NHS
Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Group

Appendix 1: Healthy Weston Programme Governance and Structure

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Healthy Weston Programme Governance and Structure

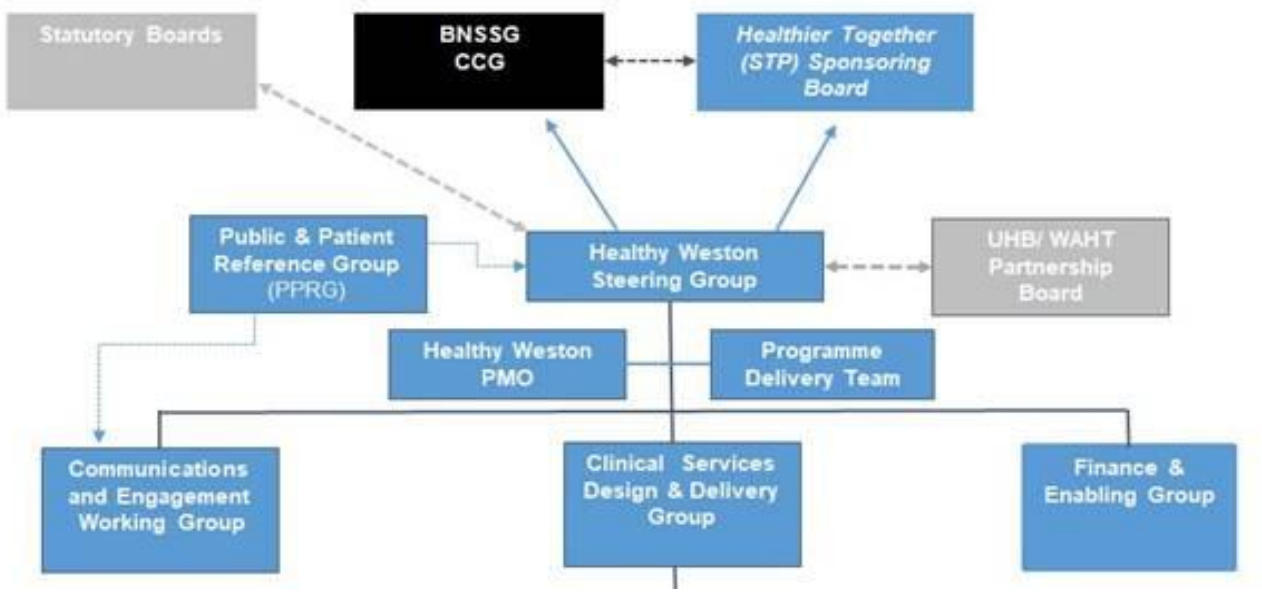
The CCG works with other local health and care partners as part of Healthier Together, the Sustainability and Transformation Partnership (STP) across the whole of Bristol, North Somerset and South Gloucestershire (BNSSG). The STP's mandate is to take a whole-system approach to moving towards a more integrated system of health and care. Figure 1 shows Healthier Together's vision for more joined up care and the journey towards this more integrated approach to care. Healthier Together is focusing on six areas of change: integrated community localities; networked general hospital care; a regional centre of excellence for specialised services; ensuring best value to deliver clinically and financially sustainable services; enabling staff to deliver exceptional care every day; digitally enabled care and intelligent use of data to inform decision making.

Figure 1: Healthier Together's strategic vision for a more integrated care system

The Healthy Weston Programme is led by BNSSG CCG on behalf of Healthier Together, the local STP. A diagram setting out the governance structure of the programme is contained in

Figure 2.

Figure 2: Healthy Weston Programme Governance Structure



Programme Governance

The Healthy Weston Programme has been overseen by a Steering Group, which includes all key local partners at chief officer level.

Table 1: Membership of Healthy Weston Steering Group

Organisation	Representative
Bristol, North Somerset and South Gloucestershire CCG (BNSSG CCG)	Chief Executive (Chair) Medical Director Area Director
Weston Area Health Trust (WAHT)	Chief Executive
University Hospital Bristol NHS Foundation Trust (UHB)	Chief Executive
North Bristol NHS Trust (NBT)	Chief Executive
North Somerset Community Partnership (NSCP)	Chief Executive
Weston and Worle GP Provider Locality	Lead GP
South West Ambulance Service NHS Foundation Trust (SWASFT)	Chief Executive
Taunton and Somerset NHS Foundation Trust (T&SFT)	Chief Executive

Somerset CCG	Chief Executive (or representative)
Avon and Wiltshire Mental Health Partnership (AWP)	Chief Executive
Healthy Weston Programme	Programme Director PMO
North Somerset Council	Chief Executive

The development of the clinical model proposed for change at Weston Hospital was driven by the Healthy Weston Clinical Services Design and Delivery Group. This group is comprised of senior clinicians from all key local partners, and includes other specialist input such as the South West Critical Care Network. Sub-groups of the Clinical Services Design and Delivery Group were also initiated to complete certain tasks relating to clinical model development and associated activity impacts under the proposals.

Table 2: Membership of the Clinical Services Design and Delivery Group

Organisation	Representative
BNSSG CCG	Medical Director (Chair) Area Director
WAHT	Medical Director (Vice Chair) Business Development Director Director of Nursing Hospital Medical Advisory Board Chair Clinical consultants
UHB	Medical Director (or representative) Acute Care Collaboration Projects Director Clinical Director of Paediatric Medical Specialties
NBT	Medical Director (or representative)
AWP	Medical Director (or representative)
T&SFT	Medical Director (or representative)
SWASFT	Clinical Lead
NSCP	Director of Nursing and Therapies
Weston and Worle Locality Lead **Woodspring Locality Lead**	Lead GP Lead GP
Healthy Weston Programme	Programme Director PMO Finance Lead
South West Critical Care Network	Medical Lead Lead Nurse

The Communications and Engagement activity prior to the consultation was led by the Healthy Weston Communications and Engagement Group, which was made up of representatives from all partner organisations, voluntary sector organisations, and independent patient care organisations.

Table 3: Membership of the Healthy Weston Communications and Engagement Group

Organisation	Representative
BNSSG CCG	Associate Director of Communications Head of Insights and Engagement Deputy Head of External Communications
Healthy Weston Programme	PMO
WAHT	Communications Lead
UHB	Communications Lead
NSCP	Communications Lead
North Somerset Council	Communications Lead
Healthwatch North Somerset	Communications Lead
Voluntary Action North Somerset	Chief Executive (or representative)
Healthier Together STP	Communications Lead
Somerset CCG	Communications Lead

The Healthy Weston Finance and Enabling Group provided expert oversight of the financial, activity, and workforce modelling to drive the development of the business plans behind the clinical models.

Table 4: Membership of the Healthy Weston Finance and Enabling Group

Organisation	Representative
BNSSG CCG	Deputy Director of Finance
Healthy Weston Programme	Programme Director Finance Lead
WAHT	Director of Finance Deputy Director of Finance
UHB	Director of Finance Deputy Director of Finance
NBT	Director of Finance Deputy Director of Finance
SWASFT	Director of Finance Deputy Director of Finance
T&SFT	Director of Finance Deputy Director of Finance

The Healthy Weston Programme Management Office (PMO) has operated a programme management approach throughout the duration of the Healthy Weston Programme. This has supported the delivery and ensured appropriate governance of decision making throughout the lifecycle of the programme. The Healthy Weston PMO is comprised of a Programme Director, a Programme Manager, a Project Manager and Programme Co-ordinator.

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Appendix 2: Engagement and Consultation Process

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Engagement and Consultation Process

Public Consultation

The Healthy Weston consultation was planned and delivered in line with national guidance, good practice and the requirements under the statutory "Duty to Involve". NHS England assured the consultation plan as part of the Pre-Consultation Business Case. More specifically, the objectives of the consultation process were as follows:

- To make people aware of the public consultation and how they could get involved.
- To help people understand how the proposals had been developed and to explain the practical impact of the proposals in the provision of local services to enable an informed response.
- To gather people's views and encourage responses to the consultation.
- To ensure a diverse range of voices were heard across the local population, with a specific focus on those with protected characteristics who would be most likely to be impacted by the proposed changes.
- To ensure that the consultation process used a range of methods to reach different audiences and maximise opportunities for engagement with the local community and key partners.
- To work with independent partners to ensure that responses to the consultation were captured and analysed in an objective and unbiased way.
- To ensure that responses received during the consultation were taken into account in decision-making, with sufficient time allocated to give them thorough consideration.

Pre-consultation engagement

Extensive pre-consultation engagement took place across the region and obtained over 1,600 pieces of feedback representing more than 2,500 people. Full details of this are available in the Pre-Consultation Business Case.

A subsequent stage of further engagement work was undertaken in December 2018, prior to the commencement of the full consultation phase. This engagement activity included an online survey and discussion groups with specific parts of the population. More details can be found in the Pre-Consultation Business Case.

Overview of public consultation methodology

The CCG Governing Body approved proceeding to public consultation for the Healthy Weston Programme proposals on 5th February 2019. The consultation began on 13th February 2019, and ran until 14th June 2019. Public events and media activity were paused on 20th March 2019 to observe purdah for the local council elections and the European Parliament elections that were taking place nationally. The consultation was resumed on 24th May 2019.

A range of qualitative and quantitative methodologies were used to support people to respond to the consultation in the way that best suited them. This also enabled the CCG to receive a high number of responses, whilst ensuring that the richness of the responses could be heard.

The variety of ways that the public, professionals and organisations could get involved and respond to the proposed changes to services at Weston Hospital can be seen below:

- Face-to-face survey with a representative sample of people from Weston Hospital's catchment population
- Online / postal survey available to any individuals and organizations
- Feedback from the Healthier Together Citizens' Panel
- Qualitative focus groups and in-depth discussions
- Stakeholder and public events
- Public drop ins / workshops
- Community meetings with local third sector and special interest groups
- Social media feedback
- Emails, letters and phone calls

Table 1 below outlines number of responses and approach for each of these.

Table 1: Responses and approach to gathering feedback during public consultation

What?	Number responses	Who?	Method / Approach
Face-to-face Survey	1,054	Representative sample of Weston Hospital's catchment population	In-home interviews selected using random location method (quota) with grouped Lower Layer Super Output Areas (LSOAs) as geographical sampling. Interviews were carried out across 7 days of the week at different times of day.
Online / postal Survey	854	Any individuals or organisations. Questionnaire available online or paper version available in consultation document, at events, in public spaces or by request from CCG	Feedback was sought from a broad section of the population through media, leafleting, direct contact with schools, businesses, councils, workshops and drop ins. Survey Monkey online survey or paper copy completion that was manually entered into the full dataset.
Citizen's Panel Feedback	182	North Somerset residents on the Healthier Together Citizen's Continuous	Questions asked as part of an online survey between February - May 2019. Respondents were offered the option

		Panel – a representative sample of total BNSSG catchment	of responding via post or telephone. Respondents originally recruited to panel via face-to-face or via social media.
Qualitative focus group and in-depth discussions	21 from 5 mini groups, 4 paired depths and 12 depths	• Frail and elderly members of the population • Those with a variety of disabilities and/or long-term conditions • Parents with young families • People experiencing social and/or economic deprivation	Discussions facilitated by an independent organisation, following an outline discussion guide focussed on gaining a deeper understanding of open-ended opinions. The independent organisation was also responsible for recruiting participants to these group discussions.
Stakeholder & public events	41 from 10 meetings	Attendees at public meetings	Table discussions led by trained CCG facilitators guiding people through agreed topics using a discussion guide. CCG scribes captured as much verbatim feedback as possible and transcribed to a structured template to be submitted to independent agency for collation of themes. The table discussions followed a presentation outlining proposed changes and an open question and answer session with a panel of health professionals from the Weston area.
Public drop ins	16 from 8 drops ins	All individuals who provided feedback at public drop ins	Public invited to write down feedback on cards or CCG staff recorded verbatim on cards and transcribed to be submitted to an independent agency for collation of themes.
Community meetings with local third sector and special interest groups, NHS	85 from 47 meetings	Attendees at community meetings, local third sector and special interest groups, NHS meetings and workshops	CCG representatives attended meetings and workshops to present proposed changes. This presentation was sometimes followed by feedback sessions which were noted and transcribed to be submitted to the independent agency for collation of

meetings and workshops			themes
Social media	44	All individuals who posted feedback on BNSSG Twitter, Facebook and Instagram pages and Facebook public event adverts	Feedback copied verbatim from social media sites.
Emails, letters, phone calls	13 letters 48 emails 8 phone calls	All individuals or organisations providing feedback to CCG by email, post or telephone	Feedback copied verbatim to response log.

Community Engagement

In order to ensure that as many people living or working in the catchment area of the hospital had the opportunity to respond to the consultation, active engagement with existing community groups and stakeholders was undertaken. In total, 32 community group meetings were attended by CCG staff throughout the consultation.

Community engagement ensured that those people who would be most affected by the proposals for change had the opportunity to respond and share their views. The feedback received at the meetings was taken on board by the CCG staff attending and, working with the Clinical Services Design and Delivery Group (CSDDG), the information was used to refine and hone the proposals throughout the consultation period. It was also submitted to the independent agency that was commissioned to analyse the feedback received and undertake a thematic review for presentation to the CCG Governing Body.

Community engagement also allowed the programme to engage with people who may have been less able to engage through other channels, for example, attending public events in person or using digital media to respond to the consultation. Groups that could be defined as disadvantaged or vulnerable under the Equality Act were particularly supported to respond to the proposals through this route. This has supported the development of a robust Equalities Impact Assessment as part of the programme, which can be found in Appendix 7.

When attending a community group the format was varied to best suit the people in the room. Generally, an overview of the proposals was given by the CCG staff member and an open discussion was held about what the proposals would mean for them and other local people. All the feedback was recorded and logged and submitted to the independent agency responsible for compiling the thematic review.

Where appropriate, engagement activity was further tailored to suit the needs of particular groups. For example, interactive workshop sessions were organised at Weston College to ensure the CCG's engagement was clear and inclusive for young people. Consultation materials were distributed to all the community groups and made available to other members as part of the visit.

The community groups visited by the CCG included:

- Addaction North Somerset
- Citizens Advice Bureau
- Clarity
- Clevedon Carers Group for Mental Health
- Communication Café
- Future in Mind
- Gypsy and Travellers Group
- Healthwatch North Somerset
- Highbridge Patient Participation Group
- Learning Disability Partnership Network
- Male Health Group
- Multicultural Friendship Association
- North Somerset GP Forum
- North Somerset Patient and Public Involvement Forum
- North Somerset Care Home Provider Forum
- North Somerset Parent Carer Group
- Older People Champions group
- Oldmixon Family Centre Health Visitors Drop In
- Patient Council
- Senior Community Links
- Somewhere To Go Day Centre Drop-In
- Speaking Up
- Vision North Somerset
- Voluntary Action North Somerset
- Weston College Health & Social Care Group
- Weston General Hospital Patient Experience Review Group
- Weston Mental Health Carers Group

As well as meeting with established groups, a proactive approach was taken to meet members of the community by positioning pop-up information stand sessions in high-use locations such as leisure centres and shopping centres. Information about the consultation proposals was given out and people took away paper surveys to complete. Any feedback received at these events was recorded verbatim for submission to the independent organisation responsible for compiling the thematic review.

Pop-up stand sessions were held at:

- Cadbury Garden Centre, Congresbury
- Morrison's, Weston-super-Mare
- Weston General Hospital
- Winscombe Market
- Tesco, Burnham-on-Sea
- Sovereign Centre, Weston
- Hutton Moor Leisure Centre
- Weston-super-Mare Railway Station

Clinical Engagement

The clinical proposals, and the supporting workforce and financial modelling, continued to be examined in detail and refined throughout the consultation period. The CSDDG oversaw the establishment and outcomes of a cross-system clinical workshop held in March 2019 to review the consultation proposals. The meeting was externally facilitated and brought together local clinicians from across primary, secondary and community care in order to review and feedback on the proposals put forward.

The workshop included clinicians who had helped develop the proposals and additional clinical representation from across the system specifically from the main service specialties impacted under the proposals. The workshop was also important to build on the Pre-Consultation Business Case and generate more detailed conversations about how the services would be delivered, whether anything further needed to be considered, what workforce changes needed to be taken into account, validating the activity data and assumptions, and how patients would be cared for under the proposals. An alternative proposal from consultants from Weston Hospital was also considered at this meeting and discussed by the wider clinical group.

Following the workshop, a sub-group was formed for each service affected by the proposals in order to robustly critique, recommend amendments and assess the impact of the changes proposed. The CCG also supported the development of the alternative proposal put forward by the consultants from Weston Hospital in order for it to be formally evaluated as part of the consultation process.

Engagement with authorities such as Health Education England and the NHS Regional Advisor for Emergency Medicine was sought as part of the consultation process to ensure that their feedback could be taken into consideration when assessing the alternative proposal. There was also active liaison with other Health Systems to share learning – for example with Grantham and Lincoln Hospitals, the Dorset Health System, the Somerset Health System and Trafford and Rochdale Hospitals in the Greater Manchester area.

The CSDDG considered all alternative proposals put forwards as part of the consultation, against the original evaluation criteria. They also received the feedback from the public consultation and considered whether any further actions were required to address the issues and concerns raised. This information was brought in by CCG staff and more formally through a presentation from the independent agency responsible for compiling the thematic review. Sharing the feedback from the public consultation with the CSDDG ensured that the proposals were refined in line with what people were saying and gave clinicians the opportunity to hear what people were concerned about and how best to address this. For example, the concerns about the capacity of infrastructure that were coming through in the feedback being received were carefully considered and much focus was given to the workforce planning and activity and capacity modelling associated with the proposals to ensure that this was as robust as possible.

An overview of the CSDDG work throughout this period can be seen in Table 2:

Table 2: Clinical design work of the CSDDG in 2019

Month	CSDDG activity
March	• System wide clinical workshop to review proposals as part of consultation process • Sub groups for further work established
April	• Review of amendments from clinical workshop • Feedback from sub groups • Confirmation of alternative proposal for evaluation
May	• Evaluation of alternative proposal • Agreement on joint working with Weston Hospital consultants to develop proposals
June	• Review of ideas developed with Weston Hospital consultants • Recommendation on critical care model • Confirmation of activity changes associated with models
July (1)	• Consideration of feedback from the public consultation (presented by independent agency) • Check and challenge session on clinical model – new ideas raised
July (2)	• Agreement of inclusion of further ideas for modelling • Options appraisal on critical care transfer service and recommendation • Review of the financial modelling – including workforce assumptions and activity and capacity modelling
August	• Further refinement and confirmation of the financial modelling • Consideration of feedback from Governing Body on the revised proposals • Review of the draft Decision-Making Business Case and Quality Impact Assessment • Consideration of travel time impact audit report

The results and key themes from the feedback received can be found in Appendix 3.

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Appendix 3: Feedback from the Public Consultation and Implications for the Clinical Model

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Feedback from the Public Consultation and Implications for the Clinical Model

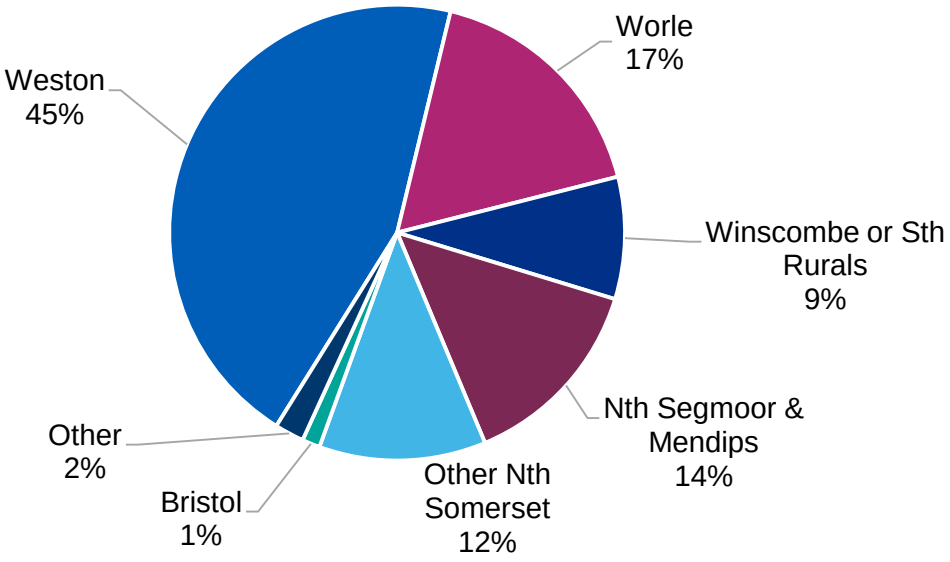
Feedback from the public consultation

The public consultation sought feedback on proposals for three aspects of the hospital model of care at Weston General Hospital (A&E and urgent care, emergency surgery and critical care), the wider improvements being taken forward as part of the Healthy Weston Programme and the vision for the longer term future of healthcare in the Weston area.

There were 2366 responses in total, representing over 3000 people who were a mix of members of the public, people working in health and social care, local organisations and interested parties such as councillors and MPs.

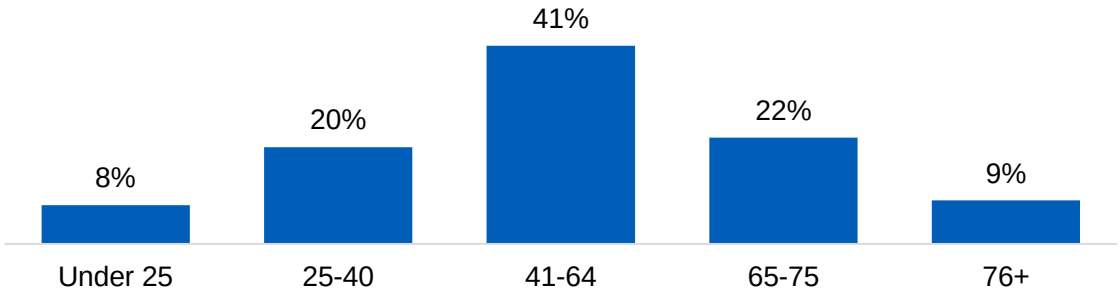
There was feedback from across the area that Weston Hospital serves and the independent door-to-door interviews that were commissioned ensured that the population that responded was representative of the demography of the area.

Response by Area (1731 responses)



Characteristics of Individuals (2213 responses)

- Where **gender** was known, 40% were men, 60% women and fewer than1% from people who define themselves in another way
- Where **age** was known the breakdown was as follows:



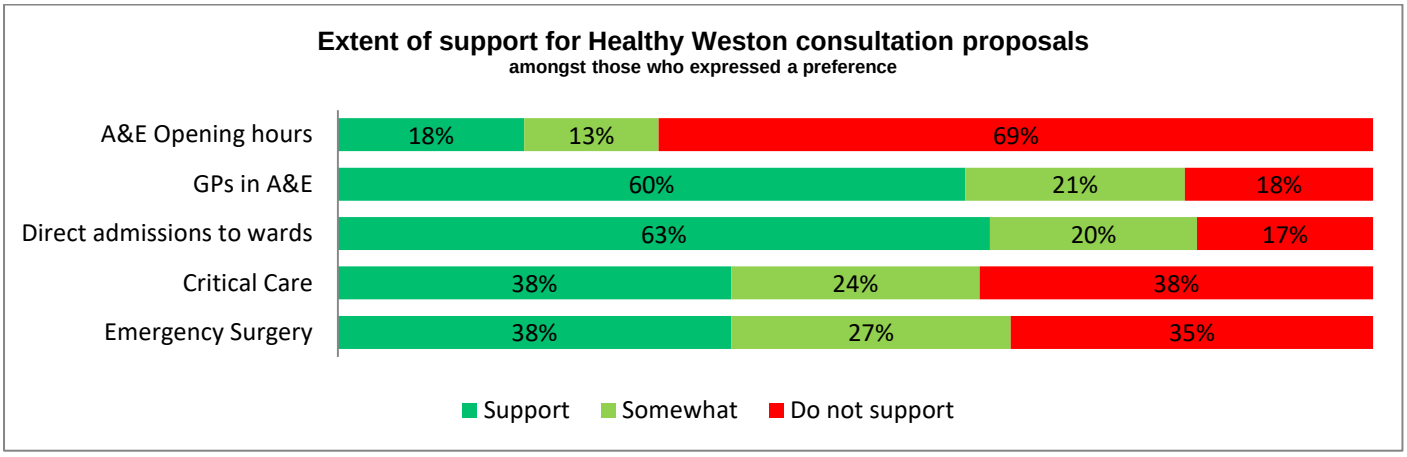
- Where **ethnicity** was known 2% were from people who identified as Asian or Asian British, 1% Black or Black British, 96% White, 1% mixed and fewer than1% other ethnic groups
- 18% of responses were from people who had a **long term physical or mental health condition**
- 11% of all responses said they **cared for someone with a health condition**
- 6% of responses were from someone who said they were **disabled**
- 8% of responses were from a **parent or caregiver of an under 5 year old** and 15% were a **parent of caregiver of a 5-16 year old**
- 7% of those who took part in face-to face-interviews were from **economically deprived or socially deprived areas**
  79% of those who took part in face-to-face interviews, the demographically representative sample, said they had **visited a GP in the past year**, 54% had **visited an NHS hospital in the past year** and 24% had **used community services in the past year**

Key themes

People shared personal stories and provided detailed reasons for their views. Regardless of people's demographic characteristics, whether responses were from organisations or individuals or what specific proposal they were commenting on, there were some recurring themes that people wanted taken into consideration when the CCG Governing Body decides on next steps. The key themes from the responses were compiled by The Evidence Centre, an independent agency, and a detailed report providing the thematic review was presented to the CCG Governing Body at its August 2019 meeting.

The quantitative aspect of the consultation asked how far respondents felt they understood the reasons for the change. Analysis of the responses to this question show that 46% said "yes", they understood why the NHS thinks that things cannot stay the same, 34% said "somewhat" and 20% said "no". Respondents were also asked how far they supported each of the proposals. The extent to which each of the proposals for change were supported can be seen in Figure 1 below:

Figure 1: Support for consultation proposals



Overall, the proposals for including GPs in the A&E workforce and direct admissions to wards, received the highest levels of support, with 81% and 83% (respectively) either “fully” supporting or “somewhat” supporting the proposals. 62% of people “fully” supported or “somewhat” supported the proposals on critical care, and 65% for emergency surgery.

The proposals on A&E opening hours received the least support with only 31% “fully” supporting or “somewhat” supporting the proposals. Table 1 below gives a further breakdown of the responses, and the main reasons given:

Table 1: Consultation responses

Proposal	Number of responses to question (% total)	Groups more likely to support	Groups less likely to support	Main reasons for supporting	Main reasons for concern
A&E opening hours (having the A&E department open 8am to 10pm, seven days a week, as it has been temporarily since July 2017)	2086 (88%)	NHS Staff (32% VS 18% total)	Carers & Disabled (12% & 9% VS 18% total)	• Temporary overnight closure showed that it would be feasible • May be positive outcomes for quality of care or use of resources	• Perceived growing population • Travel times to other hospitals • Emergencies happen outside proposed hours • Difficulties for visiting family & friends • Impact on other services (ambulance, police)
GPs working in A&E (having GPs work alongside hospital staff in the A&E to treat patients who need urgent care but do not need to be seen by a specialist doctor)	1946 (82%)	Parents of child under 5 (71% VS 60% total)		• More doctors may lead to prompter and more efficient care • Reduced pressure on specialist doctors so they are free to see more complex patients • People don't always need to see a specialist so having GPs in A&E would support assessment & help people get the right level of care	• May not be enough GPs for this to be feasible • It might cause longer waiting times at GP surgeries • GPs may not have skills or qualifications to provide safe A&E care • GPs may not have time as already perceived to be over worked
Direct admissions to wards (having GPs admit more people who need urgent and emergency care directly to a hospital bed, which would be available 24 hours a day)	1782 (75%)	Parents of child under 5 (74% VS 63% total)	Carers (56% VS 63% total)	• Perceived that people would receive prompter access to care without having to wait in A&E • It is logical • Might reduce pressure on other services such as A&E and ambulances • GPs know patients' needs and qualified to decide when people need to be admitted	• Might not be enough beds or staff available at Weston Hospital • Perception that it is difficult to access a GP 24 hours a day or that not enough GPs for this to be feasible • Poor substitute for 24 hour A&E • Might not be safe as GPs are not specialists & may not be qualified to make decisions / may need further training
Critical care (to provide critical care for very ill people in a high dependency unit at Weston Hospital, with the most seriously unwell people who need an intensive care unit being cared for in Bristol or Taunton)	1975 (83%)	Parents of child under 5 (47% VS 38% total)	Disabled (29% VS 38% total)	• Hospitals in Bristol/Taunton were thought to have more specialised equipment and facilities • An effective use of resources for the region, ensuring people with the most complex needs were treated in the right place • Perceived to provide better or safer care and improve patient outcomes	• Perceived to be difficult for families to visit those needing critical care, especially visitors who were elderly and those reliant on public transport • Bristol/Taunton may be too far or difficult for patients to travel to • It might be unsafe for unwell patients to travel • Facilities at Weston work well at present
Emergency surgery (to provide emergency surgery, where possible, during the day at Weston Hospital. People who need immediate surgery overnight, or more complex cases, would have surgery in Bristol or Taunton before being returned to Weston Hospital for ongoing care, once well enough)	1930 (82%)	Parents of child under 5 (46% VS 38% total)		• Perceived to be more specialist facilities, care and staff available at hospitals in Bristol and Taunton • Weston Hospital perceived not to have capacity or facilities to provide all services • Having centralised specialist centres logical and works well	• Bristol and Taunton were thought to be too far for patients to travel • It could be unsafe moving unwell patients or there may not be time to travel in an emergency • Other hospitals were perceived to be too far for visitors and carers and costly to travel to • Lack of clarity about why it is possible to provide emergency surgery during the day but not at night

The quantitative feedback from respondents gives an overall indication of how much people support the changes proposed. However, it is the qualitative feedback that demonstrates what people are worried about and why, and what the CCG must take into consideration in making the decision. The recurring themes that people wanted taken into consideration can be seen below:

- **Population demographics**, including the size, level of growth, age profile, and rural location of the population and the number of holiday makers that visit the area.

- **Travel issues** including whether it is safe to travel to another hospital, the inconvenience and stress of travel for patients, the inconvenience and stress of travel for family and visitors, the expense of travel, the practicality and cost of returning home from another hospital particularly when discharged at night, the environmental impact of increased longer ambulance and car journeys and the lack of public transport to and from other hospitals.

- **Capacity of infrastructure and other services** to cope with the proposals including the capacity of the ambulance service, other hospitals and transport services.

- **Capacity of primary care** to support the proposals, including concerns about not having enough GPs available locally and difficulty accessing GPs, which was stated as a reason that people may rely more on hospital urgent and emergency care.

- **Accuracy and feasibility of evidence and statistics** upon which modelling and proposals may be based, including concerns about the accuracy of travel time estimates, population numbers, catchment numbers for Weston Hospital and the availability of hospital and primary care personnel to support the proposed changes.

The next section looks at the feedback on each of these themes in more detail, the work undertaken as a result and the implications for the model of care.

1. Population Demographics

Some responses were concerned that the Healthy Weston proposals did not adequately account for the number of people who use the hospital. A key issue that was expressed, particularly when considering A&E opening hours, was whether the proposals were appropriate for the population size, age profile and rural location of Weston, Worle and Villages. A second concern that came through was whether the most appropriate and up-to-date data sources had been used in the population modelling.

Further Analysis and Actions Taken

The CCG took these concerns seriously and reviewed all available information to ensure the population figures had been appropriately considered within the proposals. Further work was completed with North Somerset Council Public Health Department and Sedgemoor District Council

to independently profile the growth, age and disease profile of the local population. This work confirmed that the population growth assumptions used in the Healthy Weston Programme are the same as those used by local authorities for planning purposes (for example in the provision of school places).

It is recognised that Weston is a growing town with housing developments taking place in the town itself and the surrounding area. The CCG has worked with colleagues in North Somerset Council and Sedgemoor District Council who have confirmed that the population growth estimations that have been used are inclusive of the house building figures in all parts of the catchment area.

The most significant developments related to the population analysis are the increase in people living with long-term and multiple health conditions and the increase in the frail elderly population, with the greatest increase in population in the over-70 age group accounting for over half the general population increase to 2025. In addition, the population profile shows that there is an expected increase in children aged 10-14, although this group is not expected to continue to grow into the longer term. A further group identified in population analysis are people based in the centre of Weston who are experiencing mental illness and substance misuse issues. These population groups, and the changes that are being seen in the health needs of the population, are well understood by the CCG and form an important part of the overall case for change and the wider ambitions of the Healthy Weston Programme.

When considering the catchment area of Weston Hospital, there are different ways in which this can be calculated. Different services at the hospital can even have different catchment areas, depending on what is available elsewhere and the reputation of the specific service, for example. To give the best possible assessment of the catchment area for the hospital, Weston Hospital's A&E data was used to identify the GP practices that people who use Weston's A&E department are registered to. The population of people registered to those GP practices has then been used to determine the catchment population of the hospital. This is considered as the population who primarily use the hospital, and not the entire population who use it.

The registered population of GP practices is deemed an accurate way of assessing the local population using Weston's Hospital because it is based on the actual population registered for healthcare in that area. Other ways of calculating the hospital catchment, such as Office for National Statistics data, would have a greater degree of estimation. It is recognised that there will be a small population of people who are not registered with a GP locally who use hospital services that will not be included in these figures, such as holidaymakers visiting the town in the summer season. Whilst this population is not included in the figures that describe the catchment population, the hospital in Weston is funded to serve this population and this will continue.

NHS England has assured the population measurements described above, as used in the Pre-Consultation Business Case. These have been refreshed as part of this business case to ensure that the latest available information is used.

Implications for Model of Care

The Healthy Weston Programme recognises the implications of population growth on the increased demand for health services, including urgent and emergency care, and has undertaken further work to validate and understand this growth. However, taking all factors into consideration, the Programme has concluded that providing a 24 hour A&E service in Weston is not the best way to provide high quality urgent and emergency care for the local population, even once population growth is taken into consideration.

Weston Hospital closed the A&E overnight as a result of safety concerns stemming from an inability to appropriately staff the department over 24 hours. As there are ongoing staffing issues in the department, as well as a national shortage of emergency medicine staff, the CSDDG has concluded that continuing with a 14/7 model is the best option in terms of safety and quality of care.

The CCG recognises the concerns raised through the consultation, the impact of population growth and the need for accessible and good quality urgent care. The Healthy Weston Programme includes a number of provisions to ensure there continues to be accessible urgent and emergency care in the local area, specifically:

- Continuation of local A&E provision during daytime hours when there is highest demand from the local population and more resilient staffing can be provided.
- Strengthening the 111 and out of hours provision: from April 2019, SevernSide 24/7 Integrated Urgent Care has been delivering a combined NHS 111 and GP out-of-hours service across the region.
- Expansion of direct admission pathways so that more people who need an admission to hospital overnight can be treated locally – this will ensure that 2-3 people who were previously being transferred to another hospital overnight as a result of the temporary overnight closure of the A&E department at Weston Hospital will avoid transfer out of area.
- Continued engagement with the local ambulance service to ensure there is adequate provision to manage the overnight journeys to surrounding hospitals, so that patients needing specialist emergency care overnight have timely access.

The Healthy Weston Programme also includes a number of initiatives to mitigate the impact of population growth on the demand for local services. These are focussed on strengthening out-of-hospital provision such as community services and primary care. Investment and more integrated working in these services will help support people to remain healthy, well and independent in their own homes, and reduce the demand for more intensive hospital-based services. The modelling underpinning the development of these services such as the Integrated Frailty Service, Mental Health Crisis and Recovery Centre, and new adult community services contract, also takes into account population growth figures in the local area and the expected increase in demand for healthcare. The modelling factors in the impact that improvements in out-of-hospital care will have in reducing demand for acute care locally. More detail on these developments is included in Section 4 of the main business case.

2. Travel

Respondents described significant concerns about the impact of the proposals on travel: whether it is safe to travel to another hospital; the inconvenience and stress of travel for people; the inconvenience and stress of travel for family and visitors; the expense of travel; the practicality and cost of returning home from another hospital particularly when discharged from A&E at night; and the lack of public transport to and from other hospitals.

Further Analysis and Actions Taken

The detailed work to estimate the average travel times for those that will need to access care at another hospital as a result of the proposed changes were included in the Pre-Consultation Business Case. Average travel times are:

- 28 minutes by blue light ambulance
- 41 minutes (peak times) by private car
- 1 hour 42 minutes (peak times) by public transport

The majority of people travelling because of the change in opening hours to A&E and changes to emergency surgery will do so by ambulance provided as part of the existing contract with South Western Ambulance Service NHS Foundation Trust (SWASFT) and it is proposed that people affected by changes to the critical care service will be transferred by a new specialist critical care transfer team. It is recognised that family and friends travelling to support someone in hospital will have to make their own way to hospital and it is also recognised that people can be taken to an out of area A&E by ambulance and have significant difficulties getting back home.

There are transport services and support already in place to help people access healthcare but it is not universally accessed by people who are eligible. A summary of the different services and support is provided below:

- SWASFT commissioned by BNSSG provides urgent transport in emergency cases and inter-hospital transfers.
- Bristol Ambulance Service commissioned by BNSSG provides inter-hospital transfers.
- E-Zec patient transport services commissioned by BNSSG provide patient transport to and from hospitals and clinics for people with a medical need.
- Healthcare Travel Costs Scheme reimburses the costs of travelling to and from hospital visits for people who need support for economic reasons.

Approximately 320 additional people per year will require travel to neighbouring hospitals as a result of the changes that are proposed, in addition to the baseline (which is the 2018/19 financial year and includes the temporary overnight closure of A&E). Family and friends who are visiting people will also be impacted by increased travel when a patient is transferred to another hospital.

Recognising what an important issue this is for the local population, the CCG established a Travel Working Group in order to hear more about the problems that people experience and to consider solutions. The concerns identified that relate to travel can be categorised into patient safety, patient and visitor experience and the environmental impact of additional travel.

Patient Safety

The main concerns regarding safety that were expressed during the consultation were about the additional travel time to hospital due to changes to A&E and the impact that this may have on people's clinical outcomes. A number of steps have been taken to understand the impact of increased travel times on clinical outcome:

1. **Review of SWASFT response times**

SWASFT operates the emergency ambulance 999 service for the whole of the region. In North Somerset, SWASFT provide in total six 24hr double-crewed ambulances and one 24hr Rapid Response vehicle (car). In addition to this, there are three further double-crewed ambulances working until 2100hrs, 2200hrs and 2300hrs respectively.

A key concern of people responding to the consultation was the response times of the ambulance service when a call is made to respond to a critically unwell patient with life-threatening illness or injury. These would be Category 1 calls triaged as the highest priority at the SWASFT Clinical Hub (Control Room).

In 2018/19 Category 1 calls represented 6.97% of all ambulance incidents across BNSSG. Of these, 64.3% received a response on scene and were then conveyed to hospital with the remaining calls receiving advice over the phone or were seen and treated at the scene without conveyance.

For the period 4th March 2019 to 2nd August 2019, the mean response time for a Category 1 was 6 minutes and 30 seconds for people in BS22, BS23, BS24, BS25, BS29 and BS49. Per day there was an average of 3 Category 1 incidents between 8-22.00, and 1 Category 1 incident 22-08.00. This is in line with the mean Category 1 response time for the BNSSG area combined which is currently 6.4 minutes. The Ambulance Response Programme sets a national standard of a 7 minute mean response time.

2. **Audit of impact of increased travel times on clinical outcome**

The CCG commissioned SWASFT to undertake a review of people who had been conveyed to neighbouring hospitals due to the temporary overnight closure of A&E. This review was undertaken with clinicians from the receiving A&E department of UHB and Musgrove Park Hospital (MPH) in Taunton. In all cases reviewed, the clinicians assessed there to be no impact on clinical outcomes as a result of increased travel time.

The full details of the audits can be found in Appendix 4.

The clinicians who undertook the MPH audit noted that, although there were no adverse clinical outcomes as a result of the additional travel time, the criteria for conveying certain people to particular specialist centres would benefit from further clarity. The Healthy Weston Programme is therefore working together with SWASFT and acute hospitals in the region to review and update all existing Ambulance Service protocols associated with Weston Hospital.

National evidence supports the audit results found locally and a review undertaken by the University of Sheffield on the mortality of the local population following the closure of five emergency departments found no statistically reliable evidence to suggest a change in the number of deaths following an Emergency Department closure in any site or on average across all sites. The data that was used to inform this conclusion included 48 data points for monthly activity or performance in the 2 years before and the 2 years after the changes were made, and also included the experiences of a far greater number of people than will have been affected by the temporary overnight closure at Weston Hospital.

3. **Review of incident reporting associated with the temporary overnight closure**

The temporary overnight closure was kept under regular review when it was initially implemented and with subsequent reviews at 6, 12 and 24 months. At the two year (24 month) review point, the provider incident reporting system was used to review clinical incidents relating to patient safety that had been recorded by provider staff (from any organisation) associated with the temporary overnight closure. It was found that there were no serious incidents resulting in patient harm attributed to the temporary overnight closure reported through the Weston Operational and Clinical Oversight Group or Accident and Emergency Delivery Boards. This is based on over 6,100 attendances at three neighbouring hospitals over two years.

A thematic review of all other incidents (those classified below “serious”) is also being undertaken under the Healthy Weston Programme in order to identify if any further work is required to improve patient safety and/or experience as a result of the temporary overnight closure of A&E. This piece of work will be led by the CCG and feedback and learning for provider organisations will flow through the usual commissioning governance routes.

Patient Experience

The Travel Working Group focused on patient and visitor experience and met to consider the following:

1. The evidence that was presented in the Pre-Consultation Business Case.
2. The likely travel impact on people and visitors of the proposals.
3. Possible mitigations to support people to access healthcare.

This group considered the evidence that was presented as part of the consultation on the implications of travelling to neighbouring hospitals for people and visitors and to provide recommendations for the future. In addition to members of the public, representatives of the following organisations attended:

Table 2: Travel Working Group attendees

Organisation	Areas of Speciality
Alzheimer's Society	Representing Carers
Cheddar Parish Council	Representing people from North Sedgemoor
E-Zec	Patient transport provider
First Bus	Local bus company
Healthwatch North Somerset	Representing users of health and social services
Members of the public	Representing users of health and social services
North Somerset Council	Transport commissioning and community transport
Weston & District Community Transport	Representing community transport providers
Weston Hospital Patient Council	Representing views of patients
Winscombe Contact Scheme	Community transport

The CCG attended the North Somerset Community Transport Forum and discussed travel and transport with key stakeholders including SWASFT and the West of England Combined Authority (WECA). The recommendations outlined below draw on the feedback that was received through the Travel Working Group, feedback received as part of the consultation and information from discussions with key stakeholders.

There was also more intensive consultation with groups which the Equalities Impact Assessment (Appendix 7) identified as being more likely to be adversely affected by the increased travel. This included in-depth interviews and meeting with groups representing the frail elderly population, families with children, people with disabilities and people experiencing economic and social deprivation. In addition, the CCG ran a workshop with expert stakeholders to validate the challenges and mitigations identified in the Equalities Impact Assessment process.

Like many hospitals in England, the catchment area of Weston Hospital covers a geographical area that includes rural locations and does not have complete public transport coverage. This means that people cannot get to Weston Hospital, or another hospital, by public transport at all times of the day. Commissioning general transport services is not with the scope of the NHS responsibilities, so when developing proposals to address issues of transport the NHS will continue to work in partnership with the relevant bodies such as local authorities and regional infrastructure bodies, who are already engaged in this programme.

In February and March 2019, WECA held a consultation on the Joint Local Transport Plan. WECA are the regional economic development and infrastructure body who work with local authorities.

The CCG is working with local authority bodies to develop an Integrated Transport Programme that will seek to align the commissioning of transport and NHS services as closely as possible.

The Travel Working Group made a series of recommendations to support people to make use of these existing services and what additional support could be provided and these are outlined in Table 3 below.

Table 3: Travel Working Group recommendations	
Access to information	1. Promote the support available for the local population to access healthcare including the Healthcare Travel Costs Scheme, patient transport services and community transport services. 2. Provide information at hospitals, GP surgeries and other sites about local transport links. 3. Provide training to hospital reception staff to support people to travel from hospital. 4. Ensure compliance with Accessible Information Standards.
Hospital services	1. Continue to monitor through commissioning channels with providers to minimise discharge from hospitals at night especially for vulnerable people. 2. Providing a safe place for people to wait following discharge from A&E until appropriate transport becomes available. 3. Provide preferred parking sites for community transport providers.
Transport services	1. Develop an Integrated Transport Programme to improve access to healthcare across the region. The intention is to achieve this objective by joining-up transport planning, commissioning and service delivery between Local Transport Authorities (LTAs) and healthcare system.

If the business case is approved, the CCG will engage with local system partners to take forward these recommendations as part of the implementation of the proposals. The recommendations related to access to information can be implemented in 2019/20 and will quickly have a positive impact on how people can find out about and access support. The changes to hospital and transport services will be developed through 2019/20 and the overseen by the Sustainability and Transformation Partnership.

Implications for Model of Care

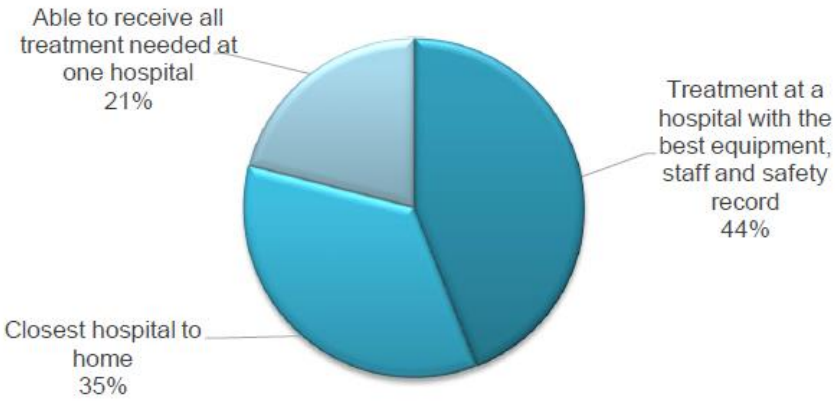
The feedback on travel and transport received from the public consultation has been taken on board in the development of the clinical proposals. The CSDDG have worked to ensure that the step changes required in the quality and safety of service provision at Weston Hospital are achieved but with as little movement of patient activity away from Weston Hospital as possible. The close partnership working with UHB has supported this and, in particular, the revised proposals for critical care mean that Weston Hospital can safely maintain more of the current A&E

and emergency surgery activity in Weston Hospital than described in the Pre-Consultation Business Case, meaning that fewer people will need to travel to receive the care they need.

Furthermore, the changes that are proposed as part of the broader Healthy Weston Programme are strengthening primary and community care and improving local access – particularly to GP surgeries. This will ensure that there is a more comprehensive care offer in the community and people will avoid the need to attend hospital to receive the treatment they need.

The model of care proposed for A&E will see more people travel further for treatment than they would under the model currently commissioned (although WAHT have not been able to deliver that model since 2017 due to safety reasons). This recommendation is balanced against all the available evidence and the risks associated with operating a service in Weston Hospital at night when the hospital cannot maintain safe staffing levels. It is important to note that the consultation feedback identified that, for a greater number of people, receiving treatment with the best equipment, staff and safety record is a higher priority than receiving all treatment in one place or in the hospital closest to home.

Figure 2: Top priority for accessing emergency care



Note: Based on 990 responses from people selected as a demographically representative sample to take part in door-to-door interviews. Participants were asked to select their highest priority from three pre-defined options.

Concerns were raised throughout the consultation related to the transfer of people who require critical care and emergency surgery but overall the majority of respondents (62% for critical care and 65% for emergency surgery) supported or somewhat supported the proposals to provide these complex services in specialist centres. The model of care for these areas has been developed to include a greater level of repatriation following treatment in specialist centres so that people can recover closer to home. In addition, a highly specialised critical care transfer team has been designed and is included as part of this business case to ensure that the most unwell people are transferred in the safest possible way.

3. Capacity of infrastructure

The feedback received from the public consultation made it clear that people are worried about the ability of other services to cope with the proposals, including the capacity of the ambulance service, other hospitals and transport services.

Further Analysis and Actions Taken

It is recognised that the local health system is under significant pressure and that the demands on acute hospital services are, at times, outstripping capacity particularly for urgent and emergency care. The CCG spends £732m of the total allocation on acute hospital services, 52% of the entire budget, and, in the past, this has limited the money available to be invested in out-of-hospital care. This is changing and capacity constraints in hospitals, and a pressing need to change the way in which healthcare is delivered, form a key component of the case for change.

The wider improvements described within the Healthy Weston Programme address these issues, and the hospital clinical model has critical interdependencies with some of these, such as the Integrated Frailty Service (described in Section 4.1). Similar challenges to those found in Weston Hospital exist in Bristol, and system-wide improvements in out-of-hospital service provision will be critical to the delivery of acute care in the longer term. These improvements are being driven through other work programmes, such as the BNSSG Frailty Programme and the re-procurement of adult community services, which increases the community contract value and associated service offer by 5% per year for the lifetime of the contract, starting in April 2020. Such changes will transform the way in which healthcare is delivered in the local area and relieve pressure on overstretched hospital services.

The whole BNSSG health system is working together on capacity planning and when an element of the system is changed a detailed activity and capacity model, with agreed baseline data and assumptions, is used to identify the impact on each provider organisation. All activity modelling and capacity implications have been revisited to develop this business case.

Operational models for each of the services impacted have been worked up through the clinical sub-groups and reviewed by the CSDDG. The associated workforce and activity changes required at each organisation have been assessed and costed by the provider organisations. These have been reviewed, challenged, and collated through the Healthy Weston Finance and Enabling Group that has included Directors of Finance from all of the hospitals in the local system and the CCG – see Appendix 6 for more details of the finance and activity modelling, and Appendix 1 for the membership of the Finance and Enabling Group.

Separate capacity assessment and costing work has been undertaken and signed off with the NHS commissioned transport providers E-Zec and SWASFT. The impact on these transport providers is also included in Appendix 4.

Implications for Model of Care

As described above, Appendix 6 collates the totality of the system impact as a result of these proposals. This has been agreed by the Finance and Enabling Group and the Healthy Weston Steering Group, who have provided assurance that their organisations recognise the impact on their services and can respond accordingly.

Weston Hospital exists as part of a wider system of healthcare services and the changes proposed will impact on the whole system. There are parts of the system that are under pressure and people are experiencing difficulties in accessing some services including longer waiting times at A&E and slower response times for ambulances. The changes that are proposed will help Weston Hospital and the local healthcare system stabilise and focus on providing the care that people need the most close to home whilst strengthening networking arrangements with specialist centres. The Healthy Weston Programme has also started to develop medium term proposals to increase the amount of elective care at Weston Hospital that would not only provide care closer to where people need it but also reduce pressure on services based elsewhere. The capacity of all services to manage the changes proposed is intricately linked with the general capacity of the regional healthcare system. These changes will better enable the local providers in and around Weston to perform a leading role in the regional system.

4. Capacity of primary care

The feedback received during the consultation showed that people are worried about the capacity of primary care to support the proposals. Concerns were raised about not having enough GPs available locally and about there being difficulty in accessing GPs, which was stated as a reason that people may rely more on hospital urgent and emergency care, and they were concerned that placing GPs in A&E would further exacerbate the capacity issues.

Further Analysis and Actions Taken

Strengthened primary care has been a core workstream of the Healthy Weston Programme since its inception in 2017, when the challenges were recognised and described in detail in the Commissioning Context. Since then, there has been an active programme of work designed to transform primary care in the Weston area to meet the needs of the local population and support the proposed acute hospital model to operate effectively at Weston Hospital.

A wide range of initiatives are underway that are increasing the capacity of primary care locally and this is improving access to GPs and other primary care health professionals already. The interdependencies of the proposals with primary care and the significant work that has been undertaken in this area is outlined in more detail in Section 4.2 of the business case.

Implications for Model of Care

The Healthy Weston Programme recognises that there are challenges to the primary care workforce in the area. However, the proposals put forwards are likely to have a positive impact on recruitment and retention, rather than a negative one. The primary care workforce is changing and the proposals for the acute hospital model provide an opportunity to attract GPs to the area who want to work in a different way. Creating the opportunity for GPs to work as part of the A&E team will provide "portfolio careers" where GPs undertake sessional work with different healthcare providers. This will bring a wider range of skills to the hospital team that will reduce pressure on the more specialist services like emergency consultants. Evidence from elsewhere in the NHS has seen between 40% and 60% of cases presenting in A&E treated through primary care streaming. Furthermore, A&E Avoidance Schemes across London show that GPs in the emergency department are able to more effectively redirect people to more appropriate care in the community.

In addition, changes to primary care as part of the wider Healthy Weston Programme (outlined in Section 4 of the main document) will help improve the resilience of the local workforce. The recruitment of more Allied Health Professions including clinical pharmacists, physiotherapists, physician associates and social prescribers through PCNs will address some of the capacity concerns in primary care, as well as providing more targeted treatment for the local population. The formation of Pier Health Group – a super-partnership of 10 GP practices in the Weston, Worle and Villages area – gives a unique opportunity for primary and community care services to work together in a more effective and joined up way. Pier Health Group are a key partner within the Healthy Weston Programme work and will continue to lead key elements of out-of-hospital care to deliver the vision of Weston being a hospital at the heart of the community.

The development of the different primary care initiatives is strengthening the ability of primary care to meet the needs of the local population out of hospital and the proposals to add GPs to A&E at Weston Hospital will not remove GPs from the community. With the wider changes described in Section 4.2 of the business case and the opportunities that the new acute hospital model affords, the ambition is that primary care in Weston will become a place of choice for primary care practitioners because of the range of opportunities available in the local area.

5. Accuracy and feasibility of evidence and statistics

Concerns were raised during the consultation about the accuracy and feasibility of evidence and statistics upon which modelling and proposals may be based. This included concern about the accuracy of travel time estimates, population numbers, catchment numbers for Weston Hospital and the availability of hospital and primary care personnel to support the proposed changes.

Further Analysis and Actions Taken

The CCG has continued to work closely with NHS England and the South West Clinical Senate to provide independent assurance of the information that has been used to inform the development of the model proposed. In addition, a significant amount of work has been undertaken with North

Somerset Council and Sedgemoor District Council on the population analysis including the catchment area of the hospital, as outlined above.

Capacity planning information has been fully reviewed and reworked in order to develop the business case for decision and closer links have been formed with the Healthier Together Workforce Modelling Project, which is described in more detail in Section 4.3 of the business case.

The increased travel time analysis received particular attention during the consultation with members of the public stating that it did not reflect their personal experience. The travel times described in the "Travel" section above are based on averages and it is recognised that this will vary from some personal experiences of individuals – the average represents a range and there will be people that are at the extreme end of this range who will experience a much longer journey time. Following the feedback from the consultation, the CCG has taken steps to review the travel analysis and it has been confirmed that the methodology that was followed to determine the additional travel times is considered to be the best practice methodology, based on the actual travel times recorded through GPS navigation systems. The CCG sought assurance on this from specialists within NHS England who confirmed that this was in line with national standards.

The additional travel times that are detailed in the audits that were undertaken by SWASFT do not match the additional blue light travel times that were included in the consultation. This is because the majority of people are not conveyed to hospitals under a blue light, so the figures are not a like-for-like comparison. Furthermore, the increase in travel time was not found to have negatively impacted on patient outcomes (see audit reports in Appendix 4) and this has been validated by independent studies elsewhere in the country, such as the University of Sheffield analysis.

Implications for Model of Care

There are assumptions built into this business case that are by their nature predictions but the evidence base that has been used to inform those assumptions is robust and has been independently assured by NHS England. The use of assumptions to inform the development of services is essential, and there will always be some variation in the actual impact of implementation. However, recognising that assumptions are necessary for planning and commissioning services, the CCG has sought out research and methodologies that provide the best possible insight into how the changes are most likely to unfold.

The proposals put forward for decision have been subject to a robust internal and external governance process throughout their development. Evidence has been scrutinised and assessed by stakeholders from within and outside of the health system, and, where necessary, further information has been sought and tested, in order to bring the proposals to decision.

6. Feedback on the longer term vision

The CCG asked the local population to comment on the longer-term ambitions of the Healthy Weston Programme: even more joined-up primary care, community-based care (physical health, mental health, social and voluntary sector services) and hospital-based services. The consultation document outlined some examples of how fully integrated healthcare services could look in the future.

363 responses commented on the longer term vision. 12% of these expressed positive opinions about the direction of travel, commenting that integrated healthcare would be beneficial to people instead of fragmented, separate organisations. Several key themes emerged from the remainder of responses, which expressed concern:

- **Practicality and feasibility**: respondents were sceptical that the vision was not achievable, that there was not sufficient funding to realise the vision and that current challenges in recruiting GPs meant that a vision reliant on primary care was not sustainable.
- **Continuity**: respondents felt that scaling services up through integration would reduce continuity of care and patient experience, and that it would mean services were less local, particularly for residents of rural areas.
- **Additional elements of focus:** respondents felt that the longer-term vision did not take into account population growth or availability of public transport, and that more focus was needed on mental health services and preventative care.

WAHT Board also commented on the longer term vision in their response to the consultation; the Board detailed their concerns that the sustainability of the longer term vision was in doubt, due to challenges in the recruitment and retention of staff. The feedback on the longer term vision for healthcare in Weston can be found in more detail in the report of the consultation themes completed by an independent organisation.

The longer term vision for healthcare in Weston and the surrounding areas will form part of the Long Term Plan for BNSSG. Feedback from the consultation will be fed into the development of the Long Term Plan.

NHS
Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Group

Appendix 4: Travel time impact audits – University Hospital Bristol and Musgrove Park Hospital

Shaping better health

Travel time impact audit - University Hospitals Bristol

April 2019

1. Introduction

1.1. Bristol North Somerset and South Gloucestershire (BNSSG) Clinical Commissioning Group (CCG) are currently leading a programme of work called Healthy Weston that is concerned with the future of health care services in Weston-super-Mare and the surrounding area. The CCG is undertaking a public consultation regarding future services at Weston General Hospital (WGH). The proposals that are being consulted on include making the temporary overnight closure of the Emergency Department (ED) permanent. The overnight closure of the ED has resulted in additional patients from the Weston area being conveyed to neighbouring hospitals University Hospitals Bristol NHS Foundation Trust (UH Bristol), North Bristol NHS Trust (Southmead Hospital) and Taunton and Somerset Foundation Trust (Musgrove Park Hospital) during the overnight period. Planning for the overnight closure that began in July 2017 was overseen by the Weston Operational Clinical Oversight Group, which has held regular reviews of system capacity and patient safety.

1.2. The CCG has commissioned South Western Ambulance Service NHS Foundation Trust (SWASFT) to undertake an audit of a sample of patients who were conveyed to UH Bristol from the Weston area overnight. With the exception of one incident, all patients reviewed were redirected to UH Bristol as an alternative hospital as a result of the temporary overnight closure of Weston General. The aim of the audit is to understand if the increased travel times impacted on clinical outcomes, and to review the clinical safety of travel times for the proposed Healthy Weston model, which proposes making the temporary overnight closure permanent.

1.3. This work follows an established methodology that has recently been followed for the Dorset Clinical Services Review.

2. Methodology

2.1. Data was requested from SWASFT's Information Management Teams using the following criteria:

- Incident postcode falls within one of the provided LLSOAs of the Weston General Hospital catchment area.
- Destination hospital is Southmead Hospital Bristol, Bristol Royal Infirmary and Musgrove Park Hospital Taunton.
- Electronic patient clinical record (ePCR) created between 01/12/2017 and 30/11/2018
- "At Hospital" time is between 2200 and 0800.

2.2. The following caveats were outlined for the data set:

- The “at Hospital” time is taken from the Computer Aided Dispatch system (CAD).
- To preserve confidentiality, postcode is truncated at the first space.
- Destination and Department names are as they appear on the Electronic Care System (ECS) device. NB. there are some inconsistencies, for example: ED might be called "ED", or "BRIH - ED", or "A&E", among others.

2.3. The following fields were returned:

- Care Episode ID
- Incident Number
- Incident Date
- Time at Hospital
- Destination Hospital
- Destination Department
- Diagnosis code (taken from ePCR)
- Incident postcode
- Patient’s NHS number

2.4. Data Protection Impact Assessments and Data Sharing Agreements were completed and signed by appropriate representatives from SWASFT and UH Bristol.

2.5. Filtered data only showing patients who were conveyed to UH Bristol Emergency Department (ED) was then shared with a nominated representative from the information team at UHB via nhs.net encrypted mail in order to identify patients who were admitted to hospital from the ED and, where relevant, the length of stay.

2.6. The audit was undertaken at UHB site on 23rd April 2019 by Katy Richards (SWASFT Paramedic and Clinical Lead, Somerset) and Richard Jeavons (ED Consultant) using SWASFT’s electronic patient Clinical Records, and hospital notes from the point of arrival at ED to discharge. The following fields were completed during the audit:

- Patient age and gender
- Discharge on diagnosis
- Treatments/interventions by SWASFT
- Treatments/interventions by UH Bristol
- Did additional journey time have any impact on outcome?
- Rationale for decision

2.7. A total of 50 attendances were reviewed, evenly distributed across varying lengths of stay (LoS):

- patient not admitted
- LoS ≤24hours
- LoS 24-48 hours
- LoS 48-72 hours
- LoS ≥72hours

2.8. Within each LoS time frame, ten attendances were selected using the *'=Rand()*' function within excel.

2.9. Actual journey times were recorded from times on the ePCR (from leaving scene to arrival at ED). Estimated journey times from the incident location to Weston General Hospital were also calculated using Google Maps, to allow for a calculation of additional journey time to UH Bristol. Dates and arrival times were adjusted on Google Maps to improve accuracy of journey time estimation for each incident.

3. Summary of findings

3.1. Increased travel times as a result of the temporary overnight closure did not have any adverse impact on clinical outcomes for any of the attendances reviewed. Where required, appropriate interventions were initiated by the attending Ambulance Clinicians, stabilising patients' prior to further treatment in hospital.

3.2. There was an average additional journey time of 26.5 minutes. The average age of all patients was 64.8 years; 58% were male.

3.3. All cases were deemed to be an appropriate conveyance as there was good clinical rationale for hospital care and all patients had further investigations or treatment on arrival at ED or under the care of specialist teams once admitted i.e. medical, surgical, cardiology.

Travel time impact audit- Musgrove Park Hospital, Taunton

July 2019

1. Introduction

1.1. Bristol North Somerset and South Gloucestershire (BNSSG) Clinical Commissioning Group (CCG) are currently leading a programme of work called Healthy Weston that is concerned with the future of health care services in Weston super Mare and the surrounding area. The CCG is undertaking a public consultation regarding future services at Weston General Hospital. The proposals that are being consulted on include making the temporary overnight closure of the Emergency Department (ED) permanent.

1.2. The overnight closure of the ED has resulted in additional patients from the Weston area being conveyed to neighbouring hospitals University Hospitals Bristol NHS Foundation Trust (UH Bristol), North Bristol NHS Trust (Southmead Hospital) and Taunton and Somerset Foundation Trust (Musgrove Park Hospital) during the overnight period. Planning for the overnight closure that began in July 2017 was overseen by the Weston Operational Clinical Oversight Group, which has held regular reviews of system capacity and patient safety.

1.3. An audit of a randomised sample of patients who were conveyed to Musgrove Park Hospital (MPH) from the Weston area overnight has now been undertaken. The aim of the audit is to understand if the increased travel times impacted on clinical outcomes, and to review the clinical safety of travel times for the proposed Healthy Weston model, which proposes making the temporary overnight closure permanent. The purpose of this audit is not to evaluate patient experience, or any potential impact on neighbouring hospitals demand as a result of the temporary overnight closure of Weston General Hospital.

2. Methodology

2.1. Data was requested from SWASFT's Information Management Teams for patients who were conveyed from the Weston General Hospital catchment area to MPH, where the Electronic Patient Clinical Record (ePCR) was created between 01/12/2017 and 30/11/2018 and the "at Hospital" time was between 2200 and 0800 (ED closure times). It must be noted that the "at Hospital" time is taken from the Computer Aided Dispatch system (CAD). A total of 575 incidents were returned.

2.2. Incident data was available for 559 of 575 incidents. The Information Team at MPH provided further information to show which of these patients were admitted to hospital from the ED and, where relevant, what the patient's length of stay was (Table 1). 64.76% (n=362) patients were admitted.

2.3. Table 1 Length of Stay (LoS) for patients conveyed to MPH

Length of Stay (LoS)	Number of patients	Percentage
<24hours	164	29.3%
>72hours	107	19.1%
24-48hours	53	9.5%
48-72hours	38	6.8%
Not admitted	197	35.2%
Grand Total	**559**	**100.0%**

2.4. The audit was undertaken at MPH site on 23rd July 2019 by a SWASFT Paramedic and Clinical Lead and MPH ED Consultant. During the audit, SWASFT's electronic Patient Clinical Records and hospital notes from the point of arrival at ED to discharge were accessed and reviewed.

2.5. A total of 50 attendances (evenly distributed across varying lengths of stay) were randomly selected and reviewed:

- patient not admitted (n=10)
- LoS ≤24hours (n=10)
- LoS 24-48 hours (n=10)
- LoS 48-72 hours (n=10)
- LoS ≥72hours (n=10)

3. Summary of findings- Travel time

3.1. Table 2 shows the average journey times, both estimated and actual, for the 50 attendances reviewed. Actual journey times were recorded from times on the SWASFT Computer Aided Dispatch system (CAD). Estimated journey times from the incident location to both WGH and MPH were also calculated using Google Maps. Dates and arrival times were adjusted on Google Maps to improve accuracy of journey time estimation for each incident.

3.2. This shows that estimated and actual travel times are highly comparable and is also reflective of the fact that the majority of ambulance journeys in to hospital are undertaken using normal road conditions i.e. without blue lights and sirens.

3.3. Table 2 Travel time calculations

	Average Time (Minutes)
Estimated travel time to WGH	14.4
Actual travel time to MPH	39.3
Estimated travel time to MPH	39.4
Difference between estimated travel time to WGH and actual travel time to MPH	24.8
Difference from estimated travel time to WGH and estimated travel time to Musgrove	25.0

3.4. Estimated (Google Maps) and actual (CAD) travel times to MPH are largely similar. Where actual travel time is greater than estimated travel time, differences may be due to:

- Traffic conditions, roadworks and diversions
- Reduced speed to facilitate smoother journeys and/or ongoing treatment and monitoring en route
- Delays between the crew indicating they were leaving scene via mobile data terminals, and beginning the journey

3.5. For the incidents reviewed, there was an average additional journey time of 24.8 minutes (based on actual travel time). The average age of all patients was 66.9 years; 46% were male.

3.6. In the summary tables below, additional travel time was calculated by using the actual travel time to MPH (taken from CAD) minus the estimated travel time to WGH taken from Google Maps.

4. Summary of findings- Clinical Impact of additional travel time

4.1. In all cases reviewed, there was deemed to be no clinical impact on outcome as a result of increased travel time.

4.2. In one incident reviewed, the patient had suffered a cardiac arrest and treatment on scene resulted in a Return of Spontaneous Circulation (RoSC). The patient was conveyed to hospital, however, sadly died on a later date. During the review, it was noted that dependent on interventions required, earlier treatment in hospital may maximise a patient's chances of survival following cardiac arrest. In this incident, access to immediate coronary angiography at MPH is likely to have prevented a secondary critical transfer from WGH and it was determined that the increased travel time is unlikely to have affected the outcome due to the patient's comorbidities.

4.3. Two patients within the sample would have been eligible for bypass to an alternative hospital even if WGH ED had been open:

- One patient would have bypassed WGH as the presenting complaint was cardiac chest pain, with symptoms fitting criteria for pPCI bypass (Primary Percutaneous Coronary Intervention) which is not undertaken at WGH. The attending crew discussed the incident with the Cardiac Catheter Unit at MPH, who advised the ED.
- One patient would have been conveyed to MPH (or North Bristol Trust-Southmead) regardless of the Temporary Overnight Closure due to symptoms of an acute ischaemic limb. In these cases, there are agreed 'vascular bypasses' to enable prompt treatment by specialist teams and WGH is not a specialist Vascular Centre.

4.4. Where required, appropriate interventions were initiated by the attending Ambulance Clinicians in all cases, stabilising patients' prior to further treatment in hospital and providing pain relief as required.

4.5. During the audit there were a number of patients with suspected sepsis. Whilst it was felt that there was no detrimental impact to these patients as a result of the increased travel time, it was noted that prompt administration of antibiotics is an important part of Emergency Department sepsis care.

4.6. Whilst the administration of pre-hospital antibiotics by ambulance services for suspected sepsis has previously been considered by SWASFT, evidence suggests that this does not lead to improved survival rates, regardless of illness severity [1]. SWASFT have also discussed the use of pre-hospital antibiotics for sepsis with national sepsis leads and emphasis remains on the early identification of sepsis red flags and pre-alerted transport to an Emergency Department.

4.7. In one further incident it was also noted that earlier arrival at hospital may have facilitated early manipulation of a fracture which may have reduced swelling, however, the clinical outcome for the patient was not affected. It is also relevant to note that WGH is an ED and does not offer Trauma Unit or Major Trauma Centre services. Therefore, trauma which exceeds simple fractures (such as open fractures or crush injuries) would ordinarily bypass WGH.

4.8. Additionally, during the audit, further influencing factors on time to treatment for all conditions were discussed. For example, the time from initial symptoms to medical help being sought (e.g. via 111 or 999) and therefore, increased travel distances must be considered as one of many influencing factors in 'time to treatment'.

References

1. Alam, N., Oskam, E., Stassen, P.M., van Exter, P., van de Ven, P.M., Haak, H.R., Holleman, F., van Zanten, A., van Leeuwen-Nguyen, H., Bon, V. and Duineveld, B.A., 2018. Prehospital antibiotics in the ambulance for sepsis: a multicentre, open label, randomised trial. *The Lancet Respiratory Medicine*, *6*(1), pp.40-50.

Abbreviations

AF- Atrial Fibrillation
COPD- Chronic Obstructive Pulmonary Disease
CT- Computer Tomography (scan)
ECG – Electrocardiogram
GTN- Glyceryl Tri Nitrate
HCP- Health Care Professional
IV- Intravenous (route of drug administration)
MRI Magnetic Resonance Imaging
pPCI- Primary Percutaneous Coronary Intervention

NHS
Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Group

Appendix 5: Meeting National Clinical Quality Standards

Shaping better health

Meeting National Clinical Quality Standards

The proposed changes to the model of care at Weston Hospital will improve compliance of the clinical services affected with national clinical quality standards. This has been the main focus of the Healthy Weston Clinical Services Design and Delivery Group (CSDDG) throughout the duration of the Healthy Weston Programme.

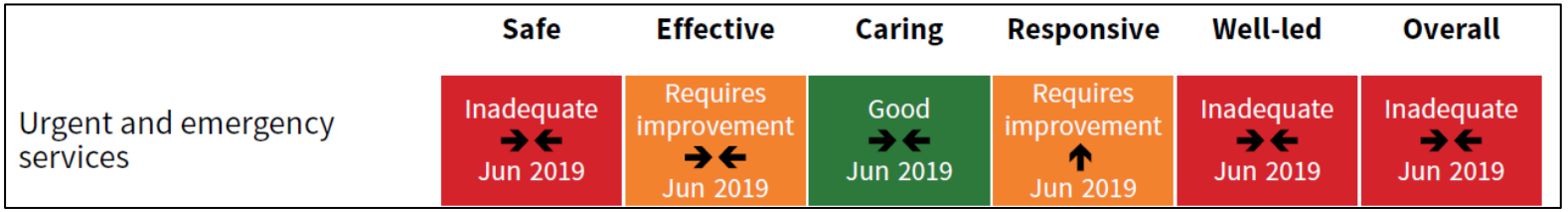
This appendix provides a detailed overview of the current compliance of each of the clinical services impacted against their associated national clinical quality standards with the expected compliance at full implementation of the proposals.

1. Urgent and Emergency Care

The Care Quality Commission (CQC) assesses provider organisations against 5 domains – Safe, Effective, Caring, Responsive and Well-led – to give an overall rating to 8 core services. The service ratings are combined to give an overall rating against each domain and an overall rating for the organisation.

WAHT was assessed as “Requires Improvement” in the June 2019 inspection, with Urgent and Emergency Service being rated as “Inadequate”:

Figure 1: CQC rating of Weston Hospital urgent and emergency services in June 2019



The full report from the CQC can be found on their website. The June 2019 rating is unchanged from the June 2017 CQC inspection, which precipitated the temporary overnight closure of the A&E at Weston Hospital because “medical staffing levels and

skill mix could not ensure safe care at all times" (June 2017 CQC report on Weston Hospital). Two years later the service has made improvements but has been unable to address the challenges sufficiently to improve the CQC rating of urgent and emergency care at the hospital.

The proposals for urgent and emergency care will support improvement against the CQC domains as described in Table 1. However, substantial work within Weston Hospital will still be required. Weston Area Health Trust (WAHT) has in place a detailed CQC action plan and this is monitored monthly by commissioners. The next CQC inspection at Weston Hospital will also be determined by internal actions taken and the organisational merger with University Hospitals Bristol NHS Foundation Trust (UHB), alongside the changes made by the Healthy Weston Programme. Having a strong model of care to work towards, alongside innovations happening inside the hospital (for example, the Geriatric Emergency Medicine Service), and outside (the planned mental health crisis and recovery centre) will enable the hospital to stabilise the Emergency Department (ED) and bring a new skilled workforce. This will facilitate the improvement of the changes required by the CQC.

Table 1: Impact of the proposed changes to urgent and emergency care on the CQC domains

Domain	CQC findings	Expected impact of the proposed changes
Safe	**Inadequate** • The service provided mandatory training in key skills to all staff; however, they did not make sure everyone completed it. Staff were not up to date with mandatory training and completion rates for medical staff were particularly poor. This meant we could not be assured they were familiar with safety systems and processes. • Systems and processes to safeguard adults and children from abuse were not robust. Staff had not received adequate training and did not always follow processes. • Staff did not always assess and respond to patient risk and monitor their safety. Patients were not always assessed promptly on arrival in the emergency department, to ensure that those with serious or immediate or life-threatening illness or injury were identified and prioritised. There were frequent ambulance handover delays and patients were not always assessed within the timescale recommended by the Royal College of Emergency Medicine. Patients were not always given identification	**Requires improvement** • The proposals make permanent the overnight closure of the A&E department. By transferring people who need urgent hospital care during the overnight period to hospitals that have the infrastructure to receive critically unwell patients, the risk to patient safety is reduced. This also removes the risk of unsafe staffing levels impacting patient outcomes during the overnight period and therefore reduces risk. • The proposals stabilise the urgent and

	wristbands to ensure the right patient received the right treatment. Staff did not routinely assess patients for the risk of falls. • The service did not have enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment. There was a shortage of registered nurses and heavy reliance on bank and agency staff. Staff reported numerous concerns about staffing levels and the associated risks. The trust was not able to provide sufficient evidence to demonstrate that all staff were suitably skilled and up to date with mandatory and ED-specific training, including the skills required to care for sick and injured children. • There were still some senior medical staff vacancies and we did not think the current senior medical staff rota was sustainable. Some junior medical staff continued to feel unsupported by senior colleagues at times, although this was improving. Some staff expressed concerns about the clinical competence of some senior medical staff. • The service did not have a good safety track record and did not manage safety incidents well. Twelve serious incidents had been reported in 12 months and a never event was reported in December 2018. Many of these incidents were still under investigation or review and there were many other incident investigations outstanding. There was little evidence that incidents, including unexpected deaths and poor patient outcomes, were regularly discussed or actions and learning cascaded to prevent further mistakes happening. However, staff recognised incidents and reported them appropriately. When things went wrong, the service apologised and gave patients honest information and suitable support.	emergency services at Weston Hospital to allow for closer collaboration and, should an organisational merger with UHB go ahead, allow the hospital to best use the resources of a merged organisation. • Improved provision of specialist paediatric staff within Weston Hospital and as part of the A&E team will support improvements associated with paediatric care and ensure that the CQC “should do” recommendations are addressed.
Effective	**Requires improvement** • Although staff could access care and treatment protocols based on national guidance and best practice, we had concerns about version control and out of date guidelines. This meant there was potential for medical staff to access out of date guidelines. Aside from participation in national Royal College of Emergency Medicine (RCEM) audits, the service did not routinely monitor compliance with national guidance or re-audit areas where national audits identified room for improvement. We could not therefore be assured that national guidance was complied with. However, during our inspection we saw good management of stroke and sepsis, which was in accordance with national guidelines. • The service monitored the effectiveness of care and treatment but there was no	**Requires improvement** • The proposed changes will ensure that there is seven day access to paediatric expertise and support the care of this patient group. • Seven day provision of a transfer team for patients requiring specialist critical care support will also be provided. This will ensure that patients that need specialist input are transferred swiftly to the hospital that can best meet the totality

	effective system to report on results and limited substantial evidence to show that the service had taken action in response to poor outcomes. • The service participated in national clinical audits so that it could compare its results with those of other services. • The service participated in three Royal College of Emergency Medicine audits in 2016/17 and three in 2017/8. Patient outcomes were generally in line with similar services. However, no action plans had been developed in response to these audits and there were no plans to re-audit where performance required improvement. However, the service monitored the identification and management of sepsis on a monthly basis and this was improving. • The service did not have effective systems to provide assurance that staff were competent for their roles. There was no oversight of nursing staff ED-specific competencies. We were not assured that poor staff performance was well managed, and staff supported to improve. Some junior doctors reported concerns about the clinical competence of some senior doctors. Whilst senior staff told us that these concerns were taken seriously and acted upon, the trust was unable to provide evidence to demonstrate this. • There was not a full range of services available seven days a week. • Staff demonstrated poor understanding about how and when to assess whether a patient had the capacity to make decisions about their care and treatment. Most staff groups were not compliant with the 90% target for attendance at mandatory training in the Mental Capacity Act.	of their care needs. • Closer links with the A&E clinical team at UHB will lead to the sharing of clinical guidelines and protocols. This will ensure that clinical treatment in Weston is in line with best practice and kept up to date. • The proposed 'mixed economy' staffing model will require a refresh of multidisciplinary skill requirements and specific competency training that will formalise the processes found to be lacking in previous inspections.
Caring	**Good** • Staff cared for patients with compassion. Feedback confirmed that staff treated them well and with kindness. Staff took the time to interact with patients in a respectful, considerate and friendly manner. We observed staff introduce themselves by name and their role. The tone of voice they used was caring and compassionate and appropriate to each patient's emotional state and needs. We observed staff using humour to engage and build a relationship with patients, as well as take their mind off their discomfort or anxiety. However, during our second visit, the emergency department was cold; staff had not taken steps to check on patients' comfort and offer them blankets. • Staff provided emotional support to patients to minimise their distress. Staff	**Good** • The decision surrounding the A&E opening hours will give staff within the department clarity on their expected rotas. The Healthy Weston Decision-Making Business Case recognises the commitment of the staff at Weston Hospital. • Developments in the care available in the community will support staff at the hospital to signpost patients and their

	understood the impact that a person's care, treatment or condition may have on their wellbeing and on those close to them, both emotionally and socially. We observed staff explaining procedures to patients in a way which was reassuring. • Staff involved patients and those close to them in decisions about their care and treatment. All patients we spoke with told us they were aware of the treatment they were receiving and why. Relatives and carers also reported they felt involved in care and decisions, where appropriate.	relatives to new types of service provision that may support them better than hospital care can.
Responsive	**Requires improvement** • Facilities and premises were not wholly appropriate for the services delivered. The emergency department was frequently crowded; patients were cared for in non-clinical areas and some were accommodated overnight, without access to suitable bathroom facilities. • The service had taken limited steps to support patients with complex needs and those in vulnerable circumstances. There was a limited understanding of the needs of patients with dementia and little evidence of a strategy or use of tools to support this patient group. However, staff spoke positively about the mental health liaison service, which responded promptly to support patients with mental illness. • People could not always access care and treatment at the right time and in the right setting. The trust was not meeting national standards in respect of waiting times in the emergency department. Some patients experienced long delays and did not receive care and treatment in the right setting. At times of high demand, when there were no suitable beds available in the hospital, patients queued in the emergency department and were sometimes accommodated overnight.	**Requires improvement** • The interdependencies of the programme support partnership working with local health and care providers and seek to redesign care pathways for key groups, including the frail and elderly population and those experiencing a mental health crisis. This will support improvements in patient outcomes and ensure that the A&E department is utilised only by those that need urgent hospital care. • New developments such as implementing the digital "AskmyGP" solution in the A&E department will ensure that patients that can be seen and treated effectively in primary care are redirected and therefore ease pressure on the A&E service. • Increased presence of frailty expertise through GEMS will address training and knowledge of dementia. • Better community integration will improve flow and allow more patients to be cared for promptly in the right place for their needs.
Well-led	**Inadequate** • Managers did not always demonstrate they had the right skills and abilities to run a	**Requires improvement** • The proposals provide clarity on the

	service providing high-quality sustainable care. The leadership lacked stability and cohesiveness; there had been many changes in the leadership team over a number of years and some further changes were due to take place in April 2019. The service failed to demonstrate effective management of workforce performance issues. • The service did not have a formal vision for what it wanted to achieve. The service was in a state of flux. The future and shape of the emergency department and other 'front door' services were currently under review by the local clinical commissioning group and this was currently subject to public consultation. Staff felt uncertain about the future and did not feel well informed, despite numerous communications and opportunities to have their say. • There was not a positive culture in the emergency department that supported staff. Some staff did not feel supported, respected or valued. Some junior medical staff continued to feel unsupported by some senior medical staff. This was a long-standing problem. A concerning number of staff reported being subject to, or witnessing, unpleasant and inappropriate behaviour from senior colleagues. • The service did not have effective governance systems to provide assurance of quality and safety. Governance meetings were poorly attended, and minutes did not provide evidence to demonstrate that senior staff had good oversight of quality and safety. Audit was not used to drive service improvement. • The trust did not have effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and the unexpected. The risk register was not used effectively to maintain oversight of and manage risks. The main forum for monitoring and managing risk was not well led. • The service collected and analysed information using secure electronic systems but did not use it well to support all its activities. The service had access to different streams of information, but it did not provide leaders with a holistic view of performance. We were not assured that information was used effectively to manage risks to performance and safety. • The service did not engage well with patients, staff and the public and local organisations to plan and manage appropriate services. Staff were aware of the public consultation exercise in relation to the future and shape of services at Weston General Hospital, but few had participated in any formal engagement to express their views.	future opening hours of the A&E department that will help stabilise the service. This will allow the leadership team to focus on internal service improvement and clinical governance, which is required to improve the current CQC ratings. This will also help attract and retain staff. • There are strong links to the UHB merger in this domain and a new leadership team is expected to be in place from April 2020.

2. Critical Care

The commissioned standards for critical care are outlined in the D05 Specialised Commissioning Service Specification for Adult Critical Care. A self-assessment against these standards was undertaken region-wide in June 2019. WAHT complied with the lowest number of standards in the region. Table 2 highlights the standards that the Critical Care Department at Weston Hospital self-assessed as "unmet" and demonstrates which of these would be met under the proposed changes to the model of care.

It should be noted that more stringent standards for the provision of Critical Care Services were published in June 2019. A full benchmarking exercise against these standards is being undertaken for both the current service provision and the planned service provision. Early review of the key June 2019 standards by the CSDDG has demonstrated that Weston Hospital will need a networked solution to deliver compliance and that more care will need to be delivered in a larger unit to enable patients to gain access to the wider multi-disciplinary team.

Table 2: D05 Service Specification Standards for Adult Critical Care unmet by Weston Hospital in June 2019 and the impact of the proposed changes on compliance.

Measures Unmet at 2019 assessment	**Comments against current assessment**	**Impact of proposals on unmet standards**
Admission to Critical Care must be timely and meet the needs of the patient. Admission must be within 4 hours from the decision to admit (unscheduled admissions).		No change - contingent on hospital bed status
The decision to admit a patient to Critical Care must be made by a Consultant in Intensive Care Medicine.	Cross cover by non-intensivists Monday to Friday 1830-0800	Met under proposed changes

Care within Critical Care must be led by a Consultant in Intensive Care Medicine (as defined by the Faculty of Intensive Care Medicine). Where providers do not meet this standard consideration should be given as to how this may be achieved through involvement in their local critical care ODN to facilitate collaboration between stakeholders.	Not weekdays overnight - see 1.4	Met under proposed changes
Consultants must be freed from all other clinical commitments when covering Intensive Care and this must include other on-call duties.	Can be in theatre as well when on call	Met under proposed changes
A Consultant in Intensive Care Medicine must be immediately available 24/7, be able to attend within 30 minutes.	Not weekdays overnight - see 1.4	A consultant in either Intensive Care Medicine or Anaesthesia will be available within 30 minutes supported by an ICM consultant with remote monitoring capabilities at UHB.
On admission to Critical Care all patients must have a treatment plan discussed with a Consultant in Intensive Care Medicine	Not weekdays overnight - see 1.4	Met under proposed changes
All admissions to Critical Care must be seen and reviewed within 12 hrs by a Consultant in Intensive Care Medicine	Not weekdays overnight - see 1.4	Met under proposed changes
Each Critical Care Unit must have a supervisory shift clinical coordinator 24/7.	Not needed due to size	Networked solution will provider supervisory shift clinical coordinator at UHB with oversight of Weston Hospital Critical Care Unit
Participation in PHE ICCIQIP		Met under proposed changes
Working towards compliance with NICE Clinical Guideline 83 and Quality Standard 158 including at a minimum benchmarking data and a SMART action plan in place to achieve compliance.		No impact as a result of the proposed changes

Evidence of effective implementation of evidenced based practice within Intensive Care Medicine.	Not done formally	No impact as a result of the proposed changes
Presence of a risk register and associated audit calendar which is regularly updated and acted upon.	Have a risk register discussed monthly and updated, no audit calendar	No impact as a result of the proposed changes
Discharge from Critical Care to ward level care must occur within 4 hours of the decision to discharge.		No impact as a result of the proposed changes
Access to Echocardiograph: Interdependent Services, available 24/7	Daytime Monday to Friday	Improved under proposed changes
Interventional Vascular and non-vascular Radiology: Interdependent Services, available 24/7		Improved under proposed changes
Neurosurgery: Interdependent Services, available 24/7		Improved under proposed changes
Vascular Surgery: Interdependent Services, available 24/7		Improved under proposed changes
Nephrology: Interdependent Services, available 24/7		Improved under proposed changes
Coronary Angiography: Interdependent Services, available 24/7		Improved under proposed changes
Cardiothoracic Surgery: Interdependent Services, available 24/7		Improved under proposed changes
Plastic Surgery: Interdependent Services, available 24/7		Improved under proposed changes
Maxillo-facial Surgery: Interdependent Services, available 24/7		Improved under proposed changes
Ear, Nose and Throat Surgery: Interdependent Services, available 24/7		Improved under proposed changes

Obstetrics and Gynaecology: Interdependent Services, available 24/7		Improved under proposed changes
Acute/Early Phase Rehabilitation Services: Interdependent Services, available 24/7		Daytime only
Additional laboratory diagnostic services: Interdependent Services, available 24/7		Improved under proposed changes
Local Hospital and Community Rehabilitation Services: Related Service	Monday to Friday daytime	No impact as a result of the proposed changes
Specialised Rehabilitation Services: Related Service	Monday to Friday daytime	No impact as a result of the proposed changes
Critical Care Follow Up: Related Service		Met under proposed changes
Clinical Psychology: Related Service		Met under proposed changes
Spinal Cord Rehabilitation Services: Related Service		Improved under proposed changes
Burns Services: Related Service		Improved under proposed changes
Voluntary Support Services: Related Service		Met under proposed changes
Measures Partially Met		
The provider must have a designated advanced level pharmacist for critical care	Starts in June 2019	Met under proposed changes
A clinical pharmacist* performs medicines reconciliation within 24 hours of critical care admission *(or suitable competent pharmacy technician with appropriate clinical pharmacist supervision)	Weekdays only	Weekdays only

A clinical pharmacist performs medicines reconciliation for patients discharged from critical care on the day of discharge	Weekdays only	Weekdays only
A clinical pharmacist performs a medicines review for each patient on a daily basis	Weekdays only	Weekdays only
A clinical pharmacist attends the multi professional ward round on a daily basis	Weekdays only	Weekdays only
Transfer from Critical Care to a ward should occur between the hours of 07.00hrs and 21.59 hrs,		Dependant on hospital bed status
Transfer from Critical Care to a ward should occur ideally between 0700hrs and 19.59hrs.		Dependant on hospital bed status
General Surgery for any site with surgical admissions: Interdependent Services, available 24/7	Tertiary centre nearby	Proposed changes provide a networked solution to UHB
Informatics support: Co-located Services – to be provided on the same site and to be immediately available 24/7	Monday to Friday daytime	Met under proposed changes
Medical Engineering Services: Co-located Services – to be provided on the same site and to be immediately available 24/7	Monday to Friday daytime	Monday to Friday daytime
Measures Not completed		
Speciality Intensive Care Units must have their speciality specific surgical service co-located with other interdependent services e.g. vascular surgery with interventional vascular radiology, nephrology and interventional cardiology; obstetrics with general surgery.	N/A	Met under proposed changes

3. Emergency General Surgery

The 2017 South West Clinical Senate review used a combination of standards from three main sources shown below:

1. RCS (2011) Emergency Surgery: Standards for Unscheduled Surgical Care
2. London Health Audit (2012) Quality and Safety Programme
3. NHS Services, Seven Days a Week Forum (2013).

Many of these standards overlap and 22 standards were created from the above sources by developing and combining linked standards on which the organisations providing emergency general surgery in the South West could assess themselves (see Emergency General Surgery – A review of Acute Trusts in the South West for information on the sources and the way in which the 22 standards were developed). The self-assessment was followed by a review visit by a team of local health professionals. Table 3 below outlines the compliance of Weston Hospital at the 2017 South West Clinical Senate review and the expected compliance at full implementation of the proposed changes.

Table 3: Compliance of Weston Hospital at the 2017 Clinical Senate review of Emergency General Surgery and the expected compliance at full implementation of the proposed changes

	Standards for Emergency General Surgery	**Compliance at 2017 review**		**Expected compliance at full implementation of the proposed changes**
No.	**Standard**	**Week**	**Weekend**	
1	Two consultant led ward rounds of all acute admitted patients, 7 days a week, with the timing of the ward rounds such that patients are generally seen within 14hrs from arrival. There is evidence of continuity of care ……..(cont)	Partially Met	Partially Met	Met for weekdays but not at the weekend under the proposed changes
2	Clearly agreed escalation policies based around an Early Warning System (EWS), are in place to deal with a deteriorating patient. Continued monitoring of the patient is carried out. If patient is not seen within 1 hour (escalation failure), the consultant is contacted.	Met	Met	Met

3	All hospitals admitting surgical emergencies to have scheduled access to diagnostic services such as plain x-ray, ultrasound, computerised tomography (CT) and pathology 24 hours a day, seven days a week to support clinical decision making: Emergency imaging reported real time. Urgent imaging reported within 12 hours.	Met	Met	Met
4	All hospitals admitting surgical emergencies to have access to interventional radiology 24 hours a day, seven days a week, either on site or through a formalised network with an agreed SLA (Service Line Agreement). Critical patients - within 1 hour if IR on site, within 3 hours if networked, Non-critical patients - 12 hours. Interventional facilities are safe for emergency patients.	Not Met	Not Met	No change as a result of the proposals - this is in place through network with NBT.
5	Rotas to be constructed to maximise continuity of care for all patients in an acute surgical environment. A single consultant is to retain responsibility for a single patient on the acute surgical unit. Subsequent transfer or discharge must be based on clinical need. There is a clear policy for handover and for transfer of care to another team or consultant, and for safe discharge.	Partially Met	Partially Met	Compliance will be improved through merger with UHB.
6	A unitary document to be in place, issued at the point of entry, which is used by all healthcare professionals and all specialities throughout the emergency pathway.	Partially Met	Partially Met	Weston will adopt the UHB policy.
7	All acute surgical units have provision for formalised ambulatory emergency care delivered by senior decision maker (ST3/SpR & above). Ambulatory emergency care to include a dedicated hot clinic, dedicated day case pathway and dedicated are	Not Met	Not Met	Met through proposed changes
8	Access to fully staffed emergency theatre, consultant surgeon and anaesthetist within 30 minutes, 24/7	Not Met	Not Met	This will be covered for the time that theatres are open – i.e.8:00-20.00 hours. Outside of this networked arrangements with UHB will be required.
9	All patients considered 'high risk' (predicted mortality greater than or equal to 10% based on P-Possum/SORT) should be admitted to a level 2/3 area and have their operations carried out under the direct supervision (in theatre) of a consultant surgeon and consultant anaesthetist; early referral for anaesthetic assessment is made to optimise peri-operative care. ……..(cont)	Met	Met	Met
10	All emergency general surgical operations are discussed with the consultant surgeon and the discussion is documented	Met	Met	Met

11	The majority of emergency general surgery to be done on planned emergency lists on the day that surgery was originally planned. The date, time and decision makers should be documented clearly in the patient's notes and any delays to emergency surgery and reasons why recorded. The WHO Safety Checklist (or local variant thereof) is used for all surgical procedures in emergency theatre.	Not Met	Not Met	Met through proposed changes
12	Handovers must be led by a competent senior decision maker (ST3/SpR & above) and take place at a designated time and place, twice a day. These arrangements to be in place for handover of patients at each change of responsible consultant/surgical team/shift or block of on-call days where it should be consultant led. Changes in treatment plans to be communicated to nursing staff and therapy staff ……..(cont)	Met	Met	Met
13	Patient experience data to be captured, recorded and routinely analysed and acted on. Review of data is a permanent item, on-board agenda and findings are disseminated. There has been an in-house audit within the last 5 years related to emergency surgery.	Partially Met	Partially Met	Will be met through adoption of UHB policies
14	Hospitals admitting emergency patients have access to comprehensive (Upper/Lower) 24 hour endoscopy service, that has a formal consultant rota 24 hours a day, seven days a week covering GI bleeding.	Met	Met	Will be met via a networked arrangement with UHB overnight with onsite provision during the day
15	Training is delivered in a supportive environment with appropriate, graded, consultant supervision.	Partially Met	Partially Met	Met through proposed changes
16	Sepsis bundle/pathway in emergency care.	Not Met	Not Met	This will be met through the implementation of the UHB sepsis bundle, this is a checklist that is used for all patients
17	There is a policy for review of all Emergency general surgery patients by a consultant, every day, 7 days a week, whilst they remain under the care of the emergency team.	Met	Not Met	Morning consultant round will meet this.

18	Emergency surgical services delivered via a network (e.g. vascular surgery, IR, Plastics,/Burns and Paediatrics.) have arrangements in place for image transfer, telemedicine, and agreed protocols for ambulance bypass/transfer and a formal SLA. Standards for the transfer of critically ill patients are adhered to and regularly audited.	Not Met	Not Met	Much of this is already being delivered and will be improved through proposed changes; critical care transfer team will improve compliance with transfer of critically ill patient.
19	For emergency surgical conditions not requiring immediate intervention, children do not normally wait longer than 12 hours from decision to operate to undergoing surgery. Children receive adequate hydration and symptom control during this time. Surgeons and anaesthetists taking part in an emergency rota that includes cover for emergencies in children have appropriate training and ……..(cont)	N/A	N/A	N/A
20	As a minimum, a speciality trainee (ST3/SpR or above) or a trust doctor with equivalent ability (i.e., MRCS, with ATLS provider status), is available at all times within 30 minutes and is able to escalate concerns to a consultant. Juniors qualifications - i.e., experience level of team.	Not Met	Not Met	Partially met – availability of surgical support from 08:00-00:00 hours, on call consultant cover between 00:00 and 08:00
21	Do you have clear protocols for senior speciality review of all general surgical in-patients to include GI surgery (Colorectal, Upper GI, Hepato-billary), Vascular, Breast & Urology) every day, seven days a week.	Not Met Met	Not Met Met	This will be written into the implementation plans. Met
22	Do you have clear protocols, including a standard for timing, for senior medical (physician) speciality review of emergency general surgical admissions?	Not Met	Not Met	Can be met through improved joint working with medical team; resilience may remain an issue as medical positions remain highly reliant on locum cover.

4. Acute Paediatrics

The Facing the Future: Standards for children in an emergency care setting were issued by the Royal College of Paediatrics and Child Health in June 2018. They were developed by the Intercollegiate Committee for Standards for Children and Young People in

Emergency Care Settings to support the highest quality care for children wherever they present in the health system. These standards were not published at the time of the temporary overnight closure of the A&E department at Weston Hospital; however they have formed an important part of the development of the Healthy Weston proposals over the course of the past 12 months. The paediatric staffing changes, in particular, have been driven by the standards outlined below, with positive "knock-on" impacts for a high number of standards associated with process and governance of children in an urgent care environment.

Table 4 provides a detailed assessment of the current compliance and the impact of the proposed changes on compliance against the individual clinical standards. This self-assessment has been completed by a consultant in Emergency Medicine and a consultant paediatrician from Weston Area Health Trust and validated by the Healthy Weston CSDDG.

Table 4: Compliance of Weston Hospital's current service model against the Facing the Future Standards and the expected compliance at full implementation of the proposed changes

	Standard	**Current compliance**	**Impact of the proposed changes on compliance**
1	Urgent and emergency care services are planned, commissioned and delivered through clinical networks.	Partially met	Commissioning changes improve alignment of paediatric expertise to the urgent care offer
2	The care of ICYP in integrated urgent care centres is planned and delivered using these standards to meet the needs of children.		Standards will continue to be used
3	Staff receiving children in urgent care centres have the appropriate paediatric competence to provide immediate assessment.	All middle grade A&E doctors have training in advanced paediatric life support (APLS)	Will be improved through increased paediatric knowledge and expertise
4	Emergency care settings are designed and provided to accommodate the needs of children and their parents/carers.	Dedicated waiting area within A&E	Children will be moved through A&E and into the Seashore Unit more swiftly under new proposals

	Standard	Current compliance	Impact of the proposed changes on compliance
5	All emergency departments that treat children employ a play specialist.	Not met	Role taken by the paediatric nursing staff with appropriate equipment and experience. Improved access to these paeds nursing skills by matching opening hours will help this standard.
6	Children, young people and their parents/carers are invited to provide feedback on the service received in the urgent and emergency care setting to inform service improvement.	Currently met	Will continue to be met
7	Children and their parents/carers must be provided, at the time of their discharge, with both verbal and written safety netting information, in a form that is accessible and that they understand.	Partially met via existing Seashore Centre opening hours	Extended hours will enable more children to go via the Seashore Centre, and the presence of more paediatric nursing in ED. Seashore Centre calls every acute admission the following day
8	Patient flow models which consider patient acuity and consultation time are used in planning capacity of the built environment.	Currently met	Will continue to be met
9	Every emergency department treating children must be staffed with a PEM consultant with dedicated session time allocated to paediatrics.	Mitigated with the employment of an acute paediatrician.	Mitigated with the employment of an acute paediatrician. One is now employed, and a second will be employed under new proposals.
10	Every emergency department treating children must be staffed with two registered children's nurses.	Not met	Met under new model

	Standard	Current compliance	Impact of the proposed changes on compliance
11	A minimum of two children's nurses per shift in dedicated children's emergency departments must possess recognisable post-registration trauma and emergency training.	N/A	N/A
12	Every emergency department treating children must enable their staff to attend annual learning events that are specific to paediatric emergency medicine.	Being met through WATCH Training Day. Simulations and PLS course (step down from APLS)	Increase in number of paediatric trained staff available will increase within new model
13	Every emergency department treating children must have a member of staff with APLS (or equivalent) training on duty at all times.	Met currently	Met currently
14	Every emergency department treating children must have their qualified staff trained in infant and child basic life support (BLS).	Partially met	Met under new model
15	PEM consultants should have adequate Supporting Professional Activities in a full time job plan in which to continue their own development and that of the trainees.	Not met	Not met but mitigated through closer working with Bristol Royal Hospital for Children
16	All children who are streamed away from an emergency care setting must be assessed by a clinician with paediatric competences and experience in paediatric initial assessment within pre-agreed parameters including basic observations.	Children are not streamed away from A&E	Children will not be streamed away from A&E in new model

	Standard	Current compliance	Impact of the proposed changes on compliance
17	All children attending emergency care settings are visually assessed by a doctor or nurse immediately upon arrival with clinical assessment undertaken within 15 minutes to determine priority category, supplemented by a pain score and a full record of vital signs.	Met currently	Will continue to be met
18	A system of prioritisation for full assessment is in place if the triage waiting time exceeds 15 minutes.	Met currently	Will continue to be met
19	Children with abnormal vital signs at initial triage assessment have their observations repeated within 60 minutes.	Under audit	Compliance will be more effective with enhanced paediatric nursing
20	Every emergency department treating children has an established Early Warning System.	Met currently	Will continue to be met
21	Policies in place for the escalation of care for critically unwell children.	Met currently	Will continue to be met
22	The appropriate range of drugs and equipment is available for facilities receiving unwell or injured children.	Met currently	Will continue to be met
23	Analgesia is dispensed for children with moderate and severe pain within 20 minutes of arrival to the emergency department and pain score is reassessed and acted upon within 60 minutes.	Not audited	Will be easier to meet under new model, but requires focus and regular audit

	Standard	Current compliance	Impact of the proposed changes on compliance
24	Registered practitioners treating children in the emergency department deliver health promotion and accident prevention advice that is recorded in discharge summary notes.	Not audited	Will be easier to meet under new model, but requires focus and regular audit
25	Discharge summaries are sent to the child's GP and other relevant healthcare professionals within 24 hours of their attendance to the emergency department.	Currently met	Will continue to be met
26	Emergency ambulatory care teams work with community services to promote and develop prevention to hospital admissions.	Currently met	Will continue to be met
27	All staff who regularly look after children must have up to date safeguarding children training and competence in line with the RCPCH Intercollegiate Document	Not met, highlighted by CQC in June 2019 inspection	Will be improved through increased access to nursing staff with Level 3 Safeguarding training and consultant paediatricians who have the competencies in line with the Intercollegiate document
28	All emergency departments nominate a lead consultant and a lead nurse responsible for safeguarding.	Yes for consultant from ED, nurse needs to be secured	Will be met under new model
29	All emergency care settings have guidelines for safeguarding children.	Currently met	Will continue to be met
30	All staff in emergency care settings have access to safeguarding advice 24 hours a day from a paediatrician with safeguarding expertise.	Currently met	Will continue to be met
31	Information from the Child Protection Plan is available to staff in emergency care settings.	Access via the Emergency Duty Team	Access via the Emergency Duty Team

	Standard	Current compliance	Impact of the proposed changes on compliance
32	Systems are in place to identify children and young people who attend frequently.	Currently met	Will continue to be met
33	The primary care team, including GP and health visitor/school nurse and named social worker, are informed, within an agreed timescale, of each attendance.	Currently met	Will continue to be met
34	A review of the notes is undertaken by a senior doctor or nurse when a child leaves or is removed from the department without being seen.	Currently met	Will continue to be met
35	When treating adults, staff must recognise the potential impact of a parent's or carer's physical and mental health on the wellbeing of dependents, and take appropriate action, including when domestic abuse is suspected.	Currently met	Will continue to be met
36	Implementation of nationally approved information sharing systems (such as the Child Protection Information Sharing (CPIS) system in England) is occurring as per contract.	Currently met	Will continue to be met
37	Policies are in place to review cases where ICYP either leave or abscond from a department unexpectedly prior to discharge or when they do not attend for planned follow up.	Currently met	Will continue to be met

	Standard	Current compliance	Impact of the proposed changes on compliance
38	ICYP at high risk of potential safeguarding presentations are reviewed by a senior (ST4+) paediatrician or PEM doctor (e.g. infants who are non-mobile presenting with injuries such as bruising, burns or fractures.)	Safeguarding systems highlighted as requiring improvement in recent CQC inspection	Will be improved through increased paediatric staffing and expertise
39	All CYP presenting to a children's ED have a developmentally appropriate assessment of their immediate emotional and mental health needs.	Not met	Will be improved through increased paediatric training and expertise
40	A documented risk and capacity assessment should be done for all patients presenting in mental health crisis and this process should commence at triage.	Currently met	Will continue to be met
41	Adequate and appropriate space is available for children/families in crisis and should include safe space with suitable supervision by emergency staff.	BRHC as appropriate, and Seashore Centre when open	Alignment of Seashore opening hours to ED
42	There is access to mental health records and development of individual crisis plans for each ICYP seen and assessed in mental health crisis in the ED.	Improvements underway through Connecting Care	No change
43	A clear system is in place with service planners to escalate care of patients who require Tier 3(+) in-patient care.	Clinical Pathway required transfer to BRHC	Clinical Pathway requires transfer to BRHC

	Standard	Current compliance	Impact of the proposed changes on compliance
44	Emergency clinicians with responsibility for the care of children receive training in how to assess risk and immediately manage children's mental health needs and support their family/carers. Training should include risk assessment, current legislation on parental responsibility, consent, confidentiality and mental capacity.	Not met	Compliance expected to improve with increased expertise in paediatric care
45	Telephone availability of paediatric mental health practitioner 24hours a day, 7 days a week, for advice and able to attend for assessment when appropriate.	Met through BRHC service provision	Met through BRHC service provision
46	Policies are in place for the management of an acutely distressed child or young person incorporating the use of acute tranquilisation and, as a last resort, restraint for those who are acutely disturbed or at risk of harm to themselves or others.	Partially met - access to BRCH policies	Will be met with new proposals
47	When CYP require access to a mental health in-patient bed but there is a delay >4 hrs, they are looked after in a suitable paediatric facility with appropriate in-patient facilities, regular CAMHS review, trained registered mental health nurses and paediatric nursing support.	Clinical Pathway to BRHC	Clinical pathway will remain to BRHC

	Standard	Current compliance	Impact of the proposed changes on compliance
48	There is a clear pre-identified pathway for patients on a Section 136 order for an identified place of safety to meet their medical and mental health needs.	Currently met via BRHC	Will continue to be met
49	Triage systems must consider the additional requirements of prioritising care for children with complex medical needs.	Currently met	Will continue to be met
50	When treating a child with complex medical needs, the need to consider early escalation for senior review should be included in all training and induction.	Met within hours of availability of Seashore Unit	Will be improved with greater access to nurses and doctors with paediatric expertise
51	When treating a child with complex medical needs, staff should ask to see the child's emergency care plan.	Currently met	Will continue to be met
52	The needs of children with complex medical needs must be considered within the planning and design of the emergency department.		
53	Where electronic alerts are available these must be used to signpost to relevant information such as emergency care plans or the requirement for an early senior assessment.	Not met	No change as a result of proposed model
54	Information about the child or young person's attendance to an emergency care setting	Partially met	Increased paediatric knowledge and expertise will help achieve compliance

	Standard	Current compliance	Impact of the proposed changes on compliance
	should be shared with the relevant professionals involved with them, including the lead clinician. Links should also be established with local specialist nurse and community children's nursing team to ensure effective follow-up care and support.		
55	The needs of children must be included in the strategic and operational planning and delivery of preparing and responding to major incidents.	Resilience exercises at Weston Hospital include children	Yes
56	Children, paediatric medical staff and nursing staff must be involved routinely in appropriate incident exercises with the relevant safeguards in place.	Resilience exercises at Weston Hospital include children	Frequency could be enhanced
57	Each region has a Paediatric Critical Care (PCC) Transport team, provided, managed and governed by its Paediatric Critical Care ODN.	Currently met	Will continue to be met
58	The regional PICU has a dedicated, 24-hour transfer helpline, for critically ill or injured children, providing clinical support and advice, and co-ordinating paediatric retrievals and transfers.	Currently met	Will continue to be met
59	Local facilities have appropriate staff and equipment readily available, for "time-critical" transfers.	Currently met	Will continue to be met

	Standard	Current compliance	Impact of the proposed changes on compliance
60	ED staff trained in stabilisation and transfer of paediatric patients.	Partially met	Met under new model
61	Parents and families of children transferred between hospitals are given practical help and information detailing their child's transfer destination.	Currently met	Will continue to be met
62	All emergency departments caring for children have local agreed policies in place for responding to the unexpected death of a child.	Currently met	Will continue to be met
63	Children that have died outside of the hospital setting are taken to a hospital with paediatric facilities.	Access via ED. Seashore Centre supports families locally	No change proposed
64	All emergency departments caring for children provide training to staff on how to support carers/parents in response to an unexpected death.	Not met	This can be included in staff training, rotational roles with BRHC will support.
65	Co-operation with the Rapid Response Team and Child Death Overview panel to ensure learning is shared between agencies.	Currently met	Will continue to be met
66	All emergency care practitioners treating children in the urgent and emergency care network have information systems that provide basic demographic and episode related information.	Currently met	Will continue to be met

	Standard	Current compliance	Impact of the proposed changes on compliance
67	All health organisations providing emergency care to children must collaborate with national information centres (i.e. NHS Digital) to involve and inform of the needs of patients, clinicians, managers and service planners/commissioners in developing emergency care information systems.	Currently met	Will continue to be met
68	All emergency departments treating children collect performance data that is used to improve services locally and to benchmark performance nationally.	Currently met	Will continue to be met
69	Emergency departments treating children adhere to Emergency Care Discharge Summary Standard.	Not met	Can be met through increased paediatric support within A&E
70	All emergency departments treating children have a nominated lead for paediatric emergency research with PERUKI membership.	Not met	Through networked arrangement with BRHC, but recognise that this is outside the scope of Healthy Weston proposals

NHS
Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Group

Appendix 6: Finance and Activity Modelling

Shaping better health

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Finance and Activity Modelling

This appendix provides a detailed activity and financial assessment of the preferred model for service changes in Weston, including the impact of the preferred model on BNSSG system partners.

1. System Financial Impact

The proposed changes are broadly cost-neutral to the system against the 2018/19 baseline, which includes the temporary overnight closure of the A&E department. By not reopening the A&E department overnight, it is estimated that £3.8m will be saved. This figure has been provided by Weston Hospital and represents a realistic assessment of the cost of appropriately staffing the A&E department throughout the overnight period, over and above the £9.2m already spent to operate the 8am-10pm service that is currently available. The costs are largely comprised of premium agency fees which would be incurred should the department reopen. This is due to a national shortage of emergency medicine staff.

The net financial system impact is shown below.

Table 1: Net financial system impact of Healthy Weston proposals

Proposed change*	Providers Perspective			Commissioners Perspective				Prod. Benefits	TOTAL IMPACT
	WAHT	UHB	Providers Total	BNSSG CCG	SWASFT	PTS	Comm. Total		
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
A&E ON Closure	3,800	-	3,800	-	-	-	-	-	**3,800**
Adult A&E	(55)	60	5	(2)	-	-	(2)	-	**3**
Direct ON Admissions	-	-	-	-	76	229	305	122	**426**
Transport Team	-	(232)	(232)	-	3	(105)	(102)	76	**(258)**
Critical Care	(195)	83	(112)	1	-	-	1	24	**(87)**
CC Impact on Wards	(364)	607	243	(25)	-	-	(25)	-	**218**
Complex Med. Pts.	(820)	672	(148)	(24)	(2)	(23)	(49)	-	**(197)**
Overnight Surgery	(204)	386	182	(12)	-	(9)	(21)	-	**161**
Paediatrics	68	(275)	(207)	9	63	-	72	-	**(135)**
Total	**2,229**	**1,300**	**3,530**	**(53)**	**139**	**92**	**178**	**222**	**3,928**
Total excl. A&E ONC	**(1,571)**	**1,300**	**(270)**	**(53)**	**139**	**92**	**178**	**222**	**128**

1.1. Interdependencies in the BNSSG system

This business case and the outcomes are interdependent with other service redesign and development activities occurring within the BNSSG system as part of a longer term view of the changes in the Weston area.

These activities are:

- The organisational merger between Weston Area Health Trust (WAHT) and University Hospitals Bristol NHS Foundation Trust (UHB)
- An Integrated Frailty Service
- A newly commissioned Mental Health Crisis and Recovery Centre
- Re-procurement of adult community services
- Changes to primary care

Each of the above independencies is considered within a separate business case, which are not part of the Decision-Making Business Case (DMBC). Therefore, their financial impact is excluded from any further considerations.

2. Methodology

The Finance and Enabling Group, which comprises Directors of Finance and representatives of commissioner and provider organisations, was constituted as part of the Healthy Weston Programme governance structure, described in Appendix 1. The group was responsible for the financial evaluation of the proposed changes in both the Pre-Consultation Business Case (PCBC) and the Decision-Making Business Case for the Healthy Weston Programme.

The group has led on the financial and activity modelling of the proposed changes by consolidating information from other specialty-specific working groups (A&E and urgent care, critical care, emergency general surgery, paediatrics), which included financial, clinical and managerial representatives of both provider and commissioning organisations. The Clinical Services Design and Delivery Group (CSDDG) has maintained oversight of all the clinical development work undertaken and has been responsible for making recommendations to the Healthy Weston Steering Group for decision at key points in the programme. The outcomes of the Finance and Enabling Group's financial and activity modelling have been reported back to the CSDDG to ensure cohesion of both the clinical and financial modelling associated with the proposed changes.

The proposals recommended for decision in this business case have been assessed for income, costs, capacity and capital requirements.

2.1 Activity Modelling Assumptions

The basis for the modelling of the proposed changes in both the PCBC and this business case are summarised below. The main difference is that the PCBC modelling was based on 17/18 estimated activity, while the baseline for the business case is actual 18/19 activity. The further details of the modelling are discussed in Section 4 of this appendix.

Table 2: Modelling approach between PCBC and DMBC

Service Line	Proposed Change	PCBC Approach	Approach in this business case
A&E	Overnight closure becoming permanent	Overnight closure included in the baseline, so not included in the financial or activity modelling.	Overnight closure included in the baseline, so not included in the activity modelling. However, the cost of potentially opening A&E overnight included.
	Impact of proposed changes to critical care	20% of A&E Majors seen transferred to other hospitals	Actual number of patients affected by proposed changes to critical care, medicine and surgery that have been admitted through A&E.
Critical care	Reduction in availability of Level 3 (ITU) critical care	Any patients with 3+ organs supported transferred. Number of actual bed-days doubled to adjust for risk-averseness.	Actual complex patients that would benefit from the transfer to UHB based on the reasons for admission.
Medical non-elective (NEL) patients	Impact of changes to critical care	Based on complex HRGs; complex patients transferred to UHB due to lack of Level 3 critical care	Based on complex HRGs; Identifying non-elective spells related to critical care spell that were identified for transfer.
Medical elective (EL) patients	Impact of changes to critical care; more complex patients transferred to UHB	Complex patients transferred to UHB due to lack of Level 3 critical care	No impact of proposed changes on the medical elective patients
Surgery non-elective patients	Impact of changes to critical care; more complex patients transferred to UHB	Complex HRGs transferring to UHB	Identifying non-elective spells related to critical care spell that were identified for transfer.
	No overnight surgeries	Not included in modelling	Based on any operations finishing between 22:00 - 8:00
Surgery elective patients	Impact of changes to critical care; more complex patients transferred to UHB	ASA 4 Orthopaedics surgeries transferring to UHB	Identifying elective spells related to critical care spell that were identified for transfer
	No overnight surgeries	Not included in modelling	Based on any operations finishing between 22:00 - 8:00
Paediatrics NEL, EL & DC patients	Increasing availability of paediatric specialist treatment; changing rota from 10 hours, 5 days a week to 14 hours, 7 days	50% of current inpatient activity due to current staffing model	Based on 30% of short-stay emergency admissions (0-1) <16 years from Weston area that currently attend UHB

Service Line	Proposed Change	PCBC Approach	Approach in this business case
	a week.		
Paediatrics A&E	Increasing availability of paediatric specialist treatment; changing rota from 10/5 to 14/7.	Not included in modelling	Number of minor A&E attendances from <16 years patient from Weston area that currently attend UHB
Paediatrics Outpatients	Increasing availability of paediatric specialist treatment; changing rota from 10/5 to 14/7.	Not included in modelling	75% of general paediatric attendances from Weston area that currently attend UHB

The activity currencies used to evaluate the volumes of changes are:

- Adult and paediatric A&E – attendances
- Critical care – bed-days (and related bed capacity)
- Adult elective and non-elective patients – spells (and related bed capacity)
- Paediatrics ambulatory care – non-elective patients spells
- Paediatric outpatients – attendances (and related consultant capacity)
- LoS efficiencies – bed-days (applying average excess bed-day tariff)

2.2 Financial Assumptions

Financial assumptions can be grouped into five categories: general financial assumptions, financial assumptions specific for WAHT, financial assumptions specific for UHB, financial assumptions for transport costs, and financial assumptions for modelling system-wide benefits.

(i) General financial assumptions

The following income, cost and tariff assumptions have been made in order to evaluate the activity changes:

- Only the changes in income and costs resulting directly from the proposed changes are modelled.
- For changes in the staffing model, the 19/20 budget is used as a baseline.
- For other changes in costs, the 18/19 baseline is used.
- Changes in income are based on 19/20 tariff prices (including CQUIN).
- Changes in costs are based on either Service Level Reporting (SLR), actual outturn, 19/20 NHS Agenda for Change pay scales or other proxies depending on availability of the information.

(ii) Financial assumptions specific for WAHT

In their impact evaluation, WAHT has applied the following assumptions:

- Income estimations are based on 19/20 national tariff prices including applicable market forces factor and 1.25% for CQUIN.
- Any recharges between Trusts are based on excess bed-days tariff.

- Pay cost assumptions are based on mid-point 19/20 NHS Agenda for Change pay scales, while the 19/20 pay budget is considered a baseline.
- Non-pay cost changes are based on 18/19 actual outturn.
- Premium staffing costs (agency/locum) are assumed to be applied if difficulties with recruiting to the post are envisaged.

(iii) Financial assumptions specific for UHB

In their impact evaluation, UHB has applied the following assumptions:

- Income estimations are based on 19/20 national tariff prices including applicable market forces factor and 1.25% for CQUIN.
- Any recharges between Trusts are based on excess bed-days tariff.
- The cost are based on 18/19 SLR data for each speciality and modified through consultation with relevant Finance Divisional Manager.

(iv) Financial assumptions for transport costs

It is assumed that independent of whether the transfer is facilitated by the dedicated transfer team, the vehicle will be provided by a Patient Transport Services (PTS) type of provider at a cost of £254 per journey.

Benefits to South Western Ambulance Service NHS Foundation Trust (SWASFT) were calculated using the National Reference Cost of £252 per Treat and Convey Service for reduction in number of journeys. For the reduction in distance travel, an estimated reduction of costs by £84 per journey is assumed using an average reduction in time and mileage by a third of the cost (35 minutes vs average journey of 105 minutes).

(v) Financial assumptions for modelling system-wide benefits

Any system-wide benefits are based on estimated length of stay (LoS) efficiencies. Benefit is calculated using the average 19/20 excess bed-rate at WAHT of £270 per bed-day saved.

3. Financial Impact of A&E Overnight Closure

The PCBC did not estimate the financial impact of making the temporary A&E overnight closure permanent, as it was already included in the 17/18 baseline. The Decision-Making Business Case includes an assessment of the impact of making the A&E closure permanent from two perspectives:

Firstly, from an activity perspective, it appears that roughly 2,700 A&E attendances per annum were transferred to neighbouring hospitals (UHB, North Bristol Trust (NBT) and Taunton & Somerset NHS Foundation Trust (T&SFT)) since the introduction of the temporary overnight closure in July 2017. This equated to an accumulated additional demand of circa 5.37 beds per annum on other providers due to the number of related admissions. Simultaneously, A&E activity in WAHT was reduced by circa 5,600 attendances per annum against an estimated trend of A&E attendances prior to the temporary overnight closure. Taking into consideration related admissions, this equates to a reduction of demand for activity by 13.34 beds per annum.

Therefore, as a result of the overnight closure, the system-wide impact is a reduction of around 2,900 A&E attendances and 380 related admissions, resulting in an overall reduction in demand on the system by circa 8 beds per annum.

Secondly, from a financial perspective, WAHT estimated that opening A&E overnight would result in an additional cost of £3.8m in pay and non-pay costs. The pay costs were estimated using predominantly premium staffing costs (agency/locum) due to the current level of vacancies within the A&E Department and the envisaged difficulties with recruiting safe staffing levels to reopen the A&E overnight.

4. Impact of proposed changes on activity transfers

This section explains the modelling of activity transfers as result of the proposed changes to the hospital model of care. All of the activity changes are based on 18/19 actual activity. The changes to bed capacity are estimated at 80% occupancy level.

4.1 Comparison with PCBC

Table 3 below compares the differences in the activity modelling between the PCBC and this business case. It should be noted that high-level modelling assumptions were used in the PCBC and the DMBC has carefully reviewed these and used available data sources in acute Trusts, the CCG and SWASFT to accurately assess the impact of the proposals at the level of health resource group (HRG) and point of delivery (POD).

Table 3: Activity impacts between PCBC and DMBC

Service Line	Proposed Change	Estimated impact on activity in:	
		PCBC	DMBC
A&E	Overnight closure becoming permanent	3,657 patients seen elsewhere	2,675 patients seen at other A&E Departments in area 2,948 patients using other commissioned services[1]
A&E	Overnight direct admissions from GP referrals due to doubling overnight Medical Registrars rota	-	On average additional 2.5 patients admitted overnight to Weston (roughly 900 per annum)
A&E	Co-locating GP services within A&E	-	-
A&E	Impact of proposed changes to critical care (CC)	1,637 patients seen elsewhere	up to 280 patients seen at UHB

[1] Estimated number of reduction in A&E attendances at Weston Hospital that is not matched by growth in A&E attendances at other A&E Departments in the area.

Service Line	Proposed Change	Estimated impact on activity in: PCBC	DMBC
Critical care	Reduction in availability of Level 3 CC; complex patients transferred to UHB	74 patients 969 bed days	135 patients 535 bed days
Medicine NEL patients	Impact of changes to CC; more complex patients transferred to UHB	86 patients	40 CC patients 105 complex patients
Medicine EL patients	Impact of changes to CC	33 patients	0 patients
Surgery NEL patients	Impact of changes to CC; more complex patients transferred to UHB	562 patients	50 CC patients
Surgery NEL patients	No overnight surgeries	-	75 patients
Surgery EL patients	Impact of changes to CC; more complex patients transferred to UHB	79 patients	28 CC patients
Surgery EL patients	No overnight surgeries	-	4 patients
Paediatrics NEL, EL & DC patients	Increasing availability of paediatric specialist treatment; changing rota from 10/5 to 14/7.	414 patients	44 patients in Year 1 153 patients in Y2
Paediatrics A&E	Increasing availability of paediatric specialist treatment; changing rota from 10/5 to 14/7.	-	539 patients in Y1 1,120 patients in Y2
Paediatrics Outpatients	Increasing availability of paediatric specialist treatment; changing rota from 10/5 to 14/7.	-	222 patients in Y1 418 patients in Y2

4.2 Activity impact summary

The CSDDG have recommended the following activity changes to be included in the business case:

- Transfer of complex critical care patients from Weston Hospital to UHB that would benefit from access to specialist care available at UHB and not available in Weston.
- Transfer of complex medical patients from Weston to UHB that would benefit from access to specialist care available at UHB and not available in Weston.
- Transfer of overnight emergency surgeries from Weston to UHB.
- Transfer of complex A&E patients from Weston to UHB that would benefit from access to specialist care available at UHB and not available in Weston.
- Collocating GPs within A&E at Weston.
- Enabling overnight direct, stable medical admissions at Weston.
- Making the temporary overnight closure of the A&E Department permanent.

- Investment in paediatric services resulting in activity transferring from UHB and T&SFT to Weston.

The activity impact summary by service line in this business case is shown below in Table 4.

Table 4: Assumptions and associated activity impacts by service line

Service Line	Service assumptions for Activity modelling purposes	Estimated activity impact
Critical care	• Transfers based on their individual needs (primary reason for admission). The full episode of critical care will be transferred. • After the critical care episode, any surgical patients will stay in UHB for up to five days to allow for post-operation observations and follow-up; if they are not discharged earlier, the patient will be transferred back to Weston after 5 days. • After the critical care episode, any medical patients will be transferred to a Weston medical ward.	Transferring away from Weston: <u>Critical care:</u> 135 patients 535 bed-days 95 repatriated patients 1 bed <u>Surgical wards</u>: 78 patients 327 bed-days 58 repatriated patients 1.12 beds <u>Medical wards:</u> 40 patients 0 bed-days 23 repatriated patients
A&E attendances	• Complex A&E patients – resultant impact due to all other assumptions about changes to critical care, complex medical patients and overnight surgery (assuming that the decision about transfer would be undertaken on ED presentation). • Enabling overnight, direct GP admissions of stable medical patients – impact on activity is deemed to be marginal (0-2 patients per night currently admitted to UHB that are repatriated the next day to Weston). • Collocating GPs within the A&E Department – impact assessment not performed due to lack of data on the proposed clinical model. • Overnight closure – impact included in baseline and hence not assessed.	280 patients
Complex Medical Patients	• Complex patients potentially requiring access to Level 3 critical care transferred to other hospitals. • Estimations based on complex medical HRGs identified by CSDDG. • Patients repatriated to Weston after 5 days if LoS longer than 5 days.	105 patients 480 bed-days 1.64 beds
Overnight Surgeries	• Patients who left an operating room between 22:00 and 08:00 assumed to be overnight surgery. • Any patients will stay in UHB up to 5 days; if LoS longer than 5 days, the patient will be repatriated to Weston	79 patients 276 bed-days 0.95 beds
Paediatric Services	• Paediatric patients classified as 16 years old or under. • Weston catchment area identified as patients living within BS20-	Transferring to Weston: <u>A&E attendances</u> 1,120 patients

	BS24 and BS40 postcodes. • Any patient travelling via ambulance between 08:00-22:00 and not admitted to hospital would be treated at Weston. • Any patients travelling by other means of transport between 08:00 and 22:00 and attending A&E minors would be treated at Weston. • 75% of General Medical Paediatric (Specialty Code 420) outpatient appointments will transfer to Weston. • 30% of short-stay emergency admission (0-1 LoS) of General Medical Paediatric patients would transfer to Weston.	Outpatients 418 appointments Short-Stay Emergency Admissions 153 patients

Table 5 below shows a total net movement of patients being transferred from and to Weston Hospital based on the proposed changes. It differs from Table 4 above, because Table 4 shows the activity shifts where one patient can represent a number of activities: for example, a patient attending A&E may represent a critical care and complex medical patient, so therefore be represented three times in Table 4 above and once in Table 5 below.

Table 5: Net movement of patients to and from Weston

Patients Treated Elsewhere		
	Annual	**Per Day**
A&E (ONC)	2,675	7.33
Critical Care	135	0.37
Overnight Surgery	79	0.22
Medical Complex Pts	105	0.29
Total Treated Elsewhere	**2,994**	**8.20**
Patient Transferred to Weston		
	Annual	**Per Day**
Paediatric (A&E)	1,120	3.07
Paediatric (Other)	571	1.56
Direct ON Admissions	900	2.47
Total transferred to WGH	**2,591**	**7.10**
Net movement	**-403**	**-1.10**

4.3 Detailed activity impact by service line

(i) Critical Care

The activity model in the PCBC has been refined in this business case by looking into primary reasons for the admission to ITU, to more accurately define the patients that would potentially benefit from transfer to UHB. Furthermore, in the PCBC, the number of bed-days was doubled as a precaution to adjust for risk-averseness about transfers, while the number of patients was not doubled. There were no similar adjustments to the volume of activity transferred applied in this business case, which explains a significant difference of patient-to-bed-days ratios identified in the PCBC and this business case.

This business case includes further modelling of the direct impact of the proposed changes to critical care on medical and surgical wards. The impact of the proposed changes to critical care has been estimated for this business case by analysing any elective and non-elective spells related to critical care spells identified for being transferred from Weston to UHB. This analysis was performed using individual hospital numbers.

To model an impact on the surgical and medical wards, the critical care sub-group agreed the following assumptions about modelling transfers of critical care patients:

- The full episode of critical care will be transferred, since it would be impossible to realistically identify a trigger point for any patients that are gradually deteriorating.
- After the critical care episode, any surgical patients will stay in UHB for up to five days to allow for post-operation observations and follow-up; if they are not discharged earlier, the patient will be transferred back to Weston after 5 days.
- After the critical care episode, any medical patients will be transferred to Weston medical wards.
- Any benefits of having access to more specialist care at UHB would outweigh any inefficiencies related with transporting the patients between sites; therefore, there will be no positive or negative impact on total LoS of patients.

The above assumptions were approved by CSDDG in June 2019.

For further assurance, the clinical members of the working group independently estimated the numbers of affected patients to be in the range of 130-150 patients using various databases, which matches the details of modelling values in Table 6 below.

Table 6: Activity transfers linked with changes to the critical care

Local Point of Delivery	Specialty	No of pts transferred	Total LoS	LoS in UHB	No of Pts repatriated	LoS in WGH
Critical care						
Critical care	-	118	521	521	75	-
No trace pts	-	17	14	14	20	-
Med/Sur Wards						
Elective Inpatient	Surgery	28	281	123	17	158
Non-Elective Inpatients	Surgery	50	670	204	35	466
Non-Elective Inpatients	Medicine	40	172	0	23	172
Total Impact	**-**	**135**	**1,658**	**862**	**95**	**796**

(ii) Complex Medical Patients

The PCBC assumed that a number of medical complex patients cannot be treated at Weston due to the reduced availability of Level 3 critical care. Despite changes in assumptions about critical care, the CSDDG recommended not to change assumptions about the medical complex patients

transferring to UHB. It was deemed that this cohort of patients would still clinically benefit from the more specialist care available at UHB.

The Complex Medical HRGs used for activity transfers in this business case are shown in Table 7 below.

Table 7: Complex medical HRGs used for activity transfers

HRG	Description
DZ11L	Lobar, Atypical or Viral Pneumonia, with Multiple Interventions, with CC Score 9-13
DZ22K	Unspecified Acute Lower Respiratory Infection with Interventions, with CC Score 9+
FZ38G	Gastrointestinal Bleed with Multiple Interventions, with CC Score 5+
GC17A	Non-Malignant, Hepatobiliary or Pancreatic Disorders, with Multiple Interventions, with CC Score 9+
GC17B	Non-Malignant, Hepatobiliary or Pancreatic Disorders, with Multiple Interventions, with CC Score 4-8
JD07F	Skin Disorders without Interventions, with CC Score 14-18
WJ06A	Sepsis with Multiple Interventions, with CC Score 9+
WJ06B	Sepsis with Multiple Interventions, with CC Score 5-8

It was assumed that patients will stay up to 5 days in UHB (after their critical care spell) after which they will be repatriated back to Weston. The above assumptions were approved by the CSDDG in June 2019. The outcome of the modelling is presented in Table 8 below.

Table 8: Complex medical patients requiring transfer out of Weston

No of pts transferred	Total LoS	LoS in UHB	No of pts repatriated	LoS in WGH
105	2,103	566	89	1,537

The activity estimates in the PCBC and this business case are respectively based on 17/18 SLAM data and 18/19 SLAM data, which has resulted in minimal differences to the numbers of affected patients and bed-days.

(iii) Overnight Surgery

As Level 3 critical care (ITU) remained available in Weston under the revised proposals, the CSDDG decided that the following PCBC assumptions would be changed in this business case:

- ASA4+ operations can still take place at Weston.
- All surgical patients that do not have an associated critical care spell can be treated at Weston.

The main recommendation of CSDDG was to stop any overnight surgeries at Weston, which results in changes to current surgical and theatre staffing and GI bleed rota.

In the activity modelling, it was assumed that any patient who left an operating room between 22:00 and 08:00 would be classified as an overnight surgery. As a result, 79 overnight operations were identified from the Weston Hospital theatre database.

It was assumed that any overnight operations will be transferred to UHB, where the patient will stay up to 5 days. If the patient is not discharged after 5 days, they will be transferred back to Weston. Table 9 below summarises the estimated impact of removing overnight surgeries.

Table 9: Overnight surgical patients requiring transfer out of Weston

No of pts transferred	Total LoS	LoS in UHB	No of pts repatriated	LoS in WGH
79	833	276	34	557

The CSDDG took the view that there might further changes to surgical departments in the future. It was expected that more complex surgical procedures will be gradually transferred to UHB as a result of a potential merger by acquisition.

(iv) Complex A&E patients

The cohort of complex A&E patients identified for transfer reflects the cumulative number of A&E attendances related to other spells of care in critical care, medicine or surgery that were identified for being transferred by the discussed above criteria.

The key assumption behind the modelling is that during A&E presentation, a decision would be made that a patient needs to be transferred as they would require overnight surgery, complex medical care or complex critical intervention. The modelling for this business case therefore identified 280 patients potentially meeting the above criteria, compared to 1,637 A&E major patients identified in the PCBC.

The CSDDG agreed that, due to the change of assumptions about critical care, the PCBC assumptions about the impact on A&E are no longer valid and agreed that 280 patients is an accurate assessment of the impact of the proposed changes to be used in this business case.

(v) Co-locating GPs within the A&E Department

This business case has not modelled the impact of this proposed change to the services. Evidence from other parts of the country has been reviewed and it is difficult to assess the impact on activity changes, with varying results described in different areas. For this reason, the clinical benefits are described but no activity assumptions are made about this element of the proposal.

(vi) Direct overnight medical admissions

The CSDDG identified 2.5 patients per day that would be suitable for direct overnight admission from a review of SWASFT records of overnight patient conveyances from the Weston area. It was assumed that these patients are currently admitted at UHB overnight and repatriated the next day to Weston. Therefore, an activity shift and impact on costs at both providers would be minimal. It was also assumed that WAHT is fully recompensed for treatment of these patients by UHB through the current provider-to-provider agreement. Therefore, no income transfers were modelled. However, an impact on transport is recognised with 1,800 journeys saved.

(vii) Paediatric Services

The PCBC suggested an investment in paediatric services to meet national standards in terms of minimal staffing levels for an A&E department receiving children across the hours the A&E is open, and to extend the availability of paediatric specialist care from 8am-6pm to 8am-10pm during the week to meet the peak in demand seen in A&E and primary care between 5pm and 9pm.

The CSDDG reviewed detailed assumptions about the actual impact of investment in paediatric medical and nursing rotas and the impact on capacity of paediatric services at Weston. It is expected that these changes would support more minor A&E attendances, as well as allow an extension of the capacity of both local ambulatory and outpatient care. The activity modelling identified any patients 16 years old or under, living within Weston Hospital's catchment area (postcodes BS20-BS24 and BS40) that currently attend UHB and T&SFT.

The key assumptions are summarised below:

- For A&E attendances, any patient travelling between 08:00 and 22:00 (14/7 model of care) via ambulance to A&E and are not being admitted to hospital can be treated at Weston under the new model of care.
- Any other patients attending A&E Minors by other means of transport between 08:00 and 22:00 can be potentially treated at Weston under the new model of care.
- Around 75% of outpatient General Paediatric appointments (Specialty Code 420) can be delivered at Weston. It was assumed that 30% of short-stay emergency admissions (0-1 LoS) can be treated in Weston due to increased hours available for clinical observation into the evening.
- The changes were assessed as materialising over a two-year period.

Table 10 below summarises the results of the modelling for transfer of service from UHB. An initial analysis of TST data showed that the change would be immaterial to the Trust.

Table 10: Increase in patients treated at Weston under proposed paediatric model

Service	2018/19 Activity	Year 1	Year 2
Outpatients	555	222 [40%]	418 [75%]
A&E Attendances	2,555	539 [21%]	1,120 [44%]
Short Stay Emergency Admissions [0-1 day]	457	44 [10%]	153 [33%]

(viii) Transport

Each of the proposed changes will have a different impact on number of transfers as presented in Table 11 below.

Table 11: Impact of model of care on patient transport

	Critical Care	Direct ON Adm.	ON Surgery	Complex Medical Pts	Paeds	Total
Weston to UHB	135	(900)*	79	105	(250)	**(831)**
UHB to Weston	95	(900)	34	89	-	**(682)**
TOTAL	**230**	**(1,800)**	**113**	**194**	**(250)**	**(1,513)**

*Reduced time from SWASFT perspective – 35 minutes per journey.

Although transfers of care related to changes in critical care, overnight surgery and complex medical patients increase the number of transports, there are significant benefits from direct

overnight admission pathways and investment in paediatric services. This means that, overall; the proposed changes reduced the net number of transfers between the two hospitals.

5. Financial Impact Assessment by Stakeholder

5.1 Impact on WAHT

The impact assessment for Weston Hospital results in changes to critical care, surgery and paediatric services. It is assumed that any other changes to activity are marginal, so they would result only in reduction of income and direct non-pay. Table 12 below summarises the changes for Weston.

Table 12: Impact of proposed changes to WAHT

	Critical Care	Impact of CC on Wards	Adult A&E	Direct ON Adm.	ON Surgery	Comp. Medical Pts	Paeds	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Income	(786)	(657)	(59)	-	(427)	(841)	339	**(2,433)**
Pay								
Medical	(40)	-	-	-	120	-	(87)	**(7)**
Nursing	500	-	-	-	-	-	(134)	**366**
Other	-	-	-	-	55	-	-	**55**
Non-pay	131	293	4	-	48	21	(50)	**448**
Surplus/ (Deficit)	**(195)**	**(364)**	**(55)**	**-**	**(204)**	**(820)**	**68**	**(1,571)**
Activity	(535)	(118)	(280)	-	(79)	(105)	1,691	**574**
Capacity (Beds)	(1.00)	(1.12)	-	-	(0.95)	(1.64)	-	**(4.71)**

Currently, critical care at Weston consists of five ITU (Level 3) beds. The new proposed model is to close one bed, and downgrade two beds from ITU (Level 3) to HDU (Level 2) status. This would mean that the required nursing rota will reduce by 8.2 WTE, saving £500k including premium agency costs.

Discontinuation of any overnight surgeries will result in changes to overnight nurse staffing associated with theatres and the medical GI bleed rota. Surgical medical rotas will remain in place to allow for local assessment and decision-making for surgical and medical inpatients that deteriorate during the overnight period on the hospital wards. This results in cumulative savings of £175k on staffing costs.

The proposal to extend paediatric cover within the ED to match the A&E opening hours from 08:00-22:00 and meet national standards increases pay costs by £221k. The proposed model assumes increasing the medical rota by 0.7 WTE and nursing rota by 3.61 WTE. Additional paediatric staff will also support the Seashore Unit to enable transfer of outpatient activity and short-stay emergency admissions from UHB. Details are included in Table 13 below.

Table 13: Staffing requirements for proposed paediatric model

Paediatric Services in WGH	WTE
Medical Consultant	0.70
Nurse Band 6	2.15
Nurse Band 5	0.28
Nurse Band 3	1.18

5.2 Impact on UHB

An impact assessment for UHB shows that the Trust can absorb the majority of activity at the marginal costs as summarised below. The only major changes to staffing are the dedicated critical care transfer team, and the critical care and agency nursing required to absorb additional complex medical patients.

Table 14: Impact of proposed changes to UHB

	Critical Care	Impact of CC on Wards	Adult A&E	ON Surgery	Comp. Medical Pts	Paeds	Trans. Team	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Income	785	683	61	440	865	(348)	-	**2,486**
Pay								
Medical	-	(15)	-	(12)	(29)	-	(129)	**(185)**
Nursing	(437)	(19)	-	(12)	(76)	-	(103)	**(645)**
Other	(87)	(8)	-	(3)	(32)	-	-	**(130)**
Non-pay	(179)	(34)	(1)	(27)	(56)	73	-	**(224)**
Surplus/ (Deficit)	**83**	**607**	**60**	**386**	**672**	**(275)**	**(232)**	**1,300**
Activity	535	118	280	79	105	(1,690)	-	**(573)**
Capacity (Beds)	2.00	0.70	-	0.89	1.64	-	-	**5.23**

UHB will make a net surplus of £83k due to changes in critical care. UHB is also expected to host the dedicated transfer team, which will facilitate any upgrades in care from Weston to UHB between 10:00 and 22:00 seven days a week. Details of required staffing model are presented in Table 15 below.

Table 15: Staffing requirements for dedicated transfer team

Dedicated critical care transfer team	WTE
Medical/Intensivist Registrar (ST3-8)	1.75
Specialist ITU Nurse (Band 6)	2.15

It should be noted that premium costs have been removed from WAHT as a result of the critical care changes but that substantive rates have been included in costing the transfer team. If substantive staff cannot be recruited there is a risk that UHB costs will be higher.

UHB assumes that they will need to hire additional agency nursing to provide additional care for complex medical patients and other patients transferring to UHB. However, no additional staffing is

required to absorb the additional A&E activity. Finally, there are no changes to the paediatric staffing level assumed related to the loss of activity resulting in a deficit of £275k.

5.3 Impact on SWASFT

It is expected that SWASFT would benefit from the reduction in number of patients being conveyed to UHB. Table 16 below presents a detailed impact of proposed changes on SWASFT.

Table 16: Impact of the proposed changes to SWASFT

	Critical Care	Direct ON Adm.	ON Surgery	Complex Medical Pts	Paeds	Total
WGH to UHB	(10)	(900)	9	-	(250)	**(1,151)**
UHB to WGH	-	-	-	-	-	**-**
Total Journeys	**(10)**	**(900)**	**9**	**-**	**(250)**	**(1,151)**
(Cost)/Benefit £'000	**3**	**76**	**(2)**	**-**	**63**	**139**

First, due to enabling direct medical overnight admissions, SWASFT will reduce the number of journeys from Weston to Bristol. This would result in estimated benefits of £76k per annum. This represents 900 patients being conveyed overnight to Weston rather than UHB.

Second, due to investment in paediatric services, SWASFT will reduce the number of journeys for paediatric patients from Weston to UHB resulting in a benefit of £63k per annum. It represents a reduction of 250 fewer paediatric patients being transferred via ambulance from Weston to UHB.

Finally, it is expected that the critical care transfer team will facilitate the ongoing critical care transfers from Weston to other hospitals (equating to roughly 10 per year). However, this benefit would be offset by emergency overnight transfers from Weston to UHB due to the closure of theatres (estimated to be circa 9 per year).

It is expected that SWASFT would reinvest this benefit into providing additional capacity to meet a growing demand. Therefore, it should be considered as a system benefit.

5.4 Impact on other transport services

It is expected that a PTS provider would be responsible for delivering the majority of transfers and repatriation. The total number of additional patient transfers (including repatriations) equates to 537. This represents an additional cost to the system of £137k. However, it is offset by a reduction in the number of patients repatriated from UHB to Weston due to direct overnight admissions. It is assumed that this number will reduce by 900 equating to a reduction in costs of £229k. As a result, a net impact on the PTS provider is a reduction in cost of £92k. Details are available in Table 17 below.

Table 17: Impact of proposed changes on other transport services

	Critical Care	Direct ON Adm.	ON Surgery	Complex Medical Pts	Paeds	Total
WGH to UHB	145	-	70	105	-	**319**

UHB to WGH	95	(900)	34	89	-	**(682)**
Total Journeys	**240**	**(900)**	**104**	**194**	**-**	**(363)**
(Cost)/Benefit £'000	**(61)**	**229**	**(26)**	**(49)**	**-**	**92**

5.5 Impact on BNSSG CCG

There is a marginal impact of the proposed changes on the BNSSG CCG financial position. All changes are related to different Market Forces Factors (MFF) of WAHT (1.050322) and UHB (1.080284). That is, any activity transferring from WAHT to UHB would be slightly more expensive (around 3%) and vice versa. The table below summarises the impact on BNSSG CCG by POD. The total impact on the CCG position would be an additional cost of £52,630.

Table 18: Impact of proposed changes on BNSSG CCG

	Critical Care	CC Impact on Wards	A&E	ON Surgery	Complex Medical Patients	Paeds	Total
	£'000	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Surplus/ (Deficit)	1	(25)	(2)	(12)	(24)	9	**(53)**

5.6 Productivity benefits to the system

It is expected that the changes will result in a length of stay reduction saving 538 bed-days per annum to the system. The three main factors are benefits related to more specialist care available to transferred critical care patients (88 bed-days) and reducing delays in treatment due to direct admissions (450 bed-days).

It is not expected that either of the providers would be able to realise these costs, but there will be an additional capacity created in the system. The value of this additional capacity was estimated using an average cost per excess bed-day in 19/20 that equates to £270 per bed-day. As a result, the total value of additional financial benefits related to length of stay is £145k. The full list of benefits, their value and assumptions behind calculations are presented in Table 19 below.

Table 19: Productivity benefits of Healthy Weston proposals

Productivity Benefit	Impact	Financial Value	Assumptions
Critical care			
Cardiac Patients	20 bed-days saved	£5,400	Based on actual 18/19 patients that waited for specialist input while under care of Weston's critical care unit
Hepatobiliary Patients	40 bed-days saved	£10,800	
Thoracic Patients	3 bed-days saved	£810	
Renal Patients	10 bed-days saved	£2,700	
Neurology Patients	15 bed-days saved	£4,050	
Direct ON Admissions			
All medical patients	450 bed-days saved	£121,500	Currently, the stable medical patients admitted to UHB overnight and repatriated within

			12 hours from an admission.
TOTAL IMPACT	**538 bed-days saved**	**£145,260**	**-**

There is also an additional benefit of £76k related to the dedicated critical care transfer team supporting critical care services at UHB during the time not utilised on patient transfers. It was estimated based on the idle time costs between transfers.

6. Comparison of financial impact with PCBC

The PCBC identified a potential saving to the system of £4.1m that was identified as per Table 20 below.

Table 20: System financial impact in the PCBC

Proposed Change	Financial impact on WAHT	Financial Impact on other providers	Net Impact	Rationale and Assumptions
Activity transfers due to changes in Critical Care	(£0.9m)	£0.8m	(£0.1m)	Transfer of activity results in transfer of income, variable and semi-variable costs, while the fixed costs remain constant. Consequently, the transfer of activity has a negative impact on WAHT's bottom-line by removing contribution to their fixed costs. Other providers benefit from increased additional contribution to their bottom line.
Integrated Frailty Service (IFS)	(£0.4m)	-	(£0.4m)	It is an outcome of two changes: • Introduction of IFS enables reduction in cost of A&E attendances by £0.4m due to changes in emergency care model (patients being redirected to Frailty Unit) • Introduction of IFS results in the non-elective admissions, which removes income, variable and semi-variable costs at WAHT. Consequently, WAHT's bottom-line is worse-off by £0.8m due to lost contribution to the fixed costs.
Agency costs reduction	£0.8m	-	£0.8m	It is expected that the primary reduction in variable and semi-variable costs will be by reducing the agency staffing costs (both nursing and medical). As a result, any reduction in direct costs would be disproportional to the activity reduction.
New model of emergency care	£5.0m	-	£5.0m	It is expected that the majority of A&E demand will be transferred to UCC and out-of-hours, which would result in the significant costs reduction for WAHT that would remain a provider of these services.
Increasing efficiencies	-	-	-	Reduction in LoS is included in the baseline forecast for WAHT's financial position in the

(reduction in LoS)				future. Consequently, it is not included in the estimation of the financial impact. However, if these assumptions are removed from the model, it worsens a baseline deficit by £1.1m.
Transport	-	(£1.2m)	(£1.2m)	Cost of patients being transported by SWASFT between both sites based on identified activity transfers.
TOTAL	£4.5m	(£0.4m)	£4.1m	

The main difference between this business case and the PCBC is change in the modelling surrounding urgent care and the exclusion of any impact from the Integrated Frailty Service. The former is considered to be included in the long-term plan under the wider umbrella of the Healthy Weston Programme. The latter is presented as a key interdependency, but out of the scope of the decision on the proposed changes to the hospital model of care. A further difference is that this business case brings in the cost of re-opening A&E overnight, which was not included in the PCBC due an assumption that the financial benefit was already included in the baseline. This is deemed to be of importance to the CCG Governing Body's decision because if the recommendation on the proposed changes is not accepted a return to the commissioned 24/7 A&E operating model would be required.

7. Capital costs

Due to marginal changes in activity, the only capital costs related to the above changes would be related to opening two additional critical care beds at UHB. However, these capital costs are part of the wider case for investment in critical care development at UHB with a potential to increase capacity by further five to ten beds. UHB have therefore accepted this cost within their strategic capital planning and a system impact is not presented.

Digital developments are costed within the UHB digital convergence project to support the WAHT/UHB merger. This is funded via central NHS funding.

The remaining changes are considered too small to require capital investment at UHB. Due to the overall number of patient transfers reducing and the increase in funding received by SWASFT as a result of the temporary overnight closure of A&E in 2017, there is also no need to make any capital investment in ambulance services.

8. Conclusions

The financial impact of the proposed changes needs to be broken down into three parts. If the decision was made to not make the temporary overnight closure of A&E at Weston Hospital permanent, it would result in additional cost of £3.8m. The net saving from the other proposed changes would be £128k, which would require an annual investment of £459k from the system to sustain them against an overall benefit of £589k. Therefore, the proposed changes to the model of care are financially viable, resulting in a net benefit to the system of around £3.9m as detailed by Table 21 below.

Table 21: Total net impact to the system of proposed model of care

	Financial Impact £'000
Additional costs saved	
Permanent overnight closure of A&E	3,800
Total additional costs saved	**3,800**
Recurrent annual investment	
Impact of activity transfers on providers	(38)
Impact of activity transfer on CCG	(53)
Dedicated Transport Team	(337)
Remaining transport costs	(31)
Total recurrent annual investment	(459)
Recurrent system-wide benefits	
LoS efficiencies	145
Other provider's efficiencies	76
SWASFT additional capacity	139
Other transport benefits	229
Total recurrent system-wide benefits	**589**
TOTAL NET IMPACT	**3,929**

NHS
Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Group

Appendix 7: Equalities Impact Assessment for the Healthy Weston Programme

Shaping better health

Healthy Weston: Equalities Impact Assessment

This Equalities Impact Assessment (EIA) builds upon the initial screening EIA that was published as part of the Healthy Weston Pre-Consultation Business Case.

Further information on the feedback received during the consultation that has been used to inform this Equalities Impact Assessment can be found in Appendix 3.

Background

Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group (BNSSG CCG) has been working over the past 2 years with clinicians and other health professionals, partner organisations, people, carers and members of the public from across BNSSG and North Sedgemoor to develop a series of proposals that seek to address the issues set out in our Case for Change, published in October 2018. This programme of work is called **Healthy Weston** and has been designed by senior doctors and other clinicians, with consistent and extensive engagement with members of the public.

The clinical design work undertaken in 2018 culminated in a preferred option for change at Weston Hospital. Regulatory bodies (South West Clinical Senate, NHS England) have been fully engaged with the Programme, and have given assurance to the process and the preferred option for the hospital model as the first step in the context of longer term service redesign that will need to take place across the system in the next 3-5 years as part of the NHS Long Term Plan to meet the changing needs of the population and address all components of the case for change.

A public consultation exercise took place in the spring of 2019 to engage with the local population and gather feedback on the preferred option for the acute hospital model, the wider changes to health services that are being progressed and the vision for the longer-term future of healthcare in the Weston area.

Recommendations to Governing Body

The recommendations to Governing Body for decision are summarised below and more detail is available in Section 3 of the Decision-Making Business Case:

- Deliver 24/7 urgent and emergency care in a different way for the local population, combining this with suggestions from the hospital consultants about improved systems and processes. The proposed model includes making the temporary overnight closure of the Emergency Department at Weston Hospital permanent, and increasing the number and range of people that can be directly admitted to a ward and access also diagnostic tests overnight.

- Develop strong networked support with UHB to deliver a more integrated critical care service. This will include retention of two Level 3 beds on the Weston Hospital site for people requiring single organ support. A new specialist team would manage the transfer of more complex cases to Bristol. Once people have completed that element of their treatment, they would be repatriated back to Weston Hospital for the remainder of their spell.

- Provide emergency surgery in the daytime only at Weston Hospital, closing theatres from 8pm to 8am. Ambulatory pathways for emergency surgery will be established in the day time to improve the quality and responsiveness of the surgical service at Weston Hospital.

- Additional paediatric expertise to be made available 7 days a week to enable a better match to demand and to prevent unnecessary transfers of cases to Bristol Royal Children's Hospital.

The feedback used to evidence this Equalities Impact Assessment is based on the hospital model that was consulted on. The consulted model and the model recommended to Governing Body are sufficiently aligned for the evidence used to be relevant, and any changes made to the model do not materially negatively impact on the equalities considerations outlined at the Pre-Consultation Business Case stage or in this impact assessment.

Equality Legislation

The Equality Act (2010), which came into force in April 2011, replaces existing anti-discrimination laws with a single act. It aims to help public authorities avoid discriminatory practices and integrate equality into their core business.

The CCG is also subject to the Public Sector Equality Duty. Section 149 of the Equality Act places an additional set of requirements upon public bodies, known as the Public Sector Equality Duty. This is made up of a general equality duty which is supported by specific duties.

The general equality duty requires public authorities, in the exercise of their functions, to have due regard for the need to:

- Eliminate discrimination, harassment and victimisation and any other conduct that is prohibited by or under the Act;
- Advance equality of opportunity between people who share a relevant protected characteristic and people who do not share it;
- Foster good relations between people who share a relevant protected characteristic and those who do not share it.

In addition, the NHS Constitution (Principle 1) states that the NHS has “a wider social duty to promote equality through the services it provides and to pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population”. With this in mind, health inequalities due to economic and social deprivation have been included as part of this analysis.

Population and demographics

The following section provides an overview of the demographics and the local population of North Somerset, and the catchment area of Weston Hospital.

Local Population

The current catchment population of Weston Hospital as defined by the registered population of referring GP practices is approximately 157,000 - living in a mix of urban and rural areas. The population across the catchment area is expected to increase by approximately 0.8% 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.

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 parts of North Somerset can expect to live ten years longer than a baby born in the most deprived areas. 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%.

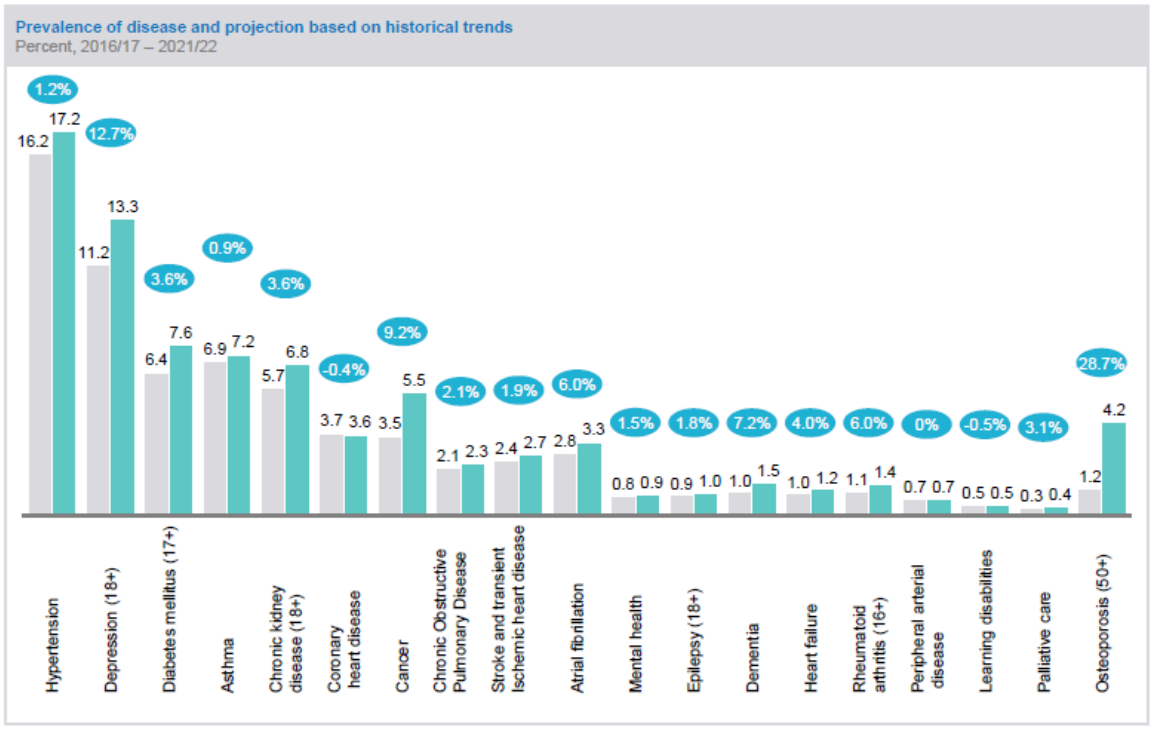
Disease and Condition Profile

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 socio-economic status.

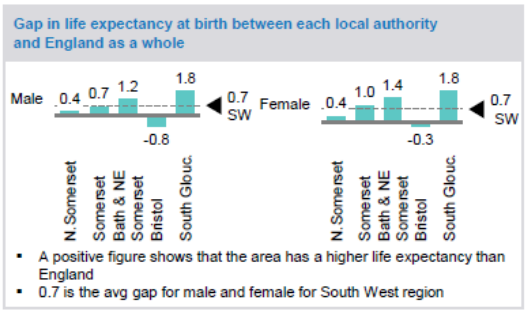
Over time, there are expected to be increases in the prevalence of several chronic conditions with particularly sharp increases in depression, diabetes mellitus, chronic

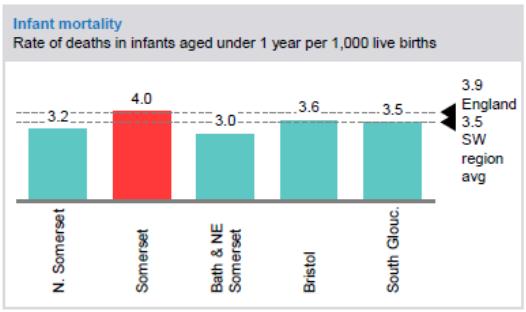
kidney disease, cancer, atrial fibrillation, dementia, heart failure, rheumatoid arthritis and osteoporosis as outlined below:

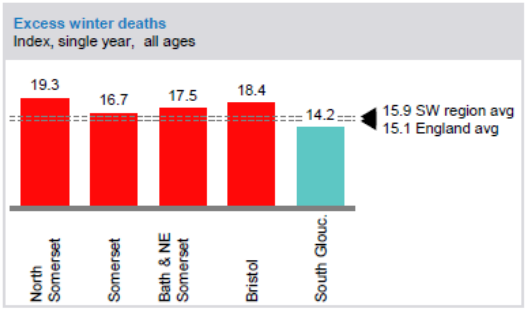


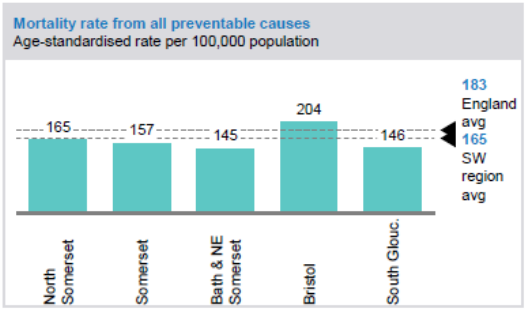
Variations in mortality, life expectancy and preventable death indicators

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.



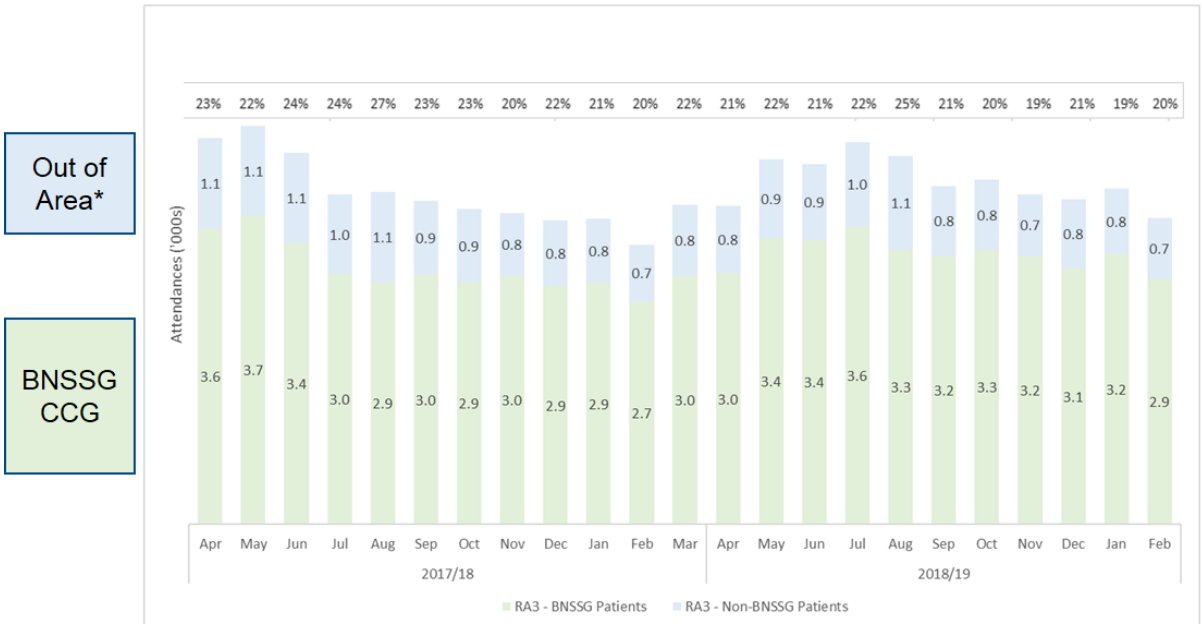






The overall population served by Weston Hospital is older than the England average, with 20% of people projected to be over 70 years of age by 2025. Older people are more likely to have a long-term health condition or experience health problems due to frailty.

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:



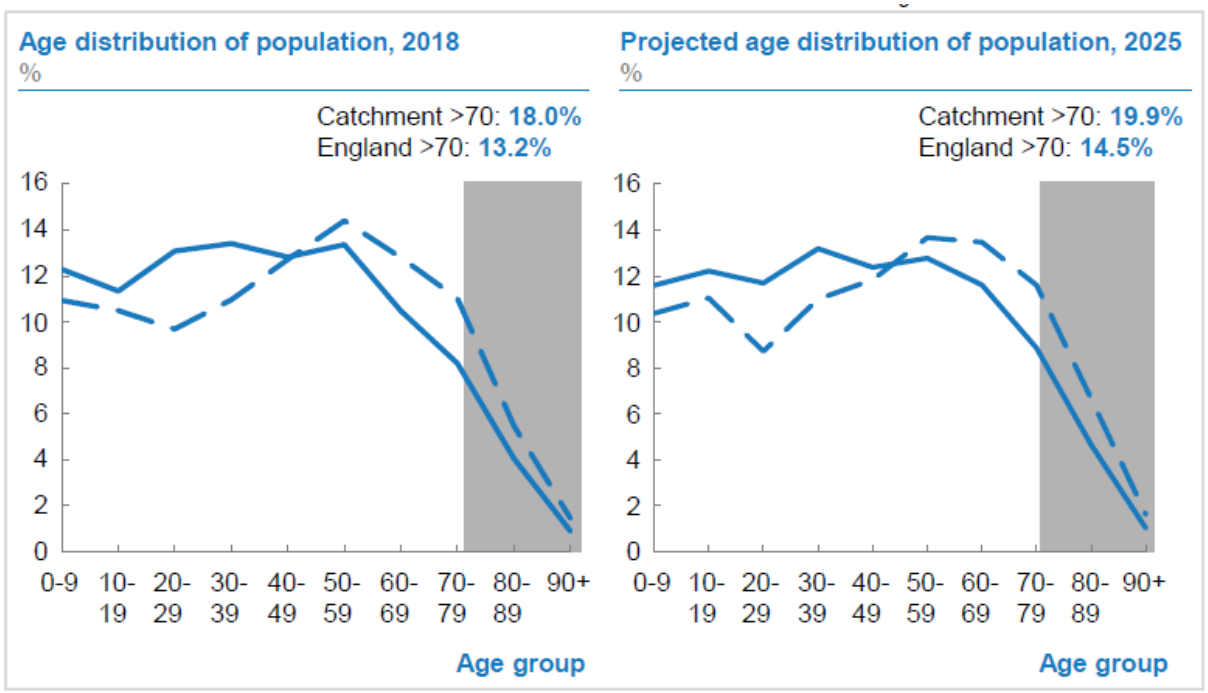
Age

Age is one of the most critical factors in planning the healthcare for Weston, Worle and the surrounding areas. The population served by Weston Area Health Trust (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.

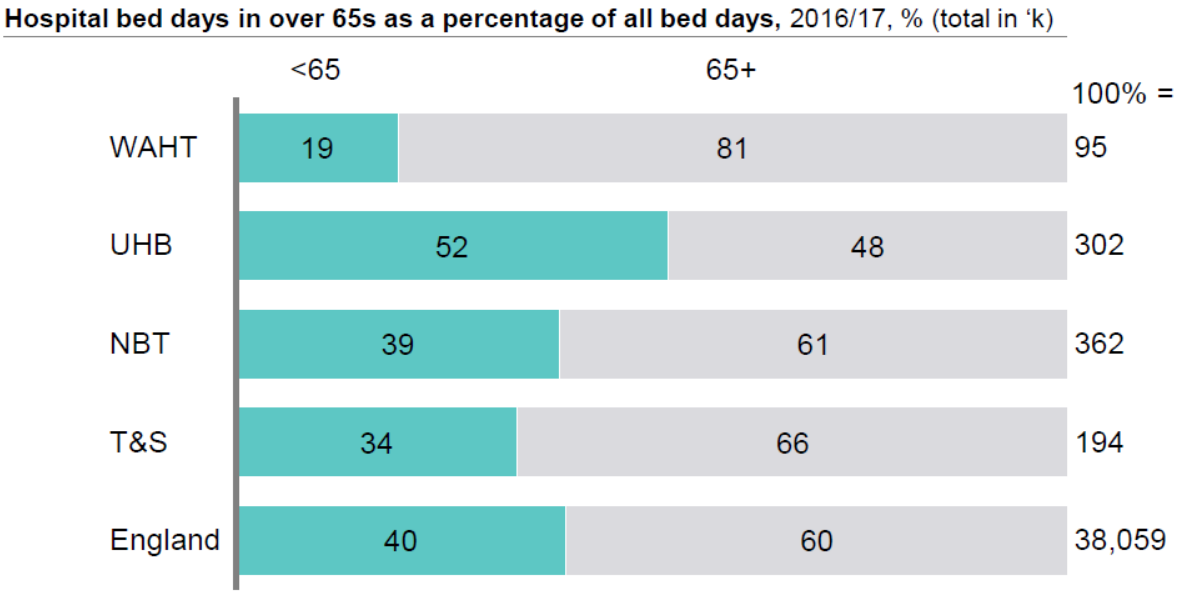
In addition, the 65+ population of North Somerset as outlined below is proportionally greater than other areas in the region.

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 Weston Hospital than for neighbouring Trusts, as shown below:



WAHT: Weston Area Health Trust
UBH: University Hospitals Bristol NHS Foundation Trust
NBT: North Bristol Trust
T&S: Musgrove Grove Park Hospital (Taunton and Somerset NHS Foundation Trust)

Although Weston has 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 Weston Hospital catchment area, and planned new housing developments are likely to attract a growing number of young families.

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 83.1 years, whereas men have seen a small but steady increase from 78 to 79.4 years. Life expectancy in the region is 84.2 years for women and 79.9 years for men.

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.

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 Practitioner 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).

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.

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.

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 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.

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.

Impact Assessment Methodology

The Healthy Weston has followed the below established steps to develop this Equalities Impact Assessment.

Time Period	**Activity**
October 2017 - March 2018	Initial engagement activity with population.
October - November 2018	Desktop exercise to map demographic and disease profile of hospital catchment area.
November 2018	Seminar to identify groups that may be affected by proposed changes.
December 2018	Review by CCG Equalities Lead established relevance to public sector equality duty.
December 2018 - January 2019	Initial Equalities Impact Assessment informs consultation activity.
January 2019	Initial Equalities Impact Assessment received NHS England assurance and published as part of Pre-Consultation Business Case.
February 2019 - June	Consultation targets specific groups identified as more likely

2019	to experience adverse impact due to proposed changes.
June 2019 - September 2019	Feedback from consultation used to inform Decision-Making Business Case.
September 2019	Seminar with key expert stakeholders to share analysis and validate mitigations.

The equalities assessment undertaken at the pre-consultation stage identified older people, people with disabilities and long term health conditions, parents with children under five and people experiencing economic and social deprivation as potentially experiencing a disproportionate adverse impact due to the proposals.

The Healthy Weston Programme team therefore planned and undertook a greater level of in-depth engagement with these specific groups as part of the consultation, to better understand the potential impact of the proposals and develop appropriate mitigations.

This included outreach with community groups, including facilitated discussions at existing community meetings, bespoke discussions and drop-in sessions. As part of this work we engaged with the following local groups and organisations, among others:

1. Addaction
2. Senior Community Links
3. Speaking Up Learning Disability Forum for service users
4. Somewhere to Go support centre for rough sleepers and disadvantaged, vulnerable adults
5. Mental Health carers group
6. Vision North Somerset hosting a disability forum for North Somerset
7. Citizens Advice Bureau
8. Oldmixon Family Centre (children's centre)
9. Corporate Gypsy and Traveller Group
10. Moorland Park Residential Mobile Home and Caravan Park
11. Weston College targeting young people.

In addition, the CCG commissioned further qualitative research to better understand the experiences and views of the identified groups in relation to the proposals. The research agency recruited to and conducted a series of focus groups, paired depth (interviews with two people) and one-to-one interviews as part of the consultation.

The feedback gathered through this targeted work - which engaged in excess of 130 people from the groups identified - as well as the feedback received through the broader consultation, has informed the further development of the impact rating and potential mitigations outlined in the following section.

In September 2019, the CCG ran a workshop with key members of the local community who are experts in working with groups identified as likely to experience an impact on access to healthcare services as a result of the changes. The workshop included representatives from:

- Addaction
- Alzheimer's UK
- Citizen's Advice
- Healthwatch
- North Somerset Council social care representative for sensory impairment
- North Somerset Council Public Health representative
- North Somerset Council People and Communities Board representative.

The CCG shared the challenges that had been identified through the consultation activity and the mitigations that have been developed. This was to validate the mitigations, check that they were realistic and to identify any gaps in both the challenges and the mitigations. The workshop also offered a number of recommendations on how the mitigations could be implemented. The conclusions of this workshop are fed into the Impact Assessment and Mitigation section below.

Consulting Accessibly

The CCG made a firm commitment to consulting accessibly in order to remove barriers to full participation in the public consultation.

- The CCG sought to engage with all sections of the community through the public consultation, and made reasonable adjustments to ensure that information was available to everyone in accessible formats. In order to do this, the CCG ensured that all information was readily available in paper form in locations around the catchment of the hospital and information was regularly updated on the Healthier Together website and through social media channels
- People could attend one of 10 public events in a range of areas across Weston, Worle and the surrounding villages.
- There were opportunities for members of the public to speak to our staff about the consultation at a range of pop-up events in the community; for example in shopping centres, Weston Hospital foyer and garden centres
- The CCG phone line was well advertised as part of the range of ways to feedback on the consultation. A 'Facebook Live' event took place in partnership with the local press so that people could put their online questions directly to a Weston GP. People could complete an online or paper-based survey to give views on the proposals.

- Consultation booklets and questionnaires were distributed to a wide range of community settings including GP surgeries, libraries, community centres, council offices, and through local voluntary groups
- An easy read version of the consultation document was made available to download from the website, and in hard copy at public events.
- 100 easy read versions of the consultation document were sent to local Gypsy and Roma traveller sites.
- Access requirements were requested as part of the registration at every public event so that adjustments could be made accordingly.
- A hearing loop was available at all public events.
- British Sign Language interpreters were provided at public events when requested.
- A full easy read presentation and discussion event was provided for groups of people with a learning disability.
- Tailored engagement activity was provided for young people, in partnership with Weston College.
- People could request materials in alternative languages and formats, and that this was made clear in all printed materials and the website.
- An audio version of the consultation summary document was made available on the website.
- A subtitled explainer animation and ‘vox pop’ style videos with clinicians were made available on our website and promoted via social media channels; all signposting to ‘ways to have your say’.
- Community groups were contacted specifically, both to attend public meetings and to make offers of outreach and updates from Healthy Weston Programme staff.

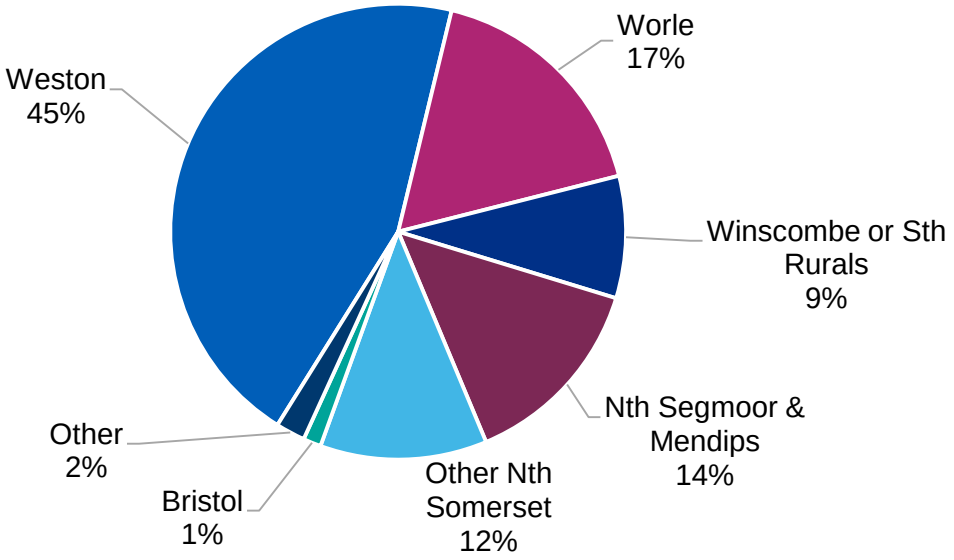
Consultation Summary

The public consultation requested feedback on the proposals for three aspects of acute care at Weston Hospital (A&E and urgent care, emergency surgery and critical care), the wider developments and the vision for the longer term future of healthcare in the Weston area.

There were 2,366 responses in total, representing over 3,100 people who were a mix of members of the public, people working in health and social care, organisations and interested parties such as councillors and MPs.

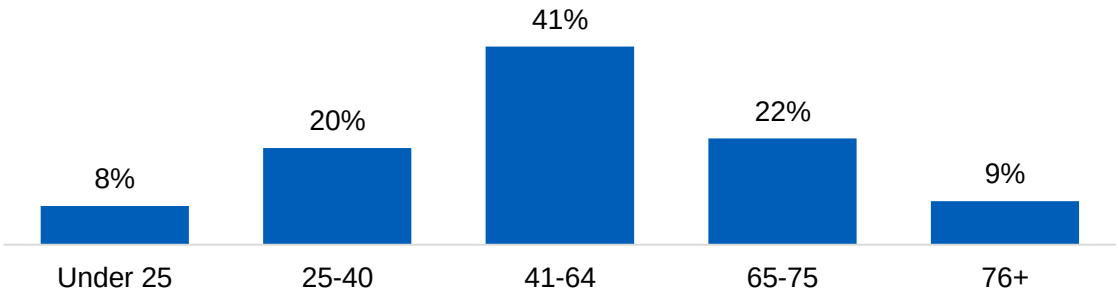
There was feedback from across the geography that Weston Hospital serves and the independent door-to-door interviews that were commissioned ensured that the population that responded was representative of the demography of the area.

Response by Area (1731 responses)



Characteristics of Individuals (2213 responses)

- Where **gender** was known, 40% were men, 60% women and fewer than1% from people who define themselves in another way
- Where **age** was known the breakdown was as follows:



- Where **ethnicity** was known 2% were from people who identified as Asian or Asian British, 1% Black or Black British, 96% White, 1% mixed and fewer than1% other ethnic groups
- 18% of responses were from people who had a **long term physical or mental health condition**
- 11% of all responses said they **cared for someone with a health condition**
- 6% of responses were from someone who said they were **disabled**
- 8% of responses were from a **parent of caregiver of an under 5 year old** and 15% were a **parent of caregiver of a 5-16 year old**
- 7% of those who took part in face to face interviews were from **economically deprived or socially deprived areas**

- 79% of those who took part in face to face interviews, the demographically representative sample, said they had **visited a GP in the past year**, 54% had **visited an NHS hospital in the past year** and 24% had **used community services in the past year**.

Impact Assessment and Mitigation

Protected Characteristic	Impact Rating	Reason for Impact Assessment Rating	Suggested Mitigation to Challenges
Age [e.g: children, young adults, working age adults, older people 60+]	Amber	Through the consultation the CCG have identified the following potential impacts as a result of the proposals: 1. It is expected that children would benefit from the proposals due to the increase in paediatric specialist cover that would mean fewer journeys to Bristol and Taunton. 2. Families with young children could also find it challenging to travel to neighbouring hospitals between 22-08.00 due to the overnight closure. 3. It is expected that frail older people will benefit from the integrated frailty service that will be delivered from the hospital in Weston and in the community, close to where people live. 4. Older people with mobility issues may experience difficulties travelling to and from	These challenges relate to transport in particular, and the ability of patients to travel home from Bristol or Taunton after receiving treatment; or for friends and relatives visiting loved ones at different sites. The proposed mitigations seeking to address these issues are as follows: 1. Repatriating patients who start treatment in a neighbouring hospital and who require an extended length of stay, and could recover well at Weston General Hospital. 2. Establishing pathways for patients to be directly admitted to Weston Hospital by paramedics and via GP referral at night, thereby minimising the need to travel to neighbouring hospitals for treatment. 3. Promoting the BNSSG integrated urgent care service that is delivered through 111 and out of hours GP services to the local population; to avoid unnecessary trips to neighbouring hospitals. 4. Improving access to information through promoting the transport support services that are available including patient transport, the

Protected Characteristic	Impact Rating	Reason for Impact Assessment Rating	Suggested Mitigation to Challenges
		neighbouring hospitals due to the closure of A&E at night. There could be a negative impact due to difficulties in travelling home after receiving treatment. This may also affect the friends and families of the older population who may experience obstacles in visiting relatives in neighbouring hospitals. The issue of older and more vulnerable members of the community being discharged at night from a hospital in Bristol or Taunton was raised throughout the consultation. This could be especially challenging for older people with dementia.	Healthcare Travel Costs Scheme and community transport providers. 5. Improving hospital policies by recommending to providers through the CCG's commissioning rounds that they do not discharge more vulnerable members of the community including the frail elderly at night following attendance at A&E. 6. Developing a Transport Strategy by working together with the West of England Combined Authority, North Somerset Council and partners from across the Sustainability and Transformation Partnership to develop an Integrated Transport Programme that will join up transport planning, commissioning and service delivery between the regional transport commissioners and the healthcare system. 7. Continuing to progress the development of the integrated frailty service that will provide healthcare to the frail elderly population to avoid hospital admissions. This will also provide support with admission and discharge when admission occurs. The integrated frailty service will provide healthcare in the community and at Weston Hospital. 8. Progress the development of primary care

Protected Characteristic	Impact Rating	Reason for Impact Assessment Rating	Suggested Mitigation to Challenges
			networks at a local level that will provide some services that people have historically sought from A&E through primary care with Community Same Day Urgent Care. 9. The CCG will lead a piece of communications work that will seek to reassure people about the impact of travel time and encourage patients to seek help through the most appropriate channels.
Disability (including long term health conditions)	Amber	The proposed changes would have a different impact on people depending on their disability. Through the consultation the CCG identified the following potential impacts on people with a disability: 1. The Integrated Frailty Service will support people who are disabled due to their age and frailty to stay well and avoid unnecessary hospital admissions and for people who are admitted, to be discharged into the community safely and with the necessary support. 2. People with any disability	1. Promote the use of patient transport services that the CCG commissions to support people who have a medical condition that means they cannot use other transport or who need support of trained staff or equipment on their journey. 2. Work with existing networks and support groups to communicate to people with sensory impairments any service changes. 3. Work with existing networks and support groups to promote the support available to people with disabilities to access the transport support that is available under existing schemes. 4. Through commissioning rounds the CCG will be recommending to providers that they do not discharge more vulnerable members of the community including people with

Protected Characteristic	Impact Rating	Reason for Impact Assessment Rating	Suggested Mitigation to Challenges
		including long term physical and mental health conditions may find the additional travel required to and from neighbouring hospitals at night challenging. 3. People with a disability will benefit from improved access to primary care including GP appointments, 111 and out of hours appointments. 4. People with a longer term health condition will benefit from developments in primary care and greater integration of healthcare services. 5. People with sensory disabilities may experience difficulties finding out about service changes.	disabilities at night following attendance at A&E. 5. Work together with the West of England Combined Authority, North Somerset Council and partners from across the Sustainability and Transformation Partnership to develop an Integrated Transport Programme that will bring joined up transport planning, commissioning and service delivery between the regional transport commissioners and the healthcare system.
Sexual orientation	Green	There is no evidence to suggest that the proposal will disproportionately affect this group.	No mitigation required at this stage. If new information becomes available this will be reviewed.
Gender reassignment	Green	There is no evidence to suggest that the proposal will disproportionately affect this group.	No mitigation required at this stage. If new information becomes available this will be reviewed.

Protected Characteristic	**Impact Rating**	**Reason for Impact Assessment Rating**	**Suggested Mitigation to Challenges**
Sex	Green	There is no evidence to suggest that the proposal will disproportionately affect this group.	No mitigation required at this stage. If new information becomes available this will be reviewed.
Religion and belief	Green	There is no evidence to suggest that the proposal will disproportionately affect this group.	No mitigation required at this stage. If new information becomes available this will be reviewed.
Pregnancy and maternity	Green	There is no evidence to suggest that the proposal will disproportionately affect this group.	No mitigation required at this stage. If new information becomes available this will be reviewed.
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 new information becomes available this will be reviewed.

Although not a protected characteristic the CCG identified people experiencing economic and social deprivation as potentially experiencing a disproportionately negative impact as a result of the changes due to the increased travel. The potential negative impact for patients would be expected to materialise by patients experiencing difficulties travelling home after receiving treatment in a neighbouring hospital at night due to the changes in A&E opening hours, and the challenges for friends and family visiting people who are receiving treatment in a neighbouring hospital. A further unknown potential impact is that people may not access healthcare because they fear that it will result in a costly journey outside of their immediate area. Relevant mitigations are outlined below under travel and transport.

It should also be noted that the changes proposed, including the wider interdependencies, will reduce the variation in access to high quality care for the local population and therefore help to reduce health inequalities in the area.

Travel and Transport

Travel and transport has been the main concern raised by people through the equality impact assessment framework that has enabled the CCG to better understand how the proposals will potentially impact on the local community. The CCG set up a Travel Working Group to best understand the concerns of people and how the CCG can best work with local partners to design mitigating actions.

The Travel Working Group focused on patient and visitor experience and met to consider the following:

1. The evidence that was presented in the Pre-Consultation Business Case
2. The likely travel impact on people and visitors of the proposals
3. Possible mitigations to support people to access healthcare.

This group considered the evidence that was presented as part of the consultation on the implications of travelling to neighbouring hospitals for people and visitors and to provide recommendations for the future. In addition to members of the public, representatives of the following organisations attended:

Table 1: Travel Working Group attendees

Organisation	Areas of Speciality
Alzheimer's Society	Representing Carers
Cheddar Parish Council	Representing people from north Sedgemoor

E-Zec	Patient transport provider
First Bus	Local bus company
Healthwatch	Representing users of health and social services
Members of the public	Representing users of health and social services
North Somerset Council	Transport commissioning and community transport
Weston & District Community Transport	Representing community transport providers
Weston Hospital Patient Council	Representing views of patients
Winscombe Contact Scheme	Community transport

The CCG attended the North Somerset Community Transport Forum and discussed travel and transport with key stakeholders including the South Western Ambulance Service Foundation Trust and the West of England Combined Authority (WECA). The recommendations outlined below draw on the feedback that was received through the Travel Working Group, feedback received as part of the consultation and information from discussions with key stakeholders.

There was also more intensive consultation with groups which the Equalities Impact Assessment identified as being more likely to be adversely affected by the increased travel. This included in-depth interviews and meeting with groups representing the frail elderly population, families with children, people with disabilities and people experiencing economic and social deprivation.

Like many hospitals in England, the catchment area of Weston Hospital covers a geographical area that includes rural locations and does not have complete public transport coverage. This means that people cannot get to Weston Hospital, or another hospital, by public transport at all times of the day. Commissioning general transport services is not with the scope of the NHS responsibilities, so when developing proposals to address issues of transport the NHS will continue to work in partnership with the relevant bodies such as local authorities and regional infrastructure bodies, who are already engaged in this programme.

In February and March 2019, WECA held a consultation on the Joint Local Transport Plan. WECA are the regional economic development and infrastructure body who work with local authorities. The CCG has identified this as a key opportunity to work with local authority bodies to develop an

Integrated Transport Programme that will seek to align the commissioning of transport and NHS services as closely as possible.

The Travel Working Group made a series of recommendations to support people to make use of these existing services and what additional support could be provided and these are outlined in Table 2 below.

Table 2: Travel Working Group recommendations

Access to information	1. Promote the support available for the local population to access healthcare including the Healthcare Travel Costs Scheme, patient transport services and community transport services. 2. Provide information at hospitals, GP surgeries and other sites about local transport links. 3. Provide training to hospital reception staff to support people to travel from hospital. 4. Ensure compliance with Accessible Information Standards.
Hospital services	1. Recommend through commissioning with providers to minimise discharge from hospitals at night especially for vulnerable people. 2. Providing a safe place for people to wait following discharge from hospital until appropriate transport becomes available. 3. Provide preferred parking sites for community transport providers.
Transport services	1. Develop an Integrated Transport Programme to improve access to healthcare across the region. The intention is to achieve this objective by joining-up transport planning, commissioning and service delivery between Local Transport Authorities (LTAs) and healthcare system.

Conclusions

The Healthy Weston Programme, with the development of the changes to hospital services and critical interdependencies in primary and community care has the potential to improve access to high quality healthcare for groups in the local population who are marginalised and currently experience barriers. However, some of the changes proposed will result in new challenges to accessing healthcare for certain groups.

The actual impact of the changes will depend on how the changes are implemented including the mitigations that are outlined above. Therefore, it will be crucial to keep this impact assessment under review and for it to continually inform the delivery of plans. Ensuring that the mitigations outlined above are delivered alongside the services changes will be monitored through the existing governance structures for the Sustainability and Transformation Partnership, and partnership working with local authorities will be crucial to take this forward.

The CCG will continue to engage with all stakeholders in the delivery of these recommendations to ensure that the programme brings benefits to the groups intended and that mitigations to address any risks are delivered effectively.

NHS
Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Group

Appendix 8: Quality Impact Assessment for the Healthy Weston Programme

Shaping better health

Quality Impact Assessment

Introduction

This Quality Impact Assessment forms part of the Healthy Weston Decision Making Business Case and should be read alongside the main document.

This Quality Impact Assessment considers the quality implications in relation to patient safety, clinical outcomes and patient experience and outlines the risks of implementing the service changes with associated mitigations.

Background

Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group (BNSSG CCG) has been working over the past 2 years with senior doctors, frontline staff, partner organisations, people, carers and members of the public from across BNSSG and North Sedgemoor to develop a series of proposals that seek to address the issues set out in our Case for Change, published in October 2018. This programme of work is called ***Healthy Weston*** and has been designed by senior doctors and other clinicians, with consistent and extensive engagement with members of the public.

The A&E Department at Weston General Hospital has been temporarily closed overnight (10pm – 8am) since July 2017, after a CQC inspection raised concerns over patient safety. The Healthy Weston Programme proposes to make the temporary overnight closure of the A&E department permanent, to change the critical care provision from 5 ITU beds to 2 ITU beds & 2 HDU beds, and transferring patients who need complex critical care, complex surgery and overnight emergency surgery via ambulance to other hospitals in Bristol and Taunton.

Patient Safety

The implications for patient safety are related to both the case for change, and the recommended clinical model.

The proposals would enable clinically safe transfer of patients overnight with minimal impact of travel time on patient outcomes. Travel time impact audits have been carried out by SWASFT with clinicians from UHB and Musgrove Park A&E departments as part of the Healthy Weston Programme. The audits found that increased travel times as a result of the temporary overnight closure did not have any adverse impact on clinical outcomes for any of the attendances reviewed.[1]

A separate academic study undertaken by the University of Sheffield also found no statistically reliable evidence to suggest a change in the number of deaths following

[1] Healthy Weston DMBC Appendix 4: Travel time impact audits – UHB and MPH

an ED closure in any site or on average across all sites.[2] Data on serious incidents that are managed through the BNSSG wide A&E Delivery Board shows that there have been no serious incidents resulting in patient harm as a result of the temporary overnight closure of A&E.[3] In the initial 12 months of the temporary overnight closure a standalone oversight group monitored patient incidents found no patient incidents that could be attributed to the closure. A further analysis from July 2018 to August 2019 of the incident reporting systems of SWASFT, UHB and Weston Hospital found no reported incidents attributed to the overnight closure, including any that could have resulted in delays in care due to transfer from the Weston area.

The South West Clinical Senate was unanimous that 'do nothing' as an option was neither safe nor sustainable for Weston Hospital, and encouraged progress to the clinical model as soon as possible.[4]

A CQC inspection in March 2019 found that staff in A&E at Weston were not receiving adequate supervision, training or support to carry out their roles and responsibilities safely. The inspection also found that nurse training lacked adequate oversight, and the consultant cover in A&E was inadequate, with junior and middle grade doctors not receiving support from senior colleagues. The Healthy Weston proposals aim to enable the hospital to safely staff the services and maintain a stable workforce through addressing fragile rotas and stabilising the service as a whole.

More people requiring major emergency surgery, complex surgery, and specialist critical care would be treated in units which are more compliant with national standards for high quality of care. There are currently low numbers of patients requiring complex surgery at Weston, and some services have historically struggled to meet national clinical quality standards and best practice due to low volume of cases and an unstable workforce. The surgical and critical care units at larger hospitals in Bristol and Taunton see a larger volume of cases and more complex cases, which contributes to the sustainable skill levels of staff on these units.[5]

Recent national standards also indicate that in order to ensure higher levels of patient safety in A&E, clinicians with specialist knowledge of paediatric care must be present on site at the hospital. The Healthy Weston recommendations will ensure that there is paediatric speciality on site for the duration of the A&E opening hours, and that any children who need emergency care overnight are transported to hospitals in Bristol and Taunton who meet these standards, as is happening now.[6]

[2] University of Sheffield, Closing five Emergency Departments in England between 2009 and 2011: the closED controlled interrupted time-series analysis, 2018
[3] BNSSG serious incidents review
[4] South West Clinical Senate, Stage Two Clinical Review Report: Future Acute Services at Weston General Hospital, February 2019
[5] GIRFT Programme National Specialty Report – General Surgery, 2017
[6] Royal College of Paediatrics and Child Health, Facing the Future: Standards for children in emergency settings, 2018

The proposals will impact provider organisations through the transfer of activity from Weston. The impact of the service changes has been evaluated by the providers participating in the Finance and Enabling Group who have agreed that they are able to absorb the activity shifts as outlined in the decision making business case. At the time of the temporary overnight closure, regular assessments of the neighbouring hospitals receiving patients found no change in quality and safety. The workforce at neighbouring hospitals may experience a greater number of complex cases, and a larger volume of cases from Weston (this has been shown in the activity modelling to be around 319 people per year over and above who is being treated elsewhere because of the temporary overnight closure of A&E). This may require more staff to be employed to manage the higher levels of activity in certain services, or further training to be undertaken by existing staff. However, it is important to note that an additional 2,591 patients will be seen at Weston compared to now because of the increase in paediatric patients who will be able to be seen at the hospital and patients who will be directly admitted onto wards. A full breakdown of the activity shifts can be found in the Finance appendix.

The Healthy Weston Programme sits under the Healthier Together Sustainability Transformation Partnership, comprised of 13 commissioning organisations and health and social care delivery partners, so there is whole-system ownership of the process used to develop the proposals, and all risks relating to the proposals are shared. The Healthy Weston Steering Group and Clinical Services Design and Delivery Group are also comprised of members from neighbouring trusts. Through this wide engagement at a senior management level, the CCG has managed the development of these proposals that have received consistent support from system partners.

Risks associated with the overnight closure of A&E in Weston have been successfully managed through the WAHT A&E Operational and Clinical Oversight Group (WOCOG), and when this was stepped down through the A&E Delivery Board. Responsibility for the risks surrounding the workforce at Weston Hospital is currently being managed by the WAHT Board. In the event of any workforce crisis at Weston, the Clinical Cabinet, comprised of clinical leaders from system-wide trusts and organisations, will take responsibility for this.

There has been an impact on service users feeling less safe. Evidence from the public consultation has shown that a key theme in the feedback received has been regarding safety when being transported by ambulance to a neighbouring hospital overnight, and worries about not having a 24/7 A&E close by.[7] It became clear through this work that the local population's concerns about travel and access to healthcare are wider than the changes proposed within the scope of the Healthy Weston Programme. The CCG will take action to mitigate the perception that patient

[7] The Evidence Centre, Healthy Weston: Independent summary of consultation themes

safety will be jeopardised through the Healthy Weston proposals, with ongoing public engagement, and emphasis on the findings of the SWASFT audit, mentioned above. Further work is being done by the CCG to improve access to travel information for patients and the public, develop hospital services and policies to minimise discharge overnight and increase patient comfort until transport becomes available following discharge. Finally, the CCG will work with local partners to take a whole-system approach to develop an Integrated Transport Programme, led by the STP, to improve access to healthcare across the region.

Clinical Outcomes

Best evidence guidance was used throughout the process for developing the clinical model for Weston Hospital. In developing the clinical models, clinical evidence was considered to create a set of best practice care pathways for each service area, drawing on national clinical standards and guidelines as set out by the relevant Royal Colleges, as well as national reports and reviews. This evidence base identified what good patient care looks like, informed the Healthy Weston clinical model development, and allowed the Healthy Weston Clinical Services Design and Delivery Group to finalise a clinical model for Weston Hospital which was robust in terms of patient safety and clinical outcomes.[8]

The South West Clinical Senate said in their review of the Healthy Weston pre-consultation proposals that there was a "clear argument for (the consulted model) as evidenced by differences in patient outcomes and clinical quality".[9]

The Healthy Weston proposals set out plans for more complex surgery to be carried out in specialist centres, as evidence suggests that concentrating specialist surgical services into fewer, larger centres of excellence can improve outcomes and save lives.[10] Relocating complex surgery and overnight emergency surgery to centres of excellence in Bristol and Taunton where staffing guidelines can also be sustainably met, with the necessary additional support available including critical care teams, will improve clinical outcomes and patient safety.

Patient Experience

The proposals will involve increased travel time for patients who need emergency treatment or surgery overnight, and patients who need a higher level of critical care would be transferred to other units. This introduces some cost to the families of

[8] Healthy Weston Pre-Consultation Business Case, Appendix 9
[9] South West Clinical Senate, Stage Two Clinical Review Report: Future Acute Services at Weston General Hospital, February 2019
[10] Royal College of Surgeons, Principles for reshaping surgical services, 2013

those patients taken to other hospitals, in visiting them, and also required some extra time needed to visit them. Patients who do not qualify for medical transport, or are well enough to be discharged, will also experience some cost in returning home to Weston and the surrounding areas after treatment, and for families who collect patients from hospital after discharge.

There is a wide network of public transport throughout Weston, Bristol, Taunton and North Somerset, which should mitigate some challenges for patient families who do not drive. For those in rural areas, where the public transport network is not as extensive, there may be some challenges in visiting family in hospital, or for returning home from another hospital after discharge. There is a network of community transport providers in North Somerset, which offer 1-to-1 services to and from hospital, and in some towns, a minibus to travel to hospital appointments. The CCG have set up a Travel Working Group to mitigate transport challenges further, and through the work of the group have made recommendations on access to travel information, hospital policies, and the provision of community transport and public transport links in Weston and the surrounding areas. Further information is available in Appendix 3.

The Integrated Frailty Service will improve access to care for the frail and elderly population of Weston. The model of care for frailty hubs on the hospital site and in the community will allow frail and elderly patients to access medical and diagnostic treatment in one place, through a streamlined care pathway and an integrated frailty team. The frailty service will also offer a greater degree of continuity of care through personalised care plans for frail patients. Comprehensive holistic care involving clinicians and practitioners from primary, secondary and community care is a key principle of the service; therefore the Integrated Frailty Service will offer more well-rounded care to promote staying well and independent. Working in tandem with the GEM Service at Weston Hospital (which successfully reduced unnecessary hospital admissions for frail older people by around 30-40%), the Integrated Frailty Service will further support the frail population of Weston to avoid hospital and remain at home, which will positively impact patient experience in turn.[11]

The mental health and recovery centre (‘crisis café’) will expand the provision of mental health services for the population of Weston. This centre will be open in the evenings and weekends to offer support and guidance to those experiencing emotional distress. Further investment into the Child and Adolescent Mental Health Service in Weston will further improve access, alongside improved psychiatric liaison services in the Weston Hospital A&E department. The crisis café will be a self-referral service, and will offer signposting for people, which supports the recovery model of mental health.

[11] WAHT Medical Director, Healthy Weston Steering Group minutes

Primary care developments support greater continuity of care, and new digital technology in some GP surgeries in Weston (*askmyGP*) improve access to appointments and treatment from a primary care clinicians. Recent analysis of *askmyGP*'s effectiveness in Weston practices showed that half of all patient requests were resolved in less than 2 hours, a significant difference from before its implementation. Funding of £3.2m has been made available for new primary care facilities in the centre of Weston, which will offer an improved physical environment for patients in Weston in a location in central Weston that is easily accessed.

The extended provision for acute children's care will improve access to appropriate care for children and parents, and allow patients and families to access this care closer to home. Any children needing an inpatient stay will be transferred to the Bristol Children's Hospital, as is the case now.

Weston Hospital has consistently rated highly for 'Caring' in CQC inspections, and patient survey results reflect that service users have had good experiences. In the most recent Friends and Family Test data, 93% of respondents would recommend using the Weston Hospital A&E to friends and family, and 96% would recommend inpatient services.[12] Patients who will be unaffected by the proposed changes to Weston Hospital will continue to experience high quality caring from staff. The Friends and Family Test data shows that all other neighbouring trusts scored highly, above the national average for the month, therefore there will be minimal impact on this aspect of patient experience to the small number of patients needing to be treated at neighbouring hospitals.

[12] FFT data, May 2019

Key Benefits and Challenges

The below table lists the benefits, challenges and mitigations to the recommended service change against each of the key areas.

Proposal	Benefits	Challenges	Mitigations
Proposals for Urgent and Emergency Care and A&E	• Opening Hours: Improves patient safety by transferring patients at night to hospitals that are better able to provide safe care. • Opening Hours: Provide certainty to allow the leadership team to focus on internal service improvement and clinical governance to better meet national clinical standards. • Direct admissions: Improves access to specialist care for stable patients locally. • Direct admissions: Reduces demand on ambulance service and A&E departments. • Integrated front door team in A&E including access to specialist doctors and GPs will provide quicker access for	• Risk to patient safety due to delays in accessing treatment caused by increased travel time to neighbouring hospitals.	• Travel time audits and the review of patient safety incidents has demonstrated that the local NHS can provide safe urgent and emergency care with the A&E department at Weston Hospital closed at night.
		• Some patients will have to travel further at night to receive hospital care. This also presents a challenge for patients returning home and for visitors of patients receiving care in neighbouring hospitals. • Patients with mobility difficulties will find it harder to travel to and from neighbouring hospitals.	• Recommendations on improving access to travel services will enable patients and visitors to travel to neighbouring hospitals more easily. Particular emphasis on providing support for patients with difficulties travelling will address challenges to this group. • Patients conveyed to neighbouring hospitals are repatriated back to Weston for further treatment and recovery when clinically appropriate.
		• Patients may delay accessing care at night due to an unwillingness to travel.	• Public communication to reassure public about safety of model and promote healthy behaviour and

Proposal	Benefits	Challenges	Mitigations
	patients to the most appropriate clinicians. • Reduces need for agency staff.		appropriate use of the local NHS.
		• Neighbouring hospitals capacity to receive additional patients.	• Temporary overnight night closure has been carefully managed via a system wide operational group. A standard operating procedure (SOP) is in place. The impact and SOP has been reviewed at 1, 3, 6, 12 and 24 months. • System wide ownership of Healthy Weston through STP and regular capacity reviews will ensure Weston Hospital is best able to perform in a network of hospitals.
		• Conveyance time for Ambulance Service is longer therefore impacting on ambulance availability in the local area.	• Additional funding provided to the Ambulance service for a double crewed vehicle as a result of the temporary overnight closure. Further funding of £12m provided to SWASFT as part of a national rebasing of Ambulance provision across the region. • SWASFT performance reviewed and found to be in line with expected response times for category 1 emergencies.

Proposal	Benefits	Challenges	Mitigations
		• Proposal does not fully address the staffing difficulties at Weston Hospital.	• Proposals enable merger of WAHT with UHB to take place and establish foundation for further changes to address staffing difficulties including shared rotas.
		• Hospital has not been able to improve “inadequate” CQC rating during the temporary overnight closure.	• Improvements in same day urgent care in the community including through primary care and the new integrated community services contract will reduce demand on hospital and better integrate the hospital with associated services. • Integrated Frailty Service will reduce demand on A&E and enable more focus on quality and safety improvement. • Proposals enable merger with UHB and Clinical Practice groups and more stable management will enable greater focus on quality and safety improvement
Proposals for Critical Care	• Better networked services will ensure that patients will receive care in the most appropriate place involving the right specialist services.	• Fewer Level 3 beds will limit the access of highly specialist intensive care to patients and this could impact on patient safety.	• Improved digital networking will ensure that patients are monitored and clinically driven decision making will make best use of the resources available for the local

Proposal	Benefits	Challenges	Mitigations
	• Weston will retain the ability to provide Level 3 critical care for patients when it is clinically appropriate. • Digitally linked critical care units will share the expertise available to assess and treat patients		population. • Provision of dedicated transfer service will ensure that the service better meets the latest standards on the transfer of the critically ill adult.
		• Need to ensure that patients are taken directly to the hospital that can most comprehensively meet their care needs.	• Provision of dedicated transfer service will ensure that the service better meets the latest standards on the transfer of the critically ill adult. • Further development work taking place to ensure that patients are conveyed directly to the hospital that can most comprehensively meet their care needs.
		• Costs of the transfer service.	• Provision is transitional whilst greater integration between regional critical care units is established.
		• Reduction in number of patients requiring Level 3 critical care will limit the experience of clinicians to	• Improved workforce networking will enable clinicians to build and maintain appropriate skill levels.

Proposal	Benefits	Challenges	Mitigations
		practice and maintain highest level critical care skills.	
Proposals for Emergency Surgery	• Patients requiring emergency surgery at night or the most complex surgery will receive treatment at specialist centres that are best able to provide safe and complex surgical intervention. • Weston Hospital will be better able to meet national clinical standards. • Improvements to ambulatory surgical care will improve patient outcomes and reduce length of stay. • Removal of emergency surgery overnight will ensure dedicated consultant cover for the critical care unit.	• Transfer of patients and increase in handovers will increase risks to patient safety and adverse outcomes.	• Clear bypass criteria established with the ambulance service. • Provision of dedicated transfer service will ensure that the service better meets the latest standards on the transfer of the critically ill adult. • Improvements in networking with specialist centres will ensure that patients will receive care in the most appropriate setting.
		• Patient safety will be compromised by delays to treatment due to increased travel time to receive treatment in the evening and at night.	• The travel time audits found that the additional travel time to neighbouring hospitals did not impact on the outcomes of patients.
		• The volume of some complex cases during the day remains low and this will continue to impact on the ability of surgeons to maintain a higher	• Improvements in workforce networking will provide opportunities for surgeons to develop and maintain skills for performing complex care.

Proposal	Benefits	Challenges	Mitigations
		skill level.	
Proposals for Acute Paediatrics	• Weston Hospital will be able to better meet the Facing the Future: Standards for children in emergency care settings • More children will be able to receive paediatric specialist care in Weston. • Primary care will be able to better access paediatric specialist advice and avoid unnecessarily referring patients to neighbouring hospitals.	• Critically unwell children will inappropriately present at Weston Hospital.	• Coordinated communication to the public, primary and community care and wider system will be explicit in where to appropriately seek paediatric expertise. • Review of the paediatric ambulance divert criteria is being led by the Healthy Weston Programme.
		• Additional costs to paediatric specialist staffing.	• Additional specialist staffing will enable unit to deliver more paediatric care and become more financially sustainable. • Increase in Weston paediatric cover will provide system benefits of reducing some demand on services at Bristol Children's Hospital.

Monitoring of Benefits

The below table outlines how the proposed benefits will be monitored.

Proposed benefit	Measurement	Monitoring frequency	Monitoring route

Proposed benefit	Measurement	Monitoring frequency	Monitoring route
Improvement in patient experience	Improvement in friends and family test scores for directly impacted services	Monthly	CCG Quality Monitoring Meeting
Improvement in compliance with national clinical quality standards Urgent and Emergency Care	Delivery against the CQC action plan	Monthly	CCG Quality Monitoring Meeting
	Improvements in key quality metrics including ED quality indicators, 12 hour waiting time breaches, serious incidents and evidence of associated learning, complaints and ED waiting time targets.	Monthly	CCG Quality Monitoring Meeting
Emergency Surgery	Improvement in compliance with Emergency General Surgery Standards as reviewed by the Clinical Senate in 2017	Audit at 6 months post implementation	Joint Merger Integration Programme Board
	Waiting times for surgical rapid access clinics at Weston Hospital	Quarterly	Joint Merger Integration Programme Board
	% emergency general surgery completed on planned emergency lists on the day that surgery was planned	Quarterly	Joint Merger Integration Programme Board
Critical Care	Improvement in compliance with the D05 Service Specification for Adult Critical Care (review of GPICS standards)	Audit at 6 months post implementation	Joint Merger Integration Programme Board
	Review of ICNARC (patient outcome measure) data submissions	Quarterly	Joint Merger Integration Programme Board
	Number of patients transferred to UHB Critical Care Unit and number repatriated	Quarterly	Joint Merger Integration Programme Board
	% patients transferred by dedicated Transfer Team	Quarterly	Joint Merger Integration Programme Board
	Incidents associated with patient transfer between	Quarterly	Joint Merger Integration

Proposed benefit	Measurement	Monitoring frequency	Monitoring route
	UHB and Weston Critical Care Units – Transfer Team and SWASFT conveyances when dedicated team are not operational		Programme Board
	Combined Weston and UHB length of stay for patients initially received by Weston Critical Care Unit assessed against pre-implementation baseline	Quarterly	Joint Merger Integration Programme Board
Acute Paediatrics	Improvement in compliance with Facing the Future standards issued by Royal College of Paediatrics and Child Health	Audit at 6 months post implementation	Joint Merger Integration Programme Board
	North Somerset attendances to A&E and short stay admissions at BRHC	Quarterly	Joint Merger Integration Programme Board
	Seashore Unit activity – outpatient and daycase, including waiting times	Quarterly	Joint Merger Integration Programme Board
	Incidents associated with children <16yrs at Weston Hospital	Quarterly	Joint Merger Integration Programme Board
	SWASFT conveyances of <16yrs to Bristol against pre-implementation baseline	Quarterly	Joint Merger Integration Programme Board
Reduction in clinical staff vacancy rates	Vacancy rates in directly impacted services	Monthly	Joint Merger Integration Programme Board
	Total vacancy rate associated with Weston Hospital	Monthly	Joint Merger Integration Programme Board
	% nursing shifts filled by agency staff	Monthly	Joint Merger Integration Programme Board
	% consultant and junior doctor shifts filled by agency	Monthly	Joint Merger Integration Programme Board
Safe transfer of patients	Number of patients transferred from Weston to other acute trusts (excluding critical care conveyances)	Quarterly	Joint Merger Integration Programme Board

Proposed benefit	Measurement	Monitoring frequency	Monitoring route
	Serious incidents related to patient transfers (excluding critical care conveyances)	Quarterly	Joint Merger Integration Programme Board
Direct admissions	Number of direct admissions overnight	Quarterly	Joint Merger Integration Programme Board
	Incidents associated with overnight admissions	Quarterly	Joint Merger Integration Programme Board