve on this in order to justify any capital expenditure.

In order to compare each of the options, a methodology for reconfiguration modelling income and expenditure has been estimated for each service line with expenditure broken down into variable cost, semi-variable cost and fixed cost.

- Variable cost represents all cost that will scale in line with clinical activity, for example, food, laundry services, and consumables such as drugs.
- Semi-variable cost represents the cost of staff, both permanent and temporary, and will change with activity albeit not in a linear fashion as economies or diseconomies of scale are realised – a 15% consolidation benefit [for receiving organisations] and a 10% diseconomies loss factor [for WAHT] is assumed. Furthermore, the premium on staff, due to use of non-permanent ED staff, was assumed to taper as activity is shifted away (up to 75% reduction in option 37b).
- Fixed cost is the cost of buildings and equipment and overheads and will not scale with activity unless an active decision that impacts this directly, such as increasing or decreasing capacity, is taken.

The full set of assumptions used in the I&E modelling is shown in Figure F27 above and the breakdown of WAHT current financial position by service line is shown in Figure F32 below.

FIGURE F32: WAHT INCOME AND COST (INCLUDING COST BREAKDOWN) BY SERVICE LINE



Modelling the impact of changes to I&E under different potential service configuration options follows the inclusion of bottom up costings and has been progressed in three stages which are summarised below:

- First, the impact of activity leaving WAHT is estimated by assuming all activity arriving at neighbouring Trusts will generate fragmentation effects within WAHT. More specifically, this means 100% of income associated with reduced activity will leave WAHT while less than 100% of expenditure associated with this activity leaves. 100% of variable cost will leave but only 90% of semi-variable cost will leave. Fixed costs will not be impacted at this stage – changes in fixed costs are modelled separately. Additionally, activity is moved to the receiving hospital assuming WAHT Average Length of Stay (aLoS) to reflect the case mix of the transferring activity and not the current case mix of the receiving hospital.
- Second, the impact of consolidation is estimated. For service lines that are seeing more activity provided by larger sites, financial consolidation benefits in terms of semi-variable costs will be observed, while for service lines that are being provided by WAHT, a small trust, fragmentation effects have been assumed. This is estimated by modelling 90% of semi-variable cost being released with decreasing activity and 85% of the **sending site semi-variable cost** added to the receiving site, as all are significantly larger than WAHT. As WAHT is making a loss on most activities this should be a conservative approach as the larger receiving hospitals should be more cost effective than this.
- Third, the change in fixed cost due to reconfiguring capacity is estimated. Fixed cost is added for increasing capacity at 10% of capital expenditure, while fixed cost to be removed in line with closed capacity is modelled in terms of inpatient beds reduction with 80% scaling factor. For example, if 10% of inpatient beds are released, 8% of fixed cost can be released at that site once a threshold of at least 45 beds has been reached – this effectively assumes that reducing beds by up to 45 does not allow the release of any fixed costs.

The result of this is that:

- options with sub-threshold activity reductions (the threshold for releasing fixed cost was agreed to be 45 beds) perform less favourably in terms of WAHT I&E than the others due to stranded fixed costs.
- options with more new bed build requirements at other Trusts perform less favourably in terms of system I&E because the consolidation benefits are unable to offset the impact of high capital costs on the fixed cost base.

Figure F33 shows the breakdown of WAHT I&E for each potential service configuration option while Figure F34 show the breakdown of system I&E by Trust.

FIGURE F33: CHANGE IN 2023/24 WAHT I&E ACROSS REVISED OPTIONS 9A AND 27B

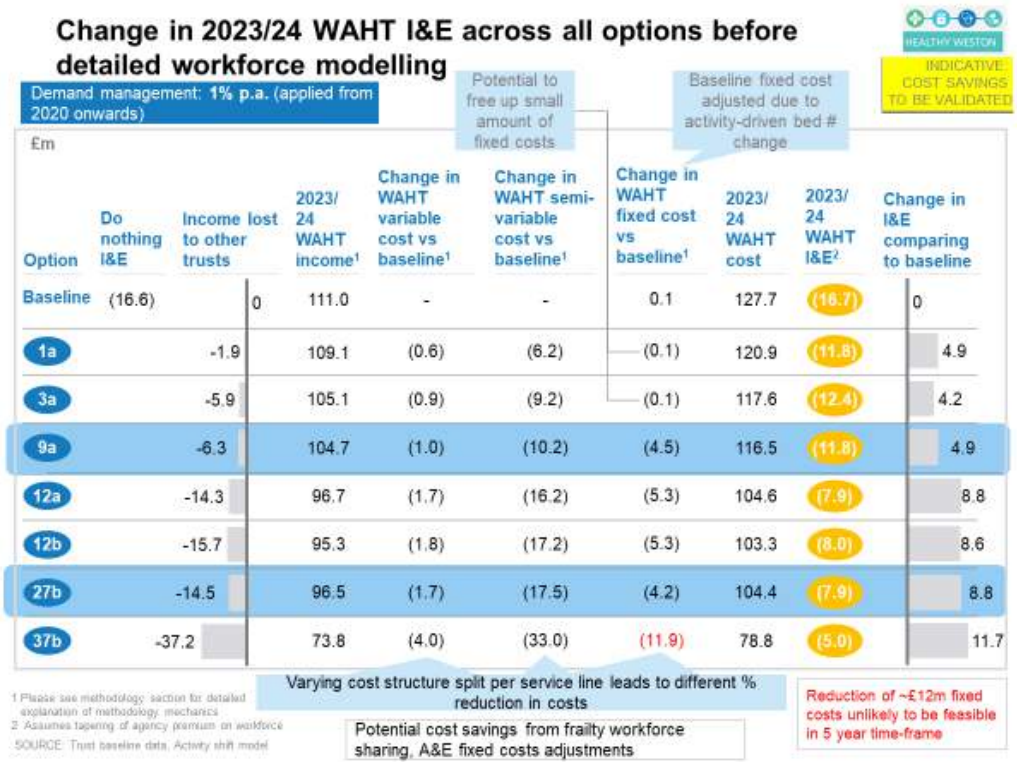


FIGURE F34: NET CHANGE TO I&E FOR OTHER TRUSTS FOR TWO REVISED OPTONS (HIGHLIGHTED IN BLUE)

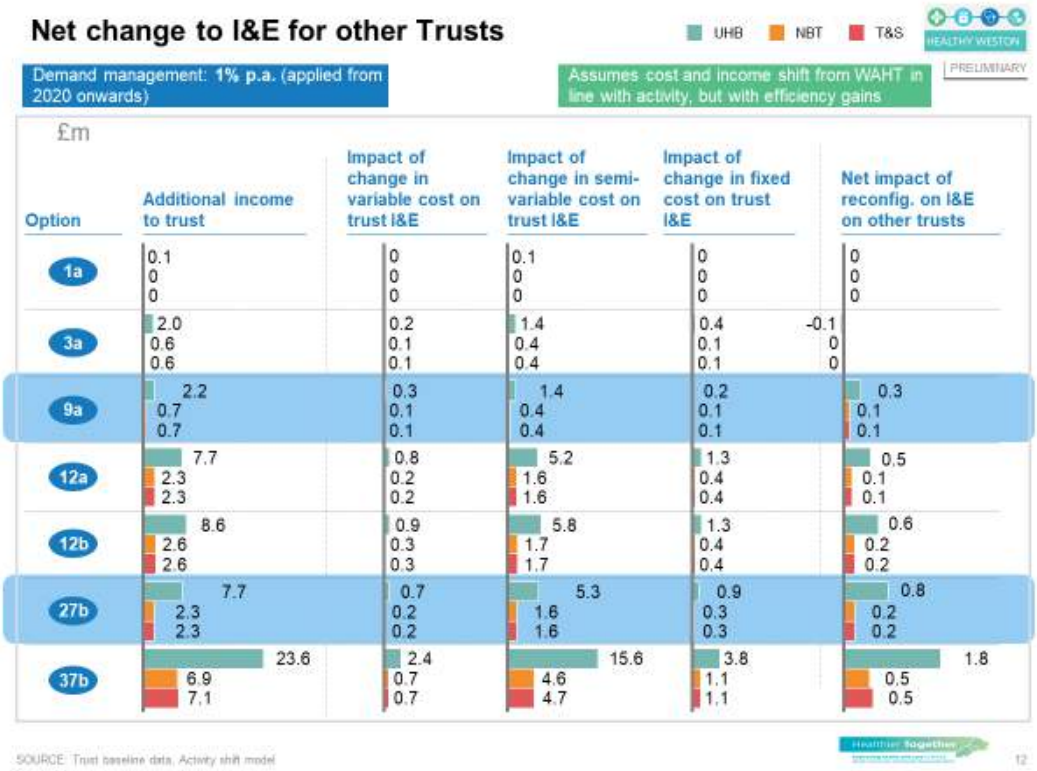
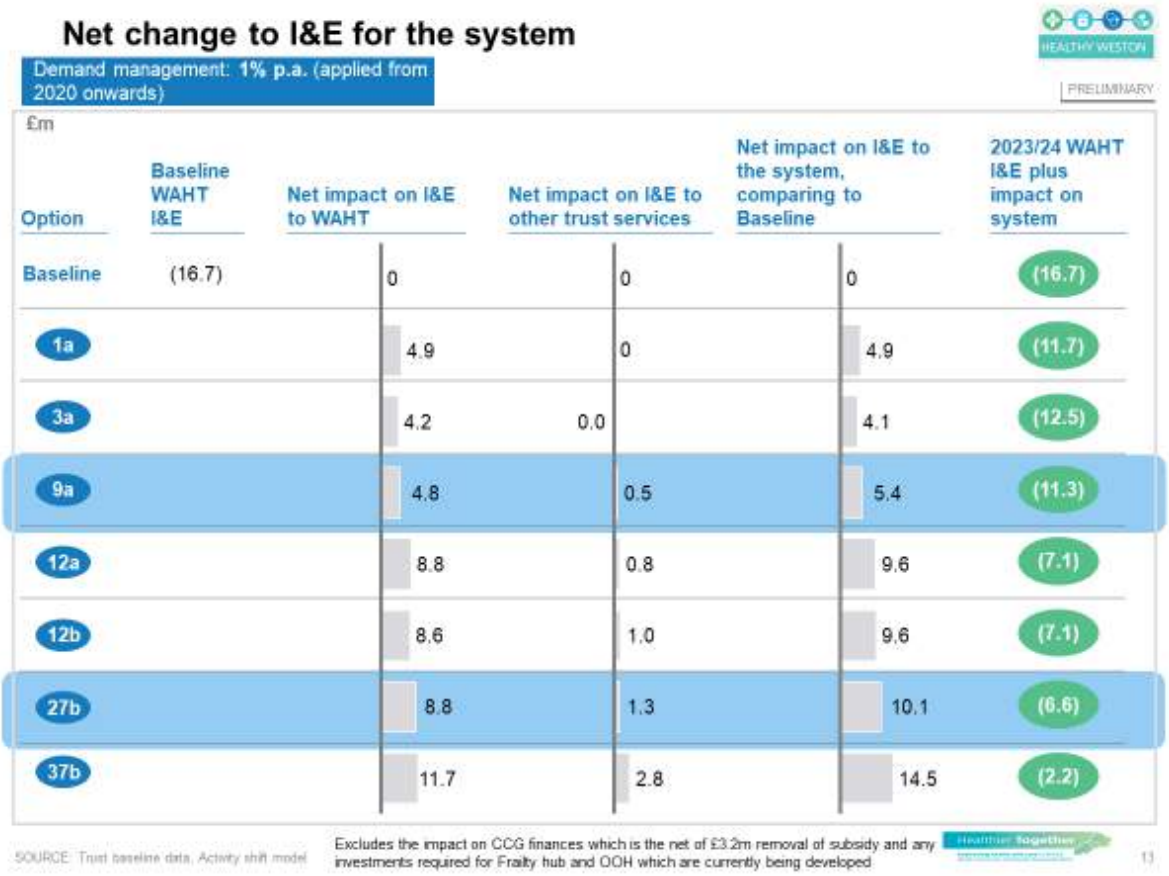


Figure F35 shows the impact on I&E on neighbouring Trusts and the system as a whole.

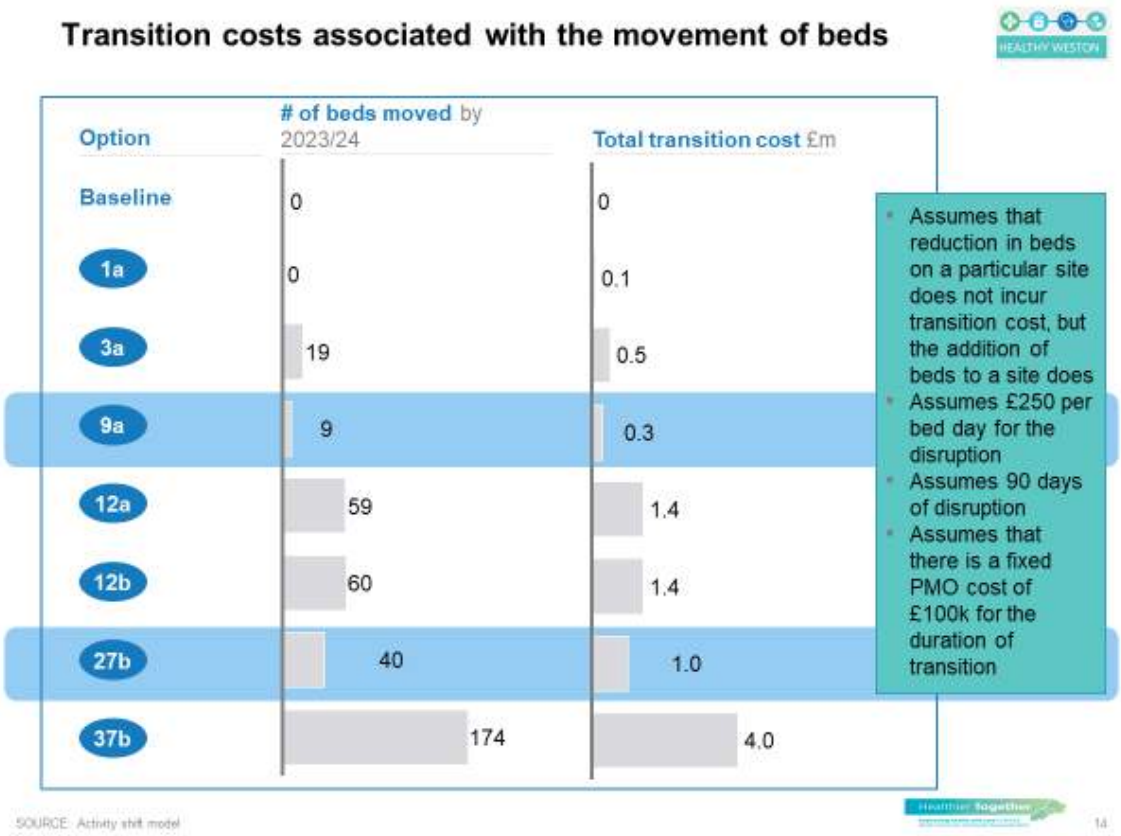
FIGURE F35: NET CHANGE TO I&E FOR THE SYSTEM FOR REVISED TWO OPTIONS (HIGHLIGHTED IN BLUE)



8.4.3 Transition Costs And Transport Costs

Transition costs are the additional costs beyond the capital build requirement that would be incurred due to the disruption caused through any changes made to the configuration of services, in particular any double running of services. This has been estimated to be incurred in line with bed movements (i.e. new bed capacity), at a cost of £250 per bed day of disruption both within WAHT and at neighbouring Trusts. Disruption is assumed to last for 90 days for each bed movement. An additional £100k is added for PMO overhead across all options. The differential transition cost per option is shown in Figure F35

FIGURE F36: TRANSITION COSTS ASSOCIATED WITH BED MOVEMENT ASSOCIATED WITH REVISED TWO OPTIONS (HIGHLIGHTED IN BLUE)



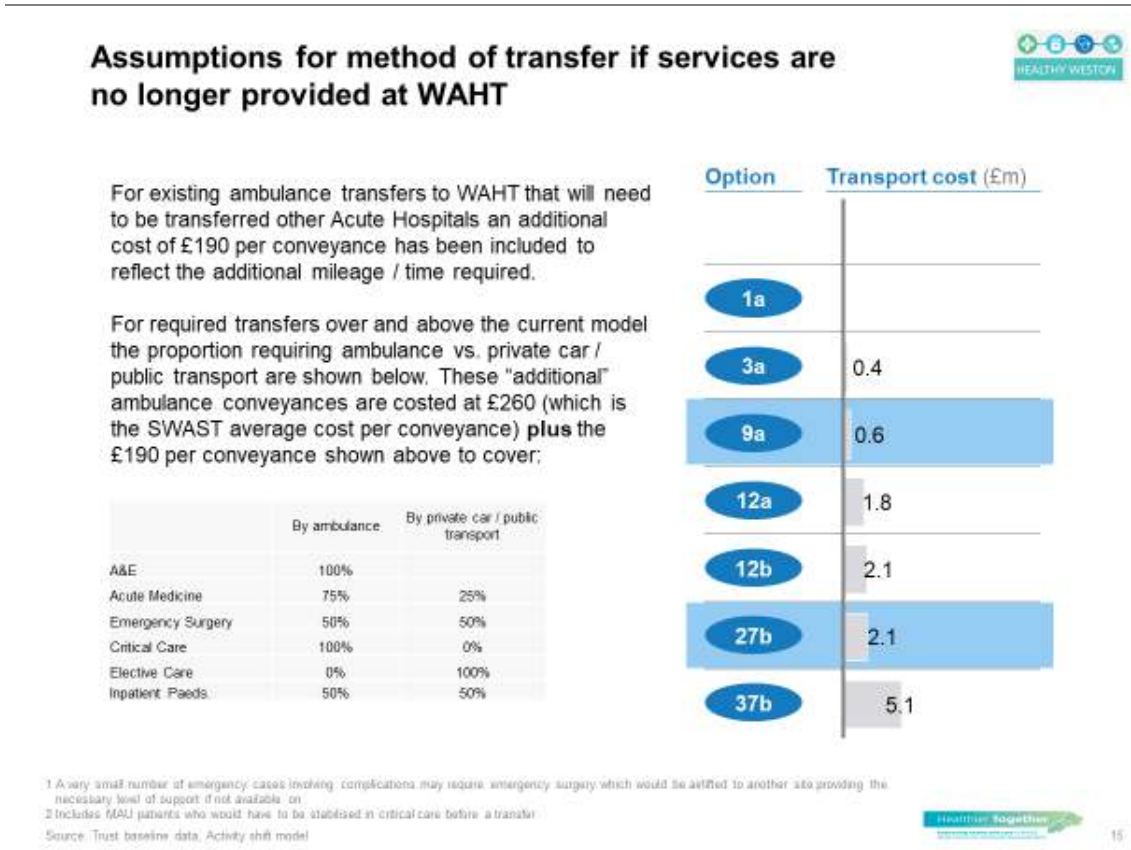
For existing ambulance transfers to WAHT that will need to be transferred other Acute Hospitals an additional cost of £190 per conveyance has been included to reflect the additional mileage / time required.

For required transfers over and above the current model the proportion requiring ambulance vs. private car / public transport are shown below. These “additional” ambulance conveyances are costed at £260 (which is the SWAST average cost per conveyance) **plus** the £190 per conveyance shown above to cover the additional mileage / time plus the impact of having a crew off the area that they are covering.

Following discussions with the ambulance service an estimate of capital required has been made at £0.6m for option 9a and £1.2m for option 27b. Detailed modelling will be undertaken during the consultation process to model the impact of the proposed changes and associated costs of providing the additional service. This detailed modelling will include estimating the impact of evidence that changes to A&E opening times or range of services offered can result in up to a 13.9% increase in ambulance calls in the locality as advised by SWASFT.

Figure F37 shows the estimated additional ambulance cost for each option.

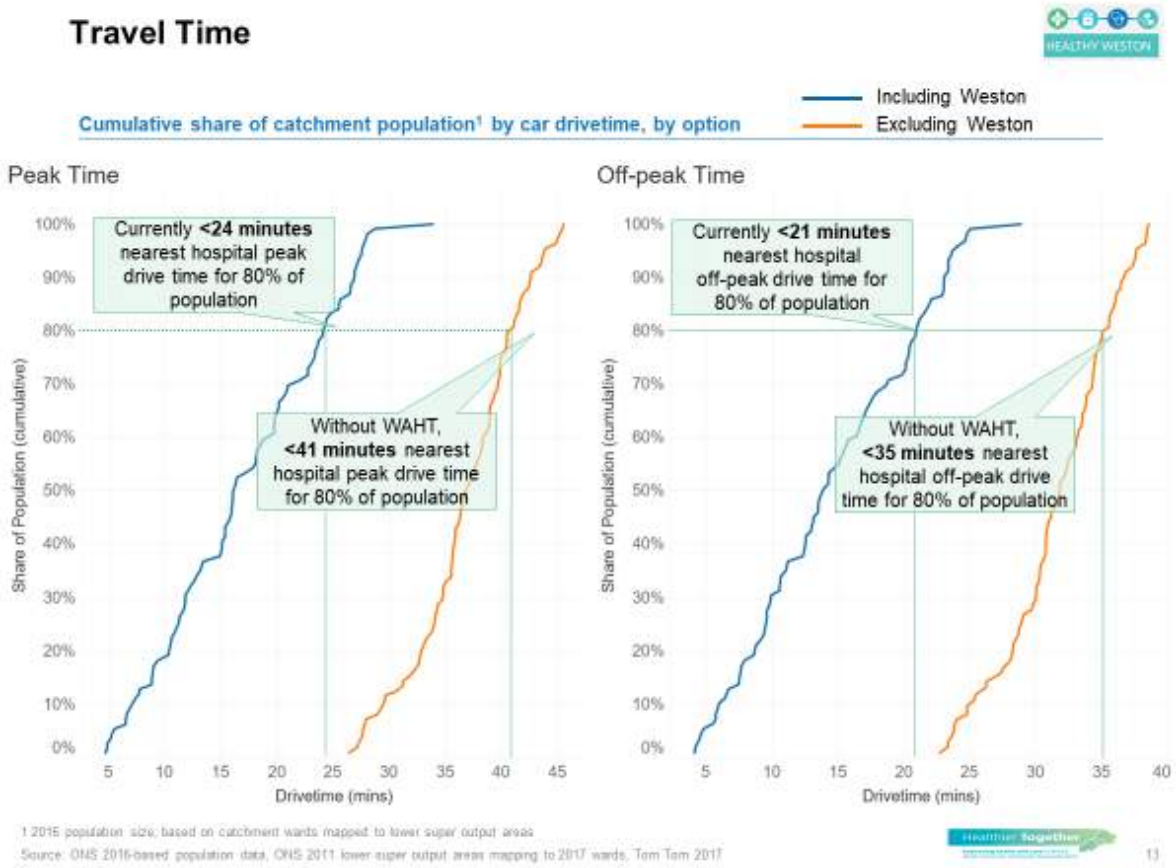
FIGURE F37: ASSUMPTIONS FOR METHOD OF TRANSFER IF SERVICES ARE NO LONGER PROVIDED AT WHAT FOR REVISED TWO OPTIONS (HIGHLIGHTED IN BLUE)



5.3 **Travel Time Analysis**

Analysis was carried out showing the time taken for the catchment population to access an Acute Hospital at both peak and off-peak times. This was then recalculated if people had to travel to a different hospital for those services. This showed at the 80th centile of population that during peak times people would need to travel for an additional 17 minutes and off peak for an extra 14 minutes. This is shown in figure F38.

FIGURE F38: CUMULATIVE SHARE OF CATCHMENT POPULATION BY CAR DRIVE TIME



5.4 Net present value

HM Treasury guidance in The Green Book states that public sector capital projects should be appraised in terms of value for money using a net present value (NPV) measure. This measure represents the return on investment: i.e., to what extent will the initial capital cost of new infrastructure be offset by future cash generated as a result of this investment? In an NHS context, cash is likely to be generated through productivity savings and consolidation benefits. Options have been evaluated based on a 30-year NPV, with a 60-year NPV also calculated for sensitivity as NHS England guidance states return on investment should be analysed over a 60 year period.

NPV is calculated as net capital expenditure plus the projected surplus or deficit I&E position each year discounted by the agreed discount rate. The terminal value of any assets is not included in this calculation at the end of the 30 or 60 year time period.

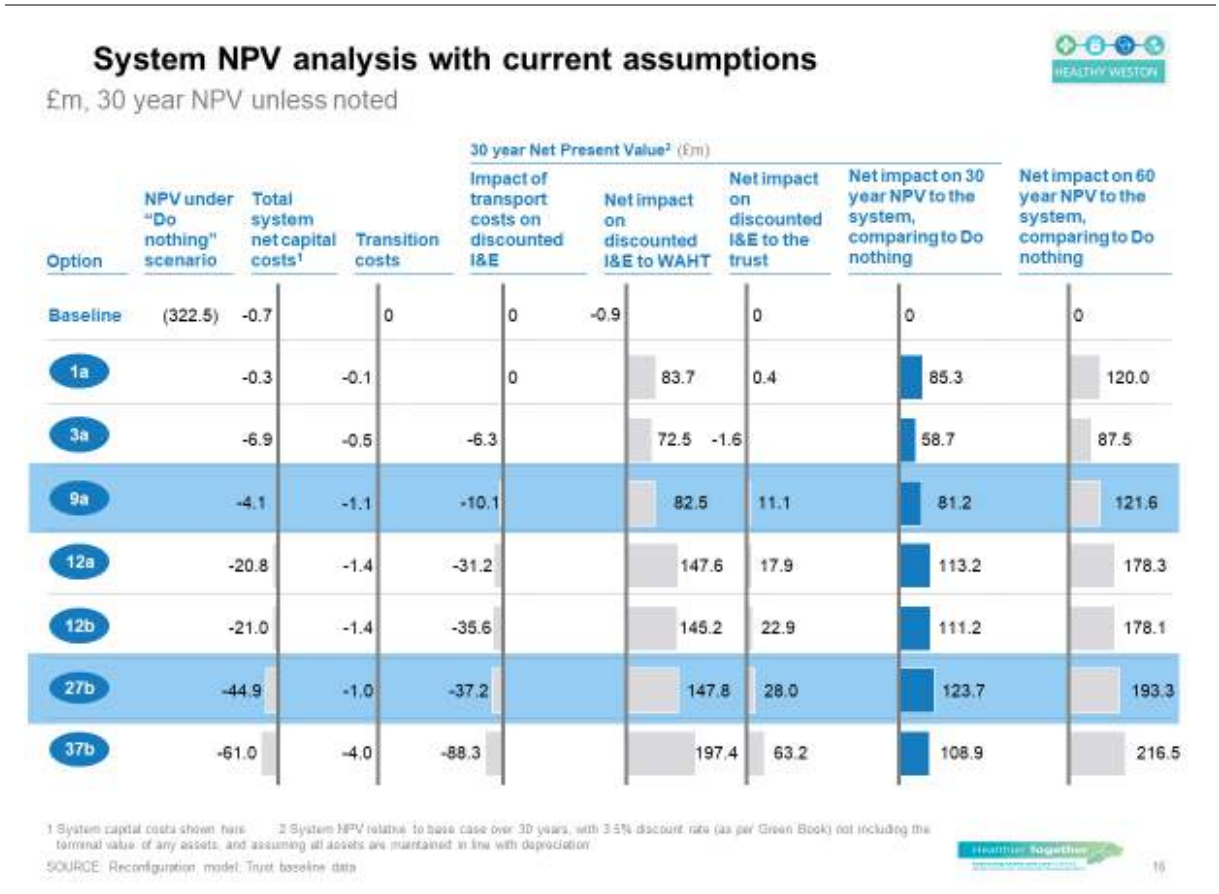
As in guidance in The Green Book, forecasts have been brought into real cash terms by discounting them with the long-term inflation rate of 2%. A discount rate of 3.5% is used for years 1-30 and 3% thereafter, also in line with The Green Book guidance. Future cash flows are discounted to correct for the belief that £100 is deemed to be worth more today than it will be in subsequent years, due to the

opportunity cost of not being able to deploy the £100 in a value creating investment or put to other beneficial use were it not to be available today.

NPV is calculated within WAHT, and within the wider health system, including all neighbouring Trusts, to provide a comprehensive metric for comparison against the "do nothing" scenario.

The breakdown of NPV over a 30 year and 60 year time period is shown in Figure F39.

FIGURE F39: SYSTEM NPV ANALYSIS WITH CURRENT ASSUMPTIONS FOR TWO REVISED OPTIONS (HIGHLIGHTED IN BLUE)



5.5 Sensitivity analyses

These are unchanged from the previous version.

6 ACTIVITY AND FINANCIAL ANALYSIS OF PREFERRED OPTION

This section of the appendix shows all the financial and activity analysis for the preferred option.

6.1 Following the NHS E Stage 2 assurance meeting in December 2018; further work was undertaken to work through the activity shift as a result of the preferred clinical model. The proposed approach was discussed at a joint STP DoF and Clinical Design and Delivery Group (CSDDG) meeting on Friday 4th January at which the DoFs agreed that if the CSDDG group did a HRG by HRG review of the impact of the model and those activity impacts were put through the McKinsey model then this was the best information we had to hand for the PCBC stage.

A CSDDG subgroup meeting was held to discuss surgery on January 9th and then medical and repatriation assumptions were discussed and agreed at a meeting on CSDDG 17th January. This resulted in further refinements of the clinical model which clarified the activity impact at a HRG level. The results by each point of delivery (POD) are laid out below:

6.2 General Surgery

A list of HRGs that could not be supported without level 3 critical care was pulled together by Andy Hollowood (*Deputy Medical Director at UHB*) and reviewed by surgeons from WGH and NBT. The number of spells for 2017-18 for each of these HRGs was then multiplied by the UHB LOS (as UHB will be receiving most of the patients) to calculate a bed day requirement. There were some urology HRGs that had not been included in the initial review (as UHB does not provide urology) which were reviewed by Tim Whittlestone (*Divisional Director for Surgery, Critical Care, Anaesthesia and Renal Medicine at North Bristol Trust*) and these were added to the list at NBT LOS.

This resulted in a 2,960 bed days (8.1 beds) requirement at other hospitals before mitigation.

This shift in activity is of a relatively low number of spells (518) that have a relatively long LOS and so repatriation was discussed at the CSDDG on 17th January. It was agreed that after 5 days at the receiving hospital we would model 90% of patients being transferred back to WGH as the likelihood of them needing critical care level 3 or above was low after that period. This would see repatriation of 1.6 of the above beds.

6.3 Trauma and Orthopaedic (T&O)

The preferred clinical model would allow surgery up to ASA 3+ (as long as there was the ability to mechanically ventilate for up to 48 hours). WGH Operating Theatre system (Opera) was used to identify which patients from 2017-18 would not have been able to be operated on if this model was in place at the time. This identified 91 patients with an ALOS of 15 days.

This generated a requirement for 3.7 beds a repatriation assumption was agreed as above for T&O which reduced the bed requirement by 2.2 beds.

6.4 **Acute Medicine**

A list of HRGs that could not be supported without level 3 critical care was pulled together by Andy Hollowood (as for general surgery) and reviewed by physicians from WGH. The number of spells for each of these HRGs was then multiplied by the WGH LOS (as Phil Warmsley - *WGH Director of Operations* indicated that the patient mix was significantly different to the current UHB patient mix) to calculate a bed day requirement.

Almost half of the patients indicating the need to be transferred were coded to “viral pneumonia” at one level or another. The WGH physicians discussed this outside of the CSDDG meetings and agreed that these patients were a core patient base for WGH and that; as long as there was “step up access to level 3 critical care support for one organ system for 24-48 hours” then the vast majority of these patients could still be received and treated at WGH. This was discussed and agreed at the CSDDG meeting on 17th January.

This resulted in a 1,745 bed days (4.8 beds) requirement at other hospitals before mitigation.

This shift in activity is of a relatively low number of spells (96) that have a relatively long LOS and so repatriation was discussed at the CSDDG on 17th January. It was agreed that after 5 days at the receiving hospital we would model 90% of patients being transferred back to WGH as the likelihood of them needing critical care level 3 or above was low after that period. This would see repatriation of 3.7 of the above beds.

Patients that deteriorate once at WGH would be stabilised and then transferred another hospital, the impact of these is picked up within the critical care section below.

6.4 **Critical Care**

WGH had 1,749 critical care bed days in 2017-18. Of these 475 were at level 3,4 or 5 with a split of 2/3rd medical and 1/3rd surgical cases. This implies a critical care requirement of 1.30 beds. These beds should be included within the main spell length of stay and so do not result in a net increase in beds but simply a reclassification between bed types.

6.5 **Additional adjustments**

It is recognised that moving a patient can have an impact on the date of their eventual discharge from hospital. There are 481 spells being moved to alternate hospitals, assuming a 2 day LOS increase and that this increase will occur at the receiving hospital (not WGH) this would increase beds needed by 2.6 beds.

It is recognised that the non-availability of a service locally can result in clinicians becoming more cautious and so an adjustment has been made to reflect that a

higher proportion of patients may transfer that the retrospective HRG analysis has indicated. A proxy to estimate this is that for every patient transferred under critical care, a patient who "may" need critical care but does not eventually need this is also transferred. This has been estimated at 1.3 bed days and their pathway is modelled in the same was as if a patient did need critical care (e.g. they go to the receiving hospital for 5 days than return to WGH).

6.6 Summary

The table below lays out the impact:

Table F5: Estimated level of activity 2019/20

	Modelled Impact Beds	Critical Care	Part Spell Repatriate to WGH	Net Bed Impact
Surgery				
General	8.11	(0.42)	(1.59)	6.10
Trauma and Orthopaedic	3.74		(2.24)	1.50
Surgery Sub-Total	***11.85***	***(0.42)***	***(3.83)***	***7.60***
Acute Medical	4.78	(0.88)	(3.68)	0.22
Critical Care Beds		1.30		1.30
Total Bed Impact	**16.63**	**0.00**	**(7.51)**	**9.13**
Changes to make				
Impact of move on lengthening stay *(481 patients at 2 day LOS increase)*	2.60			2.60
Increase critical care due to clinical caution *(double the number of critical care patients)*	1.30			1.30
Proposed total	**20.53**	**0.00**	**(7.51)**	**13.03**

The system is working on further mitigation to remove the need for any additional bed capacity to be developed; a sub-group of the CSDDG and STP DoFs is exploring what elective activity could potentially move from UHB, NBT and TST to transfer into WGH which would release capacity for them to absorb the above small movements in beds.

The activity shifts shown above were then put through the model that had been used for the two earlier exercises with the results laid out in the following sections.

Please note the above model is using current year activity, when this is put through the McKinsey model it walks the activity forward by 5 years and so the additional demographic growth adds an additional bed being transferred.

6.7 Calculation of the numbers of Patients requiring travel

The model developed by McKinsey takes the 2018/19 expected levels of activity by point of delivery (POD) and applies demographic growth to calculate the expected

levels of activity in 2023/24. As planning for 2018/19 was completed based on 2017/18 outturn the levels of activity need to be adjusted by the impact of the temporary overnight closure which saw around 10,564 A&E attendances reduce through the temporary closure of WGH A&E overnight from July 2017. Of these only around 3,657 attendances have increased at the surrounding hospitals' A&E departments. The remainder either wait until the WGH department is open the following morning or access other local services e.g. NHS 111.

The proportion of patients that will be seen at WGH for each POD is shown below

Table F6: Analysis of activity retained by Point of Delivery

			2018/19			Preferred Option			
	Activity	**Units**	**Predicted**	**Impact of temporary overnight closure**	**Normalised to commissioned Model**	**Retained at WAHT**	**Impact of Frailty**	**Provided Elsewhere (TONC)**	**Provided Elsewhere**
1	A&E major	Attendances	7,700	1,766	9,466	5,599	464	3,657	1,637
2	A&E standard	Attendances	21,923	5,028	26,951	21,127	795		0
3	A&E minor	Attendances	16,439	3,770	20,209	16,166	273		0
	A&E Total	***Attendances***	***46,062***	***10,564***	***56,626***	***42,893***	***1,533***	***3,657***	***1,637***
4	Acute medicine	Spells	10,336		10,336	8,965	1,286		86
5	Emergency surgery	Spells	3,266		3,266	2,393	310		562
							0		
							0		
6	Elective medicine	Attendances	283		283	250	0		33
7	Daycase medicine	Attendances	8,518		8,518	8,518	0		0
8	Critical Care	Bed days	1,784		1,784	815	0		969
9	Elective surgery	Spells	1,255		1,255	1,176	0		79
10	Daycase surgery	Spells	4,828		4,828	4,828	0		0
	Total Planned Surgery	***Spells***	***6,083***		***6,083***	***6,004***	***0***		***79***
11	Outpatient	Attendances	108,171		108,171	108,171			0
12	Paediatrics	Spells	827		827	1,241			(414)
	Total Patient Contacts		**185,330**	**10,564**	**195,894**	**179,249**	**3,128**	**3,657**	**2,952**
			185,330	10,564	195,894	179,249	3,128	3,657	2,952
	Services as % of commissioned					91.5%	1.6%	1.9%	1.5%
	Services as % of commissioned adj. for TONC					96.7%	1.7%		1.6%
	A&E as % of commissioned					75.7%	2.7%	6.5%	2.9%
	A&E as % of commissioned adj. for TONC					93.1%	3.3%		3.6%

This shows that for all services currently commissioned from WGH 91.5% will continue to be provided there with a further 1.6% being provided through the Integrated Frailty Service (IFS) and so either at WGH or closer to the patients' homes. When compared to the current service provision (including the impact of the TONC) this percentage rises to 96.7% at WGH and 1.7% through the IFS.

The system is reviewing what other activity can move from where it is currently being provided onto the WGH site to ensure that it continues to be at the heart of healthcare provision in the area. This includes reviewing GP OOH location and moving more elective procedures to the hospital.

Of the patients that will need to travel to other sites to receive services, the table below presents the expected method of travel that has been modelled to understand the impact on the Ambulance service.

Table F7: Travel method

	By ambulance	By private car / public transport
A&E	100%	
Acute Medicine	75%	25%
Emergency Surgery	50%	50%
Critical Care	100%	0%
Elective Care	0%	100%
Inpatient Paeds.	50%	50%

The impact of the above assumptions are shown below in terms of the number of journeys that will be needed split between ambulance and independent journeys.

Table F8: Travel analysis

				Preferred Option Travel > Current Delivery			TONC			Additional conveyances (above Commissioned levels)		
	Activity	Units		Conveyances	Travel Independently	Total People Travelling	Conveyances	Travel Independently	Total People Travelling	Conveyances	Travel Independently	Total People Travelling
1	A&E major	Attendances		1,637	0	1,637	3,291	366	3,657	4,928	366	5,294
2	A&E standard	Attendances		0	0	0		0		0	0	0
3	A&E minor	Attendances		0	0	0		0		0	0	0
	A&E Total	***Attendances***		***1,637***	***0***	***1,637***	***3,291***	***366***	***3,657***	***4,928***	***366***	***5,294***
4	Acute medicine	Spells		65	22	86		0		65	22	86
5	Emergency surgery	Spells		562	0	562		0		562	0	562
6	Elective medicine	Attendances		0	33	33		0		0	33	33
7	Daycase medicine	Attendances		0	0	0		0		0	0	0
8	Critical Care	Bed days		75	0	75		0		75	0	75
9	Elective surgery	Spells		0	79	79		0		0	79	79
10	Daycase surgery	Spells		0	0	0		0		0	0	0
11	Outpatient	Attendances		0	0	0		0		0	0	0
12	Paediatrics	Spells		(207)	(207)	(414)		0		(207)	(207)	(414)
					0			0				
	Total			2,131	(74)	2,058	3,291	366	3,657	5,422	293	5,715
	Total (excl. Paediatrics)			**2,338**	**134**	**2,472**	**3,291**	**366**	**3,657**	**5,629**	**500**	**6,129**

	Travel Impact		
	Conveyances	Travel Independently	Total People Travelling
TONC	3,291	366	3,657
Preferred Option	2,338	134	2,472
Total	5,629	500	6,129

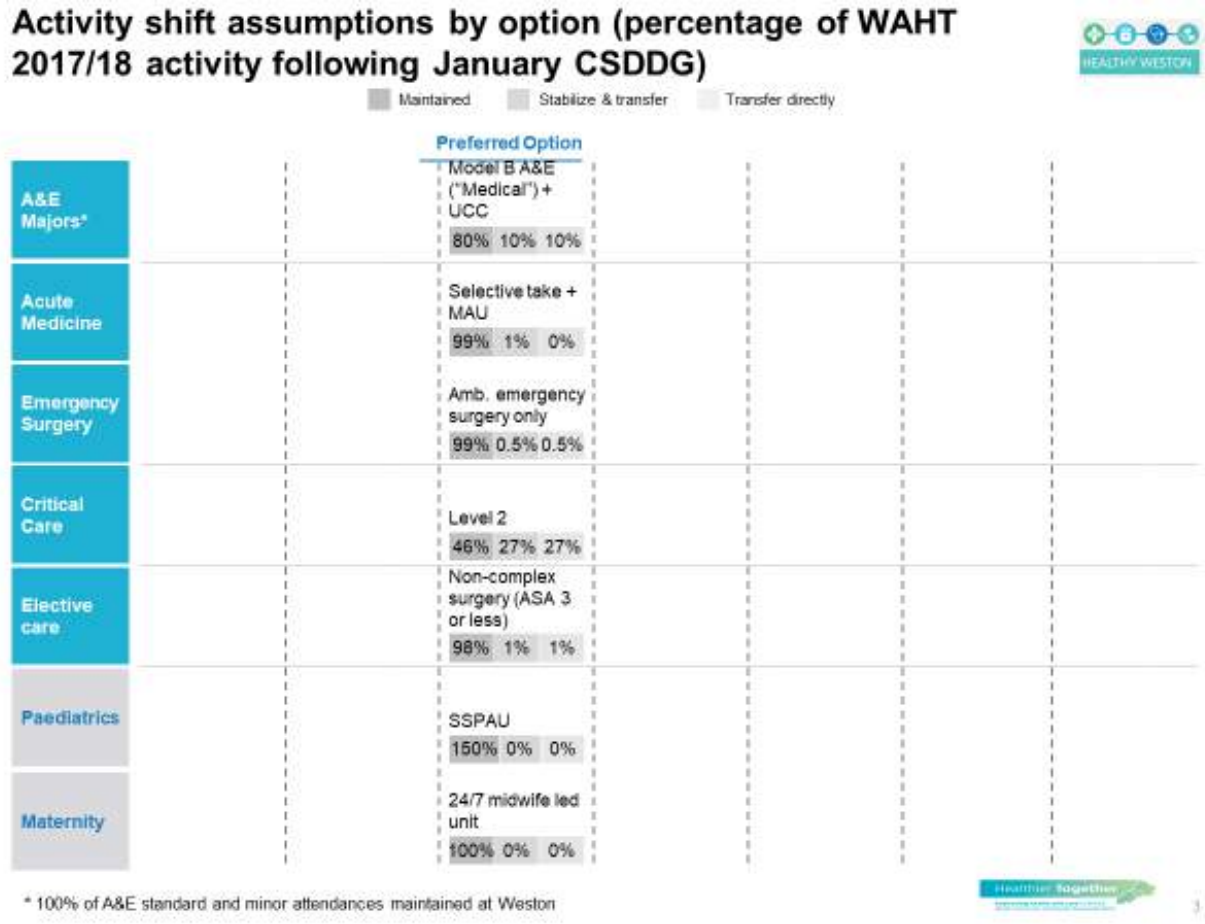
This shows that more than 50% of the additional journeys in total are as a result of the TONC and for patients travelling independently this rises to almost 75%.

7 PREFERRED OPTION FINANCE AND ACTIVITY

7.1 The high level modelling and calculation of the baseline are unchanged from the earlier two exercises as is the planned working of the Integrated Frailty Service.

7.2 The proposed activity shifts that were calculated above can be represented as per the figure below:

FIGURE F40: EXPECTED ACTIVITY SHIFT RESULTING FROM THE PREFERRED OPTION



7.3 Components of the financial evaluation

7.3.a *Capital costs*

Capital costs have been estimated by looking at the cost of building new hospital capacity, using the number of new inpatient beds to estimate this, both within WAHT and at neighbouring Trusts. This has been modelled on £350,000 per new bed built (or £7,000,000 for a 20 bedded ward) with no threshold / step function included. No assumptions have been included for any net land receipts generated from releasing capital for capacity no longer required.

Sensitivity has been applied to this assumption to show the potential impact of different bed build costs on system capital costs (including a step change where lower costs are incurred per bed built below a set threshold). No assumptions on one-time cost requirements for releasing fixed costs (e.g. demolition of buildings) have been included.

The above has been used as a proxy to generate a capital cost; however the system expects that the only Capital required to build capacity will be in UHB critical care which is part of an existing scheme and so will be funded by the Trust. The

small amounts of capital for the Ambulance Service and for WGH backlog will be met through usual sources.

Additionally, following discussion with the ambulance service, a capital allowance has been made in this PCBC for additional ambulance capacity needed as a result of increasing the numbers of conveyances. £0.2m has been allowed for the preferred option.

Financial assumptions used in the modelling work are listed in Figure F41.

FIGURE F41 Key assumptions for finance MODELLING

Evaluation criteria	Analyses and assumptions (WAHT and marginal on other Trusts)
1 Capital cost to the system	▪ Marginal impact on bed numbers by Trust is calculated from activity shifts ▪ Capital costs are calculated for provision of new beds for the option across the system ▪ Bed capacity by Trust estimated using activity, demand management and shift to top quartile ALOS
2 Costs & income	▪ Other trusts assumed to use WAHT's income & cost structure but adjusted as below ▪ Income shifts in the system are based on activity and move 1:1 between Trusts ▪ Variable cost shifts in the system are based on activity and move 1:1 between Trusts ▪ Semi-variable cost shifts in the system are based on activity and are calculated using a efficiency scale factor of 90% at WAHT (i.e. 10% of costs are not transferred to other trusts when activity shifts) and 85% at other trusts ▪ Additional fixed costs are assumed to be 10% of incurred capital costs[1] and become recurrent ▪ Decreasing fixed costs are estimated in line with bed capacity reductions and use an 80% scaling factor for more than 45 beds changes at WAHT
3 Transition & transport costs	▪ Transition costs (e.g., relocating staff, training and education costs) are based on activity shifts and increasing bed numbers in other Trusts ▪ Transport cost assumed at £260 per journey (SWASFT input)
4 NPV	▪ First 30 years discounted using the 3.5% rate, with 3.0% applied for the following 30 years as per the Green Book ▪ First 10 years of forecast deflated using 2.0% long term inflation as per Green Book

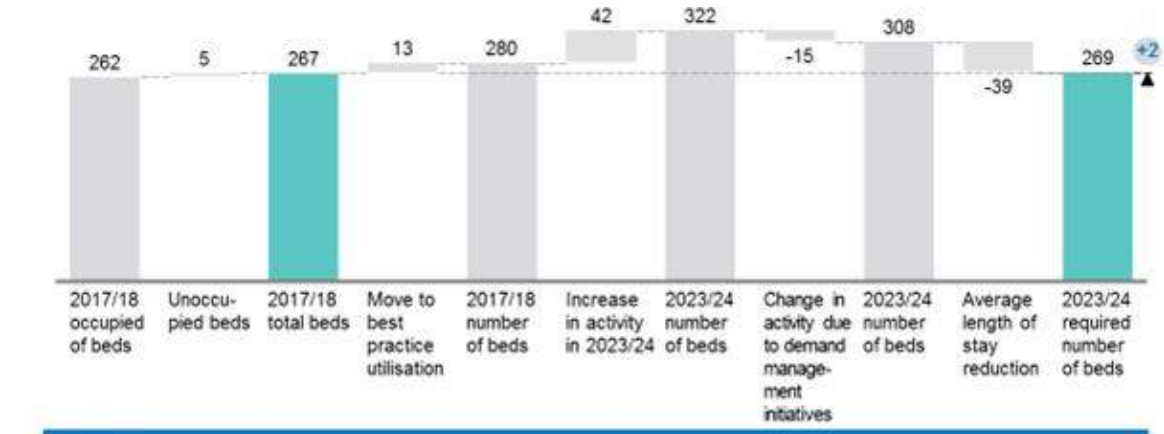
1 Includes 3.5% PDC (public dividend capital), 4% operating costs, and 2.5% depreciation (assuming 40 year average life span of fixed asset)

Source: Expert input

In terms of bed numbers at Weston General Hospital no significant change in bed numbers would be forecast if current services continued based on the following assumptions which are illustrated in Figure F42

- an 11% reduction in length of stay to reach top quartile performance;
- Activity changes in response to population growth
- target utilisation for beds of 92%
- Demand management of 1%

FIGURE F42: PROJECTED CHANGE IN INPATIENT ACTIVITY BY 2023/24 AND IMPACT ON WESTON TRUST BED REQUIREMENT BEDS



Assumptions

1. Beds include only overnight inpatient beds. This excludes all daycase beds, ED beds and assessment unit, birthing units, neonatal cots, critical care beds, maternity, community and mental health beds
2. Target utilisation 92% for all service lines – **note currently running at 98% utilisation overall**
3. Assume change in activity due to demographic and non-demographic factors as per "do nothing" baseline
4. Assume demand management of 1% per year
5. Assume **11% inpatient average length of stay reduction**

With the same assumptions around demand management and length of stay as in the "do nothing" scenario, applying the activity shifts results in bed requirements for the preferred option would reduce the beds in WGH by 40.

Of this reduction of 40 beds; 24 would be as a result of the Integrated Frailty Service, these patients would be seen and supported at WGH, their local GP or health centre or at their own home. 14 of the beds would be reprovided; 9 at UHB, and 2.5 each at NBT and TST. The remaining 2 beds are gained as efficiency due to improved LOS at the receiving hospitals.

For worst case financial modelling we have assumed no net land receipts. To allow the calculation of a proper Net Book Value we have calculated the value of £5.2m of capital costs; however, as detailed in the capital section the system will fund this through business as usual with the only significant element being the Critical Care capacity at UHB which is an already approved business case and will be funded by the Trust.

More detailed planning will be carried out for the decision making business case to ensure that capital requirements for any reconfiguration are able to be met from individual Trust capital plans and these changes will be high priority STP plans and so will have first call on capital made available through STPs.

7.3.b *Income and expenditure*

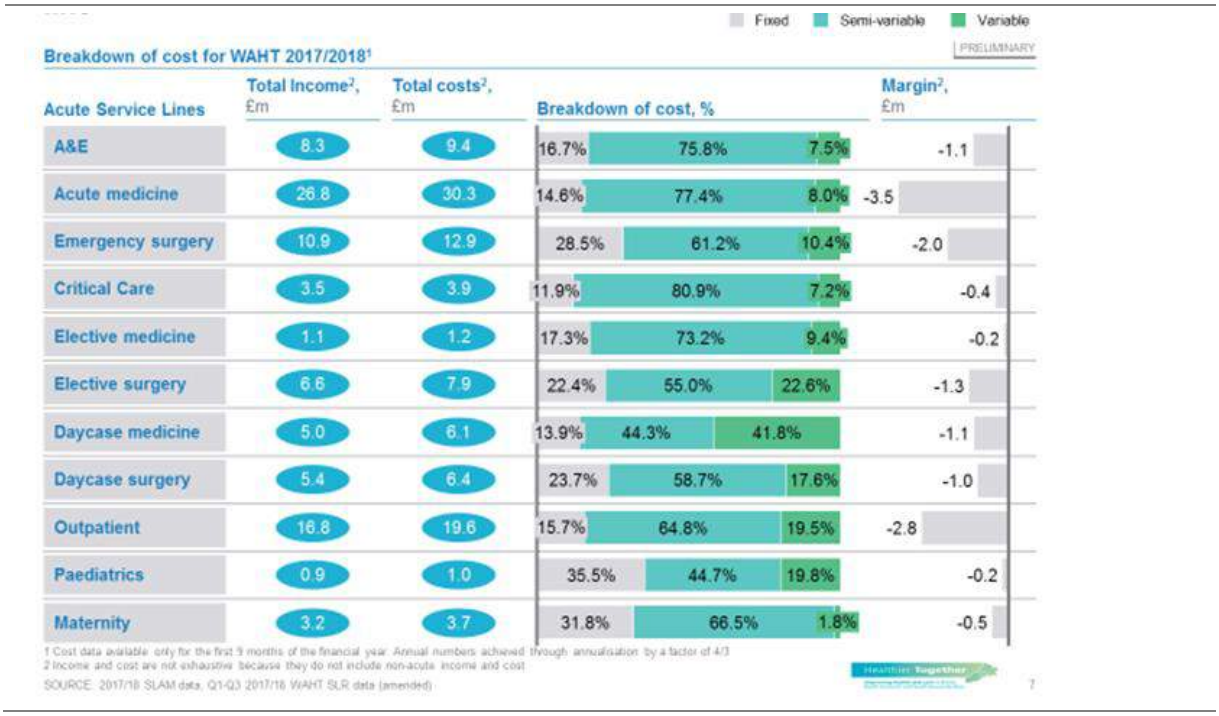
The baseline indicates an underlying deficit at WAHT of £16.6m. The methodology for reconfiguration modelling income and expenditure has been estimated for each

service line with expenditure broken down into variable cost, semi-variable cost and fixed cost.

- Variable cost represents all cost that will scale in line with clinical activity, for example, food, laundry services, and consumables such as drugs.
- Semi-variable cost represents the cost of staff, both permanent and temporary, and will change with activity albeit not in a linear fashion as economies or diseconomies of scale are realised – a 15% consolidation benefit [for receiving organisations] and a 10% diseconomies loss factor [for WAHT] is assumed. Furthermore, the premium on staff, due to use of non-permanent ED staff, was assumed to taper as activity is shifted away (up to 75% reduction in option 37b).
- Fixed cost is the cost of buildings and equipment and overheads and will not scale with activity unless an active decision that impacts this directly, such as increasing or decreasing capacity, is taken.

The full set of assumptions used in the I&E modelling is shown in Figure F43 above and the breakdown of WAHT current financial position by service line is shown in Figure F43 below.

FIGURE F43: WAHT INCOME AND COST (INCLUDING COST BREAKDOWN) BY SERVICE LINE



Modelling the impact of changes to I&E for the preferred option includes some elements of bottom up costings and has been progressed in three stages which are summarised below:

- First, the impact of activity leaving WAHT is estimated by assuming all activity arriving at neighbouring Trusts will generate fragmentation effects within WAHT. More specifically, this means 100% of income associated with reduced activity will leave WAHT while less than 100% of expenditure associated with this activity leaves. 100% of variable cost will leave but only 90% of semi-variable cost will leave. Fixed costs will not be impacted at this stage – changes in fixed costs are modelled separately. Additionally, activity is moved to the receiving hospital assuming WAHT Average Length of Stay (aLoS) to reflect the case mix of the transferring activity and not the current case mix of the receiving hospital.
- Second, the impact of consolidation is estimated. For service lines that are seeing more activity provided by larger sites, financial consolidation benefits in terms of semi-variable costs will be observed, while for service lines that are being provided by WAHT, a small trust, fragmentation effects have been assumed. This is estimated by modelling 90% of semi-variable cost being released with decreasing activity and 85% of the **sending site semi-variable cost** added to the receiving site, as all are significantly larger than WAHT. As WAHT is making a loss on most activities this should be a conservative approach as the larger receiving hospitals should be more cost effective than this.
- Third, the change in fixed cost due to reconfiguring capacity is estimated. Fixed cost is added for increasing capacity at 10% of capital expenditure, while fixed cost to be removed in line with closed capacity is modelled in terms of inpatient beds reduction with 80% scaling factor. For example, if 10% of inpatient beds are released, 8% of fixed cost can be released at that site once a threshold of at least 45 beds has been reached – this is not reached in the preferred option.

Figure F44 shows the breakdown of WAHT I&E for the preferred service configuration option while Figure F45 shows the breakdown of system I&E by Trust.

FIGURE F44: CHANGE IN 2023/24 WAHT I&E FOR THE PREFERRED OPTION

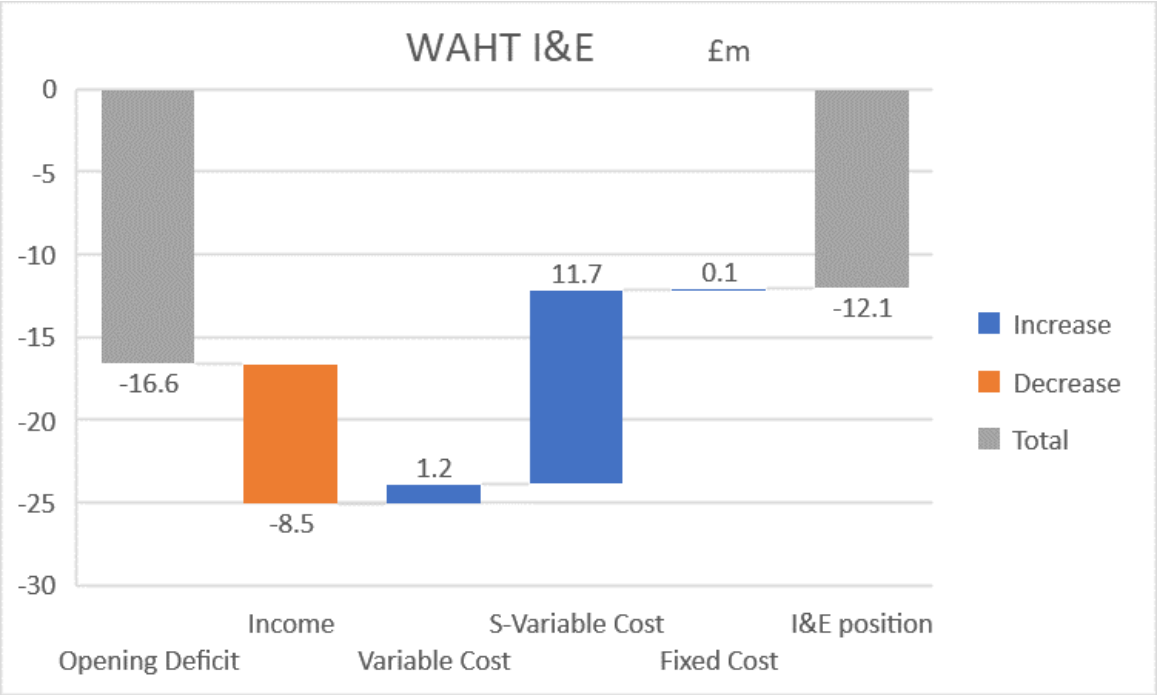
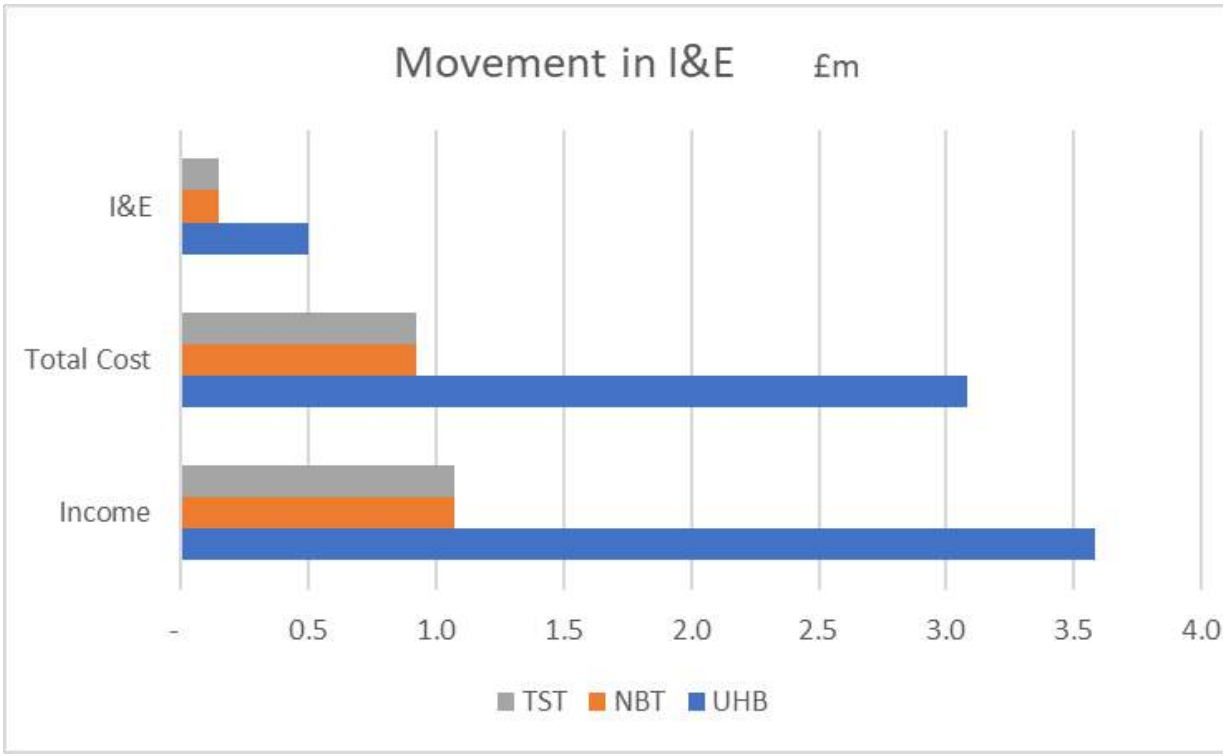


Figure F45 shows the impact on I&E on neighbouring Trusts

FIGURE F45: NET CHANGE TO I&E FOR OTHER TRUSTS FOR THE PREFERRED OPTION



Transition Costs And Transport Costs

Transition costs are the additional costs beyond the capital build requirement that would be incurred due to the disruption caused through any changes made to the configuration of services, in particular any double running of services. This has been estimated to be incurred in line with bed movements (i.e. new bed capacity), at a cost of £250 per bed day of disruption both within WAHT and at neighbouring Trusts. Disruption is assumed to last for 90 days for each bed movement. An additional £100k is added for central PMO bring total transition costs to £0.4m.

For existing ambulance transfers to WAHT that will need to be transferred other Acute Hospitals an additional cost of £190 per conveyance has been included to reflect the additional mileage / time required.

For required transfers over and above the current model the proportion requiring ambulance vs. private car / public transport are shown below. These “additional” ambulance conveyances are costed at £260 (which is the SWAST average cost per conveyance) **plus** the £190 per conveyance shown above to cover the additional mileage / time plus the impact of having a crew off the area that they are covering.

An estimate of capital required has been made at £0.2m for the preferred option. Detailed modelling will be undertaken during the consultation process to model the impact of the proposed changes and associated costs of providing the additional service. This detailed modelling will include estimating the impact of evidence that changes to A&E opening times or range of services offered can result in up to a 13.9% increase in ambulance calls in the locality as advised by SWASFT.

Additional costs of £1.2m per annum have been included in the model for additional transfers which includes the cost of repatriating patients as described in section 6.

7.4 Financial Summary

The modelled impact of the preferred option is summarized below:

1. WGH will reduce its deficit by £4.5m to £12.1m
2. The system impact on Acute trusts is an improvement of £5.3m
3. The impact on SWAST is a cost of £1.2m
4. The capital costs are estimated at £5.2m the majority of which are at UHB and relate to Critical Care beds which are part of their existing capital plan and will be funded by the trust.
5. There are transition costs of £0.4m
6. Using the same basis for calculating NBV as previous versions, the NBV of the scheme including all of the above is £255m at 30 years and £444m at 60 years.
7. Sensitivity analysis remains as the earlier two versions (shown in figures 40 and 41)

Healthy Weston Pre-Consultation Business Case

Appendix 21: Patient Travel

This chapter gives further detail to the travel time analysis in the PCBC in particular to the methodology.

1. INTRODUCTION

The impact of the proposed model on patient travel has been examined in the framework of the evaluation criteria that has been approved by the CCG Governing Body.

The units of analysis to understand how the preferred option will impact on patient travel are as follows:

1. Numbers of patients who will have different travel arrangements
2. The travel time impact for these patients.

In considering the numbers of patients who will have different travel arrangements to the status quo, this applies to patients who will no longer need to visit hospital due to improved primary and community care, as well as patients who will no longer receive treatment at Weston and therefore have to an alternative site. The level of acuity and mode of transport are crucial for planning patient access and the preferred option and have fed into the modelling for understanding the impact of the changes.

2. KEY FIGURES

2,472 patients will require additional travel above the current delivered model

3,657 are already being transferred as a result of the temporary overnight closure.

It will take on average between 13 and 19 additional minutes of blue light travel time to transfer to a neighbouring hospital.

It will take on average an additional 17 minutes at peak time and an additional 14 minutes at off peak time to travel to a neighbouring hospital by private car.

Travel to a neighbouring hospital by public transport will take an average of an additional 18 minutes at peak and 41 minutes at off-peak times.

Approach

It is challenging to analyse travel data because of the large range of factors that affect any one journey. Patients travel to hospital at different times of the day from

a wide geographical area, and each journey will have multiple factors that will impact on the length of time taken from start to finish. The circumstances in which people travel to hospital also affects the time taken to travel, including for ambulance journeys, that do necessarily travel under 'blue light'. There is no 'home to hospital' database of travel distances, methods and times.

The CCG commissioned specialist organisations to assist with this analysis, drawing on expertise to access and analyse these complex data sets using well established and validated algorithms for private car, ambulance blue light and travel by public transport.

The travel time analysis is used to:

1. Estimate the potential change in travel time as a result of the preferred option. For example, if a particular service is offered from a different hospital, what would be the difference in travel time compared to the status quo?

2. Help predict which hospitals patients are likely to travel to, if a particular service is offered from a different site. This helps plan for demand and capacity in neighbouring hospitals.

The following elements have been considered:

- Transport types considered
    - Blue light ambulance
    - Private car (travelling at peak and off-peak times)
    - Public transport peak and off-peak travel times
- Population covered
- Areas covered.

Types of analyses:

- Population weighted averages
- Distribution of population reaching their nearest acute hospital based on different travel time (i.e. S-curve)
- Estimated activity changes if services were offered from a different site.

3. METHODOLOGY

Refer to section X in the finance and activity appendix for the methodology to calculate the changes in activity between hospitals.

A. CALCULATING TRAVEL TIMES

Point-to-point travel times were used to evaluate the distance and time for patients to access services. Journey times from a patient's normal place of residence to any hospital site were used to estimate average travel times for the population.

Ordinance Survey Lower Super Output Areas (LSOAs) were used to analyse travel times to different hospital sites. LSOAs are small geographical regions with approximately 1,000-3,000 people living in each. Office for National Statistics data was used to determine the population of each of these units. The times taken to travel from these Lower Super Output Areas by private car and public transport at different times of the day were used to estimate the travel time for each LSOA within the WAHT catchment population to their nearest hospital for different services. The scope of the analysis contains 101 LSOAs covering a slightly larger population of ~160,000, more than the WAHT catchment population of ~150,000 to ensure sufficient coverage before any filters were applied for analysis. The travel time data draws from the TomTom Speed Profile dataset to generate highway journey times.

The data can be used to look at:

- Travel times for different populations to access different services and under different conditions (time of day, type of transportation)
- Average and maximum travel times for the entire population to access different services under the preferred option.
- Which geographies of the current WAHT population are most or least impacted by service change under different options.

The travel time data has been generated by sampling billions of measurements from real time journeys across the UK, using GPS enabled devices such as satellite navigation devices and mobile phones. The data provides an average speed for each individual road link across the road network that can be combined to produce an output of an overall average journey time. The travel time calculations take the average journey time from the centre of the Lower Super Output Area to a defined point, or the nearest hospital.

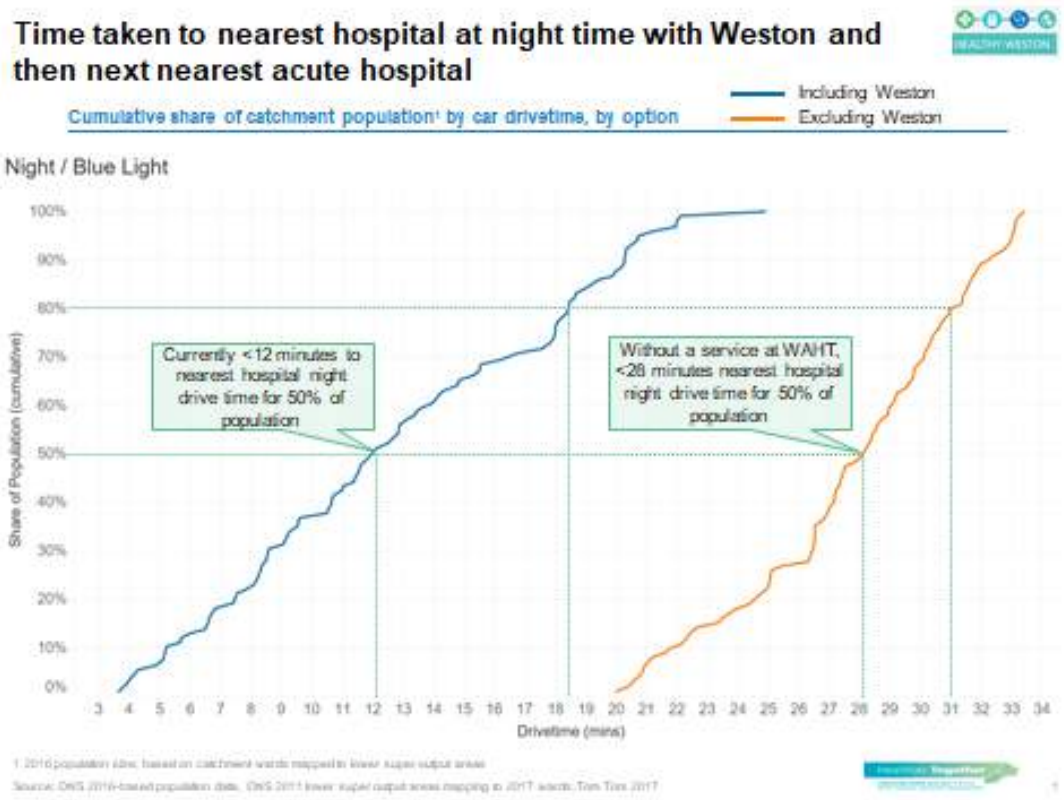
Ambulance 'Blue light' times use night time travel as a proxy. Across the country this has been shown to be more similar to blue light times than application of a simple formula as it takes into account differences in road conditions. Night time travel is approximately 30% faster than day time travel.

Public transport travel times are generated using TRACC software, recognised as the industry standard for generating public transport journey times. This software is endorsed by the Department for Transport and was developed to allow Local Authorities to generate reliable, accurate and reproducible journey times for use in their accessibility studies.

S-curves are used to graphically assess the travel times against the cumulative population (aggregated at lower super output area level (LSOA)) plotted against the travel time to a set point or the nearest hospital for populations.

4. AMBULANCE TRAVEL TIME

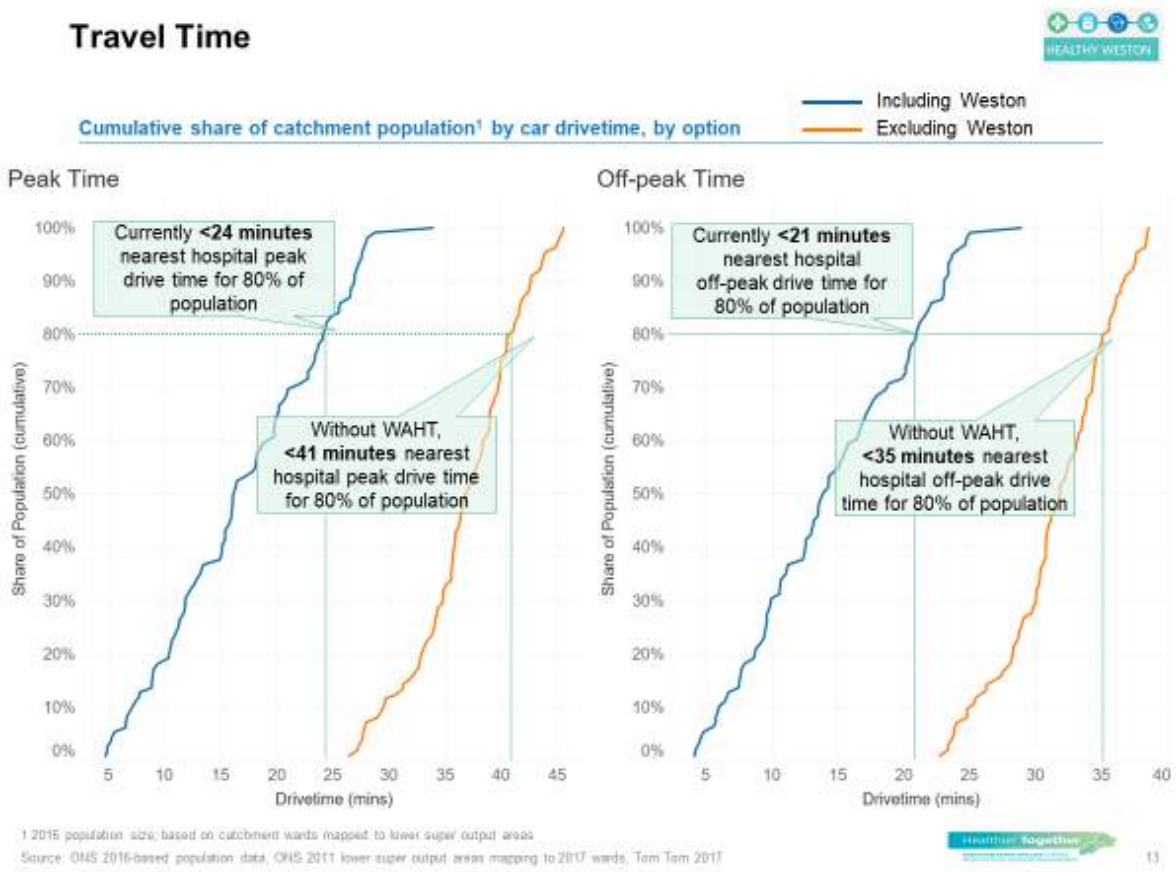
The analysis illustrated in the below S-curve shows the ‘blue light’ travel times using night-time travel time as a proxy for ‘blue light’ ambulance travel time.



5. PRIVATE CAR TRAVEL TIME

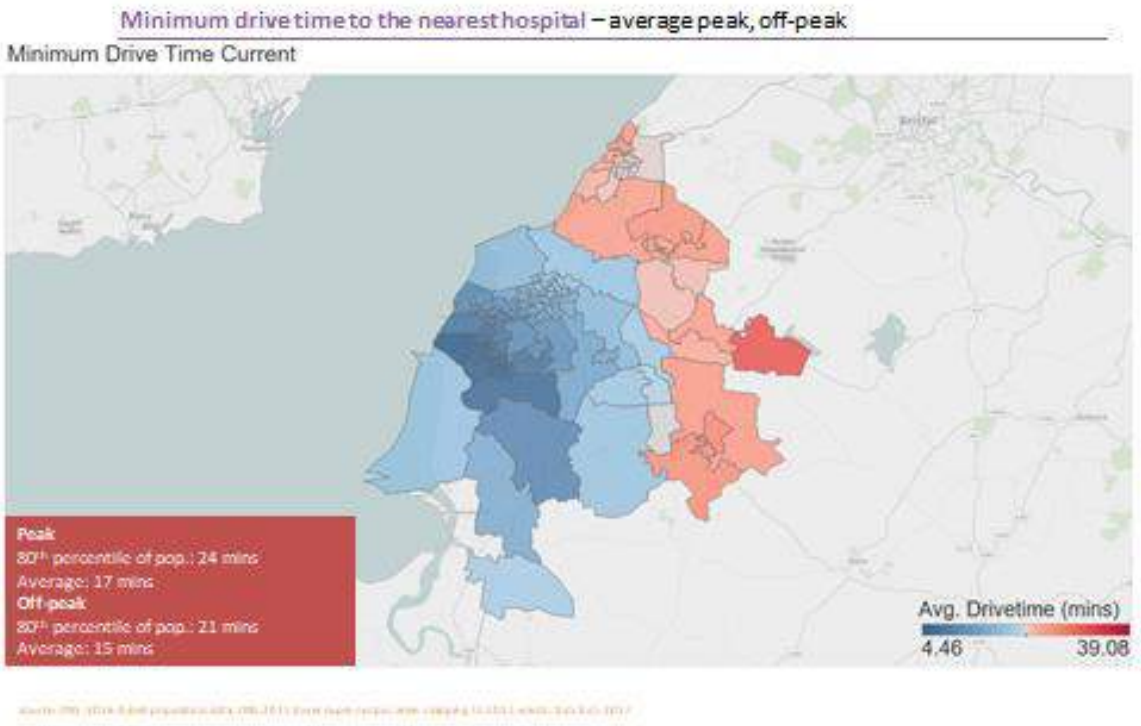
Using ONS population data and TomTom driving time data analysis shows that 80% of the catchment population can currently access a hospital within 24 minutes at peak times and 21 minutes at off-peak times. If patients cannot be treated at Weston and care is provided elsewhere, this rises to 41 minutes at peak times and 35 minutes at off-peak times – increases of 17 and 14 minutes respectively.

The travel times for the current catchment population to reach their nearest acute hospital during peak and non-peak times by car are shown in the graph below.



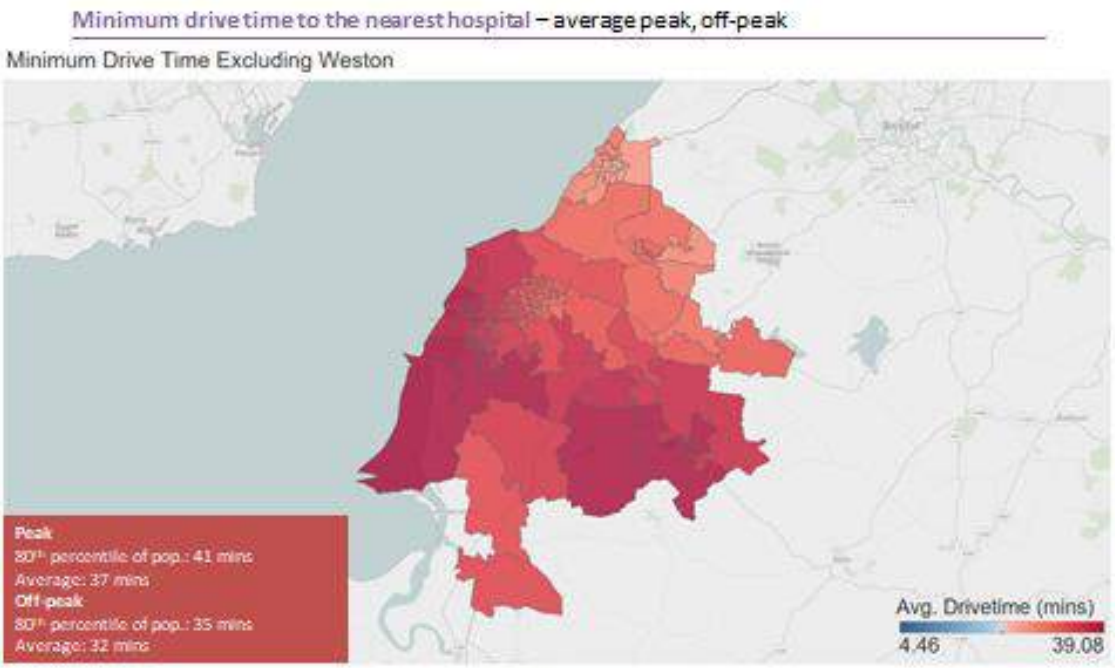
The first map below shows the average drive time to the nearest hospital with services provided at Weston:

Travel time for 80th percentile of WAHT catchment population as defined by GP practices is 24 minutes at peak time



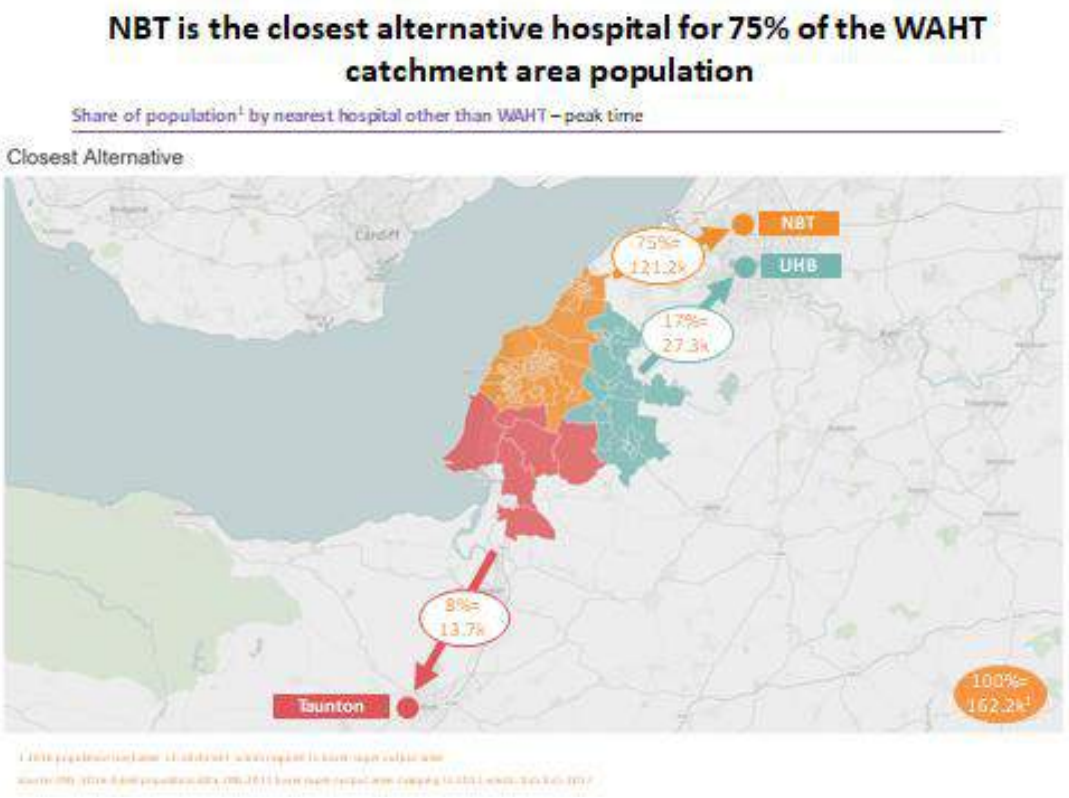
The below map shows the average drive times to the nearest alternative hospital.

Alternative nearest hospital, the 80th percentile travel times for the catchment area increase to 41 minutes at peak time

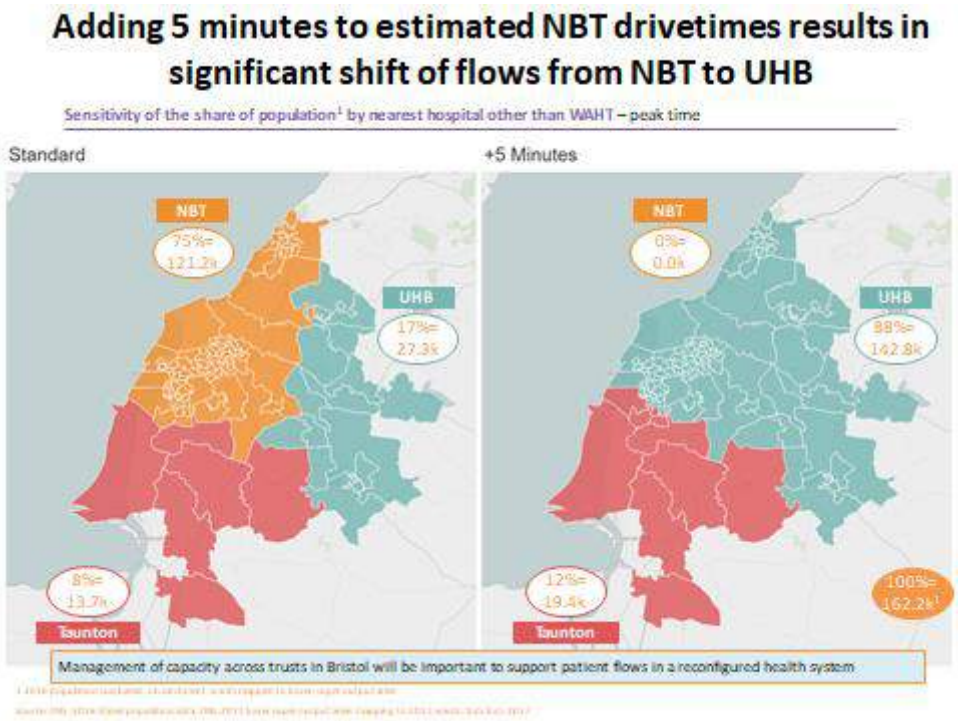


Under this analysis, it is assumed that people will travel or be taken to the closest site which provides the care they need. The population flow analysis therefore predicts what proportion of activity will take place where under the proposed model.

Factoring in travelling to an alternative site, the nearest acute hospital for 75% of the Weston catchment population is Southmead and this is shown in the map demonstrating population flows below:



Adding five minutes to estimated NBT drive times results in significant shifts in activity with 88% of the Weston catchment population being able to access UHB. The flexibility of the wider healthcare system to accept additional patients has been crucial in the planning of the TONC and in planning for the preferred option and will be kept under constant review.



Public Transport Travel

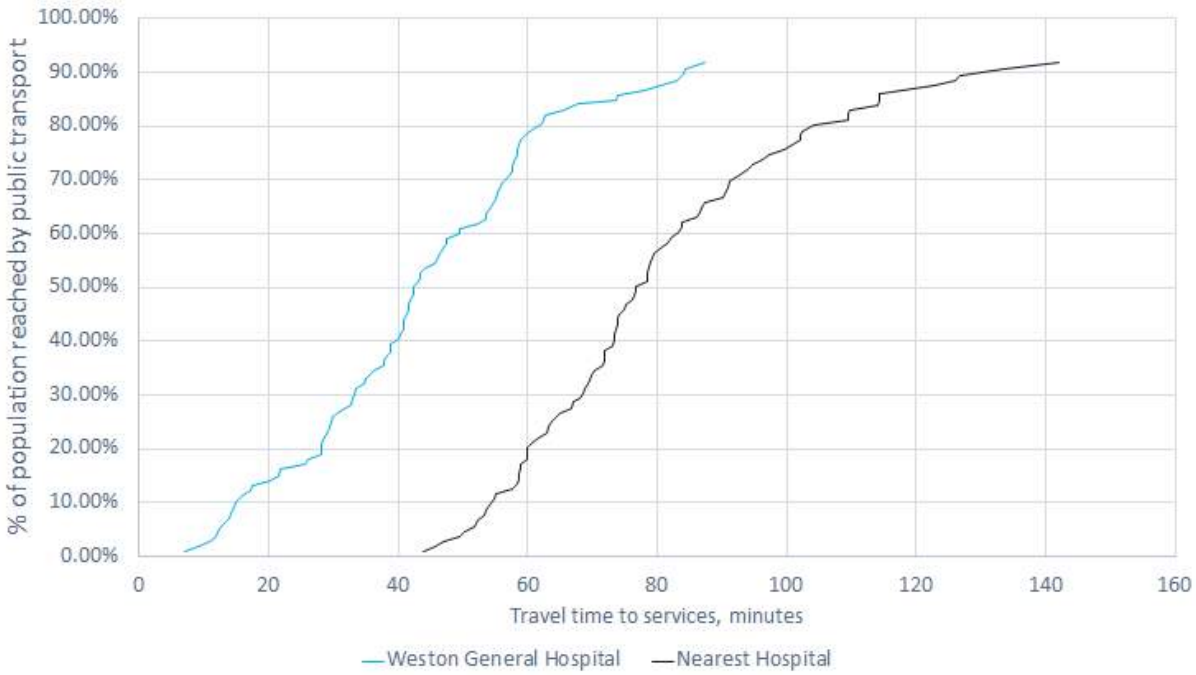
In order for the TRACC software to generate the travel times a number of parameters must be specified, which were as follows:

- Origins and destinations must connect within 1000 meters to a public transport node, inter change distances was set to 500 meters, and an interchange penalty was set at 3 minutes.
- The inter change distance sets a maximum distance for walking to another public transport service mid journey and time penalty prevent unrealistic changes in public transport services.
- Finally journeys must be completed within the time periods for AM Peak (07:00 to 10:00) and Inter Peak (10:00 to 16:00). If a journey can't be completed with these parameters the journey is deemed not accessible via public transport..

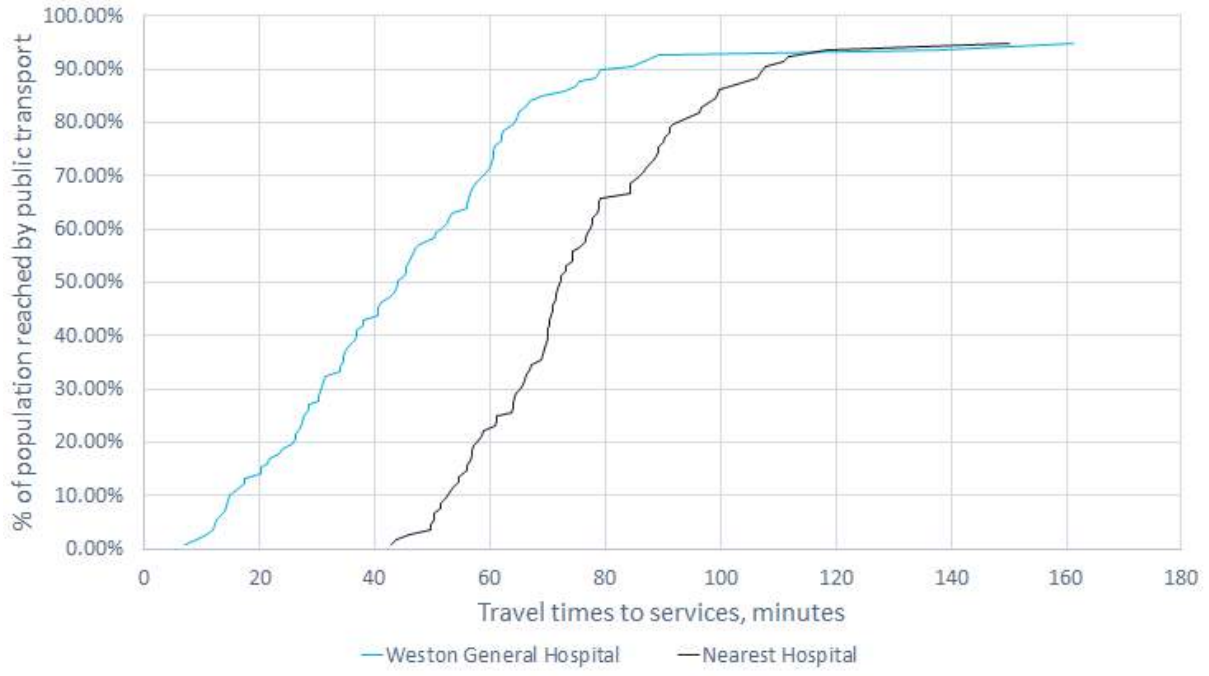
As such, 8% of residents in the overall area cannot currently complete a journey using public transport to a hospital during peak times and 5% at off-peak times.

Using ONS population data and public transport modelling software, data analysis shows that 80% of the Weston catchment population can currently access a hospital by public transport within one hour and one minute at peak times and one hour and four minutes at off-peak times. If patients require treatment at an alternative site and care is provided elsewhere, this rises to one hour and 42 minutes at peak times and one hour and 31 minutes at off-peak times – increases of 41 minutes and 27 minutes respectively.

Cumulative share of population and travel time by public transport at peak time



Cumulative share of population and travel time by public transport at off-peak time



Travel Working Group

The CCG is establishing a Travel Working Group to support with the area of patient travel. The aims of the group are outlined below:

1. Provide expert advice and assurance that Healthy Weston has sufficiently planned for and consulted on any travel implications of the preferred option.

2. Develop solutions in partnership with the CCG to mitigate any potential negative impacts.

Membership recommended as follows:

- Clinical Commissioning Group
- North Somerset Council transport commissioner
- Bristol Council transport commissioner
- Taunton transport commissioner
- West of England Local Enterprise Partnership transport expert
- Community Transport representative
- Patient Transport representative
- Patient Public Involvement Group representative.

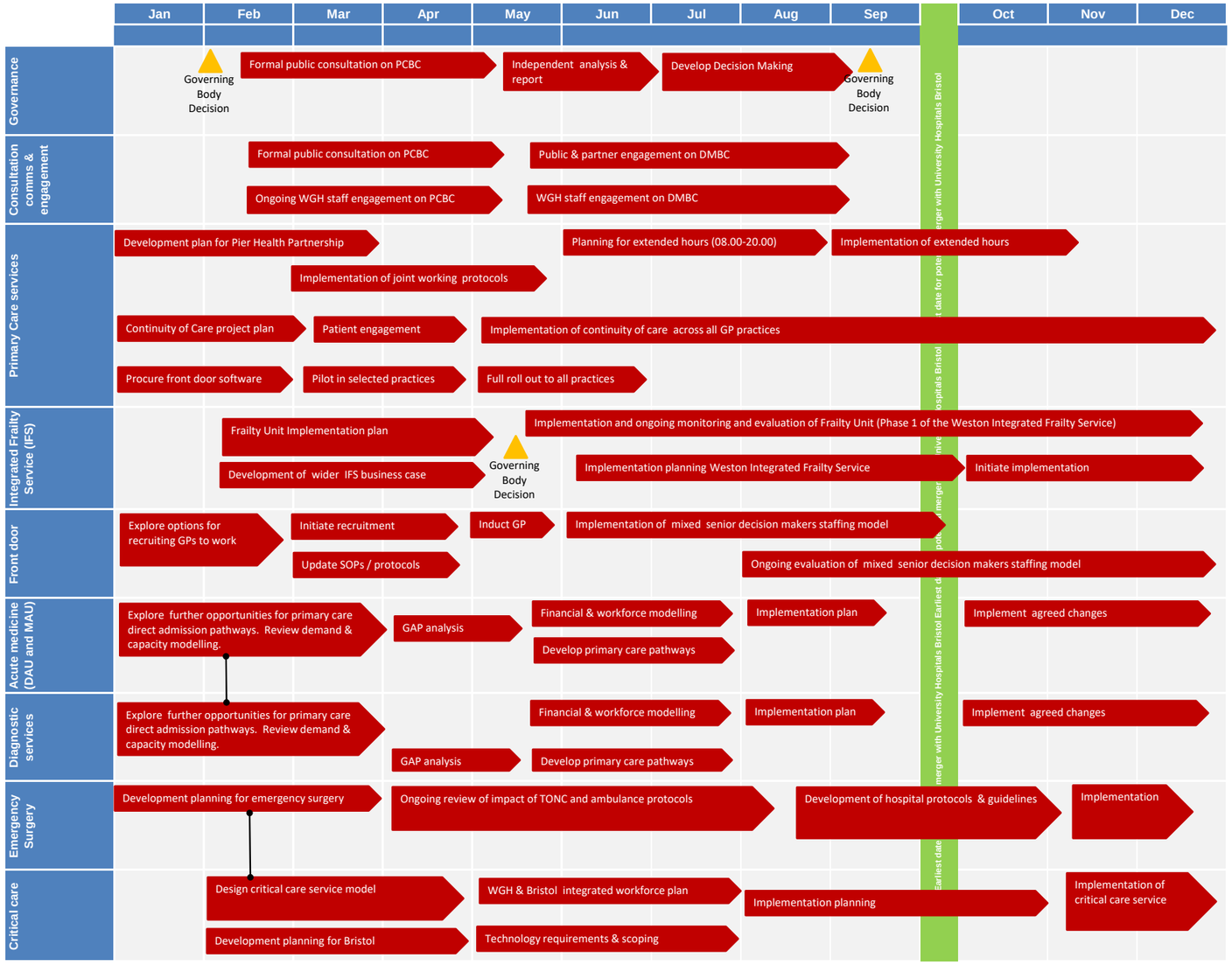
Solutions will be developed for the decision making business case and the group will collaborate with wider health and general transport initiatives going forward.

Healthy Weston Pre-Consultation Business Case

Appendix 22: Initial Implementation Plan

2019

Consultation and planning for changes at Weston General Hospital



Healthy Weston Pre-Consultation Business Case

Appendix 23: System Risks

System Risk Assessment

Preferred Option

Category	Risk	Description of Risk	Mitigations
System capacity (beds / theatres)	There is a risk that the receiving hospitals will not have capacity to absorb the activity being moved from WAHT which means that patients will not receive the serivces needed and the additional activity will make the services received by the wider population less safe.	1. The shift of activity from WAHT to other providers will require 14 beds in other Trusts which do not have surplus capacity at present. 2. This option moves 476 surgical spells which will require theatre sessions at other hospitals which may not have surplus capacity at present.	1. Detailed planning needs to be done to identify which patients would flow to which hospitals (by specialty as well as geography), 2. Moving elective activity from the other hospitals to WAHT to make use of their theatres and bed capacity, 3. The impact of the Integrated Frailty Service in Weston needs to be modelled on the populations accessing services at UHB and NBT to make sure that all learing is captured and maximised to reduce the call on secondary care, 4. Productivity opportunities need to be understood and modelled for all Trusts 5. No changes will be made in terms of redirecting activity until there is assurance of the availablity of capacity.
Access to capital	There is a risk that the system will not be able to access the required capital to fund the indicated additional capacity which would mean that the transfers of care could not proceed.	The estimated capital requirement of £5.2m for this option may not be accessible meaning that capacity cannot be created.	1. The majority of the capital required is to build additional cirtical care capacity at UHB. This is part of an already approved capital plan and will be funded by the Trust 2. The other capital elements are relatively minor and will be funded through normal processes.
Complexity of service change required	There is a risk that the change required is too complex to be managed across the multiple impacted organisations leading to delays in delivery or inconsitent assumptions / workplans delaying implementation or poorly implementing the chosen solution.	The implementation of this options impacts Primary, Secondary, Community Health providers; commissioners and Social Care; without detailed co-ordinated planning and programme management it is unlikely that the program will deliver in line with expectations.	1. Healthy Weston is being managed under the Healthier Together STP and so all BNSSG organisations involved in Healthy Weston are activtely involved and aligned through that Governance. For Somerset patients the Healthy Weston Program team has established links with Somerset CCG and with Taunton and Somerset Foundation Trust to ensure that they understand impacts on them and requirements for their input. 2.Detailed planning will be completed at a organisation and system level to ensure that the program delivers the required outcomes and is resourced accordingly. This will be reported through the Healthier Together STP governance.

Capacity to manage service change	There is a risk that insufficient resource is allocated to manage the transition.	A lack of dedicated programme resource will result in poor co-ordination across the multiple entities which will result in delays and poor delivery of the required changes.	Sufficient dedicated programme support will be needed to implement with assurance provided through Healthy Weston and Healthier Together STP governance proving links into statutory Board assurance processes.
Workforce	There is a risk that the workforce required by this option will not be available sustainably meaning that care will not be able to be provided in the planned way.	Without access to a sustainable workforce the system will not be able to deliver the appropriately skilled capacity to safely deliver the revised model of care.	1. The full business case will model the detailed workforce requirement 2. Workforce plans will be developed and places that have implemented similar models will be contacted to take learning re: implementation of the new workforce models
Transition Costs	There is a risk that transition costs have been underestimated or the system will not be able to access the required transition funding that will mean that the changes are either not completed or delayed.	If sufficient funding is not identified then the transition will not be planned in enough detail to provide assurance of its deliverability which will delay implementation and / or implement the change badly which will impact on the availability and access to care.	1. Transition costs have been modelled using bed numbers as a proxy for complexity of change, this will be replaced by bottom up planning of the preferred option to support a full business case, 2. Healthy Weston is a priority program of the Healthier Together STP and so may be able to access funding from the existing STP arrangements (subject to it being agreed as the priority for the STP), additionally, through the STP funding will be sought from NHSE
Demand assumptions	There is a risk that underlying demand growth has been under-estimated meaning that required capacity increases are underestimated and that there will be insufficient beds available to provide care.	If demand growth has been underestimated then the planned capacity will not be able to address the level of demand leading to delays in implementing the change or an inability to deliver appropriate levels of care.	1. Demand levels have been aligned with system planning assumptions and NHSE planning standards. 2. Underlying demand management has been planned at 1%, the plans underpinning this need developing and modelling to ensure there is granularity of how this will be delivered.
Clinical assumptions	There is a risk that the system will not be able to deliver the clinical pathways safely and effectively that will impact on the ability delivery of safe and effective care	If the interfaces between different parts of the care system are not understood and pathways checked to ensure seamless delivery of care then pateitns will receive poorer care from the new models	1. The modelling to date has been completed at a high level. This now needs to be developed on a bottom up, patient pathway basis to allow patient journeys to be developed which then need to be walked through the proposed systems to ensure that clinicians are comfortable that the proposed changes can be delivered safely and effectively.
Long Term System Sustainability	There is a risk that the model being proposed are not sustainable from a workforce and volume of activity basis.	If the workforce cannot be recruited / retained or the work environment provide appropriate training opportunities to sustain a training environment then the models may prove unsustainable.	1. The clincial models will be developed to a point where staffing rotas against a defined workforce skills matrix, 2. This matrix will then be reviewed by the STP workforce group to produce a recruit, retention and training plan which will be reviewed for assurance before any proposed model is signed off for implementation.

Healthy Weston Pre-Consultation Business Case

Appendix 24: Equality Impact Assessment

1. Introduction

Healthy Weston has been developed to ensure the very best healthcare for everyone in Weston, Worle and the surrounding areas. Our vision is for Weston General Hospital (WGH) to become a vibrant and dynamic hospital at the heart of the community - an exemplar of excellent healthcare that has been designed specifically to respond to the needs of the local population.

We published 'Healthy Weston: why our local services need to change' in October 2018, and the document sets out a compelling case for the need to organise healthcare differently to better meet the needs of the communities we serve. In summary it shows that we face four significant challenges:

- **Health needs are changing:** Our population is growing and getting older, people are living with more long-term conditions and there are significant inequalities in health.
- **Variations in care and in access to primary and community care:** There are differences in the way care is currently provided, with some patients finding it harder than others to get the right care.
- **Meeting national clinical quality standards:** Some services at Weston General Hospital don't see enough of certain cases to meet national quality standards and there is a shortage of specialist staff.
- **Getting value for money:** We have a duty to spend every pound for the greatest public benefit. We must live within our financial means and make sure we use our available resources most effectively to meet local needs.

The communities served by WGH are diverse, with significant differences between the richest and poorest areas of the county of North Somerset, and the catchment area of the hospital. The population is both rural and urban, and 21% of the population are over the age of 65.

This Equality Impact Assessment (EIA) gives an insight into the local population and their health needs, and what we have learnt through our extensive engagement so far. The EIA is an iterative document, and further work to understand the impact of the changes will take place during the consultation phase, as we seek the views of more people.

2. Our proposals

Our proposals relate to immediate changes at WGH (run by Weston Area Health Trust, or WAHT), as well as the longer term vision for healthcare in the area; including joined-up primary care, enhanced community services and improved mental health support.

Specifically this means:

- Delivering round-the-clock emergency care in a sustainable way. This would mean making the current A&E opening times permanent. A&E at Weston would be open 8 am to 10pm, seven days a week.

- Recruiting General Practitioners (GPs) to the A&E team to alongside hospital doctors, assessing and treating patients. This would help reduce waiting times in A&E, and ensure that the most seriously ill patients are seen by a specialist, sooner.
- Changes to the way critical care and emergency surgery is delivered, which would allow us to bring other important services, such as chemotherapy, back into WGH.

3. Equality legislation

The main Public Sector Equality Duties 2011, set out in section 149(1) of the Equality Act 2010 ("the Act") applies in three ways:

- it applies to "public authorities" including the National Health Service in respect of all of their functions, unless the authority is specified in respect of only certain functions;
- where a public authority is specified in Schedule 19 of the Equality Act 2010 in respect of only certain functions, the Duty applies to the authority in respect of only those functions;
- where persons are not public authorities but exercise public functions, the Duty applies in respect of the exercise of those functions.

A public authority must, in the exercise of its functions, **have due regard to the need to**:

(a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act, but not age, so far as relating to persons who have not attained the age of 18, or marriage and civil partnership.

(b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it; in particular, to the need to:

- remove or minimise disadvantages suffered by persons who share a relevant protected characteristic that are connected to that characteristic;
- take steps to meet the needs of persons who share a relevant protected characteristic that are different from the needs of persons who do not share it;
- encourage persons who share a relevant protected characteristic to participate in public life or in any other activity in which participation by such persons is disproportionately low.

(c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it. In the context of this limb, public

authorities need to: tackle prejudice, and promote understanding between person who share a relevant protected characteristic and persons that do not share it.

These are known as the three sections of the “general duty”. In addition to the “general duty”, NHS organisations also need to evidence compliance against the specific equality duty, and under this section of legislation, NHS organisations are required to:

(a) Set specific, measurable equality objectives;
(b) Analyse the effect of our policies and practises on equality and consider how they further the equality aims;
(c) Publish sufficient information to demonstrate that we have complied with the general duty on an annual basis. This compliance is in respect of the effect of their services and employment on the protected characteristics: Age, Disability, Gender Reassignment, Race, Religion or Belief, Sex, Sexual Orientation, Pregnancy & Maternity and Marriage and Civil Partnership.

4. Population and demographics

The following section provides an overview of the demographics and the local population of North Somerset, and the catchment area of WGH.

4.1 Local Population

The current catchment population of WGH as defined by registered population of referring GP practices is approximately 150,000 - living in a mix of urban and rural areas. The population across the catchment area is expected to increase by approximately 0.8% to 161,000 by 2025, with higher increases for people over 70 years of age. Life expectancy across the area is broadly in line with the England average but with significant variations as set out below.

4.2 Health Inequalities

There is significant variation in the health outcomes for the population across the area served by the hospital. The most deprived areas around Weston town are associated with high rates of obesity and harm from drugs and alcohol.

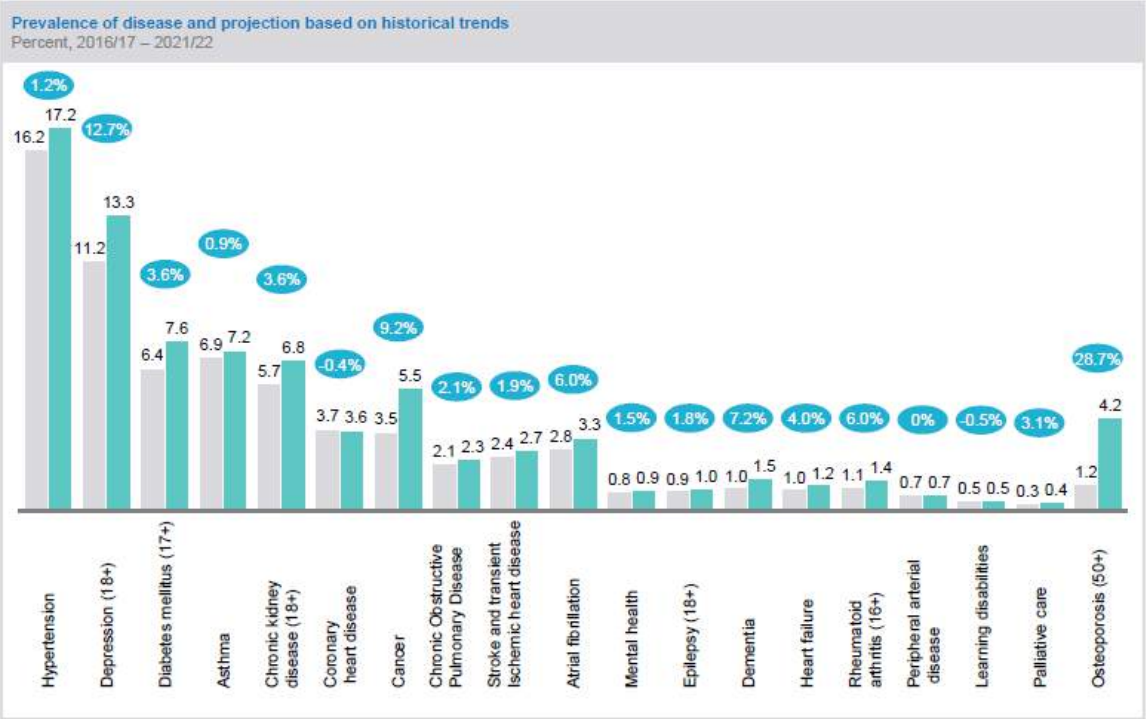
A baby born today in the most affluent part of North Somerset can expect to live ten years longer than a baby born in the most deprived area. A baby boy born today in the most deprived area can expect to have 22 years of poor health compared with 14 years in the most affluent area. In some areas of high deprivation, smoking rates are as high as 41% compared with the national average of 15%.

4.3 Disease and Condition Profile

Prevalence of diseases in North Somerset is broadly similar to peer-CCGs and the average for England.

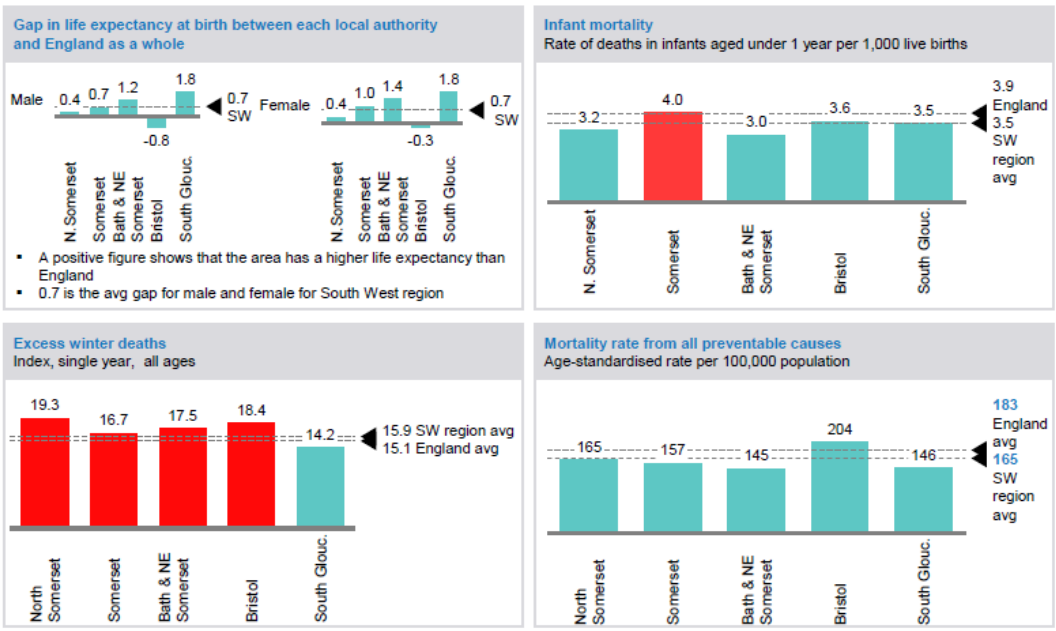
Overall North Somerset performs well when compared nationally, with better than average premature death rates for each of the four groups. North Somerset is ranked 22nd for cancer, 39th for heart disease and stroke, 21st for lung disease, and 17th for liver disease (where 1st has the lowest rate of deaths from that cause). A large number of these premature deaths are preventable with lifestyle changes and there are links between this and social-economic status.

Over time, there are expected to be increases in the prevalence of several chronic conditions with particularly sharp increases in depression, diabetes mellitus, chronic kidney disease, cancer, atrial fibrillation, dementia, heart failure, rheumatoid arthritis and osteoporosis as outlined below:



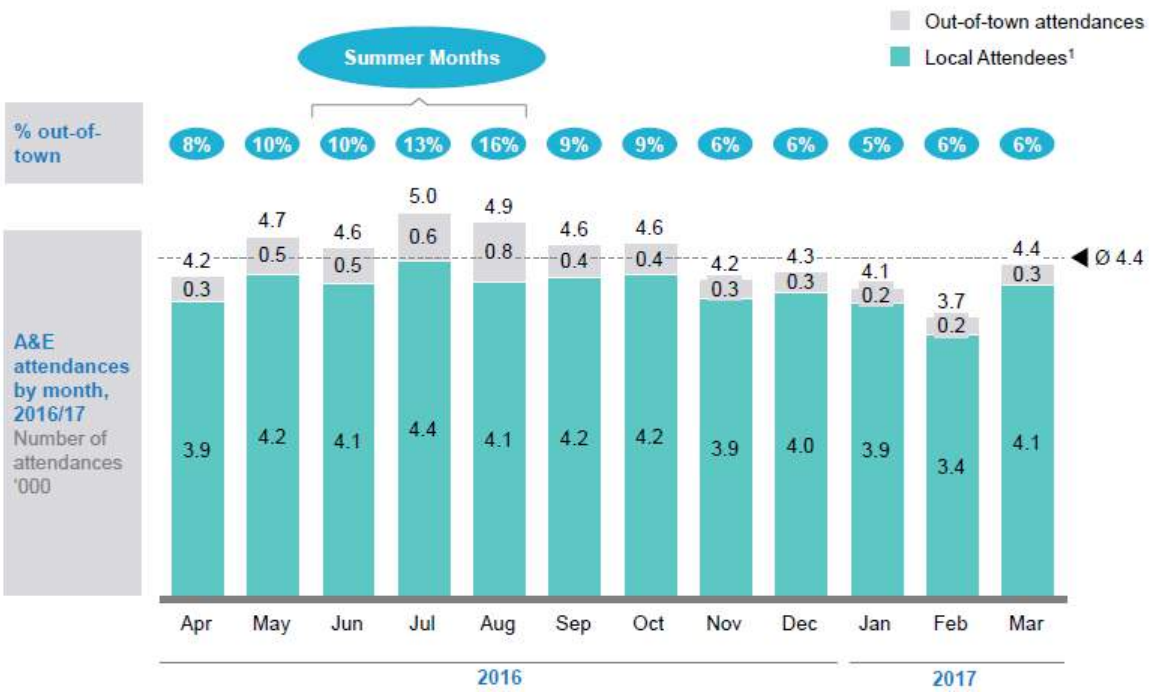
4.4 Variations in mortality, life expectancy and preventable death indicators

In North Somerset, there are also regional variations across mortality, life expectancy and preventable death indicators as outlined below with red showing worse than the national average.



The overall population served by WHAT/WGH is older than the England average, with 20% of people projected to be over 70 years of age by 2025. Older people are more likely to have a long-term health condition or experience health problems due to frailty.

Weston-super-mare is a seaside town that sees an increase in visitors over the summer months. This results in an increase in A&E attendances by out-of-town visitors as outlined below:



4.5 Age

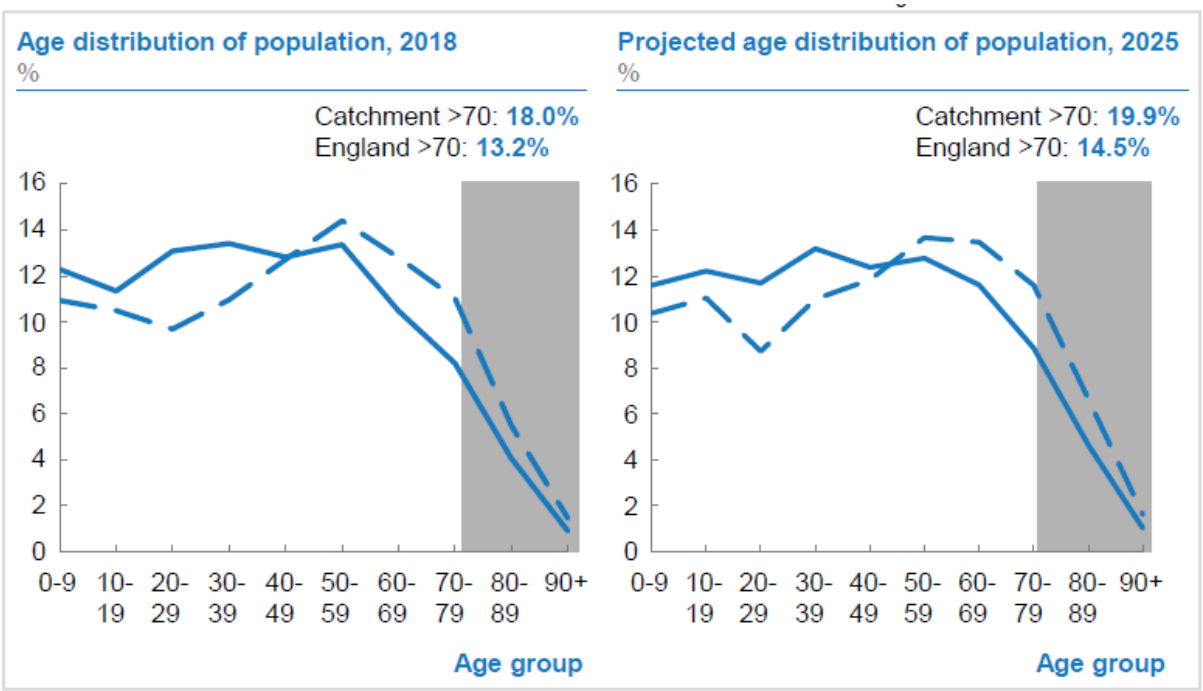
Age is one of the most critical factors in planning the healthcare for Weston, Worle and the surrounding areas. The population served by WAHT is older than the England average,

with 20% people expected to be over the age of 70 by 2025. Over half of the total population increase between 2018 and 2025 will be in the 70+ group.

In addition, the 65+ population of North Somerset as outlined below is proportionally greater than other areas in the region.

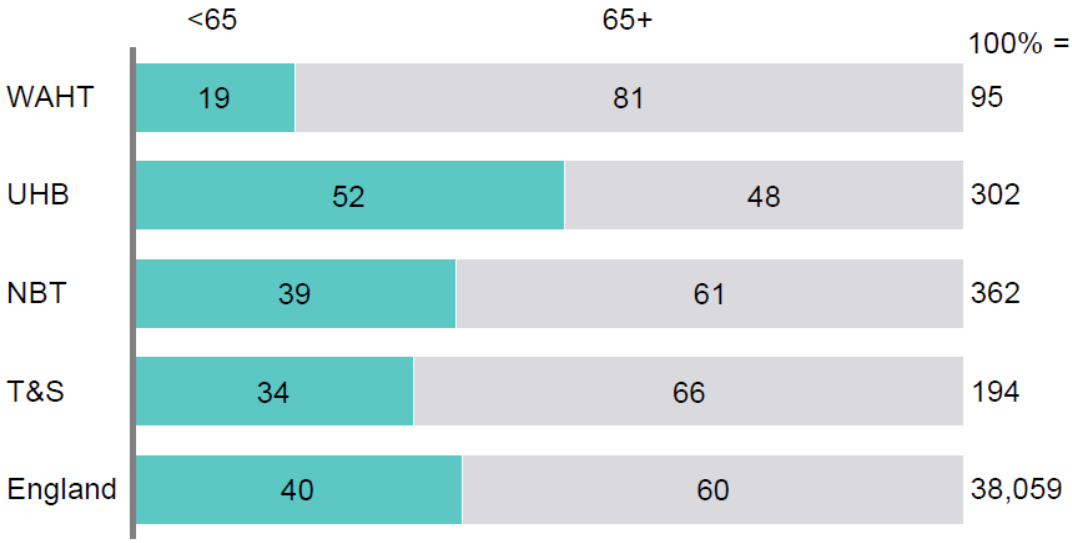
Group description	Bristol population (2011 Census)	North Somerset population (2011 Census)	South Glos population (2011 Census)
Aged 0-15	18.4%	18.1%	18.6%
Aged 16-64	68.5%	60.9%	63.5%
Aged 65+ (85+)	13.1%	21.0% (3.2%)	17.9%

The age distribution of the population is shown below against the national average.



Hospital bed days in over 65s as a percentage of all bed days is significantly higher for WHAT (WGH) than for neighbouring Trusts, as shown below:

Hospital bed days in over 65s as a percentage of all bed days, 2016/17, % (total in 'k)



WAHT: Weston Area Health Trust
UBH: University Hospital Bristol
NBT: North Bristol Trust
T&S: Musgrove Grove Park Hospital (Taunton)

Although we have an older profile population, the needs of the young population in the area must also be reflected in the planning and provision of high quality care. A&E attendances in under-5s are particularly high in the south of the WAHT catchment area, and planned new housing developments are likely to attract a growing number of young families.

4.6 Gender

The gender distribution across the area is broadly in line with the regional picture.

Group description		Bristol population (2011 Census)	North Somerset population (2011 Census)	South Glos population (2011 Census)
Sex	All population, all ages	49.8% male 50.2% female	49% male 51% female	49.5% male 50.5% female

In England, average life expectancy has been relatively static for women at 64.1 years, whereas men have seen a small but steady increase from 63 to 63.4 years. Life expectancy in the region is 66.3 years for women and 66 years for men.

4.7 Ethnicity

The population of North Somerset is less ethnically diverse than England and Wales as a whole, with 97% of people living in North Somerset classifying themselves as belonging to a white ethnic group (including White Irish and Other White ethnic groups). Of those classified as a Black or Minority Ethnic (BME) group, 44% were Asian and 37% were mixed race (Census, 2011).

There is variation in the percentage of the population from a BME group by ward within North Somerset. Population numbers by ward range from 8% in Weston-super-Mare central to 1% in Clevedon Walton.

4.8 Disability

Of the total population in North Somerset, 8.6% (17,335) have a disability that limits their day-to-day activities a lot and 10.6% (21,405) have a disability that affects their day-to-day activities a little. Of these, many may need support to continue working (Census, 2011).

In North Somerset the number of adults with a learning disability known to their General Practitoner was 809 (2011-12), creating a value of 4.77 (95% CI 4.45 to 5.11) per 1,000 population (Learning Disabilities Profile, 2013).

In 2011, ONS estimated that there were 1,582 children in North Somerset aged between 0 and 4 years old with a long-standing illness or disability. 4,923 children in North Somerset have special needs, of which 486 have statements and 4,437 do not (School Census, 2014).

Disability Adjusted Life Years (DALYs) take into account the number of years of a person's life are lost but also the amount of time spent with a disability, hence they capture the impacts of chronic conditions and those associated with pain and morbidity. In North Somerset the leading causes of DALYs lost are cancer (neoplasms), mental health and behavioural disorders, musculoskeletal conditions and cardiovascular disease; in particular low back and neck pain (6,249), ischaemic heart disease (4,887), chronic obstructive pulmonary disease (2,377) and cerebrovascular disease (2,233).

4.9 Religion and Belief

The religious make up of North Somerset is 61.0% Christian, 29.5% No religion, 0.4% Muslim, 0.3% Buddhist, 0.2% Hindu, 0.1% Jewish, 0.1% Agnostic. This compares with the national levels of 59.4% Christianity, 24.7% No religion, 5% Muslim, 1.5% Hinduism, 0.8% Sikhism. There are faith networks operating throughout the county, in particular around Weston-super-Mare.

It is recognised that people who practice other faiths could be vulnerable to religious discrimination. Muslims can be particularly vulnerable to religious discrimination; research conducted by the Joseph Rowntree Foundation in 2008 found that nearly a third of British Muslims had experienced religious discrimination.

4.10 Sexual Orientation

Sexual Identity in the UK 2015 report (ONS) stated that 1.7% of people in the general population identified themselves as lesbian, gay or bisexual. In the 2011 census data for North Somerset, 6% of people identified as lesbian, gay or bisexual, notably higher than the national average.

It is important for organisations commissioning and providing health and social care to be aware of the existence and needs of 'hidden' lesbian, gay and bisexual people who are older, from black and minority ethnic or working class backgrounds.

4.11 Gender Reassignment

Based on research by the Gender Identity Research and Education Society, 1% of the population people have some degree of gender variance. If applied to the catchment population of Weston General Hospital, this would mean that approximately 1500 people have some degree of gender variance.

A review of trans people's health needs and access to health care by Mitchell and Howarth for the Equality and Human Rights Commission in 2009 found that, in addition to needs directly related to gender reassignment treatment, trans people may experience isolation and discrimination, and face greater risk of alcohol and drug abuse, depression, suicide / self-harm or violence than the general population

4.12 Pregnancy and Maternity

The birth rate is expected to decline 0.2% p.a. until 2025 in North Somerset. However, there are a number of planned housing developments that will attract families with young children to the area.

5. Overview of engagement

Our vision and proposal for change have been developed through close working with local health professionals and, importantly, members of the public and patients.

From the outset, we have sought the views of clinicians at Weston Area Health Trust, North Somerset Community Partnership, South Western Ambulance Service NHS Foundation Trust, North Somerset Community Hospital, Brisdoc, Avon and Wiltshire Mental Health Partnership and GP practices across the area.

In addition we have engaged with a range of frontline staff; patient, carer and public representatives; the voluntary sector; local councillors, Members of Parliament and national bodies.

The proposals have been directly informed by our pre-consultation public engagement work, which took place between October 2017 and March 2018, resulting in **1, 627** pieces of feedback representing **2, 518 people**, received via workshops, letters, emails and social media posts.

The following activity took place as part of the public engagement phase:

- A large-scale event for organisations working across health and social care
- Eight public meetings
- Six workshops about children's services, maternity care, vulnerable groups, older people, care homes and services at the site of Weston General Hospital
- Five meetings open to staff from healthcare organisations
- Visits to 27 committees, community groups and voluntary sector organisations
- Surveys.

All of this feedback has been carefully considered in developing and refining our pre-consultation business case (PCBC). A detailed independent report which summarises the feedback received during the public engagement phase is included in the appendices to this document.

In summary, we learned the following from our engagement, which informs our focus during the consultation phase:

- There are significant concerns about travel which need to be explored; including availability, accessibility and cost. The next phase of engagement needs to further consider these concerns from the perspective of different groups.
- More engagement needs to take place specifically with the frail elderly population.
- 25% of the 1, 315 people who responded to our survey declared a long term condition, 8% declared a physical disability and 8% a mental health condition. The consultation phase will require deeper engagement with these groups to understand the impact of our proposals more fully.

Engagement has continued throughout November and December 2018 with:

- Further public events including pop-up info stands at the Sovereign Centre
- 15 community group meetings
- An online survey that has garnered 95 responses to date

5.1 Hard to reach groups

Proactive engagement activity has taken place with hard to reach groups through the public dialogue phase of this work, as well as more recent engagement. This has involved going in to different community settings. A full list of meetings attended is set out in the appendix.

The different groups that we have met with include:

- Homeless populations
- People experiencing substance misuse issues
- Older people, including those in care homes
- Condition specific support groups
- People with learning disabilities
- LGBT+ communities
- People affected by mental ill health.

5.2 Engagement in governance

The programme governance structure was set up to ensure that clinicians were at the heart of the programme, and the membership of the Clinical Service Design and Delivery Group (CSDDG) and programme steering group includes senior clinicians from across the

health community. These groups have met monthly with additional meetings where required.

The development of clinical service models was led by the Clinical Service Design and Delivery Group plus a wide range of clinicians from primary, community, social care, mental health and acute services.

5.3 Engagement with staff

We have held specific meetings with staff at Weston General Hospital, and provided regular information via *Healthy Weston* bulletins.

In addition, *Healthy Weston* has been a standing item at the Healthier Together Social Partnership meetings which feature staff, unions and HR representation from across the Sustainable Transformation Partnership (STP), and they have been regularly updated on the progress of the programme.

5.4 The role of the PPRG

A Patient and Public Reference Group (PPRG) was set up in 2017 to inform our overall approach, and the group continues to meet regularly. This group provides guidance to support the programme and is being aligned to the newly established North Somerset Patient and Public Involvement Forum, which is chaired by the CCG's Independent Lay Member for patient and public involvement and has a direct reporting route to the CCG's Governing Body.

6. Equality Impact Assessment Methodology

The approach to undertaking an Equality Impact Assessment commenced with an initial screening in the form of a desktop exercise. This exercise has been supported by a robust engagement approach outlined in this report. Findings from both the desktop exercise and engagement processes underpin our plans for the consultation process going forward.

6.1 Desktop analysis

Following an initial pilot of the process, a larger group comprised of internal and external stakeholders evaluated the proposed model and the currently commissioned service against the protected characteristics:

Age, Disability, Gender Reassignment, Race, Religion or Belief, Sex, Sexual Orientation, Pregnancy & Maternity and Marriage and Civil Partnership.

Each of these characteristics was discussed individually against the preferred option in terms of whether the service was likely to have any implications people with these

characteristics and, if so, what the consequences would be either positively or negatively. Each was then scored in terms of both impact and likelihood. Where a service was considered to potentially have both positive and negative impacts (such as access to services and the impact on people with frailty), or to affect different groups differently within one protected characteristic (such as younger people and older people) then these were each scored and the scores added to create a single score. The scoring system used is shown in Table 1. The high level summary of the issues considered in determining these scores can be found in Appendix 3.

Table 1: The scores used for the anticipated impact and likelihood of positive or negative impacts

	Likelihood				
Impact	Rare 1	Unlikely 2	Possible 3	Likely 4	Certain 5
Significant negative impact - 2	-2	-4	-6	-8	-10
Moderate negative impact -1	-1	-2	-2	-4	-5
No significant effect 0	0	0	0	0	0
Moderate positive impact +1	1	2	3	4	9
Significant positive impact +2	2	10	6	8	10

Key Outcomes:

Using the scoring guide in **table 1**, the current commissioning model along with proposed preferred option were evaluated for likely impact. The findings are as follows:

- Currently commissioned model

The overall score was – 32.5, that is, a significant negative impact. Notable components of this are as follows:

Race

Cultural competence around understanding the needs of BME patients was highlighted as a particular concern.

Sexual Orientation:

Competence and sensitivity of the service to the needs of Lesbian, Gay and Bisexual patients was highlighted as a concern.

Age

Fewer services specific to the needs of children available. Similarly, no specific frailty service available.

Disability:

Local services are likely going to be more supportive of accessibility.

Deprivation

People living in more deprived areas are more likely to experience poorer health. They are less likely to have easy access to transport. More local services are thus likely to be an advantage in terms of access. The range of services currently available is less likely to sufficiently meet all of their health care needs.

- Proposed model:

  The overall score was – 10.5, that is a negative impact but one that is substantially less than the currently commissioned model. The improved scores mostly concerned:

  -the availability of a greater diversity of staff and therefore an anticipated improvement on the cultural competence of staff at specialist centers;

  -the greater availability of more age-appropriate services for children and for people with frailty;

-and an overall increased range of services;

Conversely, the negative impacts may occur due to:

-access for people with disabilities, frailty and/or multiple co-morbidities may be more difficult.

-a 14 hours/day A&E services would reduce access slightly.

Mitigation

The services of the preferred option have been designed specifically to mitigate many of the current disadvantages of the currently commissioned services. This doesn't mean however that the preferred option do not in themselves raise some potential issues, these are outlined in **table 2** along with proposed mitigation. The impacts for the preferred option are RAG (Red, Amber, Green) rated according to impact.

Table 2: A breakdown on the anticipated impact of the preferred option on protected groups with potential mitigation:

Protected Characteristic	Preferred Option	Reason for Impact Assessment	Potential Mitigation
*Age [eg: young adults, working age adults; Older People 60+]	Amber	The preferred option is universal with open access to all members of the population regardless of age. The increased emphasis on care and services for the elderly including the frailty service will have a significant benefit. Conversely, any additional travel to Bristol or Taunton will present obstacles for older people considered as a potential factor, in terms of the additional stress it could potentially cause, especially to older people. Parents with young families may experience more difficulty if they need to travel further to access services. However, the plans include provision of a more comprehensive and dedicated paediatric centre in Western General Hospital that would be of benefit.	The programme team to work with strategic partners in the area to ascertain what solutions may be identified to alleviate the concerns around extra travel time. This will also be incorporated into the consultation plan to ensure that we involve those that this may potentially impact in a meaningful dialogue around these concerns.
Disability	Amber	The proposed model will have an effect of patients with a variety of disabilities. For those patients with a disability who require traveling to another site, the preferred option will be a negative impact.	The programme team to work with strategic partners in the area to ascertain what solutions may be identified to alleviate the concerns around extra travel time.

		However, many patients will be able to access more integrated care to support them to stay well and out of hospital including through the frailty service.	This will also be incorporated into the consultation plan to ensure that we involve those that this may potentially impact in a meaningful dialogue around these concerns. The consultation will ensure that it is contextualised to meet the needs of people with disabilities to ensure that are enabled to participate fully in the consultation process. This will include: 1. Developing Easy Read formats of the consultation documentation. 2. Ensuring adherence to the guidance outlined in the Accessible Information Standard and ensuring a comprehensive plan is in place to vary the consultation approach to suite those with sensory impairments to enable them to participate fully in the consultation process (such sign language facilitated focus groups and information videos, screen

			reader compatible digital information and information leaflets in Braille)
Gender Reassignment	Green	There is no evidence to suggest that the proposal will disproportionately affect this group.	Monitoring the impact of any service changes on this characteristic will continue throughout the entire process. Training and education of all staff on equality and diversity and embedding equality and diversity through the implementation of service change alongside ensuring staff confidence in discussing transgender issues.
Race	Green	There is no evidence to suggest that the proposal will disproportionately affect BME communities. Whilst the proportion of BME communities in the area represent 3% of the total population, very little contextualised engagement has been undertaken to date. This is not to say that the views of some BME communities have been captured as part of the wider engagement activity, however this will be something that will be undertaken as part of the consultation process going forward.	Further work needs to be done to ensure that the views of BME communities are captured as part of targeted activity within the consultation going forward. This will include considering the cultural sensitivity around mixed (male-female) focus groups, and language considerations. In addition, any online surveys will ensure that equality monitoring information is attached appropriately to enable the CCG to undertake a

			robust analysis on the data. As part of the implementation going forward, cultural competence training will ensure that the needs of BME communities are recognised (language and cultural sensitivities) enabling an appropriate level of service provision.
Religion and Belief	Green	There is no evidence to suggest that the proposal will disproportionately affect religious communities.	As part of the implementation going forward, appropriate education and training will ensure that the needs of religious communities are recognised enabling an appropriate level of service provision.
Sex	Green	There is no evidence to suggest that the proposal will disproportionately affect this group.	No mitigation required at this stage. If any new information becomes available as part of the consultation going forward then this, this will be reflected accordingly.
Sexual Orientation	Green	There is no evidence to suggest that the proposal will disproportionately affect this group. Stonewall research shows that sexual orientation is often clumsily addressed in services and the assumption is from a bias of heterosexuality which means that people feel that they cannot be open about their needs. There is also an assumption that any mental health	Based on the assessment no mitigating actions required. It is recommended that health care professionals are educated on the needs of Lesbian, Gay and Bisexual patients and service users.

		conditions identified are directly linked to a person's sexual orientation which means that these conditions are not addressed as fully or as holistically as they could be.	
Pregnancy & Maternity	Green	There is no evidence to suggest that the proposal will disproportionately affect this group.	No mitigation required at this stage. If any new information becomes available as part of the consultation going forward then this, this will be reflected accordingly.
Marriage and Civil Partnership.	Green	There is no evidence to suggest that the proposal will disproportionately affect this group.	No mitigation required at this stage. If any new information becomes available as part of the consultation going forward then this, this will be reflected accordingly.

* Under-18s are only protected against age discrimination in relation to work, not in access to services, housing, etc. Children's rights are protected by several other laws and treaties, such as: The Children Act; the Human Rights Act 1998; the UN Convention on the Rights of the Child; the European Convention on Human Rights; the UN Convention on the Rights of Persons with Disabilities; and the UN Convention on the Elimination of Discrimination against Women.

6. Next steps

The impacts identified so far will be further considered as part of the contextualised consultation process going forward where the consultation approach and methods must reflect the needs of our diverse populations. This Equality Impact Assessment is an iterative processes, and any findings identified throughout the consultation process will be added to existing themes identified and used to inform the decision making process going forward.

We will continue to actively engage with protected groups through the consultation period and incorporate this into the consultation plan going forward, particularly as outlined, the frail elderly and people with disabilities.

A further particular focus will be the engagement of those groups who will be affected by the increased travel time to specialist centres. There is a concern that the increased travel time will prevent some people from engaging in treatment for chronic conditions, and therefore in the public consultation we will proactively engage with affected groups to ensure that appropriate mitigation actions can be planned.

As such, we are currently in the process of agreeing the terms of reference (TOR) for the “Travel Working Group” which will include North Somerset Council, Weston Hospital Trust, local travel companies, the Patient and Public Involvement Forum, the University Hospitals Bristol, North Bristol Trust, voluntary and community sector organisation representing people that are frail and elderly, people with disabilities, and people experiencing social and economic deprivation. The main aim of this group is to discuss and agree mitigations for the preferred option. We will share details of the preferred option and discuss potential mitigations with the initial meetings of the Travel Working Group. This will then be collated and collected as part of the consultation findings and reflected in the Equality Impact Assessment accordingly.

Social and economic deprivation is another area that we are factoring into our plans in particular around the ability of people to travel to specialist provision outside of Weston.

Appendix 1: Scores attributed to each equality consideration for the currently commissioned model and the preferred option.

				Protected characteristics						
Service	**Disability**	**Ethnicity**	**Gender**	**Sexual orientation**	**Transgender**	**Maternity and pregnancy**	**Age**	**Religion**	**Marital status**	**Deprivation**
Current commissioned service	+1 x 5 (=10)	-2 x 5 (=-10)	0	-2 x 5 (=-10)	-2 x 5 (=-10)	0	Younger people: -1 x 5 (=-5) Older people: -2 x 5 (=-10) Overall score = -15	0	0	Access: +2 x 5 (10) Range of services: -2 x 5 (=-10) Overall score = 0
Preferred Option	Access: -1 x 4 (=-4) Frailty: +1 x 4 (=4) Overall score = 0	-2 x 4 (=-8)	0	-2 x 4 (=-8)	-2 x 4 (=-8)	0	Younger people: +1 x 5 (=5) Older people: +2 x 5 (=10) Overall score = 15	0	0	Access: +2 x 4 (8) Range of services: +1 x 4 (=4) Overall score = 12

In each instance in the table, the first number is the impact score and the second the likelihood.

Appendix 2:

Title: Drop in session for LGBT+ community regarding Healthy Weston

Date and time: Tuesday 13th November 201819:00 – 20:30

Location: Proud Bar, 20 Boulevard, Weston-super-Mare BS23 1NA

Attended by (on behalf of CCG):	❖ Mary Adams, Partnerships & Engagement Manager ❖ Nicole Young, Executive PA ❖ Abi Galley, Administration Assistant
Resources:	❖ Healthy Weston booklets handed out by CCG ❖ A number of leaflets taken by CCG showing the work and events the LGBT+ community are providing. ❖ Participant questionnaires collected
Main points of discussion:	❖ Clear desire from the LGBT+ community to have a non-medical safe place to go, particularly for those who are confused with their identity. This was the main want from all, particularly as Weston is becoming increasingly diverse. ❖ Both Bristol and Exeter have funding but North Somerset do not and have little council support. ❖ Concern that the organisation who wins the bid for the crisis café model will forget the needs and wants of minor communities after they have been awarded the contract. ❖ Both younger and older LGBT+ community feel isolated. ❖ Concern regarding the lack of LGBT+ awareness in Nursing Homes. Many elderly residents simply revert to hiding their sexuality in fear of being treated differently or not understood. ❖ LGBT training wanted for nursing home staff. ❖ Nursing Homes to address resident discrimination. ❖ YMCA to 'up their game' supporting young people. ❖ Previously a 'youth drop in' was available in Weston but this has now stopped – can it restart? ❖ Workplace training to reduce hate-crime and increase understanding is encouraged. ❖ Proud bar are aiming to create a drop in clinic for HIV awareness and sexual health information; can the CCG support? ❖ Lack of GP knowledge of the support available – ensure patients are being made aware. ❖ A lack of response noted from the public aged under 20. NY has some ideas to engage Weston College – discuss with MA outside of meeting. ❖ Social media means that people cannot escape.
CCG actions:	❖ NY / MA to discuss Weston College engagement ❖ Provide ongoing support and attend LGBT+ events

Healthy Weston Pre-Consultation

Business Case

Appendix 25: Healthy Weston Consultation Plan

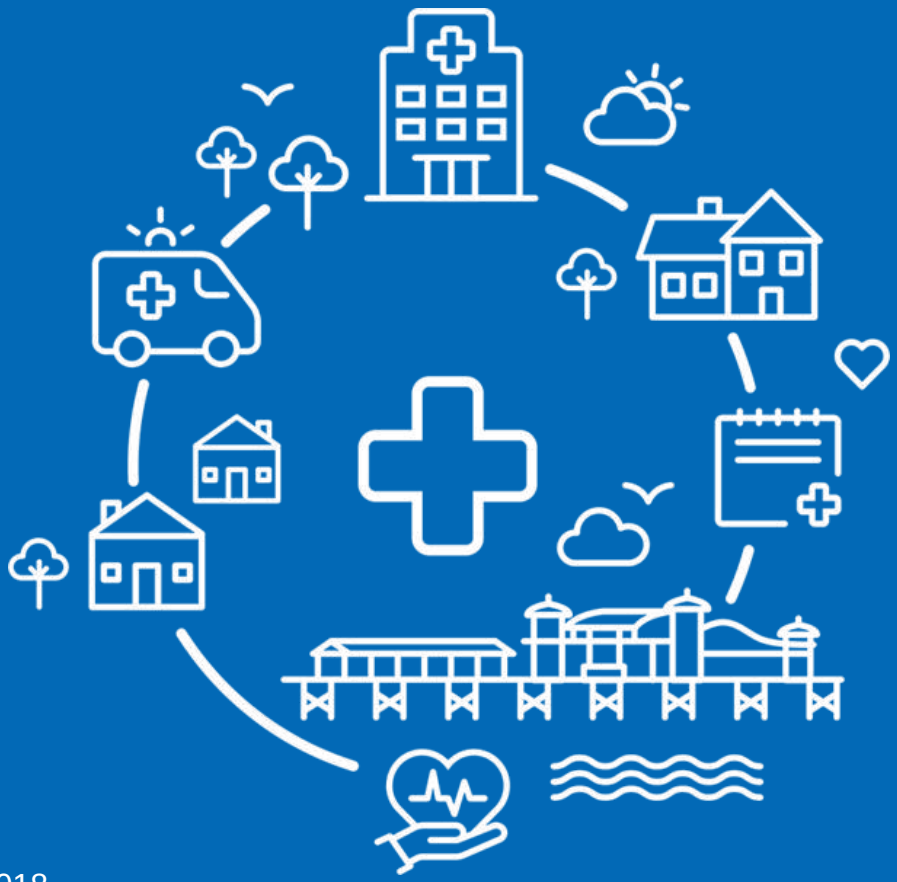
NHS
Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Group

HEALTHY WESTON

Part of **Healthier Together** – a partnership approach to improving health and care in Bristol, North Somerset and South Gloucestershire

HEALTHY WESTON CONSULTATION PLAN

Plan for Bristol, North Somerset, and South Gloucestershire Clinical Commissioning Group on public consultation activity



31 December 2018
Version no: 0.8
Status: DRAFT

Contents

Please note: This is a working document and it will be further developed as we deliver our consultation. More detail will be published as supplementary information to Appendix C as plans are put in place (e.g. meeting dates and venues) and research services are commissioned (e.g. dates of focus groups)

1. Introduction

Healthy Weston is the name of the work Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group is leading together with a range of health and care organisations to change and improve local services. It is part of Healthier Together – our Bristol, North Somerset and South Gloucestershire Sustainability and Transformation Partnership.

Following detailed engagement with the public, patients, carers, staff, stakeholders, partners and providers of services we will be consulting on changes to services at Weston General Hospital in the context of wider changes taking place across primary and community services in Weston-super-Mare, Worle and the surrounding area.

A pre-consultation business case (PCBC) outlining our proposals in detail and including detailed information about our communications and engagement work so far, has been developed. This will be published in early 2019 once we have decided to go to formal consultation. We are aiming to run a formal public consultation, to test and gather feedback on our proposals for changes to services at Weston General Hospital, in early 2019.

About this plan

This plan sets out how we will approach a formal consultation on changes to services at Weston General Hospital. More detailed plans and additional information are included as appendices to this document.

This plan is being informed by discussions with colleagues from commissioner and provider organisations across the Bristol, North Somerset and South Gloucestershire Sustainability and Transformation Partnership, our Healthy Weston Communications and Engagement Group and our Patient and Public Reference Group (PPRG) and the CCG's Patient and Public Involvement Forum (PPIF).

It is also being informed by best practice principles from NHS England and NHS Improvement, Cabinet Office guidelines on consultation and from The Consultation Institute, as well as examples of good practice found across healthcare and other organisations in England. The PPRG and PPIF will continue to play an active role in the development and refinement of our consultation plan, and to review and comment on consultation materials and activities as they are developed.

Governance

Development and implementation of this consultation plan will be largely delivered by the BNSSG CCG Communications Team, with support from colleagues in the Healthier Together Communications Network, and the Communications and Engagement Group workstream of the Healthy Weston programme. The work will be overseen by the Healthy Weston Steering Group and ultimately the CCG's Governing Body.

The Healthy Weston Programme Director (CB) is accountable for the effective delivery of the programme, including this workstream – working closely with the BNSSG CCG Executive Director responsible for communications and engagement (DES).

This plan will be formally approved and signed-off by the CCG's Governing Body on the recommendation of the Healthy Weston Steering Group. The plans for consultation will be discussed by North Somerset Council's Health Overview & Scrutiny Panel on 11 December 2018 and formally agreed by the BNSSG CCG Governing Body as part of its decision to consult in early 2019.

2. Scope

In **geographical** terms, the consultation will cover:

- the North Somerset area covered by Bristol, North Somerset and South Gloucestershire CCG including Weston-super-Mare, Worle and the surrounding areas
- the north Sedgemoor area covered by Somerset CCG. This is because Weston General Hospital currently provides services to some patients from north Sedgemoor
- neighbouring/boundary areas whose communities may be impacted by the proposed changes, and particularly where there are any material patient flows from these areas to Weston

In **service** terms, the consultation proposals focus specifically on changes to hospital services at Weston General Hospital, but these are very much within the context of changes and improvements to primary and community-based services in the North Somerset area and a vision of an integrated system of health and care.

3. Pre-consultation engagement

Extensive engagement has been undertaken throughout 2018 with all key audiences including frontline staff, stakeholders such as MPs and local government representatives, and patients, public, carers, and their representatives such as Healthwatch, to ensure that the proposals are clinically led, co-designed and developed with significant input from a wide range of people.

This work is detailed in the Pre-Consultation Business Case (PCBC) which will be published in due course and further information can be found at www.bnssghealthiertogether.org/healthyweston

Statutory duties and legislation

As an NHS organisation we are required to show how the proposals we are putting forward meet the four tests for service change laid down by the Secretary of State for Health. These are:

- Strong public and patient engagement
- Consistency with current and prospective need for patient choice
- Clear clinical evidence base to support the proposals
- Support for the proposals from clinical commissioners.

The Chief Executive of NHS England has introduced a 'fifth test' that requires NHS organisations to show that any proposals for significant hospital bed closures, subject to the current formal public consultation tests, can meet one of three conditions before NHS England will approve them to go ahead:

- Demonstrate that sufficient alternative provision, such as increased GP or community services, is being put in place alongside or ahead of bed closures, and that the new workforce will be there to deliver it; and/or
- Show that specific new treatments or therapies, will reduce specific categories of admissions; or

Where a hospital has been using beds less efficiently than the national average, that it has a credible plan to improve performance without affecting patient care (for example in line with the Getting it Right First Time programme).

There is also a legal duty on NHS organisations to involve patients and the public in the planning of service provision, the development of proposals for change and decisions about how services operate:

- Section 242, of the NHS Act 2006, places a duty on the NHS to make arrangements to involve patients and the public in planning services, developing and considering proposals for changes in the way services are provided and decisions to be made that affect how those services operate.
- Section 244 requires NHS bodies to consult relevant local authority Overview and Scrutiny Committees on any proposals for substantial variations or substantial developments of health services. This duty is additional to the duty of involvement under section 242 (which applies to patients and the public rather than to Overview and Scrutiny Committees).
- The NHS Act 2012, Section 14Z2 updated for Clinical Commissioning Groups places a duty on CCGs to make arrangements to ensure that individuals to whom the services are being or may be provided are involved (whether by being consulted or provided with information or in other ways):
    - in the planning of the commissioning arrangements by the group
    - in the development and consideration or proposals by the group for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals or the range of health services available to them
    - in decisions of the group affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.

Current guidance on involvement is called 'Transforming Participation in Health and Care' and is available here - https://www.england.nhs.uk/2013/09/trans-part/

We need to make sure that our consultation activities meet the requirements of The Equality Act 2010, which requires us to demonstrate how we are meeting our Public Sector Equality Duty and how we take account of the nine protected characteristics of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation.

We also need to consider other relevant legislation and show:

- How we have learnt from the views and requirements of those who may use our services and their carers, families and advocates and responded to their feedback
- How the proposals will bring significant clinical benefits and improve outcomes and accessibility
- How the proposals consider people's diverse and individual needs and preferences including people with protected characteristics.

The approach and activity outlined in this document demonstrates how we will meet these obligations.

4. Consultation principles

Our consultation plan is underpinned by some fundamental principles. As well as shaping the content and activity of our consultation, these principles will form the basis of our evaluation of the plan.

Consulting with people who may be impacted by our proposals

- We will reach out to people where they are, in their local neighbourhoods and in local networks.
- We will make sure that there are 'no surprises' for staff whose jobs may be affected by the review and that they will hear from us first about the proposals and have an opportunity to respond. We will ensure that they are aware of the process, understand how their roles may be impacted and will ensure they understand how they can give their views on the consultation.
- We will cover the geography, demography and diversity of Weston, Worle and the surrounding area including the working population, silent majority, seldom heard, people who are mostly well, and people who aren't, and those with protected characteristics, to gather a fair representation of views and feedback.

Consulting in an accessible way

- We will provide detailed information on websites to ensure transparency. We will also produce targeted public-facing documents (some printed as we know not everybody wants to access information digitally), summaries, case studies and social media content.
- We will make sure our public information is consistent and clear; written and spoken in 'plain English' avoiding jargon and technical information; accessible to everyone and available on request in a range of languages and formats.
- We will make clinical information and agreements available to the public.
- We will provide a range of opportunities for involvement and engagement with our consultation; reaching out to people where they are, in their local neighbourhoods and in local networks, physically and digitally.

Consulting well through a robust process

- We will make sure that local people and the staff working in organisations affected by the proposals across Weston-super-Mare, Worle and the surrounding areas have confidence in our consultation process, ensuring it is open, transparent and accessible.
- We will be clear and up front about how all views can influence decision-making, explaining it will not be possible to do everything everyone wants and why difficult decisions have to be made.
- We will widely advertise and do our best to make sure people are aware of our consultation even if they choose not to participate.
- The consultation will run for 15 weeks [beyond the standard 12 weeks in anticipation of accommodating a period of local authority 'purdah'] to allow people to give their views and we will provide regular reminders about progress and the closing date.
- We will strive to ensure we are acknowledged locally and nationally to have undertaken a meaningful and effective consultation process and will seek support for our consultation plan and process from the Health Overview and Scrutiny Panel in our ongoing engagement with them.

Consulting collaboratively

- We will work collaboratively with individuals, stakeholders and partner organisations to deliver the agreed consultation principles and make the most of the opportunities of partnership working to reach out to as many people as we can in a meaningful way across Weston-super-Mare, Worle and the surrounding areas.
- Our information will be relevant to local groups, being clear about what the proposals mean for each geographical area and for each group of people taking account of their interests, diverse needs and preferences.

Consulting cost-effectively

- We will strive to ensure our consultation budget is spent wisely and used effectively in terms of reach and response, delivering good value for money.

Consulting for feedback

- We will monitor and evaluate our consultation process consistently and in a systematic way, including capturing feedback and comments from events, meetings, surveys, discussions and individual responses
- We will commission several 'mid-term' reports in terms of consultation response analysis, to assess progress on where, how and from whom we are receiving feedback and responses, so we can target our activity to address gaps in feedback geographically or demographically
- The analysis of feedback will be done independently, and the independent report shared publicly
- The results of our consultation and the feedback received will be thoroughly and conscientiously considered and used to inform decision-making.

We will strive to deliver a best practice consultation within the timeframe and budget allocated and will work with independent providers to analyse the results to ensure an objective outcome. We will use a mix of qualitative and quantitative methodologies to allow for both volume and richness of response.

To help us achieve this aim, we have the following objectives:

- Make people aware of the public consultation and how they can get involved
- Comply with the duty to inform people about how the proposals have been developed and describe and explain the proposals and what they will mean in practice for the provision of local services so that people can make an informed response
- Seek to actively gather people's views and encourage responses to the consultation
- Ensure that a diverse range of voices are heard and that the engagement activities target specific community groups to ensure the local population is represented
- Ensure that the consultation process uses a range of methods to reach different audiences and maximises opportunities for engagement with the local community and key partners
- Consider the responses made as part of the consultation and take them into account in decision-making, with sufficient time allocated to give them thorough consideration
- Deliver a public consultation in line with best practice that complies with our legal requirements and duties.

5. The consultation document – outlining our proposals for the future of health care in North Somerset

At the heart of our consultation is a public-facing consultation document that will:

- outline our reasons for change, our ambitions and the proposals for changes to services at Weston General Hospital to create a stronger, more focussed hospital, in the context of wider changes taking place across primary and community services in Weston-super-Mare, Worle and the surrounding area
- provide explanatory, supporting information and a set of questions to allow people to tell us what they think of the proposals

We will make this document available in a range of formats and through a variety of different channels (see Section 9). A range of consultation products and collateral will be developed and is described further throughout this document. All will be available on the CCG website as they are developed.

6. Target for reach and responses

The total registered population of the North Somerset area covered by Bristol, North Somerset and South Gloucestershire CCG is 212,000, and the catchment population for Weston General Hospital is 152,000, with an estimated 125,000 adults in that population. We want to reach a representative sample of this population to ensure that there is awareness of the proposals, sufficient opportunity to comment and a rich source of feedback and insight for us to make sure that future decisions on how health services are organised and provided in Weston-super-Mare, Worle and the surrounding areas are ones that reflect the needs of the local population.

We have set three core targets for our consultation activity which will be a key measure of our evaluation for the success of the consultation:

Raising awareness through opportunities to see or hear about the consultation

Our objective is to provide multiple opportunities to see or hear about the consultation through, for example, broadcast, print and social media, paid-for advertising, targeted leaflet drops etc in addition to more personalised and interactive engagement. We would expect to be able to generate at least 125,000 opportunities to see or hear about the consultation*.

**NB: We recognise that 'opportunities to see or hear' do not necessarily equate to people reading or listening and are a relatively superficial measurement, so will put more focus on and weight into the engagement and response figures below*

Active and direct engagement

Our objective is to reach 2,500 people, equivalent to approximately 2% of the adult catchment population for Weston General Hospital, through direct engagement (e.g. mailings to stakeholder distribution lists, meetings and events, roadshows, social media interaction, focus groups, polling etc).

Responses to the consultation

Our objective is to generate 1,250 separate responses to the consultation, equivalent to approximately 1% of the adult catchment population for Weston General Hospital. These could be emails, questionnaires, Tweets, phone calls, letters or comments made at events. Where we can show whether the same person or group has replied twice, we will do, but it might not always be possible.

Whilst we want to hear from as many people as possible, we are clear that our consultation is not a referendum or vote. What is important is that we seek and get a broad, representative and diverse range of views to give rich insights to support our decision-making. If we set our targets for reach too high we will need to use a lot more resource to generate higher numbers in the limited timeframe of the consultation, which may not then result in a very different outcome or feedback. The quality of feedback to our consultation is important alongside the quantity.

These targets will be a key measure of our evaluation for the success of the consultation.

7. Stakeholder mapping

We aim to engage as many people and groups as possible from the local area as the timeframe and budget for our consultation permits. We will be seeking to work with our colleagues and organisational partners across the county to enable this. Our stakeholder map below illustrates the broad range of stakeholders we anticipate will have an interest in responding to the proposals and this plan outlines our strategy for engaging each of these key groups.

The groups and organisations we have identified will be engaged during the consultation period, where they will be encouraged to share their views on the proposals for change and the potential options. In addition, to help us reach as many people as possible, we will ask all organisations and groups to act as conduits and to actively help us promote the consultation (via their communication and engagement channels and distribution networks) to any relevant stakeholders, patients, carers and other users or potential users of the services being consulted on.

Patients and public	Clinicians and staff	Local and national government and regulators	Political	Partners and providers	Media
• Residents of Weston-super-Mare, Worle, Winscombe and the surrounding area including Bristol, North Sedgemoor and the neighbouring areas served by Taunton and Musgrove NHS Trust in Somerset • Patients, carers and their families • Those previously involved in pre-consultation engagement activities • Seldom heard groups • Groups with protected characteristics • Healthwatch • Local patient groups (GP Patient	• Trades unions, staffside groups and professional organisations • all acute hospital staff (WAHT, UHB, NBT, T&S) • South Western Ambulance trust staff • NSCP, SPFT and NHS community services provider staff • social care teams • AWP mental health trust staff • BNSSG CCG Governing Body members • BNSSG CCG GP members and GP providers including BrisDoc • GP practice staff,	• NHS England (national and regional) • NHS Improvement (national and regional) • South West Clinical Senate • Health Education England • North Somerset Council and Somerset County Council	• Local MPs • Health Oversight Scrutiny Panel members • Neighbouring HOSC/JHOSC members where relevant • Health and Wellbeing Boards • Councillors	• Acute NHS hospital, ambulance and community services providers – boards and frontline staff • NHS Boards and staff in neighbouring areas • NHS Boards and mental health trust staff • BNSSG CCG GP members and GP providers including BrisDoc • GP practice staff, dentists, opticians, pharmacists • Care homes • Domiciliary care providers • Drug and alcohol	• Local print and broadcast channels • National print and broadcast (while we will not proactively seek national media coverage, we should be prepared to handle enquiries from these outlets) • Trade press (professional media outlets such as nursing or medical journals and publications, as well as online and social media counterparts, are often useful channels for raising awareness of

Participation Groups, Health Reference Groups etc) and including peer support groups • Carers groups • PPIF members • PPRG members • Campaign groups • Voluntary and community sector groups including faith groups • Schools, colleges and local education bodies • Tourist representatives and tourist information bodies	dentists, opticians, pharmacists and their local council bodies • Royal Colleges and other professional bodies • Universities and medical schools • Health Education bodies • Academic Health Science Network			rehabilitation service providers • Voluntary, community and faith groups • Local business organisations and Chamber of Commerce	proposals to staff and professional groups) • Partner organisation news channels such as council papers, local directories, parish bulletins and leaflets and voluntary sector organisation newsletters

8. How we have developed this plan

In developing this plan, we have built on the pre-consultation engagement activities that have been undertaken before and since the publication of the Commissioning Context document, *Joining up services for better care in the Weston area,* in October 2017.

The local community

We have undertaken a variety of activities to reach the local community including holding public meetings, running an online survey, focus groups, roadshows in the community, and attending meetings hosted by others in the community.

We have also undertaken targeted outreach work with seldom heard groups and those with protected characteristics to ensure that we have contacted the range of groups protected under equalities legislation. We will continue with this work and ensure that as many people with diverse views as possible are able to feedback on the proposals. All groups we have engaged with will be sent a copy of the consultation document and questionnaire and be invited to respond, with an offer of more copies, further engagement opportunities and attendance at meetings if requested.

Independent delivery partners

We will work with an independent research partner to develop the consultation questions and to analyse and report the responses from groups and individuals. We are also recommending commissioning additional focus group and telephone survey research as part of the consultation activity to ensure a breadth of views from a representative sample of the target population.

North Somerset Health Overview Scrutiny Panel (HOSP), Somerset Health Overview Scrutiny Committee and BNSSG CCG Joint Health Overview Scrutiny Committee

We have engaged with and regularly updated the HOSP on the progress of the Healthy Weston work including the engagement activity that has been undertaken since October 2017. We presented our consultation approach and plan on 11 December 2018 and will be formally consulting with them as part of our statutory duties. We will keep the Panel regularly updated through the consultation period, and at the appropriate time, with our decision-making and detailed implementation plans. We have also regularly updated colleagues in Somerset HOSC and BNSSG JHOSC and will continue to do so.

Voluntary and community sector and local elected representatives

We have worked closely with community and patient groups and welcome further partnership working through consultation and beyond. We have held meetings and engaged with representatives from the voluntary, charity, and social enterprise (VCSE) sector, and with local authority councillors from North Somerset and neighbouring Somerset. We plan to work closely with these groups and partners, including those in our boundary areas, during our formal consultation to ensure that as wide a cross-section of the community is informed about and made aware of the consultation as possible, and to increase the range of opportunities available for our patients, their relatives and carers and the public to have their views heard.

Staff

Clinicians, leaders and representatives from all the partner organisations in Healthy Weston have been involved in the pre-consultation co-design and engagement phase of work, particularly through the programme governance infrastructure and specifically the Clinical Services Design and Delivery Group, and supporting sub groups e.g. the Finance & Enabling Group, the Healthy Weston Steering Group, the Communications and Engagement Group and through the Healthier Together Executive

Group and Sponsoring Board. These groups have advised and commented on plans and activities and will receive regular reports on the consultation once it is underway.

We make a commitment in this plan to staff who may be affected by the proposals that they will hear about them first internally from their organisation's leadership, rather than from their local newspaper or via social media.

Patient and Public Involvement Forum and Patient and Public Reference Group

Group members have been, and will continue to be, invited to advise on how engagement can be strengthened and to act as a 'critical friend' to this work, including giving feedback on draft public-facing materials to make sure they are clear and easily understood.

Healthwatch

North Somerset Healthwatch conducted a research project on behalf of the North Somerset Partnership Board and published it in July 2017, which informed the CCG's Commissioning Context document, and has been actively involved in work since it was published. North Somerset Healthwatch is also a core member of the Healthy Weston Communications and Engagement Group. We will continue to work in partnership with Healthwatch and to use their networks to deepen engagement and encourage responses to our consultation. We will also be requesting them to promote the consultation through their own newsletters and channels.

Integrated Impact Assessment (IIA)

Our consultation activity will be informed by the results of the IIA conducted by the Healthy Weston programme team. We will make sure we specifically target those sectors of the population who have been identified as potentially most impacted by the proposals. This for example is likely to include: older people; carers; parents with young children; those who do not have access to private transport, and so on. *[DN: Further detail to follow from PMO and IIA)*

9. Consultation activities – an overview

A good consultation exercise should employ a range of techniques and channels to ensure that members of the public and stakeholders may fully participate. Our approach will make efforts to reach a broad range of people, in addition to and beyond statutory organisations, partner organisations and those with a vested interest or those already highly engaged who usually respond to consultations. We aim to do this through using a variety of methods to engage with the public and stakeholders.

It is recommended that activity takes place via two core routes which is described in more detail in Appendix C:

1. **Active and visible leadership at a system level, led by system and clinical leaders and the Healthy Weston Programme Team**: briefings and meetings with groups and stakeholders (e.g. HOSP, MPs, some patient and voluntary groups, regulators, partners, royal colleges, clinical senate, staff briefings etc)
2. **Activity at CCG/Trust 'local' level, led by the communications and engagement team**: generation and clearance of core content, production and distribution of consultation materials, planning and delivery of a launch event, responses to correspondence, FOI, media requests and proactive media activity, digital engagement etc.

Our techniques will recognise the different ways in which various stakeholder groups and audiences might choose to participate, allowing for differing levels of engagement or interest as reflected in the

stakeholder analysis. By using a range of different methods, we will be able to facilitate a wide range and breadth of feedback.

We will use a range of techniques to enable people from all local communities to take part in the consultation and to give feedback. Consultation methodology generally falls into two main categories - giving information and getting information.

At the core of our consultation will be a consultation document and summary which clearly lay out the basis on which we are consulting, the background to the consultation, a summary of the data upon which options have been developed and what the proposals/options are, and signposting for more detailed technical information if needed. This document will also seek feedback and promote the various other methods by which people can engage in the consultation.

In line with best practice the consultation document will meet the following criteria:

- The consultation document will be concise and widely available
- The language of the consultation document will be accessible, clear, concise and written in plain English. It will be available in other languages and formats on request
- The objectives of the consultation document will be clearly stated
- The consultation document will provide details of all options for change with well-balanced pros and cons for each option, including the implications of no change
- Proposals will be set out clearly and transparently
- The consultation document will contain specific, relevant, clear information
- The consultation document will explain why service improvement is required, setting out what the results of change will look like in terms of benefits to patients (whether in terms of clinical outcomes, experience or safety) as well as any financial benefits, but also setting out any potential disadvantages, presenting a balanced view
- A set of key questions will be included
- The consultation document will inform the public about how they can contribute to the consultation and state clearly how feedback will be used
- An email as well as a freepost address will be given for responses
- The consultation document will include a list of the partners involved in the consultation, but be clear it is led by the CCG
- The document will include details of how patients and the public have been involved so far
- The consultation document will include contact details for a consultation enquiry line, staffed by someone/people who will respond to questions and who will pursue complaints or comments about the consultation process
- The consultation document and other supporting collateral will be available in paper format, free of charge
- The consultation document will be on the Healthy Weston part of the Healthier Together website in digital format from the start of the consultation
- The document will give the dates of the consultation period (start and finish).

We will test our draft document and other consultation materials with our Patient and Public Involvement Forum, Patient and Public Reference Group and the Communications and Engagement Group to ensure that they are clear and well-understood. In addition, we will seek advice from an independent research and evaluation organisation to help us design non-leading questions that meet the highest standards of research design for this sort of exercise and undertake cognitive testing on the consultation questionnaire to ensure that our target audiences find it easy to understand and respond to.

Distribution channels

As noted in our section on stakeholder mapping, we will distribute a range of consultation materials throughout our consultation area to our partners and stakeholders and encourage them to disseminate information through their own networks. These include:

- All NHS acute hospital sites
- All NHS community and mental health hospitals and clinics
- All other providers of NHS services
- All GP practices
- All community pharmacies
- Voluntary and community services organisations for onward distribution to community networks
- Faith groups
- Residents associations
- Leagues of Friends
- Other NHS acute, mental health, ambulance and independent services provided by other providers for use internally and for placing in patient and public areas
- Local authorities via existing community communication channels; for example, we will explore opportunities to promote the consultation via North Somerset Council's *Life* magazine which is distributed to c92,000 households
- Local education bodies
- Public libraries and public information points
- Local media, for publication about the proposals and consultation events
- Social media (including Twitter and Facebook)
- Local MPs, councillors and council offices.
- Local businesses/business representatives and large local employers

Consultation briefings, updates and frequently asked questions

In addition to the consultation document, a series of updates, briefings and frequently asked questions will be produced during the consultation period. These will be used to provide answers to common issues and questions, share emerging information and respond to issues that have arisen.

Displaying and distributing information

The objective is to convey information in plain English in an easy to understand format and encourage participation, ultimately to drive responses to the consultation.

Physical distribution

Distribution of promotional material will take place across hospitals, primary care and other health settings, community centres, leisure centres, health, libraries, and other public places.

Virtual distribution (see also section 14 on digital communications approach)

This will be supported via:

- Websites – the main website is the Healthy Weston part of Healthier Together (www.bnssghealthiertogether.org/healthyweston) and across all partner websites within the consultation area, signposted from partner websites where they are content to support in this way.
- Email bulletins
- Online video
- Social media (Facebook / Twitter etc)

Media (see also section 14 on media approach)

Information will be conveyed either as editorial that is free but not within our control, and via local media adverts that we pay for and control.

We will issue regular media releases throughout the consultation period to local newspapers, local broadcasters (tv and radio) and community magazines (including newsletters produced by residents' associations, parish, borough, district and county councils, community, faith and voluntary groups etc).

Display

Displays in key locations will promote the opportunity to respond to the consultation. This will include displays at the acute hospitals and in other public areas where these can be accommodated.

Workshops, roadshows and public meetings

As part of the consultation there will be further workshops and public meetings, which local people can attend by booking their place in advance. There will also be opportunities to distribute materials and engage local people through roadshows and existing local engagement events. These will focus on explaining the case for change, the options for consideration, sharing information and answering questions to increase understanding, and inviting feedback and formal responses to the consultation questionnaire.

Getting information

Discussion groups are guided conversations with smaller groups of people. We intend to use these groups primarily to seek feedback on proposals with small targeted groups and specific user groups – especially those who may find it difficult to engage in other consultation methods such as people with learning difficulties or communications impairments. (We may use interpreters or advocates at these sessions).

Questionnaire

Our questionnaire will be used to ask people for their feedback on our proposals for change and their opinion on our consultation options, and to gather views and feedback on issues, concerns, and areas of support so that these can be understood, and taken account of, including mitigating where possible, in terms of decision-making and implementation of that decision. The consultation is also an opportunity to seek additional evidence, insight and ideas that may not have been known about or considered thus far. We will send out our consultation document by email to a wide range of stakeholders and will also make hard copies widely available in the community. People will also be able to download the document from the Healthy Weston part of the Healthier Together website and respond online or via freepost.

Drop–in sessions

Drop-in sessions are informal methods which invite people to take part in discussions on a one-to-one or very small group basis. This will allow for more detailed conversations about specific topics of interest. We plan to hold these sessions at Weston General Hospital, in community spaces, in primary care/health centres and with NHS staff. We will provide a mechanism for capturing the content and themes from these discussions, as well as using them to encourage completion of the consultation questionnaire.

Patient and carer groups

In line with the results of the Integrated Impact Assessment, we will also look for additional targeted opportunities to engage with groups who have been identified as potentially more impacted than others by the proposed consultation options.

Outreach

As part of the approach to equality and inclusion, we will carry out proactive outreach to target seldom heard groups, with a focus on those representing the nine protected characteristics: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex, sexual orientation. We will proactively approach community groups with information about the consultation, as well as attending pre-existing meetings. Like the drop-in sessions above, this outreach will allow for more detailed conversations and the opportunity to encourage people to complete the consultation questionnaire.

Focus groups

We plan to hold focus group discussions with the following groups [*tbc*]:

- frail older people, including those with long-term conditions
- parents of young children (up to age 18 years)
- carers
- those particularly identified in the IIA as potentially more impacted by the proposals
- staff

Focus groups will be held across the consultation geography. They will enable us to gather rich data about the views of these groups who are most likely to be impacted by the proposed changes. Members of the public could be financially incentivised to take part if recruitment is difficult (as per standard industry practice).

Citizen's Panel

We will engage with our recently established BNSSG Citizen's Panel; asking for feedback on the consultation proposals via the consultation questionnaire and supported by the consultation document, summary and other materials.

Telephone survey

We will commission a telephone survey with representative samples of the population from across the consultation geography. This will allow us to gather a broad range of views from those who may not otherwise contribute (e.g. working well).

All events, activities and meetings will be scheduled and diarised as part of a 15-week consultation diary, once agreed. We will keep an up-to-date schedule of public meetings publicised on the Healthy Weston and BNSSG CCG website. In line with best practice engagement, and our recommended approach of going out as much as possible into the local community to engage, most meetings and briefings will form part of pre-existing meetings rather than being stand-alone events. Clearly this activity is dependent on the capacity and availability of spokespeople to attend these meetings, answer questions and facilitate discussion with our target audiences for consultation. It is recommended that a team of clinical and other leaders from the Healthy Weston programme is developed and supported, with sufficient time scheduled to deliver this face-to-face activity as part of a dedicated cohort of spokespeople for the consultation.

10. Our commitment to an accessible and inclusive approach

It is essential to ensure that we target, and cater for, the needs of seldom heard groups and others with special requirements. These groups include, for example: the young, the working well, those in

deprived communities, those in more rural communities, migrants, those with learning disabilities and those from BAME groups. We are also committed to seeking views on the proposals from those representing the nine protected characteristics: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex, sexual orientation.

Our commitment to engage specific groups is underpinned by legislation to ensure that all public services make every effort to engage specific groups in consultation to improve and redesign services. The 2010 Equalities Act (updated to Equality Duty 2011) makes clear the responsibility of public services to make additional effort to engage specific groups as a means of improving decision-making.

To best meet needs of people with additional requirements we will:

Produce an 'Easy Read' summary consultation document and response form:

- This nationally recognised scheme uses words and pictures in an easy to read format to effectively communicate with people with learning needs or who have only a basic knowledge of English language. The draft version of the document will be piloted with a Learning Disability advocacy group to ensure it is readable and understandable. This document will be cascaded through our voluntary community sector contacts, sent or taken to relevant focus groups and meetings, and will be available online.

Produce materials in different print formats on request

To meet the needs of individuals with visual impairments and or with other communication needs, we will produce consultation documents in a range of formats upon request.

- Large print
- Braille
- Audio
- Offer a translation service (e.g. Language Line).

We are aware that not everyone speaks English and will explore the most commonly spoken languages across the consultation catchment area to select the top 10 languages and offer a translation service on request. This means, that throughout the consultation period and during all our events and roadshow activities, if we need translation we can immediately access a telephone service. In addition, we will offer to translate the consultation document upon request. This will be noted on the back of key documents in the 10 top languages spoken across the area.

Produce documents in plain English

Essential to a good consultation is a clear consultation document and summary. We will continue to use our Patient and Public Involvement Forum Group, Patient and Public Reference Group and the Communications and Engagement Group as part of our drafting and testing process to make sure materials are clear and easy to read. We will also ensure the questions we ask are checked in the same way and are developed and approved by an independent research company.

Ongoing analysis

Throughout the consultation period we will receive regular response monitoring reports from the independent consultation analysis agency (who we will use to collect and analyse the responses). We will monitor this information closely to identify any demographic or other trends which may indicate a need to adapt our approach regarding consultation activity, or refocus efforts elsewhere, for example a high response rate from a particular ethnic group/age group/borough or equally a very low response from a potentially affected group.

11. Direct engagement with NHS staff and stakeholders

Our approach to direct staff engagement is two-fold:

1. Staff who are potentially affected by the proposals – in our 'Consultation Principles' we make a commitment to a 'no surprises' approach for staff who may be affected by the proposals. Targeted engagement activity with these groups will be at the forefront of our staff engagement effort in advance of the consultation launch as well as during the consultation period.
2. Staff are often local residents, patients and carers too, with the same concerns as other members of the public, carers or patients about health and care services. It is essential that they are aware and engaged about the consultation and have the opportunity and means to tell us what they think.

Workforce considerations are a major part of any service reconfiguration and as part of this plan we recommend that it is the responsibility of the commissioner and provider organisations to ensure that they fulfil their legal duty and consult their staff on the proposals. The consultation materials generated will be used to support health and care organisations in this regard, but they will need to be localised, and 'what could this mean for me?' plans should be developed by and aligned with local HR Directors and their workforce teams' ongoing work. We will work with partner organisations as appropriate, to determine and agree the range of activities that will meet the needs of their staff.

In advance of the consultation launch, staff who may be affected by the proposed changes will be briefed on the proposals and options for consultation and made aware of the opportunities to attend face-to-face briefings and meeting sessions to find out more and give their views.

Following the launch of the consultation, our approach will include the following activities:

Events

Events/briefings for health and social care staff, including GPs and their practice staff, across acute, ambulance, community and mental health, primary care and social care.

The aims of the events will be to:

- provide detailed information and to answer questions which enable people to make a considered response to the consultation
- to gather rich feedback on the benefits, concerns and issues in a structured and constructive way
- to explain the proposals and enable leaders and clinicians to be questioned about them and to understand the balance of opinion by exploring the preferences on the consultation proposals.

Existing internal communications channels

Intranets, newsletters, materials available in high-traffic areas and staff briefings and existing meetings and fora will all be used to engage with staff.

We will contact and distribute materials to GP practices, via practice forums and promote the consultation via existing bulletins to GPs and their practice staff.

We will also seek to work through existing networks to reach independent contractors such as dentists, pharmacies and opticians.

Our communications and media approach

Digital communications

Digital communication does not replace engaging with people face-to-face, but is a way of raising awareness, providing information and accessing more people; including some people like the working well, parents of young children or carers, and some older people who find it harder to leave the house and attend meetings.

For a large and growing section of the population digital communication is now their preferred means of communication. Cabinet Office Guidance advises that “digital is the default method for consultation”. ‘Digital First’ is the preferred mass method as it reduces waste, money and time – web and social media activity should be the starting point. The guidance states that paper surveys must be reduced as their evidence suggests people do not like them and few fill them in. It does emphasise that tailored, evidence-led inclusion of target groups must use additional appropriate tools to suit the needs of these groups i.e. face to face road shows and focus groups. However, we are aware, through feedback from our own patient and public groups, representatives and networks that there is still a requirement for paper-based copies of documents and we will make sure that we have adequate supplies of paper-based materials and that these are targeted and distributed appropriately.

Given the above, our approach will be balanced using the full range of different channels of communication: face to face activities, digital and news media. We hope this will ensure that all people are able to get involved in a way that best suits them.

Our approach to digital communications will be via:

Website

We will use the Healthy Weston part of the Healthier Together website as our ‘online consultation hub’ and visitors to the site will be able to access all consultation information here in one place, with quick links on every page to clearly highlight key documents and online feedback channels. It will also include an events diary and document store (for more detailed technical information) and integrate with our social media channels.

Social media and video

Twitter, Facebook, YouTube and a blog will be used to signpost and facilitate discussion, during and after the consultation period.

We will provide the option to hold online discussions using Twitter – ‘tweet chats’ - at times that evidence suggests will attract these audiences, e.g. weekday evening chats for working adults and parents. Twitter will also be used to complement offline engagement.

The blog will be an opportunity for individual clinicians to interact with an online audience in a less formal way, emphasising that the work is clinically led, and keeping them updated with progress of the review at every step of the way. It will also enable us to rapidly respond to inaccurate media and social media stories.

In addition, we will make use of video and try to bring the consultation to life for people using Voxpops, interviews with key spokespeople, patients and carers to help engage our target audiences, disseminate key information, share understanding and encourage responses to the consultation.

Animation – *[DN: option depending on budget, resource to produce etc]*

As part of the consultation materials, we could develop an animation outlining the proposals in an engaging and easy to understand way and as a 'call to action', encouraging feedback on the options that are being put to the public.

The animation would follow standard Equality Act 2010 (EQA) accessibility guidelines with English subtitles and graphics that are suitable for sight-impaired viewers.

Media approach

Our media approach will be proactive during the consultation period (as well as reacting, of course, to any enquiries or issues that arise). In the consultation catchment area, the local media continues to be important in influencing public perception and reaction to all aspects of health and care changes and we will work with them and communicate key messages for the consultation through the channels they provide.

During the consultation phase we will adhere to the following key principles:

- Work with the media. This activity will include a media programme of promoting case studies, inviting journalists to events and facilitating interviews with key clinicians involved in the development of the proposals, patients and carers
- Ensure we can provide clinical spokespeople wherever possible to explain the reasons for change and our proposals, and to support them appropriately in this role
- Work closely with local journalists and ensure they are fully briefed on the reasons for the consultation and why local clinicians believe it will improve services.
- Invite members of the media to all relevant engagement events and meetings, to maintain transparency throughout the process.
- Work with media teams at all partner organisations to make sure messages are consistent. We will ask NHS communication colleagues to include a link to the Healthy Weston consultation review in their proactive relevant press releases.
- Respond to all media enquiries in a timely and helpful manner.
- Regularly monitor the media and ensure that inaccurate information about the consultation and Healthy Weston programme is rebutted.
- Evaluate all media coverage to assess its effectiveness, and the inclusion of our key messages, adapting our approach as appropriate.
- Focus on professional journals to engage local clinicians, for example Nursing Times, Pulse, Allied Health Professional journals and the Health Service Journal.
- Explore the value for money of paid-for advertising to generate a good response to the consultation and explain the programme to local people.

The media audiences we will target with information about the consultation include:

- All local newspapers
- Professional journals such as Health Service Journal, Pulse, Nursing Times, Nursing Standard and GP
- Council newsletters and websites
- Local NHS Trust newsletters and websites
- Local community newsletters and websites
- Online media via social media strategy
- Identified and targeted key NHS and health policy commentators and bloggers, as appropriate.

12. Mechanisms for response

We will provide the following mechanisms for response:

- Freepost address – for returning paper responses to the consultation questions
- Dedicated consultation email address
- Online – including a web form and via social media e.g. Twitter and Facebook
- Free phone line/voicemail
- Face to face.

All feedback, whether verbal or written, will be collected and sent on, as part of the formal response, to an independent research organisation that will receive, collate, monitor and analyse and report on the responses received.

13. Analysis of consultation responses

An independent organisation will be commissioned to manage the response process and will be responsible for collation and analysis and reporting of all responses. This is best practice for a public consultation such as this, and ensures a formal, independent, non-biased and objective provider is in place to analyse the responses and to produce the final consultation response analysis report.

14. Impact of consultation on outcomes and decision-making

The outcome from the consultation, in terms of the final report from the independent analysts (and any raw data specifically required), will be used alongside the range of other evidence gathered as part of the Healthy Weston decision-making process (including clinical, financial, workforce, estate, travel time evidence etc). It will be used to help decide on any changes to the way we organise and provide health care services at Weston General Hospital and will help to inform our ongoing thinking about how we develop primary and community services too in support of this.

This decision-making process will comply with the NHS England guidance 'Planning and Delivering Service Changes for Patients'.

It is important following the consultation that the consultation team develops timely feedback mechanisms to ensure that those who participated in the process are informed about the feedback received, its likely impact and, in due course, the decisions made as a result. It is also important that any ongoing process and further decision-making is understood by stakeholders. This will build on the mechanisms already developed in the engagement phase including the Healthy Weston part of the Healthier Together website and regular stakeholder cascade briefings.

After the consultation has closed, we will publish a report setting out the major themes emerging from the consultation, a summary of the responses relating to our consultation proposals and options, an overview of the process, an explanation of how the final decisions will be taken (including dates of meetings in public) and the high-level timeline for implementing any changes.

A framework for the response to the public consultation is shown below, based on best practice guidance.

The report will include the following information:

- Introduction and background
- Review of case for change
- Review of proposed changes

- Summary of responses to consultation
- Number of responses and how many were deemed suitable/usable
- Respondent background, e.g. voluntary organisations, faith groups, clinical, public
- Responses to specific consultation questions
- Summary of responses for individual questions
- Summary of themes in responses
- Information on themes that came out of consultation not covered by the questions
- How the CCG will address concerns
- Link to website where responses can be viewed
- Recap of final decision-making process and next steps.

This report will draw on the independent evaluation report. It will be available online, with printed copies available on request. The full evaluation report will also be available to the public on the Healthy Weston part of the Healthier Together website, with hard copies available on request. The Health Overview Scrutiny Panel will be invited to review the consultation process and comment on the outcome. The final decision on the future of services will be taken by the BNSSG CCG governing body expected in the autumn/winter of 2019. Following this decision, a detailed communications and media plan, will set out how this decision will be communicated to all stakeholder groups.

15. Measure of a successful consultation

The success of our consultation will be measured against:

- the aim and objectives set out in section 7 of this plan
- whether we have met our statutory and legal duties during the consultation
- feedback from stakeholders
- depth and breadth of analysis from feedback gained by activity and engagement methods during the consultation period
- measurement against the target for reach set out in section 9 of this plan
- analysis of social media and other media coverage for penetration of key messages; and
- depth of analysis resulting from feedback gained during the consultation.

16. Resourcing plan

Resources are needed to deliver the consultation approach outlined in this plan.

Our best practice consultation approach aims to ensure that statutory requirements have been met and, in the event of a legal challenge, that the correct process has been followed.

It is important to note that consultations tend to be challenged on process (typically equalities and options development and consultation process) – and this could lead to long delays, potential re-consultation and increased costs, and of course too the opportunity costs for patients in delays to making improvements to services. In summary, although the investment outlined below is significant, it is recommended that investment is secured so that the process may be run properly, effectively and robustly. As well as enabling an effective consultation which we hope will produce rich feedback and insights, this will also help mitigate the risk of successful challenge around a poor consultation process at a later stage.

A dedicated consultation team

To successfully deliver this consultation approach, and the activity plan, we recommend that BNSSG CCG identify a dedicated core team, focused solely/largely on the consultation. This team

would mainly consist of existing staff working for the CCG and the Healthy Weston programme. We have indicated the resource required below.

This core team will need to be supported by colleagues in provider organisations who will lead local delivery of activity, maintain engagement with staff, and help cascade and disseminate key information and materials as necessary.

Running a public consultation exercise is challenging and requires a core team that is resilient, professional and ideally consistent to take the programme through from start to finish. It is wise for the CCG to also consider how they may handle potential reviews by the Independent Reconfiguration Panel or a Judicial Review, in due course.

Details of the proposed core/central Healthy Weston consultation team is shown in Appendix A.

Resource costings

While most of the staffing costs are already met as detailed above, there may be some additional costs for additional external capacity/capability to support delivery of the work for a short period of time in the lead up to and/or during the consultation, and potentially for short-term administrative staff. In addition, there will be costs for document design and printing and other materials and events required to run a successful consultation. The costs for these resources are estimated in this plan at this stage.

Non-pay resources

Non-pay resources should be agreed in advance. This will give the consultation team the flexibility to be responsive to change and focus their delivery and activity within the agreed envelope.

A current work in progress, indicative budget is set out in Appendix B. *[DN: to follow for BNSSG CCG consideration]*

17. Conclusion

By its nature this plan will be iterative, although based on the comprehensive approach described here and agreed with key colleagues and stakeholders. It will be updated as necessary and appropriate in the lead up to consultation and adapted as necessary during consultation to make sure it supports the maximum reach to our target audiences and is flexible enough to address any gaps or duplications or issues that may emerge.

Appendix A: Core consultation team

Role	Resource in place?	Any additional costs?	Responsibilities
Senior leadership			
Programme Director	Y	N	For sign-off of new materials and to provide steer and advice as needed throughout the consultation period
Associate Director of Communications and Engagement	Y	N	Strategic oversight of consultation programme and activity; board level advice and counsel; attendance at key Steering Group programme meetings; messaging and narrative development
Clinical support	Y	N	For sign-off of any materials requiring clinical view or evidence
Leads for stakeholder relations and key meetings	Y	N	To support the planning and delivery of stakeholder engagement activity at system level, working closely with the communications Lead; providing briefing and slide packs as needed using core narrative and messaging; attending and recording events and supporting response to stakeholder issues and actions
Cohort of spokespeople/core leadership team	Y	N	Cohort of: CCG Chief Executive, plus a deputy; Clinical Chair and Medical Director, plus a deputy; other clinical spokespeople (including from WAHT) to: • Speak at public and community meetings and engagement events across the consultation geography • Speak and present at key stakeholder meetings • Potentially be a media spokesperson for proactive work, and to support responses to media bids and reactive work • Support online engagement activity e.g. webchats

Role	Resource in place?	Any additional costs?	Responsibilities
			• Be a spokesperson for staff communications, engagement and consultation activity
Communications and engagement expertise			
Communications and Engagement Lead	Y	N	Day to day operational leadership of the consultation programme and activity from a communications and engagement perspective; liaison with comms and engagement network; messaging and narrative development; shaping and coordination of consultation C&E activity and delivery of core materials, working closely with core C&E team; liaison with independent analysis company for consultation responses and reporting; liaison with any providers commissioned to support consultation e.g. through telephone polling; focus groups etc
Communications: FOI, briefing and correspondence	Y	N	Drafting and ensuring delivery to time of FOI and briefing enquiries and correspondence
Communications: media and social media	Y	N	Planning, oversight, coordination and delivery of all media and social media activity (proactive and reactive) for the duration of the consultation
Communications: content for digital and other collateral	Y	N	Drafting and production (based on core messaging) of digital content and other collateral (working closely with Communications Lead); developing content as needed throughout the consultation to keep content regularly refreshed and to respond to issues and gaps, whilst keeping consistency across the network
Meetings and events manager	Y	N	To project manage and lead delivery of public meetings and events through planning and booking of accessible venues, management of invitation and registration system,

Role	Resource in place?	Any additional costs?	Responsibilities
			coordination and booking of panel speakers, oversight and delivery of all logistics including printed and projected materials, table facilitators/scribes, AV and recording, refreshments, etc
Engagement/Patient and Public Involvement	Y	Additional external support may be required at cost to work with seldom heard and protected characteristic groups, audiences identified in the impact assessments, and to facilitate events	Planning and delivering engagement activity at system level and working closely with wider C&E network to support CCG led delivery of engagement and local events; ensuring delivery of outreach to seldom heard and protected characteristic groups
PMO support			
Policy support	Y	N	To provide technical and policy support and information to help answer enquiries and briefing requests, respond to issues, and in preparation of consultation collateral; gather facts, figures and evidence to support clear and comprehensive communications and engagement activity throughout the consultation period
Admin support/consultation response and enquiries unit	Y	N	Staffing enquiries telephone and email; logging, responding to and coordinating response to enquiries; management of meetings invitations and coordination of speakers/consultation team to respond to those, ensuring they have the necessary briefing and latest materials; support for events and meetings management e.g. booking venues; support in distribution of consultation collateral; logging of all consultation activity

Appendix B: Indicative non-pay budget

[DN: To follow for BNSSG CCG consideration]

Appendix C: Consultation delivery plan

NB: This delivery plan is work in progress – mapping existing meetings opportunities and planning and booking dates and venues for meetings and events throughout the consultation period etc is required.

Week no. and key topic for communications	Activity taking place at system level	Activity taking place at local level
	Activity at all levels will be a mix of face-to-face, online, proactive and reactive (including responding to requests for attendance at meetings and events hosted by others etc)	
Week -1 Topic/focus: Engagement with affected staff	• Further briefings and meetings with staff at WAHT who may be affected by the proposals – led by WAHT Medical Director and CEO, supported by CCG Healthy Weston Programme Director and CCG Medical Director) • Further briefings with VIP stakeholders including MPs John Penrose, James Heappey and Liam Fox, and HOSP Chair	• Local support to affected staff groups and feedback to consultation team and Steering Group on reaction and response to briefing sessions.
Week 1 Topic: Introducing the consultation - case for change/current challenges and overview of proposals, how to engage & respond	• Central electronic dissemination of consultation document across consultation area including stakeholder briefings and communication to staff. • Physical dissemination of printed versions of consultation document to health premises, stakeholder organisations, plus community organisations (e.g. libraries, Citizen's Advice, Healthwatch etc) – timing tbc, depends on final sign-off date for print and lead times • Online consultation presence and collateral goes live. • Media and stakeholder launch	• Promotion via existing channels – e.g. BNSSG CCG, Healthier Together and provider websites, social media, bulletins, newsletters, staff intranets etc - of consultation and opportunities to attend meetings, listening events and other local activities etc • Physical dissemination of consultation doc to staff and patient areas in provider organisations • Physical dissemination of consultation doc to staff areas and to GP practices by BNSSG CCG • Wider/non-affected staff

Week no. and key topic for communications	Activity taking place at system level	Activity taking place at local level
	Activity at all levels will be a mix of face-to-face, online, proactive and reactive (including responding to requests for attendance at meetings and events hosted by others etc)	
	event (launch plan to be developed including sequencing of announcement, key messages, event shape and logistics etc). • Start of consultation discussions and presentations at existing mapped meetings including: HOSP, Health and Wellbeing Board, VCSE sector meetings and networks, LMC, and other professional groups and bodies, MPs, North Somerset Council etc • Staff events at BNSSG CCG and WAHT [and to be offered at UHB, T&S, NBT], and with GP members • Consultation survey hosted on Healthy Weston part of Healthier Together website. Links to website from all partner organisations. • Push via social media including Twitter and Facebook as well as in all other communications channels. • Advertisements in local press/media about consultation and details of public meetings/engagement opportunities.	briefings in CCG and provider organisations (briefing notes supplied by consultation team to ensure consistency) • Information display about consultation at WAHT, UHB and NBT • Attendance at local pre-existing events and meetings, both proactively identified and in response to requests for speakers, for example staff team meetings, parish council meetings, patient/health reference groups, 'Friends of…' groups, meetings of local (patient) organisations etc • Other activities in this first week may include roadshow presence in town centres/shopping/community areas and public areas of provider organisations to raise awareness of consultation among public, patients and staff
Week 2 Topic: Our vision for the future – benefits, patient stories, staff stories, case studies from	• Consultation survey hosted on Healthy Weston part of Healthier Together website. Links from all partner organisations. • Push via social media including Twitter and Facebook as well as in all	• Promotion via existing channels as above • Attendance at local pre-existing events and meetings, as above • Presence in town centres/shopping areas and public areas of provider

Week no. and key topic for communications	Activity taking place at system level	Activity taking place at local level
	Activity at all levels will be a mix of face-to-face, online, proactive and reactive (including responding to requests for attendance at meetings and events hosted by others etc)	
elsewhere	other communications channels. • Webchat with PC/MJ/JH on future vision • Focus groups with identified groups • Start of seldom heard outreach work	organisations as above • Staff briefings/drop-in sessions as needed
Week 3 Topic: The opportunities for Weston General Hospital – vibrant and dynamic future at heart of the community delivering services to meet the most common needs of the local population	• Consultation survey hosted on Healthy Weston part of Healthier Together website. Links from all partner organisations. • Push via social media including Twitter and Facebook as well as in all other communications channels. • Advertisements in local press/media about consultation and details of public meetings/engagement opportunities. • Web content highlights related to this week's topic • Seldom heard outreach work continues	• **Listening events/public meetings held in Weston Town Centre** • Promotion via existing channels as above • Attendance at local pre-existing events and meetings, as above • Staff briefings/drop-in sessions as needed • Stall in Weston General Hospital providing information about consultation and opportunities for the hospital; information displays about consultation in UHB and NBT • Focus groups with WAHT staff
Week 4 Topic: Primary care and community role – how things will change, focus on joining up services, what the benefits will be	• Staff events in commissioner and provider organisations • Consultation survey hosted on Healthy Weston part of Healthier Together website. Links from all partner organisations. • Push via social media including Twitter and Facebook as well as in all other communications channels. • Web content highlights related to this week's topic	• **Listening events/public meetings held in the Bournville area** • Promotion via existing channels as above • Attendance at local pre-existing events and meetings, as above • Staff briefings as needed • Advertisements in local press/media about consultation and details of public meetings/engagement opportunities.

Week no. and key topic for communications	Activity taking place at system level	Activity taking place at local level
	Activity at all levels will be a mix of face-to-face, online, proactive and reactive (including responding to requests for attendance at meetings and events hosted by others etc)	
	• Web chat with JH/MJ/KH on primary care and community working more closely together, opportunities, keeping more people out of hospital • Telephone survey begins with representative populations • Staff survey Seldom heard outreach work continues • Proactive media push	• Focus groups with WAHT staff • Information display about consultation at WAHT, UHB and NBT
Week 5 Topic: Examples of patient treatment– how these will be accessed, where you would go for different conditions	• Staff events in commissioner and provider organisations • Consultation survey hosted on Healthy Weston part of Healthier Together website. Links from all partner organisations. • Push via social media including Twitter and Facebook as well as in all other communications channels. • Web content highlights related to this week's topic • Telephone survey continues with representative population • Staff survey (to include cross section of staff from all provider organisations and primary care) • Seldom heard outreach work continues	• **Listening events/public meetings held in the Weston area** • Promotion via existing channels as above • Attendance at local pre-existing events and meetings, as above • Staff briefings as needed • Advertisements in local press/media about consultation and details of public meetings/engagement opportunities. • Information display about consultation at WAHT, UHB and NBT
Week 6 Topic: Looking in detail at the proposals– How we decided to consult on the	• Staff events in commissioner and provider organisations. Consultation survey hosted on Healthy Weston part of Healthier Together website. Links from all partner organisations.	• **Listening events/public meetings in the North Eastern area and Bournville area** • Promotion via existing channels as above • Attendance at local pre-

Week no. and key topic for communications	Activity taking place at system level	Activity taking place at local level
	Activity at all levels will be a mix of face-to-face, online, proactive and reactive (including responding to requests for attendance at meetings and events hosted by others etc)	
proposed new model of care, the benefits and disadvantages	• Push via social media including Twitter and Facebook as well as in all other communications channels. • Webchat with PC/MJ/JH on rationale for models • Web content highlights related to this week's topic • Focus groups with identified groups continue • Telephone survey with representative population continues Seldom heard outreach work continues • Mid-point media push	existing events and meetings, as above • Staff briefings as needed • Information display about consultation at WAHT, UHB and NBT
Week 7 (repeat of above) Topic: Looking in detail at the proposals– How we decided to consult on the proposed new model of care, the benefits and disadvantages	• Staff events in commissioner and provider organisations. Consultation survey hosted on Healthy Weston part of Healthier Together website. Links from all partner organisations. • Push via social media including Twitter and Facebook as well as in all other communications channels. • Webchat with PC/MJ/JH on rationale for models • Web content highlights related to this week's topic • Focus groups with identified groups continue • Telephone survey with representative population continues • Seldom heard outreach work continues	• **Listening events/public meetings in the Town Centre** • Promotion via existing channels as above • Attendance at local pre-existing events and meetings, as above • Staff briefings as needed • Information display about consultation at WAHT, UHB and NBT
Week 8	• Staff events in commissioner and provider organisations.	• **Listening events/public meetings held in Burnham-**

Week no. and key topic for communications	Activity taking place at system level	Activity taking place at local level
	Activity at all levels will be a mix of face-to-face, online, proactive and reactive (including responding to requests for attendance at meetings and events hosted by others etc)	
Topic: Travel times and addressing common concerns on this topic	Consultation survey hosted on Healthy Weston part of Healthier Together website. Links from all partner organisations. • Push via social media including Twitter and Facebook as well as in all other communications channels. • Web content highlights related to this week's topic • Webchat with CCG clinical chair/medical director and senior clinician from SWASFT on travel times • Focus groups with identified groups continue • Seldom heard outreach work continues	**on-Sea** • Promotion via existing channels as above • Attendance at local pre-existing events and meetings, as above • Staff briefings as needed • Information display about consultation at WAHT, UHB and NBT
Week 9 Topic: Focus on frailty – describing the approach to putting frailty at centre of services to meet the needs of the local population	• Staff events in commissioner and provider organisations • Consultation survey hosted on Healthy Weston part of Healthier Together website. Links from all partner organisations. • Webchat with ML explaining the purpose of the frailty model and its benefits • Push via social media including Twitter and Facebook as well as in all other communications channels. • Web content highlights related to this week's topic • Telephone survey ongoing with representative population • Staff survey Seldom heard outreach work continues	• **Listening events/public meetings held in the North Eastern area** • Promotion via existing channels as above • Attendance at local pre-existing events and meetings, as above • Staff briefings as needed • Information display about consultation at WAHT, UHB and NBT • Advertisements in local press/media about consultation and details of public meetings/engagement opportunities.

Week no. and key topic for communications	Activity taking place at system level	Activity taking place at local level
	Activity at all levels will be a mix of face-to-face, online, proactive and reactive (including responding to requests for attendance at meetings and events hosted by others etc)	
	• Pro-active media push	
Week 10 Topic: Workforce – how we will support our staff, what the changes mean for staff, how we will work to attract, recruit and retain the best staff, benefits of multi-disciplinary teams	• Staff events in commissioner and provider organisations • Consultation survey hosted on Healthy Weston part of Healthier Together website. Links from all partner organisations. • Push via social media including Twitter and Facebook as well as in all other communications channels. • Web content highlights related to this week's topic • Telephone survey continues • Seldom heard outreach work continues	• **Listening events/public meetings in the Weston Area or Town Centre** • Promotion via existing channels as above • Attendance at local pre-existing events and meetings, as above • Information display about consultation at WAHT, UHB and NBT • Provider staff briefings • Staff focus groups (to include cross section from all provider organisations and primary care) • Advertisements in local press/media about consultation and details of public meetings/engagement opportunities.
Week 11 Topic: round up of common questions asked during consultation, key issues that have come up etc	• Staff events in commissioner and provider organisations • Consultation survey hosted on Healthy website part of Healthier Together website. Links from all partner organisations. • Push via social media including Twitter and Facebook as well as in all other communications channels. • Advertisements in local press/media about consultation and details of engagement opportunities. • Web content highlights related to this week's topic Seldom heard outreach work	• Promotion via existing channels as above • Attendance at local pre-existing events and meetings, as above • Presence in town centres/shopping areas etc and public areas of provider organisations – highlighting deadline for close of consultation and encouraging responses • Staff briefings as needed • Staff focus group

Week no. and key topic for communications	Activity taking place at system level	Activity taking place at local level
	Activity at all levels will be a mix of face-to-face, online, proactive and reactive (including responding to requests for attendance at meetings and events hosted by others etc)	
	continues	
Week 12 Topic: Close of consultation – recap of key issues, encouraging responses, thanking people for being involved, next steps	• Consultation survey hosted on Healthy Weston part of Healthier Together website. Links from all partner organisations. • Final push via social media including Twitter and Facebook as well as in all other communications channels – highlighting close of consultation deadline • Webchat with PC/MJ/JH/JR? – summary of consultation questions & next steps • Web content highlights related to this week's topic • Press release on close of consultation	• Promotion via existing channels as above • Attendance at local pre-existing events and meetings, as above • Staff briefings as needed

Healthy Weston Pre-Consultation Business Case

Appendix 26: NHS England Regional Director Assurance Letter

NHS England and NHS Improvement

1st Floor Jenner House
Avon Way, Langley Park
Chippenham SN15 1GG

Julia Ross
Chief Executive Officer, BNSSG CCG

By e-mail

29th January 2019

Dear Julia,

Re: Regional Director Assurance of the BNSSG Healthy Weston Proposals

My thanks to the BNSSG Healthy Weston Team for the constructive manner in which they have addressed the points arising from discussions with our local service reconfiguration assurance panel on 19th December 2018 and 25th January 2019, in addition to our subsequent questions/concerns.

Statement of Assurance

Following consideration of the evidence presented and the discussion at the Stage 2 Assurance Meetings on 19th December 2018, 25th January 2019, and subsequently, it is concluded that this scheme is Fully Assured against the four Key Tests, NHS England Patient Care "Beds Test", Finance and Best Practice requirements:

Test 1: Strong Public and Patient Engagement	Fully Assured
Test 2: Consistency with Current and Prospective need for Patient Choice	Fully Assured
Test 3: Clear Clinical Evidence Base	Fully Assured
Test 4: Support for Proposals from Clinical Commissioners	Fully Assured
Test 5: NHS England's Test for Proposed Bed Closures	Not Applicable
Financial Assurance	Fully Assured
Implementation Plan	Fully Assured
Digital	Fully Assured

A positive Stage 2 Assurance recommendation was issued by Rachel Pearce, Director of Commissioning Operations on 25th January 2019 subject to the following conditions being met:

- Final version of the PCBC to be shared with NHS England and the South West Clinical Senate by 12:00 on 28th January 2019. **[This action is now complete]**
- Confirmation of support from system stakeholders. **[This action is now complete]**
- Clinical Review Panel to confirm support for changes to length of time Level 3 critical care patients with single organ failure will be supported to remain at Weston General Hospital.

I am aware that the STP is keen to move things forward despite the current position regarding Clinical Review Panel support for length of time Level 3 critical care patients can be supported to remain at Weston General Hospital. I am therefore content for the BNSSG Healthy Weston proposals to proceed to public consultation on 13th February 2019 provided that:

- It is made clear within the Pre-Consultation Business Case and Consultation Documents that Level 3 critical care is available for up to 12 hours, with the option to extend this as discussed on a case by case basis.

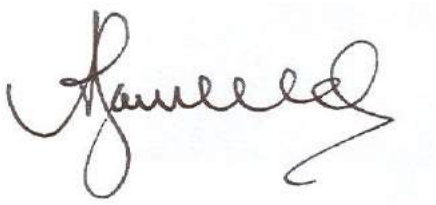
For the avoidance of doubt, my agreement to proceed to public consultation does not constitute approval or sign-off for:

- Capital expenditure or confirmation of capital availability. This is a particularly significant point given the constrained national capital funding position.
- Control totals for the trusts or surplus/deficit for the CCG for future years.
- Funding from the Sustainability and Transformation Fund for future years, either for provider deficits or policy/transformation.
- Any other funding beyond routine allocations.

Furthermore, there may be a need for BNSSG CCG to undertake a public consultation on its longer term vision for urgent and emergency care (Option 27b) in the future, if this is considered to be a 'major service reconfiguration'.

I wish you and colleagues every success over the coming years in taking forward these proposals.

Yours sincerely



Adam Sewell Jones
Regional Director South West
NHS England & NHS Improvement

Copy to:

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