Healthy Weston
Pre-Consultation Business Case

Transforming Weston General Hospital as part of whole-system redesign

Shaping better health

Intended audience

This Pre-Consultation Business Case is written by the *Healthy Weston Programme* for two audiences:

- The Governing Body of NHS Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group (CCG) which will decide whether there is a case to launch a public consultation. The CCG is the legally accountable Consulting Authority so has final responsibility for approving next steps.

- NHS England which will assure that the *Healthy Weston Programme* has followed appropriate processes for planning service change and consultation. NHS England's recommendations will influence decisions made by the CCG's Governing Body about next steps. The CCG will not proceed to public consultation without assurance from NHS England.

A draft version was reviewed by the South West Clinical Senate to examine the clinical appropriateness and feasibility of the case put forward and this iteration takes account of their feedback.

NHS Somerset Clinical Commissioning Group have been fully engaged in the programme, given that a significant proportion of the patients using Weston General Hospital services live in the Somerset area.

If the CCG decides to proceed to consultation, a public-facing consultation document will be finalised following formal scrutiny of the planned consultation process and draft consultation documentation by local authority elected members and NHS England. For the purposes of transparency, the final draft of this Pre-Consultation Business Case will be made available publicly, but the document is not written with a public audience in mind.

Document status

Until published this is a confidential document for discussion purposes and any application for disclosure under the Freedom of Information Act 2000 should be considered against the potential exemptions contained in s.22 (Information intended for future publication), s.36 (Prejudice to effective conduct of public affairs) and s.43 (Commercial interests). Prior to any envisaged disclosure under the Freedom of Information Act the parties should discuss the potential impact of releasing such information as is requested.

The material set out in this document is for discussion purposes. The involved NHS bodies understand and will comply with their statutory obligations when seeking to make decisions that will have an impact on the provision of care services. The case set out does not represent a commitment to any particular course of action on the part of the organisations involved. The aim is to support continuing discussion and formal public consultation.

Executive summary

Vision for integrated care in Weston

There is an overwhelming case for transforming health services in Weston, Worle and the surrounding areas to improve the care available for local people, population outcomes and sustainable use of resources. Developing a stronger, more focused Weston General Hospital is a key component of more integrated and resilient health and care services.

The *Healthy Weston Programme involves* a wide range of health, care and voluntary sector organisations working together. *Healthy Weston* is a priority programme for *Healthier Together Sustainability and Transformation Partnership*, focused on developing more integrated and sustainable healthcare for the people of Weston, Worle and nearby areas. Over the past two years, the Programme has worked with clinicians and other frontline staff, partner organisations, patients, carers and members of the public to consider the services that will best serve the population now and in future.

This business case sets out the vision for transformed and integrated healthcare in Weston. It focuses on proposed changes to **acute hospital services at Weston General Hospital.** The proposed changes constitute a substantial variation to currently commissioned services so a formal public consultation about the proposals is planned. These changes are part of a wider programme of work context of improvements taking place in the wider health and care system. The overall vision is for Weston General Hospital to be closely aligned with healthcare in the community and the work of neighbouring hospitals to ensure that local people can access safe, timely and sustainable services. Working in this new and integrated way is part of the changing culture set out in the NHS *Five Year Forward View* and the *NHS Long Term Plan*.

Why we think that change is needed

Technical analysis of the current context, examples of best practice nationally and internationally, external and national benchmarks, guidance from the Royal Colleges and National Institute for Health and Care Excellence (NICE) and extensive public and clinical feedback about what is important locally suggests that it is essential to improve health services for the people of Weston, Worle and the surrounding areas. The evidence-base shows that the current model of care in and out of hospital cannot continue as it is because:

- **Health needs are changing:** The population is growing, getting older, living with more long-term conditions and there are significant inequalities amongst local communities**.** New ways of working are needed to meet changing health and care needs and help local people enjoy the best possible health and independence.

- **There is variation in access to and continuity of care:** There are differences in the way care is provided in various geographic areas. Extensive public and clinical engagement over a one-and-a-half-year period highlighted opportunities to offer better access and continuity of care, focusing on prevention and supporting people to maintain their independence. More joined up working across primary care, community care and hospital care is a key part of this.

- **There is variation in the extent to which services are being provided in line with national and local guidance:** Some health services at Weston General Hospital are not able to consistently meet national and local clinical quality standards because of shortages of specialist staff and low numbers of particular types of medical conditions to help staff keep their skill levels high.

- **There is a need to manage within NHS resources:** There is a growing gap between the cost of healthcare and available funding, with the Bristol, North Somerset and South Gloucestershire region having a deficit of £86m in 2017/18. The system needs to live within its means, get best value and make sure available financial resources most effectively meet the needs of the whole population. This will ensure improved sustainability of the wider local health and care system as a whole. Weston General Hospital currently requires a recurrent annual subsidy to run that diverts resources away from other populations, providers and investment in services.

Changes are needed to help the NHS respond to future changes in health and care delivery whilst being mindful of the resources available. The system will be even more stretched in the future if it does not act now to design services in a different way. Changes are proposed for Weston General Hospital in direct response to the real and urgent challenges with delivering consistently safe and sustainable services, including long-term staffing issues that have significantly affected services.

Primary, community and hospital care are all part of the solution

The *Healthy Weston Programme* includes a range of service improvement initiatives to respond to the reasons why change is needed. These include developing a stronger model of primary care at scale, addressing workforce challenges for primary care and integrating primary care, community care, mental health and social care into more integrated local teams. These integrated teams will work proactively to support people to stay healthy, well and independent in their community without the need for inappropriate hospital admission. A range of business cases for service development are underway as part of this wider work including a 'mental health crisis and recovery centre' to be positioned in the centre of Weston, significant new investment in local Children and Adolescent Mental Health Services (CAMHS) and a new approach to primary care support for local nursing homes. A single adult community health services provider is being commissioned across Bristol, North Somerset and South Gloucestershire.

There is an ambition for Weston General Hospital to provide coordinated, comprehensive and integrated services for patients to help avoid admissions where possible, expedite discharge and provide urgent care from the most appropriate place. The *NHS Long Term Plan* reinforces this ambition to integrate hospital and community-based care as part of a single, joined-up system. There is also wider work to develop an acute care collaborative across the Bristol, North Somerset and South Gloucestershire system to support increased networking of acute care, including fully integrated clinical teams that deliver consistent quality and standards of care for the whole population, wherever they access services.

Changes are proposed to Weston General Hospital in the context of this much wider programme of transformation.

Working together to identify proposals for Weston General Hospital

More than 3,000 people have been involved in shaping proposals for acute services at Weston General Hospital. An iterative co-design process was used to identify, evaluate and shortlist potential options for public consultation. The process was driven by clinicians, with widespread engagement with patients, frontline staff and partners from across health, social care and the voluntary sector.

A comprehensive engagement process began in June 2017 and informed the development of a 'Commissioning Context' which was published in October 2017. This outlined the principles for whole-system change. People's feedback was sough about the broad vision during public dialogue between October 2017 and March 2018. Over 1,600 pieces of feedback representing more than 2,500 people were received and independently compiled. More than 100 stakeholders took part in system-wide workshops to consider next steps. Ongoing engagement activities continued throughout 2018, particularly focusing on gathering insights from seldom heard groups, vulnerable groups, faith groups, the voluntary sector and clinicians and other frontline staff. Clinical teams met regularly through 2018 to help develop and refine potential ways forward.

A structured process was used to identify possibilities

A structured, clinically-led process was used to develop potential new approaches for acute services at Weston General Hospital. This involved looking at best practice care pathways using national and international guidelines for areas such as the Accident and Emergency Department (A&E), maternity care, intensive care unit (ICU), emergency surgery, children's services and others. Potential options for delivering care of each type were considered and clinical interdependencies explored. Evaluation criteria were used to identify approaches for full clinical and financial analysis and this analysis helped to shape recommendations about preferred options to be tested and refined through public consultation.

More than 1,000 potential clinical models were identified via clinical input, reviews of national best practice and Royal College guidelines. Reviewing clinical interdependencies helped to narrow this down to fewer than 200 models. Looking at the extent to which models would be applicable in Weston based on workforce, access and safety constraints narrowed the models to approximately 40.

Feedback collated from stakeholders during the codesign period and ongoing engagement was used to prioritise focus areas and develop criteria by which to judge options for change that would be appropriate to publicly consult about. The criteria used to evaluate potential options, which are directly linked to the reasons for change and the themes from engagement activities, were:

- **Quality of care**: clinical effectiveness, patient and carer experience, safety
- **Access to care**: patient choice, distance, cost and travel time
- **Workforce**: scale of impact, impact on recruitment, retention and skills
- **Value for money**: capital costs, income and expenditure, net present value
- **Deliverability**: expected time to delivery, co-dependencies

Clinicians reviewed all 40 long-list models using these criteria. This led to shortlisting seven models for formal detailed evaluation, including financial and activity modelling. Three of these models were then identified by clinicians as being most feasible and robust.

Following all evaluation and feasibility testing, the *Healthy Weston Programme* Steering Group, made up of the Chief Executives from all partner organisations and senior clinicians, identified a preferred option for public consultation which aligned to a longer-term direction of travel. The South West Clinical Senate and NHS England reviewed the process and supported the overall direction of travel, commenting that immediate change was needed to ensure the ongoing safety of services.

Why Weston General Hospital cannot stay the same

The Healthy Weston Programme analysed in detail whether Weston General Hospital could continue as is or with minor changes. This ‘status quo’ option was compared against others. After considering all the clinical, population, financial and activity evidence, the *Healthy Weston Programme* concluded that the status quo of having a consultant-led A&E 24 hours a day, seven days per week (as currently commissioned) was not viable. Nor was it viable to have an A&E 14 hours a day, seven days per week that is only staffed by specialist emergency doctors (as has been implemented during temporary overnight A&E closures due to staff shortages). Neither of these approaches enables health services to deliver the quality of care that local people deserve. Despite great commitment by existing staff, it has been difficult to fully staff these models appropriately, meaning that care does not consistently achieve expected safety standards. A Care Quality Commission (CQC) inspection in 2017 rated the hospital as inadequate for urgent and emergency services. This meant that A&E needed to be temporarily closed overnight.

Weston General Hospital’s reliance of a high proportion of agency and locum staff means that services such as A&E suffer from a lack of continuity in staffing which in turn can lead to care at times being less joined-up and efficient. The relatively small number of people visiting Weston General Hospital for rare or complex procedures also means that staff are not always able to keep up their practice and comply with national standards.

NHS Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group (CCG) needs to provide a significant financial subsidy to keep A&E and specialist services at Weston General Hospital operational. This means that resources are diverted away from other key local services, including those that may be able to help people remain healthy and reduce the need for unplanned A&E visits.

The consensus from the *Healthy Weston Programme* is that doing nothing carries the greatest risk for both Weston General Hospital and the wider system as it brings with it the possibility of continuing unplanned changes that have the potential to destabilise the system and affect patient care.

A Review Panel from **the South West Clinical Senate agreed that ‘do nothing’ is not an option**, stating that there is significant and robust clinical evidence that it is neither sustainable nor safe to continue services as they are.

Preferred option for acute services

After detailed clinical, technical and financial analysis, the *Healthy Weston Programme* has identified a ‘preferred option’ for acute services at Weston General Hospital to consult the public about. This includes the following changes:

1. **Urgent and emergency care**

- To have a medically led A&E for urgent and emergency care open 8am-10pm seven days per week with a multi-disciplinary team (supported by overnight GP out of hours service and 24/7 direct admissions to the hospital via GP referrals). This is a change from the 24 hour service currently commissioned, but in line with the current opening hours under a temporary overnight A&E closure

2. **Critical care**

- To change the critical care service from an intensive care unit to a high dependency unit with the ability to escalate to level 3 critical care to stabilise and transfer (level 3 can be provided for up to 12 hours with the ability to extend on a case by case basis)
- As a result, a small number of the most complex and serious acute medical and surgery patients would be treated at neighbouring hospitals.

3. **Emergency surgery**

- to move a small number of the most complex emergency surgery cases from Weston General Hospital to neighbouring hospitals

Under these proposals, most patients will continue to be treated at Weston General Hospital (97% of the current hospital activity given the temporary overnight closure of A&E, or 92% compared to activity before the temporary closure).

Other developments

- **direct admissions out of hours** for GP referrals and suspected fractured neck of femur patients available 24 hours a day, seven days per week (*as now*) and in time also giving paramedics the ability to admit (*different from current)*
- an **integrated frailty service** to position Weston as a centre of excellence for frailty complemented by a centre of excellence for dementia care
- a strengthened and more integrated offer for **acutely unwell children** and children with complex needs operating 14 hours per day, seven days per week
- continued and strengthened **access to specialist outpatient services** (such as more oncology, haematology and respiratory treatments)
- an expanded role in the ability to **provide non-complex elective surgical services** for example in orthopaedics, ophthalmology and ear, nose and throat services and others
- **closer working between acute partners** throughout Bristol, North Somerset and South Gloucestershire and Somerset, which has the potential to reduce unwarranted variation in care

Under the preferred model, many things would stay similar at Weston General Hospital, including having a consultant led medical bed base, operating 24 hours a day, seven days per week; diagnostic and therapy services including for example X-ray, MRI, ultrasound, pathology, physiotherapy, occupational therapy, dietetics and speech and language therapy; midwifery-led maternity services, with strengthened access to antenatal and postnatal services, and continuation of existing pathways and protocols for patients who are currently directly transferred to a specialist centre. The developments to primary care, community services and relationships with neighbouring hospitals would take place alongside any changes to acute services, as part of a whole-system model.

Weston General Hospital would manage people with needs across most levels of severity but all major surgical emergencies would continue to be transferred to larger centres that see greater numbers of similar patients. Clinically-led modelling suggests that 79% of total commissioned A&E activity and 96% of current A&E activity, 99% of acute medicine and 83% of emergency surgical activity would continue to be managed at Weston General Hospital compared to the current level of services commissioned. Overall, around 98% of the current episodes of care commissioned for delivery at Weston General Hospital would remain at Weston. How services will be provided for those affected is detailed in the main body of the PCBC.

Table 1 summarises how the preferred option addresses the reasons that change is needed.

Table 1: How the preferred option addresses elements of the case for change

Reason for change	How preferred option addresses this
Health needs are changing	The preferred option helps to address the fact that the population is growing, getting older, living with more long-term conditions and there are significant inequalities amongst local communities. It starts to refocus the hospital on the population groups identified as priorities, with enhanced frailty services and strengthened services for children.
Variation in access to and continuity of care	This change would reduce variations in access or continuity of care. Most current episodes of care commissioned for delivery at Weston General Hospital would remain under this model of care.
Variation in the extent to which services achieve guidelines	More people requiring major emergency surgery and Level 3 ICU care would be treated in larger units which are better able to be compliant with national standards for high quality care.
Need to manage resources	This option would not fully address the ongoing workforce issues of staff recruitment and retention at Weston General Hospital, particularly for A&E and critical care. A £4.5 million improvement in net revenue income and expenditure is predicted for Weston

	Area Health Trust, which runs the hospital. There would be no need for large capital expenditure.

The overriding benefits of this approach are that it would address safety issues, would be relatively quick and easy to implement and would help to stabilise the hospital. There are elements within this preferred option that could be implemented within one-year subject to public consultation and decisions about next steps by the CCG's Governing Body.

In November 2018, the South West Clinical Senate review panel stated that this approach should be delivered as soon as possible in order to assure ongoing quality and safety for local residents receiving acute care.

The *Healthy Weston Programme* recognises that these changes alone do not meet the case for change fully. In particular, significant staffing and financial challenges remain. To address this, the Programme has a long-term vision for the next five years which includes more integrated care resulting in more primary care and community-based services being delivered in conjunction with hospital-based services to better meet the needs of the majority of the population. This future direction of travel includes greater focus on the frail and elderly, people with long-term conditions and vulnerable groups who will have more local access to core services**.** This approach is fully aligned with the aspirations set out in the NHS Long Term Plan to avoid admissions where possible and keep care close to home. Evidence suggests that similar services put in place elsewhere in the country have had a significant benefit for helping people stay well and out of hospital.

Proposed public consultation

Following one and a half years of engagement, clinical development and appraisal, the *Healthy Weston Programme* recommends formally consulting the public about the three significant variations to services proposed under the preferred model:

- **A&E** would be available 14 hours per day, seven days per week (supported by 24/7 direct hospital admission) staffed by a combination of specialist A&E doctors and GPs (not 24 hours a day as commissioned). People needing immediate urgent care who could not be directly admitted to Weston General Hospital would be treated at other hospitals in Bristol and Taunton

- a **high dependency unit** (level 2 critical care) would be available with 24 hour, seven day per week acute medicine or anaesthetic cover (rather than level 3 critical care as currently)

- **emergency surgery** would be available seven days a week during the day time (instead of the current 24 hours a day). People needing immediate overnight surgery who cannot wait until the morning would be treated at other hospitals in Bristol and Taunton

The Programme proposes outlining during the public consultation that 'no change' is not a viable option because it will not meet population need in the future and is not a safe and sustainable model for Weston General Hospital or the wider health and care system. Immediate changes are required at Weston General Hospital to bring stability for safety and quality reasons, as endorsed by the South West Clinical Senate. The proposed option will help to stabilise Weston General Hospital and ensure that key services are provided in a location that are best able to meet national standards.

Any changes to acute care would be implemented in the context of wider positive developments so the *Healthy Weston Programme* proposes to seek some level of feedback about these developments and the longer-term vision for more integrated services during the consultation process – though **these aspects would not be proposals formally being consulted about** in fulfilment of the CCG's statutory obligations.

Any alternative options put forward during the public consultation will be considered, along with the perceived benefits and challenges raised about the preferred approach and how best to address them. **For example, an emerging alternative model of urgent and emergency care developed by consultants at Weston General Hospital will be fully considered through the consultation process.**

The *Healthy Weston Programme* has benefitted from extensive engagement and local input to date and wishes to continue this through varied routes that reach a wide range of people. A detailed consultation plan has been developed with a range of public meetings, surveys, discussion groups, targeted meetings with groups that are traditionally less engaged, and social media postings. It is proposed that consultation takes place between February and June 2019, allowing for purdah for local authority elections.

Table 2 sets out key milestones towards formally consulting stakeholders.

North Somerset Health Overview and Scrutiny Panel has confirmed that it will scrutinise the consultation process, continuing to involve Somerset, Bristol and South Gloucestershire local authorities as required. This approach has been endorsed by the neighbouring local authorities. The *Healthy Weston Programme* has benefitted from ongoing scrutiny at the *Healthier Together* Joint Health Overview and Scrutiny Committee which includes Bristol City Council, North Somerset Council and South Gloucestershire Council and has been regularly presented at Somerset Council's Health Overview and Scrutiny Panel. All of these bodies will continue to be informed moving forward.

The themes from the public consultation will be independently analysed and this analysis will be drawn on when creating a decision-making business case to consider next steps. Decisions about next steps after public consultation rest with NHS Bristol, North Somerset and South Gloucestershire CCG, as the commissioner with statutory responsibility.

Table 2: Key steps for public consultation

Milestone	Target date
CCG Governing Body considers Pre-Consultation Business Case, including consultation plan (closed meeting)	4 December 2018
Publication of HOSP papers, outlining proposals to determine whether they constitute a substantial variation in services and therefore require formal public consultation	5 December 2018
North Somerset HOSP Meeting	11 December 2018
NHS England Stage 2 Assurance Meeting	19 December 2018
CCG Governing Body papers published	2 January 2019
Programme update and consultation plan considered by the CCG Governing Body	8 January 2019
Second NHS England Stage 2 Assurance Meeting	25 January 2019
Pre-Consultation Business Case published with CCG Governing Body papers	29 January 2019
CCG Governing Body considers Pre-Consultation Business Case	5 February 2019
If approved by the Governing Body, consultation begins, with full programme of events and engagement straddling purdah and running for a **total of 14 weeks**	13 February 2019
Consultation ends	24 May 2019
Independent analysis of consultation feedback	June 2019
Development of Decision Making Business Case taking into account feedback from consultation.	June - August 2019
Share Decision Making Business Case with NHS England for comment	August/Sept 2019
CCG Governing Body makes decision about next steps	September 2019

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1. Introduction

This section outlines the purpose of this Pre-Consultation Business Case and the *Healthy Weston Programme*.

1.1 Purpose

Across the UK, health and care systems are seeking ways to respond to the changing health needs and demographics of the population and opportunities associated with new technology and medical advances. Key policy drivers such as NHS England's *Five Year Forward View* and the *NHS Long Term Plan* note that it is essential to focus on proactive care and approaches to improve the underlying health of the population, support people to manage their own health, work in a more joined up manner to break down boundaries between primary and secondary care and ensure that urgent and emergency care is efficient and effective. The Bristol, North Somerset and South Gloucestershire geography's status as an aspirant Integrated Care System reinforces the emphasis placed locally on integration, innovation and working together to best meet the needs of the population.

This Pre-Consultation Business Case sets out how the *Healthier Together* Sustainability and Transformation Partnership's *Healthy Weston Programme* has worked with clinicians, partner organisations, patients, carers and members of the public to consider the health services that might best serve the population of Weston, Worle and the surrounding areas in an integrated manner. The work has been clinically-led throughout and there is whole-system ownership of the process used and the proposals put forward. More than 3,000 people have been involved so far.

Healthy Weston is a comprehensive programme designed to improve and 'future-proof' care across the whole system. The specific changes proposed for Weston General Hospital have been deemed by the local Health Overview and Scrutiny Panel to be substantial variations in provision and therefore require formal public consultation. Hence, **this Pre-Consultation Business Case focuses specifically on proposed changes to acute care at Weston General Hospital, particularly in relation to A&E services, critical care and emergency surgery.**

There is an overwhelming case for transforming health services in Weston, Worle and the surrounding areas to improve the care available for local people, population outcomes and system efficiencies. Based on one and a half years of engagement, analysis and clinical leadership, this Pre-Consultation Business Case shows that developing a stronger, more focused Weston General Hospital is a key component of more integrated and resilient health and care services, and sets out a preferred model for consultation.

This Pre-Consultation Business Case:

- sets out why health and care services **need to be transformed** in Weston
- describes how **clinicians and leaders across the whole health and care system** have worked together to engage with local people, consider population needs and best evidence and develop models for the future
- describes the **robust process** used to generate and assess options to ensure strong and focused general hospital services as one component of the broader model of care
- sets out the anticipated benefits and challenges of **the preferred option**
- **provides assurance** that the processes used and evidence considered are in line with good practice
- recommends a **strategy for consulting** the public, staff and other stakeholders formally about the preferred way forward

This section provides a brief overview of the *Healthy Weston Programme* and its status as a whole-system priority programme for *Healthier Together* in transforming health and social care across Bristol, North Somerset and South Gloucestershire.

Section 2 highlights the need to change the way that services currently work to meet population needs, ensure better access to healthcare, provide care in line with national and regional standards and ensure efficient use of resources.

Section 3 describes the robust process used, led by clinicians and based on extensive public and clinical engagement, to develop and assess potential models for Weston General Hospital.

Section 4 sets out a preferred option to address the need for change and the potential benefits and risks associated with this approach.

Section 5 describes how the process used to develop this Pre-Consultation Business Case has been assured and summarises how it addresses the five tests of change NHS England applies when considering service change.

Section 6 describes the proposed approach for consulting the public and other stakeholders about the preferred option.

1.2 The Healthy Weston Programme

Healthier Together is the Sustainability and Transformation Partnership (STP) for the Bristol, North Somerset and South Gloucestershire geography. Thirteen local health and care organisations sit on the *Healthier Together* Board, including:

- **Health commissioners:** NHS Bristol, North Somerset and South Gloucestershire CCG, NHS England
- **Local authorities:** South Gloucestershire, Bristol and North Somerset local authorities, which includes the West of England Public Health Partnership
- **Providers:** Weston Area Health NHS Trust; North Bristol NHS Trust; University Hospitals Bristol NHS Foundation Trust; Avon and Wiltshire Partnership Mental Health Trust; Sirona; Bristol Community Health; North Somerset Community Partnership; Brisdoc, South Western Ambulance Service NHS Foundation Trust

The Sustainability and Transformation Partnership's key mandate is to take a whole-system approach to moving towards a more integrated system of health and care. Currently care is fragmented. 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.

The *Healthy Weston Programme* is one of the priority initiatives being spearheaded by the Sustainability and Transformation Partnership, alongside other programmes such as mental health, digital, maternity services, acute care strategy, integrated community localities, general practice resilience and transformation, prevention, urgent care and workforce.

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

Scope of the Healthy Weston Programme

The *Healthy Weston Programme* was established by *Healthier Together* to transform services to better meet the needs of the Weston, Worle and nearby population and to address a number of significant challenges with regards to clinical and financial sustainability. The ambition is to provide coordinated, comprehensive and integrated services for people using services across primary care, community care, secondary care, mental health, social care and voluntary services. The direction of travel nationally, including as outlined in the NHS Long Term Plan, is to provide care to avoid admissions where possible and expedite discharge back to people's homes. This includes enabling and empowering people to choose self-care options wherever appropriate, primary care working at scale and providing strong system leadership, and supporting individual practices to be more robust and work together more effectively with each other and with other health and care providers.

The *Healthy Weston Programme* is developing a fully integrated model of care for frail and older people, which brings together the hospital, primary care and community based providers and social care to deliver a holistic, one-stop shop approach to proactively meeting the needs of this significantly growing cohort in Weston, Worle and the surrounding areas.

The *Healthy Weston* vision also includes stronger, more integrated community services supported by a 'Health and Care Campus' model at the Weston General Hospital site. This brings together services and resources that are already in place, centred around people, families and communities, with closer collaboration between primary care and community services. This work has already started in a number of services, including maternity care.

There are also efforts to develop an acute care collaborative approach across the Bristol, North Somerset and South Gloucestershire system that would see increased networking of acute hospitals, including fully integrated clinical teams that deliver consistent quality and standards of care for the whole population, wherever they access services.

Addressing challenges in acute care at Weston General Hospital was identified as a priority due to critical workforce issues and other challenges at the hospital which have had a significant impact on the whole health system – such as making necessary a temporary closure of the A&E overnight. There is a need for a managed solution addressing the risks and issues so that changes can be actively planned and their impact on other providers and populations appropriately mitigated. By delivering a more stable model for key acute services at Weston General Hospital, there will be an increased opportunity to attract and retain staff to work at the hospital. This Pre-Consultation Business Case makes a case for consulting about a stronger more focused Weston General Hospital because this is seen as an **urgent challenge**. However potential options for the hospital were developed within the context of *Healthy Weston*'s whole-system approach to health and social care.

Members of the Healthy Weston Programme

This Pre-Consultation Business Case is the result of extensive whole-system work, with partners from across primary care, community healthcare, acute hospital care, social care and the voluntary sector all championing the direction proposed. The *Healthy Weston Programme* is led by NHS Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group (CCG) on behalf of the Sustainability and Transformation Partnership.

The *Healthy Weston Programme* includes the following partners, all of whom have actively participated in the process that has led to the development of this Pre-Consultation Business Case and the preferred direction of travel for consultation set out herein:

- **Avon and Wiltshire Partnership NHS Trust** provides inpatient and community based mental health care for people living in Bath and North East Somerset; Bristol, North Somerset, South Gloucestershire; and Swindon and Wiltshire. It also provides specialist services extending throughout the South West. The Trust employs over 4,000 staff who deliver services from more than 90 locations, working in approximately 150 teams across a geographical region of 2,200 miles, for a population of approximately 1.8 million people.

- **Healthwatch North Somerset** is the independent champion for people who use health and social care services in North Somerset working to ensure that those running services, and the government, put people at the heart of care. Healthwatch aims to understand the needs, experiences and concerns of people who use health and social care services and to speak out on their behalf.

- **NHS Bristol, North Somerset and South Gloucestershire CCG** was established in April 2018, bringing together NHS Bristol CCG, NHS North Somerset CCG and NHS South Gloucestershire CCG. The CCG has 85 member practices, working together with other clinicians and patients to decide how the local NHS budget should be spent.

- **NHS Somerset Clinical Commissioning Group** works on behalf of its member practices with clinicians and patients to commission healthcare services for the 544,000 people who live in Somerset. There are four GP practices in the North Sedgemoor area covered by the *Healthy Weston Programme*.

- **North Bristol NHS Trust** provides acute general hospital services for people living in Bristol, South Gloucestershire and North Somerset, with a number of more specialist services serving a wider population across the South West. The Trust is the region's major trauma centre. It employs over 8,000 staff delivering healthcare across Southmead Hospital Bristol, Cossham Hospital, Bristol Centre for Enablement and within the local community of Bristol and South Gloucestershire.

- **North Somerset Community Partnership** an employee-owned social enterprise. It provides a wide range of community based health services across North Somerset, including community nursing, health visiting, therapy services and North Somerset Community Hospital. The Trust employs almost 600 staff.

- **South Western Ambulance Services NHS Foundation Trust** is the primary provider of 999 services across the South West. The Trust employs more than 4,000 staff and has 96 ambulance stations, three clinical control rooms, six air ambulance bases and two Hazardous Area Response Teams.

- **Taunton and Somerset NHS Foundation Trust** runs Musgrove Park Hospital, providing acute hospital care and some specialist services for the whole of Somerset. The Trust employs over 4,000 staff.

- **University Hospitals Bristol NHS Trust** provides acute general hospital services for the population of Bristol, South Gloucestershire and North Somerset, with a number of more specialist services serving a wider population across the South West. The Trust employs over 9,000 staff who deliver over 100 different clinical services across nine different sites.

- **Voluntary Action North Somerset** works to represent, support the development of, and empower voluntary, community and social enterprise organisations in North Somerset.

- **Weston and Worle GP Provider Group** comprises 14 primary care practices providing general medical services in Weston, Worle and the surrounding area, with practices increasingly working collaboratively.

- **Brisdoc** a co-operative social enterprise providing out of hours GP services across Bristol, North Somerset and South Gloucestershire.

- **Weston Area Health Trust** provides a range of acute health services to the population of North Somerset and North Sedgemoor at Weston General Hospital, and works closely with other hospitals in Bristol as part of clinical networks including, for example, cancer, pathology and cardiology. The Trust also provides community paediatric and Child and Adolescent Mental Health Services. The Trust serves a catchment population of around 152,000 people, with about 20% of Trust activity coming from Somerset (North Sedgemoor).

The *Healthy Weston Programme* has a clear governance structure and accountabilities, with a number of workstreams providing input into an overall Steering Group. The structure of the *Healthy Weston Programme* is provided in Appendix 1.

Table 3 sets out members of the *Healthy Weston Programme* **Steering Group**, which reports directly to the Sustainability and Transformation Partnership. This is the group that are ultimately proposing plans for public consultation for consideration by the CCG.

The North Somerset Council Chief Executive sits as an observer on the Steering Group in recognition of the Council's role in scrutinising the consultation process. Officers from North Somerset Council have been fully engaged in the operational planning and development of service models (such as the Integrated Frailty Service).

Table 3: *Healthy Weston* Steering Group membership

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

** formally invited as full members from September 2018. Other system partners and representatives from NHS England and Somerset are invited as required.

The *Healthy Weston Programme* has strong clinical leadership through the **Clinical Service Design and Delivery Group**. This group led the development of options for change set out in this Pre-Consultation Business Case. Table 4 outlines the membership of

the Clinical Service Design and Delivery Group and shows that clinicians from the wider system across Bristol, North Somerset and South Gloucestershire and Somerset have been involved throughout.

Table 4: *Healthy Weston* Clinical Service Design and Delivery Group membership

Organisations represented	Personnel
NHS Bristol, North Somerset and South Gloucestershire CCG	Medical Director (Chair) Locality Commissioning GP Lead
Weston Area Health Trust	Medical Director (Vice Chair)
Avon and Wiltshire Partnership NHS Trust	Medical Director (or representative)
Healthy Weston Programme	Programme Director Chair of Finance and Enabling Group
North Bristol NHS Trust	Medical Director (or representative)
North Somerset Community Partnership	Director of Nursing and Therapies
North Somerset Council	Head of Adult Social Care
South Western Ambulance Services NHS Trust	Clinical Lead (Somerset)
Taunton and Somerset NHS Trust	Medical Director (or representative)
University Hospitals Bristol NHS Foundation Trust	Medical Director (or representative)
Weston and Worle Locality Lead	Lead GP
Woodspring Locality Lead	Lead GP

The **Finance and Enabling Group** provided expert oversight of modelling for financial, activity and workforce data. Table 5 outlines the membership of the group which includes the Directors of Finance from across the Bristol, North Somerset and South Gloucestershire system.

Table 5: *Healthy Weston* Finance and Enabling Group membership

Organisations represented	Personnel
NHS Bristol, North Somerset and South Gloucestershire CCG	Director of Finance
Weston Area Health Trust	Director of Finance
Healthy Weston Programme	*Healthy Weston* Finance Lead
North Bristol NHS Trust	Director of Finance
North Somerset Community Partnership	Director of Finance
Taunton and **Somerset NHS Foundation Trust**	Deputy Director of Finance
University Hospitals Bristol NHS Foundation Trust	Director of Finance

The *Healthy Weston* **Communications and Engagement Group** provided expert oversight of the communications and engagement activity required to support the *Healthy Weston Programme*, recognising the commitment to codesign and community engagement. Table 6 lists the membership of this group.

Table 6: *Healthy Weston* Communications and Engagement Group membership

Organisations represented	Personnel
NHS Bristol, North Somerset and South Gloucestershire CCG	*Healthy Weston Programme* Director (Chair) Head of Communications North Somerset Locality PPI Lead
Weston Area Health Trust	Communications Lead
Healthier Together	Communications Lead
Healthwatch North Somerset	Communications Lead
North Somerset Community Partnership	Communications Lead
North Somerset Council	Communications Lead
Somerset CCG	Communications Lead
University Hospitals Bristol NHS Foundation Trust	Communications Lead
Voluntary Action North Somerset (VANS)	Communications Lead

The purpose of listing the members of the *Healthy Weston Programme* is to highlight that there is wide representation across the health and care sectors and that all of these organisations support and have been involved in developing the case for change, the

process used to generate and appraise options for the future and the proposed direction for public consultation.

The patient and public reference groups that have supported the development of the work described in this document are detailed in Section 4.1.

The *Healthy Weston Programme* sourced expert advice as follows:

- Legal advice was provided initially through Bevan Brittan LLP and full legal advice through Capsticks Solicitors LLP.
- Additional communications and engagement advice was provided by Hood & Woolf.
- Clinical design and financial modelling support was provided by McKinsey.

Key points

- This Pre-Consultation Business Case summarises the work that the *Healthy Weston Programme* has undertaken with clinicians, partner organisations, patients, carers and members of the public to consider acute services at Weston General Hospital.

- The *Healthy Weston Programme* is a key workstream within *Healthier Together*, the whole-system Sustainability and Transformation Partnership and as such is owned by the whole health and care system. The *Healthy Weston Programme* is one of a number of priority programmes aiming to support a system-wide transformation towards more integrated primary, community, social and hospital care, in line with the NHS Long Term Plan.

- The processes used and the preferred direction of travel set out in this Pre-Consultation Business Case are supported by the entire *Healthy Weston Programme*, which includes representatives from NHS provider and commissioned agencies covering Weston, Worle and the surrounding areas.

- The *Healthy Weston Programme* includes extensive work to strengthen primary and community healthcare, as well as hospital services. However, this Pre-Consultation Business Case focuses on consulting about changes to Weston General Hospital because this is as an urgent challenge. The proposed changes constitute a significant variation to service delivery and thus the CCG is required by law to publicly consult about these changes to acute care.

2. Why do we need to change?

This section describes why health and care services need to be transformed in Weston, Worle and the surrounding areas.

There are four key reasons why health and care services in Weston, Worle and the surrounding areas need to change:

- **The health needs of the population are changing:** The population is growing, getting older, living with more long-term conditions and there are significant inequalities amongst local communities**.** It is essential to develop new models of care that are better able to meet changing health and care needs.

- **There is variation in access to, and continuity of, care:** There are differences in the way care is currently provided and opportunities to offer better access and continuity of care, focusing on prevention and supporting people to maintain their independence. Opportunities to join up primary care, community care and hospital care are a key part of this.

- **There is variation in the standards of care provided:** Some health services, particularly at Weston General Hospital, are not able to consistently meet national and local clinical quality standards because of low volumes of particular cases and shortages of specialist staff. There are opportunities to use Weston General Hospital more effectively and efficiently to provide care in line with national and local standards, and to help to address workforce sustainability.

- **It is essential to ensure value for money:** There is a growing gap between the cost of healthcare and available funding, with the Bristol, North Somerset and South Gloucestershire region in deficit by £86m in 2017/18. The system needs to live within its means, get best value for money and make sure available financial resources most effectively meet the needs of the whole population.

Each of these reasons for change is set out in turn in this section. Together they comprise the Case for Change. It should be noted that this Case for Change encompasses the entire *Healthy Weston Programme* and therefore some elements of it are more relevant for the public consultation about changes to acute services than others.

2.1 Better meeting population health needs

This section presents figures from North Somerset Council's Joint Strategic Needs Assessment. It shows that Weston, Worle and the surrounding areas have an older population compared to the England average. The age and size of the population is predicted to grow over the next 20 years, with many new housing developments planned and an increase of students likely. There are pockets of deprivation and increases in the proportion of people with long-term conditions are predicted. The population of frail and older people is projected to increase significantly, as is the number of children under the age of 14. There is a higher concentration of people living with mental health issues, learning disabilities and those struggling with drug and alcohol addiction in the Weston area compared to North Somerset as a whole. The *Healthy Weston Programme* is developing primary and community services to help address these needs and hospital services must be well integrated.

Population demographics

The population of the Weston and Worle area is in region of 110,000, but this document includes the wider population served by Weston General Hospital, including the surrounding villages and population in Somerset who are referred to and use Weston General Hospital because any changes to services would affect this population too.

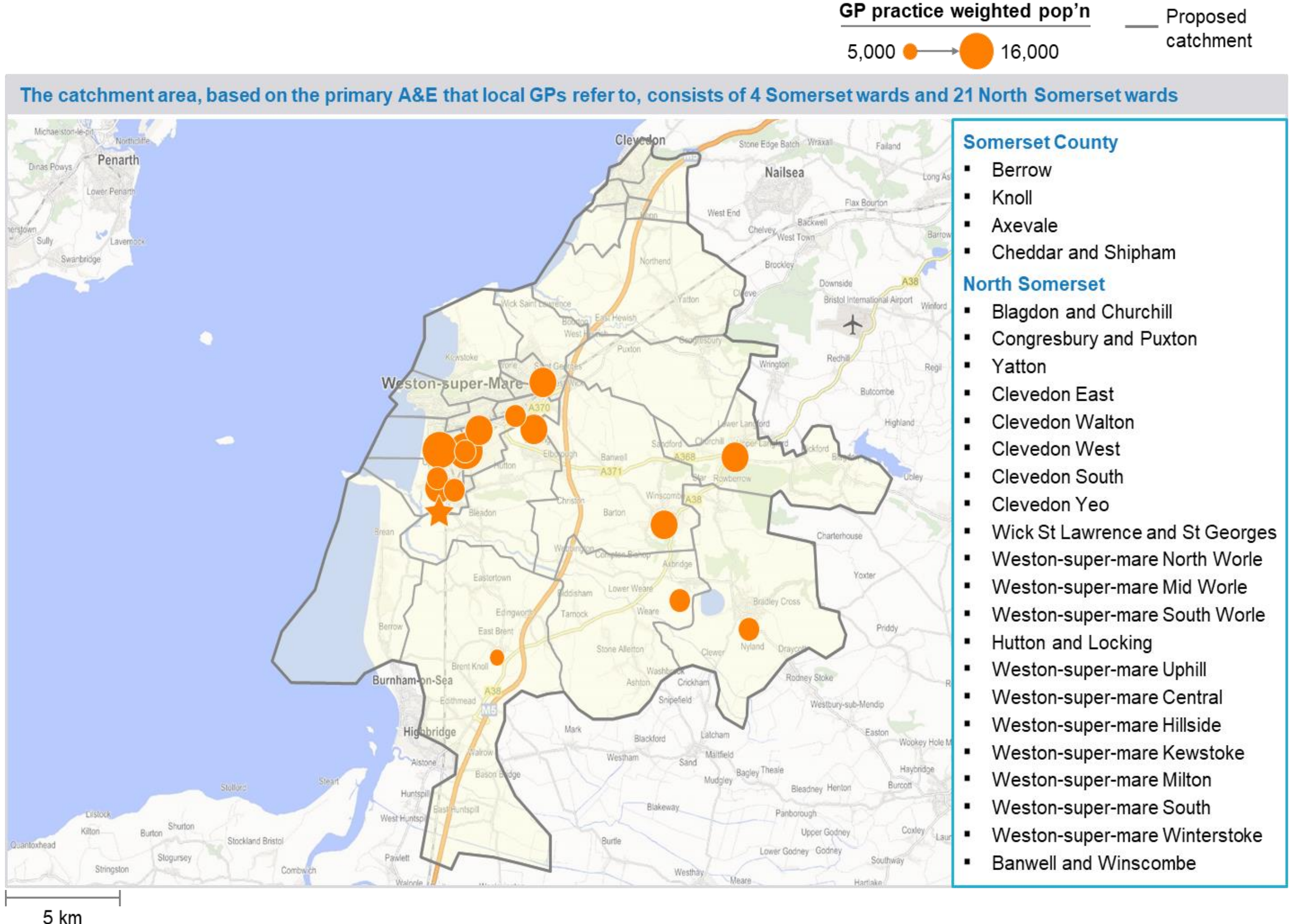
The population served by Weston General Hospital is just over 150,000, as determined by the registered population of referring practices. This area includes the coastal town of Weston-super-Mare, the adjoining village of Worle, the village of Winscombe and the surrounding rural villages in the south of North Somerset. There are also the villages in the North Sedgemoor area of Somerset and parts of the other locality of North Somerset, known as Woodspring (see Figure 2).

The population in Weston, Worle and the surrounding areas is on average older than the England national average, with 20% of people predicted to be over 70 years of age by 2025. The population is expected to increase by about 0.8% per annum by 2025, with proportionally higher growth in the over seventies age group. The birth rate is projected to fall by 0.2% per year until 2025 in both North Somerset and Sedgemoor, but the number of children and young people is expected to rise by 12% (4,000) over the same period. This is largely due to projected housing developments, with the majority of future growth expected to be in Weston, Worle and the surrounding areas.

Significant new build housing developments are planned in central Weston, many of which will be for younger families. This has implications for the type and number of local services needed including primary care and children's services. Additional new build developments are also expected near Nailsea, Yatton and Portishead and between Long Ashton and Bristol, although residents in those areas typically receive acute care from hospitals in

Bristol. In total, 42% of the CCG's spend in 2017/18 on acute care services for the residents of North Somerset went to Weston General Hospital.

Figure 2: Areas served by Weston General Hospital (by referring GP practice)



Source: Hospital Episode Statistics (HES) 2016/17

Health inequalities

The health status of people in Weston Town is poor compared to North Somerset overall and the other CCG locality areas. While life expectancy in North Somerset is broadly in line with the England average, it varies by area, with Weston-super-Mare Central Ward having the lowest life expectancy (67.5 years for males and 76 years for females). Conversely Clevedon Yeo has the highest life expectancy for both males and females at about 86 years and 92 years respectively.

Pockets of deprivation exist, particularly around the town of Weston-super-Mare. The national rate of children living in poverty in England is 25%, with the average for North Somerset being 19%. However, in Weston-super-Mare Central Ward it is 36% and Weston-super-Mare South Ward it is 38%.

Obesity and binge-drinking are particularly prevalent around Winterstoke and South Worle. Weston has a higher number of people living with mental health issues, learning disabilities

and those struggling with drug and alcohol addiction than other areas in North Somerset. These people tend to have much poorer physical health and lower life expectancy.

Long-term health conditions

Nearly two thirds (64%) of those registered with Weston Town practices report having a long-term health condition, compared to 51% in Worle and 57% in the North Somerset area. More than one in five people in Weston Town (23%) and Worle (21%) reported a long-term health problem or disability that limits their day-to-day activities compared to 17% in both the Clevedon and Portishead and Nailsea and rural localities. Consequently, disease prevalence figures are highest in the Weston Town where 17% of people are recorded as having hypertension, 7% suffer from diabetes, 4% from coronary heart disease and 3% from stroke. By 2030 it is expected that more than 10,000 additional local people will be living with high blood pressure, 6,000 more will have diabetes and a similar number will be living with the serious lung condition chronic obstructive pulmonary disease (COPD).

Thus more people are living with long-term conditions and the burden of disease is expected to increase. To address this there is a need to break down traditional silos between primary, community and hospital care and for health services to adopt a more proactive, asset based approach that empowers people to stay happy and well.

Frail and elderly people

With a significant increase in the projected frail and elderly populations in the future, the system must change the way services are delivered to better meet their health and care needs. In North Somerset, 22,000 residents are aged over 75 (about 10%), of which around 6,500 are aged over 85. There are 110 care homes (69 residential homes and 41 nursing homes) and about 3,000 care home beds in North Somerset, of which 38% are in Weston.

As in other parts of the country, over 75 year olds in Weston, Worle and surrounding areas are more likely to attend A&E and be admitted to hospital than others. Those aged over 75 years make up 12% of the Weston General Hospital catchment population but accounted for 20% of all A&E attendances at Weston General Hospital in 2018 (compared to 13% nationally, 10% at University Hospitals Bristol, 17% at North Bristol Trust and 17% at Taunton and Somerset Trust 17%). The over 75 population currently accounts for 30% of all acute admissions, 60% of hospital beds and 40% of admitted patient costs at Weston General Hospital.

There is evidence that older and frail people locally are being admitted to hospital for non-medical reasons such as their usual carer being unable to look after them.

Unplanned and emergency admissions are not good for older people. Frail older people experience 5% muscle wastage for every day spent in a hospital bed, meaning they can find it difficult to return to their previous level of independence. Thresholds for admission are often lower than medically necessary and lengths of stay are longer than they need to be, resulting in poorer outcomes.

All of this evidence and statistics show that services are not currently well tailored for key local population priority groups such as the frail elderly who regularly experience unplanned acute admissions and then stay in hospital longer than they need to; children who need access to comprehensive physical and mental health care; and vulnerable groups, particularly those with drug and alcohol problems who often experience fragmented care.

2.2 Better access to and continuity of care

Increasing access to and continuity of care is a priority. This is particularly true for primary care and community health services, but is also important for joined up working with hospital care. The scope of other health services is described only briefly here, with most focus on services currently provided at Weston General Hospital. The descriptions below show that whilst there is a solid foundation of services in Weston, Worle and surrounding areas, there is not equal access to services across the region or across demographic groups.

Primary care

With over 90% of patient contacts in the NHS taking place in general practice, primary care is the foundation of the local health system. While local primary care services in Weston, Worle and the surrounding area are generally of high quality, they are facing a number of significant challenges associated with an ageing workforce, increased workload and an ageing and growing population with complex medical needs.

At the beginning of 2018 there were 10 GP practices in the Weston and Worle localities, with services delivered from 14 sites. As a result of increasing collaboration and mergers, this picture is dynamic. There are no closed lists which means that people are able to register with any practice in their local area. All practices have been inspected by the CQC and all have been rated as good overall. Recruitment is an issue for a number of practices, which has been complicated by issues with premises. This is being addressed following an NHS England grant to improve retention and recruitment of GPs in the Weston area, which is in addition to the wider strengthening of primary care that will in itself help improve recruitment and retention.

In Weston, Worle and the surrounding areas there is variation in the size of GP practices and the numbers of patients per GP. Patient survey results highlight that there continue to be significant issues associated with access to general practice so it is a priority to improve access to these services. Providing continuity of care for people with more complex conditions is known to improve outcomes.

Community health services

North Somerset Community Partnership (NSCP) is a community interest company providing community services in North Somerset. This organisation is managing an increasing number of frail and complex patients in the community. The high number of care home beds in North Somerset and the imperative of admission avoidance, rehabilitation and recovery for this cohort of patients add to service pressures.

Despite good work to enhance community services, such services are often not joined up with each other and health professionals are not able to share information easily. This sometimes means that people must repeat their details and stories multiple times. This lack of integration leads to both duplication and gaps in care. NHS Bristol North Somerset and South Gloucestershire CCG is currently procuring adult community health services to ensure a consistent offering across the entire Bristol, North Somerset and South Gloucestershire area. Procurement will take place in 2019 and it is estimated that a single provider will provide services across the CCG's geography from April 2020.

There are a range of services available but there is a clear opportunity to develop an integrated system where the different agencies work together more effectively to deliver better quality care for patients, in close cooperation with Weston General Hospital. Many people today live with multiple conditions and may receive care from a variety of different organisations. By integrating services more effectively people will experience more seamless care and be treated as a whole person.

Services for children

The changing nature of childhood illness means that fewer children require an inpatient hospital stay and those that do need to be admitted tend to have a shorter length of stay than in the past. Parents are, however, more likely to go directly to A&E services, particularly with children under the age of two.

Changing epidemiology means that there has been an increase in children with complex long-term conditions. Technological developments have enabled a children's health service delivery model that is much more community-based and multidisciplinary. Community paediatric services face operational challenges including with workforce recruitment and long waiting times. Currently the community paediatric service is physically separated from children's services on the Weston General Hospital site, with high levels of children under the age of five attending A&E.

There have been historic issues in access to support for children and young people with emotional and mental health needs in Weston, Worle and the surrounding area. Additional funding has been identified to improve capacity and access. Work is also underway with the local authority and schools to help build resilience in young people.

Services for vulnerable groups

Parts of Weston, Worle and the surrounding area have concentrations of people living with mental health issues, learning disabilities or drug and alcohol addiction. People who have a mental health condition in the Weston area are three times more likely to go to A&E and four times more likely to have an emergency admission to hospital than people without a mental health condition. Local evidence suggests that people with complex needs are attending A&E and being admitted to hospital because they were not able to see a GP or other health or care professional at the right time. This underlines the need to put in place the right support to enable primary care to more effectively respond to urgent care needs.

People with urgent and emergency care needs

Engagement and codesign work undertaken for the *Healthy Weston Programme* found that local people and professionals find access to urgent and emergency care complex. Of those people who attend A&E at Weston General Hospital, audits have found that around 35% could be better or equally well assessed and treated by a different service, for example a pharmacist, NHS 111 or a GP. There is also substantial variation in A&E attendance rates between patients registered at different GP practices. More work is therefore needed to ensure patients know how, when and where to access urgent care when needed.

2.3 Acute care in line with guidance and standards

Weston General Hospital overview

Weston General Hospital is managed by Weston Area Health NHS Trust which also provides community paediatric and child and adolescent mental health services in North Somerset. Weston General Hospital is one of the smallest district general hospitals in the country. It is commissioned to provide the following emergency and planned care services:

- A&E 24 hours a day, seven days per week (24/7). For safety reasons associated with the availability of staff, there has been a temporary overnight closure of the A&E in place since mid-2017, following an inspection from the CQC. The A&E is currently operating 14 hours a day, seven days a week
- ambulatory emergency care unit, providing ambulatory care for patients requiring an urgent review, investigation and/or treatment
- acute medical admissions through the Medical Assessment Unit onto one of the 10 inpatient wards for further ward-based care. Patients requiring specialist medical review or intervention (such as emergency percutaneous coronary intervention for heart attacks) are stabilised either in A&E or the Medical Assessment Unit, prior to transfer to specialist centres

- general surgical admissions and emergency operating for acute surgical admissions requiring life or limb threatening emergency surgery. Surgical patients requiring specialist surgical interventions (such as patients with head injuries who need urgent neurosurgery) are stabilised in A&E prior to transfer to centres which can provide further specialist surgical management
- intensive treatment unit for critically unwell patients up to and including level 3 critical care and one to one specialist nursing
- short stay Paediatric Assessment Unit (8am to 8pm, 5 days a week) for children who need a period of observation/treatment with links to the Bristol Royal Hospital for Children for onward referral or transfer if an inpatient admission is required
- non-complex elective surgical services including urology, orthopaedic and gynaecological elective surgery. Patients requiring extended post-operative specialist care are transferred to appropriate tertiary surgical centres
- community antenatal and postnatal services, day assessment and midwife-led birthing options at home or in the midwife led unit at Weston General Hospital
- a range of therapy services including occupational therapy, physiotherapy, nutrition and dietetics, and speech and language therapy to support inpatient and outpatient activity
- oncology, cancer and palliative services, including chemotherapy provision, with strong links to the Bristol Oncology and Haematology Centre.

Table 7 illustrates current levels of acute activity at the hospital. In 2017/18 there were a total of 55,643 attendances at A&E, 9,302 of which were for 'major' issues. There were a total of 5,960 spells for planned surgery.

Table 7: Acute services at Weston General Hospital in 2017/18

Activity	Units	2017/18*
A&E major	Attendances	9,302
A&E standard	Attendances	26,483
A&E minor	Attendances	19,858
Acute medicine	Spells	10,132
Emergency surgery	Spells	3,201
Elective medicine	Attendances	277
Day case medicine	Attendances	8,349
Critical care	Bed days	1,749
Elective surgery	Spells	1,228
Day case surgery	Spells	4,732
Outpatient	Attendances	105,639
Paediatric day case	Spells	811

* Numbers have been calculated based on likely demand if commissioned services were in place (i.e. assuming the availability of A&E 24 hours a day, seven days per week, even though a temporary overnight closure is in place).

For a number of pathways, unwell people who can be readily identified by clinicians in the community or by paramedics are transferred directly to a more specialist centre in Bristol or Taunton, rather than going to Weston General Hospital. This includes major trauma, some types of heart attack and vascular surgery. South Weston Ambulance Services NHS Trust have protocols and pathways in place to support this (see Appendix 2). These protocols have been developed over time and, while they work well, it can be confusing for paramedics and patients, so there is an opportunity to update transfer protocols.

Variation in standards

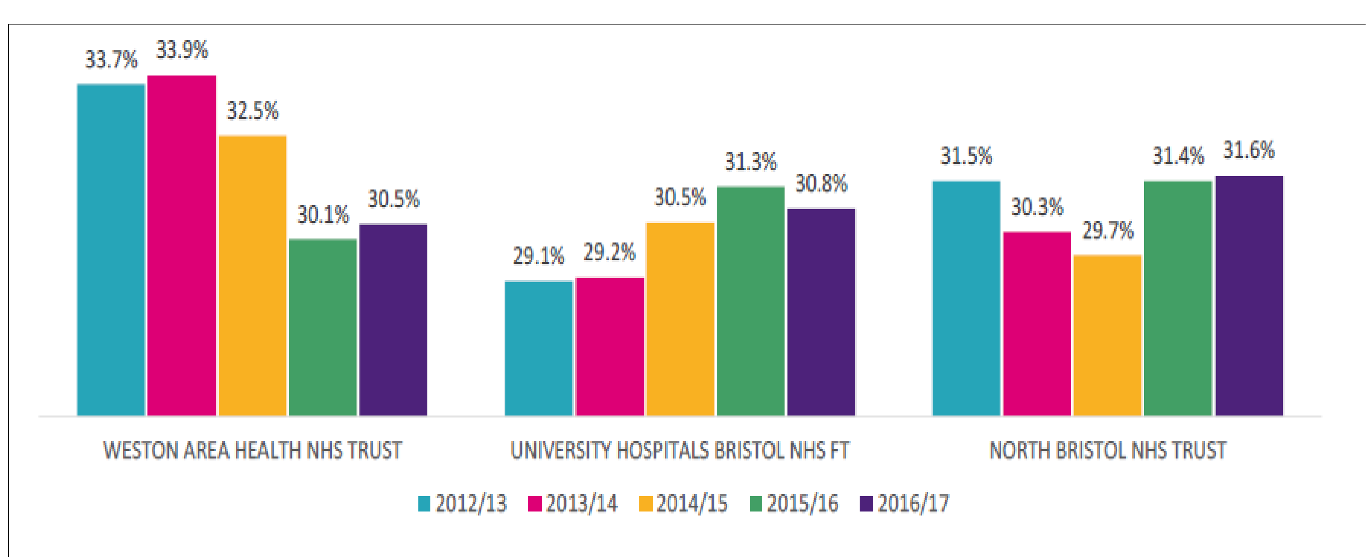
Health and care teams work hard to provide good quality services, but the *Healthy Weston Programme* identified that there are some particular challenges ensuring that care at Weston General Hospital is delivered in line with national and local guidance and standards.

A June 2017 CQC inspection of Weston Area Health Trust (with updates in December 2017 and December 2018) showed that there are many areas of good care and practice and that staff work hard and provide compassionate care to their patients. However, there were concerns about urgent and emergency services and the domains of safety, effectiveness, responsiveness and leadership. Overall the Trust's services, including Weston General Hospital, were rated as 'requires improvement'. This section lists some of the key issues identified which all partners have committed to improving.

A review of emergency general surgery published by the South Weston Clinical Senate in 2017 found that of the fourteen acute hospitals in the region, Weston General Hospital came joint 13th in the number of standards it met. In relation to those that were met or partially met, Weston General Hospital was fourteenth out of fourteen.

As the smallest acute hospital in the country, Weston General Hospital has found it difficult to preserve the full range of services that a district general hospital of its type might have provided in the past. This has largely been as a result of its inability to recruit and retain specialist staff. There has been a year-on-year reduction in 'market share' of inpatient and outpatient activity at Weston General Hospital between 2014 and 2017, while A&E attendances have remained broadly steady (see Figure 3).

Figure 3: Comparing Weston Area Health Trust market share with other Trusts



The NHS Five Year Forward View recommended that networks of linked hospitals are developed to ensure patients with the most serious needs get to specialist centres. This draws on the success of major trauma centres, which have saved 30% more of the lives of the worst injured compared to other models of care. The Five Year Forward View further suggested that smaller district hospitals should not be providing complex acute services where there is evidence that high volumes are associated with high quality. Some services need to be shifted to other locations.

The Five Year Forward View Next Steps outlined the national policy to roll out Urgent Treatment Centres to treat people who do not need the most specialist types of emergency care. The NHS Long Term Plan reinforced this by restating the ambition to fully implement the Urgent Treatment Centre model, noting that in recent years, attendances at urgent care services have grown at a faster rate than acute A&E attendances. Appendix 3 summarises the clinical evidence for this approach.

Weston General Hospital sees fewer A&E attendances each month than other local hospitals (although this increases over the summer months as a result of out-of-town visitors). On top of this, the A&E struggles financially, largely because it finds it difficult to recruit and retain specialist staff and therefore has high agency fees, accounting for almost 10% of its overall turnover in 2017/18.

As a result of these staffing challenges and the CQC ‘requires improvement’ rating, the system implemented a temporary overnight closure of A&E at Weston General Hospital in July 2017. This was largely driven by an inability to attract sufficient numbers of specialists to provide safe staffing 24 hours a day. The A&E is currently open between 8am and 10pm, which is when the majority (80%) of the people seen there have always used it.

CQC issued a warning notice with a number of conditions the hospital needed to meet regarding A&E. Restricting the opening hours for A&E during the temporary closure allowed the hospital to improve the service which led to the subsequent lifting of the warning notice.

Since the temporary overnight closure, the hospital has been trying to substantively recruit a minimum 80% of the clinical staff required under national guidelines for A&E staffing. So far this has not been possible and, even if the required number was reached, turnover of staff means there would be an ongoing risk of repeated unplanned closures in the future.

The impact of the overnight closure on patient care was predicted in advance of the temporary closure and the actual impact was reviewed after six months and 12 months (see Appendix 4). There was no step change in the four-hour performance of other neighbouring trusts associated with the timing of the temporary overnight closure, although demand was inevitably displaced to other local hospitals. The reviews concluded that there was no deterioration in safety at neighbouring hospitals and no deterioration in patient safety for people cared for at Weston General Hospital as a result of the temporary overnight closure.

The 12-month review found that overall predictions about the impact of the temporary overnight closure were sound. There were between 11 and 13 additional A&E attendances per night spread across other sites as a result of the temporary overnight closure. However, this reflects only 41% of patients that were previously using the A&E at Weston General Hospital overnight. The remaining 59% of people who were previously accessing overnight services either waited until the A&E opened the next morning, accessed alternative overnight care such as GP out of hours services or found that they could self-manage without the need for a hospital visit.

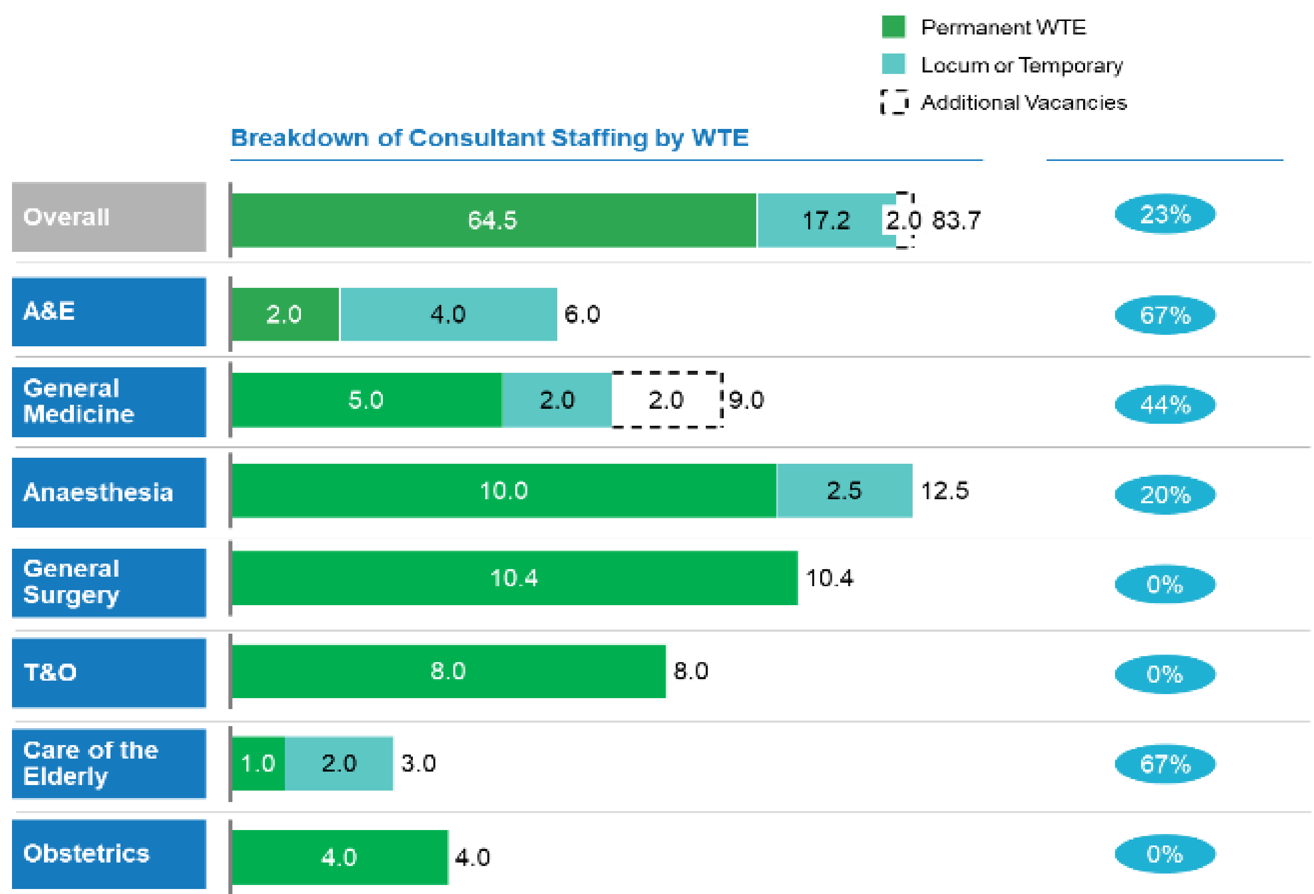
Workforce

While working to recruit and retain high quality staff, for a number of years Weston General Hospital has had a lack of substantive consultants to provide 24/7 care in acute specialties, with a **67% vacancy rate** (excluding locums) in A&E Whole Time Equivalent (WTE) staff numbers and a 44% vacancy rate (excluding locums) in general medicine as at March 2018 (see Figure 4). There are also high rates of medical and nursing agency staff (810 nursing agency shifts in January 2018 alone), which leads to high costs and less continuity of care for patients. This also makes team working and team development more challenging.

Because of the staffing challenges, junior doctors do not always get the level of supervision they need and report low levels of satisfaction in their jobs. Overall junior doctor satisfaction with training is 68% which is significantly lower than the national average of 79% and has caused the South West Deanery to question the role of the hospital in training junior doctors, adding additional pressure to the ability to appropriately staff the service.

All of these challenges mean that action is needed to ensure that care at Weston General Hospital can be delivered in line with national and local guidance and standards now and in future.

Figure 4: Weston General Hospital vacancies as of March 2018



Elective surgical services

Weston General Hospital is well placed and has good facilities for the provision of elective surgical activity, with scope to improve productivity and capacity through new ways of working. There is strong research evidence that providing routine planned care in dedicated surgical units, such as hip and knee replacement operations or cataract surgery, reduces waiting times and cancellations. This is because it is easier to plan workloads and because beds, staff and theatres are not taken up with unplanned admissions. **There are significant opportunities for the facilities at Weston General Hospital to be used to provide more planned care**. Offering Weston as an elective centre of choice for a wider population across Bristol, North Somerset and South Gloucestershire could also lift some of the capacity constraints on Bristol hospitals.

Maternity services

The decreasing number of births projected in the future supports the need for a strong networked maternity service across Bristol, North Somerset and South Gloucestershire that provides choice and personalisation. This is being driven forward by the Bristol, North Somerset and South Gloucestershire Local Maternity Network through their Local Maternity System plan, which is working to create a single maternity system that brings together capacity and expertise across all providers.

In Weston, there is a strong midwife-led-service with local access to antenatal and postnatal care. This provides a good solution in the context of the wider Local Maternity Network plan. The ***Healthy Weston Programme*** **does not propose any changes to the maternity model of care** at Weston General Hospital.

There have been changes to the staffing model over the course of 2017/18, essentially moving from a 24-hour staffed unit to a 24-hour on call system. The experience for women giving birth has not changed in that they are still able to give birth at Weston General Hospital. Additional obstetric consultant support is now available for midwives and further work is being undertaken to strengthen community provision across the Weston and Worle areas. The North Somerset Health Overview and Scrutiny Panel has advised that this is an operational change that does not constitute a substantial variation in services and does not require public consultation.

2.4 Ensuring sustainability and value for money

Bristol, North Somerset and South Gloucestershire CCG is responsible for ensuring that the funds available to the local healthcare system are used in the best way to maximise life expectancy and ensure consistently good quality services for the local population on an equitable basis. Based on 2017/18 spend, 56% of all NHS funds available for the local population were spent on acute hospital care even though 90% of patient interactions took place in primary and community services.

To address the future health needs of the whole population, the system needs to change this balance of funding to ensure greater resources are available to meet the needs of increasing numbers of older people and those with long-term conditions in Weston and across the CCG geography.

There is considerable potential for increased investment in primary and community care to support more people outside of hospital and reduce acute admissions to hospital, thus improving health and quality of life for the local population and getting better value for money. This change of emphasis is in line with the NHS Long Term Plan and is likely to result in proportionately less funds available for acute hospital services in the future.

The CCG is currently subsidising Weston Area Health Trust for about £3.2m annually to support a number of services, primarily the A&E at Weston General Hospital. This short-term measure is not sustainable and it diverts funding away from other services and populations. In addition, this does not cover the shortfall in costs at the Trust.

Weston Area Health Trust continues to experience significant financial challenges, partly due to the need for higher agency and locum costs as a result of the workforce challenges described above and partly due to underutilised services due to its smaller size and decreasing market share. Even with productivity gains, the Trust's financial deficit is expected to increase to £16.6m by 2024 if there are no significant changes in the way care is delivered. This deficit would be equivalent to 15% of total Trust income.

In 2018 Weston Area Health Trust and University Hospitals Bristol jointly commissioned independent consultants to review Weston General Hospital's position as part of the two Trusts' Partnership Agreement. This work concluded that even if Weston General Hospital was to move to top quartile efficiency and attract the largest share of its catchment population possible, under the current model it would still be facing a projected recurrent deficit of over £13m per annum (see Appendix 5)

Key points

- The population living in Weston, Worle and the surrounding areas is just over 150,000. This population is predicted to grow faster than the national average over the next 30 years, with the number of frail elderly and people with long-term conditions expected to rise. The number of children under the age of 14 is also predicted to rise. There are pockets of high deprivation and health inequalities in the Weston area. All of these characteristics of the population have implications for the health and care services that will be needed in future.

- Weston General Hospital is one of the smallest district general hospitals in the country. For safety reasons associated with staffing, the A&E has been temporarily closed overnight since mid-2017. There are significant ongoing issues with staffing and the Trust that runs the hospital is in continuing deficit. Even if the Trust achieved maximum efficiency and patient numbers, it would remain in deficit.

- There is an overwhelming case that the model of healthcare in Weston, Worle and surrounding areas needs to change to accommodate population needs; essential improvements in access to and continuity of care; issues with the potential quality and safety of acute care available and making best use of available staff and financial resources. Working in a new and more integrated manner will allow the delivery of stronger and more resilient primary and community care as well as an assured future for acute services at Weston General Hospital.

3. System changes to address local needs

This section describes developments to care outside hospital to show how proposals for acute services at Weston General Hospital are part of a series of wider integrated changes.

3.1 National context: the NHS Long Term Plan

The NHS Long Term Plan, published in January 2019, set out the direction of travel for the NHS over the next 10 years. It define a new service model for the future of health and care, building on the models developed and tested through vanguard programmes and further integrating primary and community care to provide more joined-up care and reduce hospital admissions. Key to this model is the development of multidisciplinary community teams and delivering primary care at scale.

The Long Term Plan highlighted initiatives being delivered to better meet the needs of people requiring urgent and emergency care. These include the connection with 111 and GP out of hours services to form Integrated Urgent Care services and the development of same day emergency care services and urgent treatment centres alongside responsive community services. All of these approaches are designed to improve access to urgent care and to reduce the pressure on emergency hospital services.

The shift towards population-based health through the development of integrated care systems was a repeated theme, highlighting the importance of collaboration between local health and care organisations to deliver ‘triple integration’ of primary and specialist care, physical and mental health services, and health with social care.

Of particular relevance for the *Healthy Weston Programme* was the national proposal to develop a standard model of delivery in smaller acute hospitals that serve rural populations.

The proposals outlined in this document are in line with the NHS Long Term Plan and provide the foundations for achieving the ambitions set out in the plan. The *Healthy Weston Programme* will work with NHS England and local stakeholders to ensure that the development of the long term vision for local services remains aligned to the Long Term Plan for the NHS.

3.2 Enhancing primary care

The *Healthy Weston Programme* has a clear rationale for focusing on acute hospital services within this document, but it is also important to contextualise this work within the wider *Healthy Weston Programme* to give assurance that out of hospital local services are being strengthened and because the reforms proposed to Weston General Hospital are linked with improvements to care outside of the hospital. This section provides an overview of improvements being made to primary and community health as background information.

Continuity of primary care can improve outcomes for people. However, the extensive engagement undertaken for the *Healthy Weston Programme* showed that many residents were concerned about their ability to get an appointment with their local GP practice. To address this, through the *Healthy Weston Programme* local GPs have come together to agree how they can operate at scale, thereby providing more effective and efficient services. To help deliver this, GP practices based in and around the Weston locality have committed in principle to operate together under the umbrella of an organisation called the Pier Health Partnership (subject to due diligence).

Practices are working together to finalise this and the organisation is intended to go live in 2019. Its objective is to make life better for patients and practices, keeping the autonomy and identity of practices whilst delivering a model of care that is flexible, resilient, delivers wealth and lifestyle and is sustainable for future generations. Pier Health has the potential to deliver benefits including more efficient services through the sharing of back office costs, shared clinical resources, improved booking and appointment systems and a more consistent offer to local care homes.

In this context, in October 2018 a small group of senior GPs used a vehicle called the Pier Health Group to step in at short notice to take over a contract serving the most deprived community in Weston, thereby preventing a list dispersal of more than 5,000 patients. This is the first time that GPs from different practices have cooperated in this way. The preparatory work done under the *Healthy Weston Programme* laid the groundwork for GP leaders to be able to prevent what would have been a negative outcome for the patients of practices threatened with closure and protecting local surrounding GP practices that would have had to absorb the impact of thousands of patients suddenly dispersed within the locality. Pier Health Group proved that things can be done differently in the Weston locality, with GPs coming together to deliver services that they could not have done on their own. This has demonstrated that the wider Pier Health Partnership can work and deliver real and tangible benefits for local people.

This may also have benefits for primary care recruitment. Local GP leaders have reported that the ability to operate a more resilient model is likely to attract new GPs and other primary care staff to work in the area. On the whole, larger and more established practices in the Weston locality already have a track record of being able to attract new staff more easily than smaller or more challenged practices.

In addition, local GPs have made it clear that being able to offer a more varied working environment (such as via the integrated frailty service and proposed A&E at Weston General Hospital with led by A&E consultants and GPs), as well as traditional general practice work will significantly increase their chances of recruiting new staff. In places such as Surrey where similar innovative models have been put in place, recruitment has been bolstered. The current GP workforce that is approaching early retirement may also in some cases delay retirement to undertake these portfolio work opportunities.

Intensive Support Scheme

Through the groundwork laid by the *Healthy Weston Programme,* Weston was successful in its bid to become one of six national NHS England Intensive Support Scheme (ISS) sites. This initiative is helping drive significant change and transformation, including new organisational arrangements that will deliver primary care at scale to improve access and continuity of care for those who need it most. Weston was awarded about £400,000 to support work from September 2018 to March 2019. NHS England supported the bid due to the following issues:

- Age profile of GPs and practice nurses in Weston is higher than the national average and there has been a historical inability to recruit.
- Average number of patients to GP is higher than the national average.
- Resilience issues of individual practices and subsequent impact on the locality.
- Deprivation in Weston with four areas in the top 5% nationally and two in the top 1%.
- Significantly growing population (additional 20,000 projected in the next ten years) and large seasonal influx of tourists.

Weston was also selected for the following more positive reasons:

- The *Healthy Weston Programme* has established credibility for the locality’s ability to deliver significant programmes of work.
- There is a shared vision and ownership of the programme from Weston and Worle practices.
- There is a move to create a local federation and strong desire to work together.
- There is an ability to ‘hit the ground running’ and make significant progress quickly due to developments with Pier Health.

The Intensive Support Scheme programme's ultimate objective in Weston is to improve the working lives of staff in practices and in turn, improve recruitment and retention rates. The programme aims to create a template and business case that can be applied to other localities. Expected deliverables by March 2019 include:

- New online booking system 'front door' implemented in all practices by March to include revised navigation processes including significant patient involvement exercise.
- Delivery of change management training for practices and coaching/mentoring for GPs.
- New apprenticeship/career structure for practice staff launched.
- Role and competency profiling complete.
- Business case for Frailty GPs complete (to ensure that there is the right workforce model to support the Integrated Frailty Service)
- Care Home project complete (to ensure that there is a more consistent and efficient primary care offer to the multiple care homes in the area)
- Launch of Pier Health

These improvements will enable GPs to focus more on patients and alleviate some of the organisational demands on their time. It will create resilience in the practices by stabilising staffing and processes and enable practices to work more closely together and therefore offer a coordinated service to the local population.

£3.2 million capital grant for a primary care facility in Weston

Another example of the transformations occurring in primary care is that the CCG has been awarded a £3.2 million capital grant to create a bespoke primary care facility in the centre of Weston. Having state of the art premises to deliver primary care is a factor that helps attract the workforce. We plan to use this consultation exercise to gather feedback and test ideas on how this new money may be best spent.

3.3 Services for vulnerable groups

The *Healthy Weston Programme* aims to provide more proactive, person-centred models to support vulnerable people experiencing a mental health crisis as an alternative to A&E. This includes the development of a 'mental health crisis and recovery centre' in the centre of Weston, building on learning from other areas and insight from the *Healthy Weston* codesign work that a central Weston location is more preferred than the hospital site. This service aims to meet the needs of people experiencing acute emotional distress associated with a mental health problem (which may or may not have been given a formal diagnosis). The centre will provide a safe, welcoming and comfortable place for people in emotional distress and for those seeking to prevent the onset of a crisis. It is a new service that is designed to complement rather than replace or supersede existing local provision, and reduce demand at Weston A&E by offering a better alternative for people with these needs.

Investment in psychiatric liaison services at Weston General Hospital is also being prioritised, with a particular focus on drug and alcohol issues. Additional recurrent funding has been committed to support local Children and Adolescent Mental Health Services too.

Another development to support the *Healthy Weston* aims is that the CCG, working with Avon and Wiltshire Partnership NHS Trust, is progressing a strategic review of mental health services, with the potential to consolidate some specialist mental health services on the Weston General Hospital site. For example, a specialist dementia service may be located at Weston General Hospital and there are opportunities to ensure that users of the Integrated Frailty Service benefit fully from this resource. Potential developments relating to mental health services will be subject to a separate consultation if required.

3.4 Integrated frailty service

NHS England's *Frail Older People, Safe Compassionate Care* and the British Geriatric Society's *Fit for Frailty* publications both identify a strong evidence base to support a holistic approach to meeting the needs of people living with frailty, saying for example *"Care needs to be just as important as treatment. Older people should be properly valued and listened to, and treated with compassion, dignity and respect at all times. They need to be cared for by skilled staff who are engaged, understand the particular needs of older people and have time to care."*

For these reasons, establishing an integrated frailty service is a core priority for the *Healthy Weston Programme*. Key features of the integrated frailty service are:

- Proactive person-centred, personalised care designed around individual needs.
- Early intervention and prevention to support people living independently for longer in community, preventing social isolation.
- Risk stratification to determine place on the frailty pathway based on frailty score.
- Shared care plan, based on a Comprehensive Geriatric Assessment, ensuring the provision of holistic care and advanced care planning.
- Supported self-care and involvement of family and carers.
- Home first approach based around primary and community care clusters.

Appendix 6 describes the design of the Weston Integrated Frailty Service. It is planned that such a service could be implemented within a year of deciding to proceed.

Evidence to support integrated frailty care

As part of the development of the Integrated Frailty Service for Weston, the CCG commissioned an independent literature review. This was combined with a separate evidence review undertaken by management consultants whilst working with Weston Area Health Trust and University Hospitals Bristol. The models, case studies and systematic reviews identified spanned a ten-year period (2006-2016) and focused on the impact of integrated care models on non-elective and A&E admissions. The reviews concluded that integrated care models reduced non-elective admissions by an average of 29% (with a range of 15-50%) and reduced A&E attendances by an average of 38% (with a range of 29-50%). The two local pilots undertaken at Weston General Hospital in 2018 resulted in a 48% reduction in non-elective admissions, a 13% reduction in conversion rate and a two-day reduction in length of stay for those patients appropriately admitted (see Appendix 6).

In addition to significant improvements in non-elective admission rates and A&E attendances, the reviews highlighted positive reductions in bed day usage as a result of integrated frailty care. In Devon, the Torbay Community Trust established five integrated health and social care teams organised in localities aligned with general practices. They reported that daily occupied beds fell from an average of 750 to 502 in 10 years resulting in their emergency bed day use among over 65 year olds being the lowest in the region. The *Healthy Weston* model for integrated frailty care will draw on the learning from Torbay.

Another example of supportive evidence is the national Partnerships for Older People Projects (POPP). These were funded by the Department of Health (2006-2009) to develop services for older people, promoting health, well-being and independence and preventing or delaying the need for higher intensity or institutional care. The programme consisted of 470 projects across 29 pilot sites, supported by 522 organisations. The services were used by more than 264,000 people. Evaluation found that a wide range of projects resulted in improved quality of life for participants and considerable savings, as well as better local working relationships.

The *Healthy Weston Programme* concluded that there is significant evidence nationally and internationally as well as from local pilots to support the importance and efficacy of establishing an Integrated Frailty Service for Weston.

Why improvements to current provision are needed

The integrated approach to frailty care is an important and beneficial change compared to what is happening currently. At present there is fragmented staffing for frailty care locally, with staff variably covering all patients in North Somerset and also non-frail patients. Dedicated frailty support in the community is led by one whole time equivalent (WTE) frailty lead practitioner, two 0.5 WTE registered nurses and one consultant across all of North Somerset. This team is further supported by the Weston, Worle and surrounding areas integrated care team (26 nurses split across North Somerset with responsibility for frail and non-frail patients), as well as a residential home support team, rapid response, community matrons, pharmacy, social services, mental health and the voluntary sector.

At Weston General Hospital there is currently one dedicated frailty specialist physician providing an acute frailty service two days a week to prevent admissions from A&E where appropriate. There is a 0.8 WTE social worker based at the hospital but not covering patients in A&E. This role provides access to social services records but is not able to make decisions and is not specifically for frail people. The Weston General Hospital discharge team consists of 4.5 WTE qualified social workers and 6.5 other social care staff covering hospital discharges of all ages from Weston General Hospital and other hospitals across the region. Only the frailty specialist physician currently coordinates discharges from A&E.

Integral to the vision for an Integrated Frailty Service in Weston is the upskilling of staff across health, social and voluntary care sectors in ageing well and frailty care. This will be achieved through formal learning and practice-based learning via multi-disciplinary teams to ensure that staff have the necessary skills and competencies to deliver the integrated frailty pathway. Importantly, the workforce supporting the Integrated Frailty Service will act as catalysts to upskill other staff across community-based services in the management of frail older patients. As part of a wider piece of work in the area called the Locality Transformation Scheme, the Integrated Frailty Service will ensure all providers of services in the community work together in a more integrated way. This will be enabled by contractual alignment as well as shared performance metrics between providers.

The Integrated Frailty Service workforce

As outlined in more detail in Appendix 6, it is planned that the Weston Integrated Frailty Service will comprise a multidisciplinary team including advanced frailty practitioners (nurses and therapists), frailty doctors (consultant geriatrician, GP, other senior clinicians), social care staff, mental health nurses, pharmacists, falls specialist physiotherapists and nurses, wellness navigators and volunteers (see Figure 5).

Figure 5: Integrated frailty service staffing roles

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

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

One of the strengths of the Integrated Frailty Service is that it draws on a wide spectrum of skills and experiences to better meet the needs of patients, putting the right tasks with the right people. Wellness navigators are new roles in the system. Their role is to support clinicians in helping patients, rather than replacing existing clinical staff. Wellness navigators will work with primary, community and voluntary care services to identify people with frailty that may benefit from additional support. This role will require competency training and be undertaken by staff who will be performing delegated duties under the supervision of the registered professionals in the Integrated Frailty Service. Each wellness navigator will have a caseload of patients within the Integrated Frailty Service with the higher risk segment patients allocated to more experienced navigators. Whilst not being able to provide clinical diagnosis, they will have enhanced skills to enable them to provide a range of activities including advice, signposting and access to activities, baseline assessment skills enabling them to proactively identify issues and help arrange for a clinician to see the patient and contributing as a key member of the multidisciplinary team. Baseline assessment skills will include nutrition, pressure sore risk, frailty and vital signs. They will use personal anticipatory care plans, taking advantage of clinical, voluntary and patient-led services specific to each individual. For the patient they will provide continuity and a key contact throughout their journey, including if a hospital admission is required.

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

The *Healthy Weston Programme* calculated the workforce requirements for the Integrated Frailty Service based on an estimated frail population of about 6,500 patients in Weston, Worle and the villages who are expected to access the full service offering. Representatives from social care, primary care and others inputted as to how frequently and for how long people in each risk segment need to be seen on average. Figure 6 shows the assumptions and estimated staffing requirements. In addition to the staffing requirements for proactive care pathways, an additional 1.5 WTE acute consultant, 1.6 WTE wellness navigators and 0.7 WTE advanced clinical practitioners are estimated to be required for unplanned care provision based on expected activity managed by the acute frailty unit including anticipated acute activity from North Sedgemoor and out of area. Staffing for routine primary care was not estimated separately as this is assumed to continue as present.

Figure 6: Integrated Frailty Service workforce requirements by tier

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

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

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

The preceding sections have provided the overall context for the *Healthy Weston Programme* and set out some of the changes to primary and community services planned as part of this. The document now turns to focus on proposed changes to acute hospital services, including how proposals were generated and the range and number of people involved.

4. Developing potential ways forward

This section describes the process for identifying and evaluating potential options for acute services at Weston General Hospital.

4.1 Engaging clinicians, the public and other stakeholders

Key to the *Healthy Weston Programme* has been engaging stakeholders to help develop potential ways forward. Stakeholders such as clinicians across primary, community, mental health and acute care; health and social care leaders and staff; patient, carer and public representatives; the third sector; local councillors and MPs and regulators have been involved in a wide range of engagement activities. This engagement has helped to shape the developments to primary and community care described previously, as well as being key to the proposals for acute care at Weston General Hospital.

In June 2017 NHS North Somerset CCG, which later became part of NHS Bristol, North Somerset and South Gloucestershire CCG, undertook extensive engagement with local communities about the potential role of Weston General Hospital. Feedback was analysed by North Somerset Healthwatch (see Appendix 7). This feedback in turn informed the development of the *Healthy Weston* Commissioning Context published in October 2017, which set out the principles for *Healthy Weston* (see Appendix 8).

A public dialogue and co-design engagement period ran from October 2017 to March 2018 and engagement continued with regular sharing and testing of emerging proposals throughout 2018. Overall more than 3,000 people have been involved in shaping proposals for the *Healthy Weston* programme, including proposals about the options for acute services at Weston General Hospital.

Clinical leadership

The programme governance structure ensured that clinicians were at the heart of *Healthy Weston*. The Clinical Service Design and Delivery Group and Steering Group included senior clinicians from across the health community as outlined in Section 2. The group is chaired by the Medical Director of the CCG. The Medical Director of Weston Area Health Trust is the Deputy Chair and together they have demonstrated partnership working and senior clinical leadership. There was representation from consultants from across Weston Area Health Trust and neighbouring acute trusts as well as GPs from Weston, Worle and villages and Bristol, and clinicians from the ambulance service, community services and mental health services. The group met at least monthly in 2018, with additional meetings and workshops where required.

The development of clinical service models was led by the Clinical Service Design and Delivery Group plus a wide range of clinicians from primary, community, social care, mental health and acute services, including the ambulance service. The process was facilitated by McKinsey and Company who brought expertise on best practice evidence and examples of clinical models used across the country and world (see Appendices 9 and 10).

The CCG's Governing Body and Commissioning Executive provided oversight and additional clinical input.

Appendix 11 outlines the clinical representation and key meetings that supported the development of options for Weston General Hospital.

Engaging with patients, the public and staff

Table 8 summarises pre-engagement consultation activities. Further detail can be found in Appendix 11.

During the pre-consultation engagement phase the Programme asked people:

- what was important to them about local health and care services
- what ideas they had for improving services and priority areas to improve
- what criteria should be used for evaluating options for change
- their thoughts about emerging proposals
- for ideas about how to deliver an effective consultation

In March 2018 the *Healthy Weston Programme* completed a period of in-depth public engagement about the issues and opportunities set out in the Commissioning Context. A codesign approach was used to encourage fresh ideas from stakeholders and local communities.

Appendix 12 contains the findings of an independent report summarising the feedback received during the public engagement period. Over 1,600 pieces of feedback representing more than 2,500 people were received including notes from workshops, survey forms, emails, letters and social media posts. All of this feedback was carefully considered when developing models of care for Weston General Hospital.

The key themes outlined in the independent report were strongly reflected in the criteria used to weigh up the pros and cons of different options for change. In April 2018 more than 100 stakeholders further inputted to the development of the evaluation criteria. Appendix 11 summaries the attendees and outputs from this event. Work continued through summer 2018 to finalise the evaluation criteria and these were tested with *Healthy Weston* Patient and Public Reference Group members via telephone calls and virtual meetings. Their feedback about the evaluation criteria is detailed within Appendix 13.

Further engagement activities took place from June to December 2018. This included:

- public, staff and stakeholder meetings and listening events, including with the voluntary, charity and social enterprise sector and community and faith groups
- community outreach meetings with the seldom heard and those with protected characteristics
- focus groups to test emerging models with members of the public
- an online survey
- political stakeholder briefings with MPs and councillors
- releasing a range of material via the *Healthy Weston* webpages

The outreach work actively involved seldom heard groups such as those dealing with substance misuse, the lesbian, gay, bi and transgender communities and disability groups. The *Healthy Weston Programme* proactively visited these groups and forums to raise awareness and to capture their views.

The Programme also worked closely with Somerset CCG to reach communities in neighbouring and border areas.

A *Healthy Weston* Patient and Public Reference Group was set up in 2017 and has met regularly since. The group provided guidance to support the programme and is now being aligned to the newly established North Somerset Patient and Public Involvement Forum, which is chaired by the CCG's Patient and Participation Manager. The CCG's Corporate Patient and Public Involvement Forum is also engaged in the programme. This is chaired by the CCG Governing Body Lay Member for Patient and Public Involvement and has a direct reporting route to the CCG Governing Body. Appendix 11 lists the meetings of these groups where proposals for Weston General Hospital were discussed. These groups inputted into the development and testing of evaluation criteria for options development during August 2018, acted as a 'reader's panel' for the public-facing case for change document and helped to develop the consultation plan.

A virtual Citizen's Panel that represents people from across Bristol, North Somerset and South Gloucestershire has recently been established and the target is to have over 1,000 members. At the end of November 2018 there were 380 members (with 86 from North Somerset). The *Healthy Weston Programme* will use this as another channel for engagement and feedback during formal consultation.

Staff at Weston General Hospital had regular updates in meetings so they could input into planning as it progressed. This includes all-staff meetings and briefings and a senior clinical leaders workshop, as well as regular information updates via *Healthy Weston* bulletins. Wider staff representation has been facilitated in workshops to develop clinical models.

Table 8: Summary of engagement across different stakeholders

	Healthy Weston Governance Groups	Clinical Engagement	Healthwatch	Staff Engagement	HOSP/HOSC	MPs/Cllrs	Public Meetings and Patient Engagement	Hard to Reach	Somerset CCG
August 2017							22/08/17 PPRG Meeting		
September 2017			10/10/17 North Somerset Healthwatch meeting						
October 2017			10/10/17 North Somerset Healthwatch Board meeting	30/10/17 WAHT Staff Briefing	26/10/17 North Somerset HOSP meeting		26/10/17 WAHT Patients Council		
November 2017	08/11/17 Comms & Dialogue Meeting			14/11/17 WAHT Staff Briefing 28/11/17 Healthy Weston All Staff Event		02/11/17 Weston Labour Party Meeting 21/11/17 Weston Town Council Meeting	14/11/17 Weston Public Meeting 21/11/18 Healthy Weston Public Meeting, Worle 29/11/17 Shipham Public Meeting		
December 2017							05/12/17 Healthy Weston Public Event	07/12/18 Victoria's Kitchen (Homeless community)	
January 2018		08/01/18 Vulnerable Communities Pathway Workshop and Feedback 11/01/18 Children and Young Peoples' Pathway Workshop 18/01/18 Frail Older Peoples' Clinical Workshops 25/01/18 Care Homes Workshop – Weston Town Hall		23/01/18 Staff meeting at Weston Football Club			05/01/18 Cheddar Public Meeting 10/01/18 Yatton Public Meeting 11/01/18 Cheddar Public Meeting – Co-Design section 16/01/18 Healthy Weston Public Event, Worle 19/01/18 North Somerset PPG Chairs Meeting	03/01/18 Community Outreach at Tisley House Nursing Home 07/01/18 Rough Sleepers' Community Outreach Meeting 12/01/18 Alzheimer's Team 13/01/18 Children's Emotional and Wellbeing Partnership 31/01/18 Fibromyalgia Support Group 31/01/18 Future in Mind	
February 2018		01/02/18 Care Campus Service Redesign Workshop 05/02/18 Frail Older People's Clinical Workshop					12/02/18 Learning Disability Parent Group 14/02/18 Learning Disability Speaking Up Group 19/02/18 Young Persons' Learning Disability Group @ Weston College 24/02/18 Domestic Abuse Co-ordinator 28/02/18 Somewhere To Go outreach		
March 2018				30/03/18 Healthier Together newsletter					
April 2018				09/04/18 Healthier Together newsletter x 4 (09/04/18, 13/04/18, 20/04/18, 30/04/18)			19/04/18 Healthy Weston Update Event		

	Healthy Weston Governance Groups	Clinical Engagement	Healthwatch	Staff Engagement	HOSP/HOSC	MPs/Cllrs	Public Meetings	Hard to Reach	Somerset CCG
May 2018				17/05/18 Meeting with Somerset Surgical Services 25/05/18 Healthier Together newsletter			29/05/18 PPRG Meeting		
June 2018	19/06/18 HW Steering Group 26/06/18 Comms & Engagement Group	07/06/18 North Somerset Clinical Leaders meeting 26/06/18 CSDDG	26/06/18 Comms & Engagement Group	Healthier Together Newsletter (08/06/18, 15/06/18)	07/06/18 North Somerset HOSP			27/06/18 Meeting with CEO Vision North Somerset 29/06/18 Meeting with VANS Leadership Group	
July 2018	17/07/18 HW Steering Group	26/07/18 Clinical Workshop	11/07/18 Meeting with Healthwatch CEO	20/07/18 Healthier Together newsletter	23/07/18 Weston Town Council Meeting	02/07/18 Meeting with Cllr Nigel Taylor			
August 2018	23/08/18 HW Steering Group 29/08/18 Comms & Engagement Group	15/08/18 Clinical Workshop 29/08/18 Urgent Care Workshop	29/08/18 Comms & Engagement Group	Healthier Together newsletter x 5 (03/08/18, 10/08/18, 17/08/18, 24/08/18, 31/08/18) 09/08/18 Update letter and onward cascade briefing circulated to staff	30/08/18 Meeting with North Somerset HOSP Chair	09/08/18 Healthy Weston update letter	15/08/18 Healthy Weston Update Letter 24/08/18 PPRG Evaluation Criteria Call 28/08/18 PPRG Evaluation Criteria Call		
September 2018	07/09/18 HW Steering Group 12/09/18 Comms & Engagement Planning Meeting 20/09/18 HW Steering Group 27/09/18 Comms & Engagement Group	06/09/18 CSDDG 25/09/18 CSDDG 26/09/18 CSDDG	06/09/18 Meeting with Healthwatch CEO 12/09/18 Comms & Engagement Group 18/09/18 Healthwatch North Somerset Meeting 27/09/18 Comms & Engagement Group	Healthier Together newsletter x 4 (07/09/18, 14/09/18, 21/09/18, 28/09/18) 28/09/18 Update letter and onward cascade briefing circulated to staff	17/09/18 Boundary/Neighbouring HOSCs – Correspondence 20/09/18 North Somerset HOSP – Informal Briefing 26/09/18 North Somerset HOSP 26/09/19 BNSSG JHOSC Meeting	18/09/18 Meeting with Nigel Ashton 28/09/18 Healthy Weston update letter	18/09/18 North Somerset PPG – Chairs 18/09/18 BNSSG PPIF Meeting 25/09/18 PPRG Meeting	24/09/18 Voluntary Action North Somerset (VANS) AGM 26/09/18 Old People Champions Group – September HW Update 27/09/18 VCSE Sector/Representatives Meeting	20/09/18 Somerset CCG Governing Body Meeting
October 2018	01/10/18 HW Steering Group 18/10/18 HW Steering Group 25/10/18 Comms & Engagement Group	03/10/18 Healthy Weston – Wider Clinical Event 05/10/18 Meeting with UHB Medical Director 08/10/18 Clinical Engagement Event 08/10/18 Healthy Weston – Wider Clinical Event 09/10/18 CSDDG 24/10/18 CSDDG	25/10/18 Comms & Engagement Group	Healthier Together newsletter x 4 (05/10/18, 12/10/18, 19/10/18, 26/10/18) 08/10/18 WAHT Staff Listening Event x 3 10/10/18 Weston Staff Event 11/10/18 Weston Staff Event	18/10/18 Somerset HOSC – HW Presentation	05/10/18 Call with John Penrose MP	10/10/18 Healthy Weston Public Event 10/10/18 Stakeholder Event 16/10/18 North Somerset PPG Chairs Meeting 17/10/18 North Somerset PPRG 23/10/18 Tyntesfield PPG 30/10/18 Case for Change published	08/10/18 'Somewhere To Go' Meeting 08/10/18 North Somerset Homeless Services 24/10/18 Request to drop in at Greenfield Way Site (Traveller community) 25/10/18 NS Locality Leadership Groups & System Partners (VCSE, local authority)	

	Healthy Weston Governance Groups	Clinical Engagement	Healthwatch	Staff Engagement	HOSP/HOSC	MPs/Cllrs	Public Meetings	Hard to Reach	Somerset CCG
November 2018	29/11/18 HW Steering Group 29/11/18 Comms & Engagement Group	20/11/18 Clinical Senate 29/11/18 CSDDG		Healthier Together newsletter x 4 (02/11/18, 09/11/18, 16/11/18, 23/11/18) 28/11/18 Weston Staff Engagement Event	07/11/18 Somerset HOSC – HW Presentation	05/10/18 Call with John Penrose MP	23/11/18 Case for Change Roadshow (Sovereign Centre) 27/11/18 PPRG Meeting 30/11/18 Case for Change Roadshow (Healthy Living Centre) 30/11/18 Healthy Weston Public Event	01/11/18 North Somerset Citizens' Advice AGM 13/11/18 LGBT+ Healthy Weston Drop-In Session 15/11/18 Deaf Community – Communication Café 23/11/18 Addaction meeting 26/11/18 Learning Disability Network Meeting	29/11/18 HW Steering Group
December 2018	19/12/18 HW Steering Group 20/12/18 Comms & Engagement Group	20/12/18 CSDDG		05/12/18 Weston Staff Engagement Event 07/12/18 Healthier Together newsletter	05/12/18 Somerset HOSC 11/12/18 North Somerset HOSP	07/12/18 Meeting with John Penrose MP and Marc Aplin	03/12/18 Public Listening Event 03/12/18 Stakeholder Event 07/12/18 Case for Change Roadshow (Tesco) 14/12/18 Case for Change Roadshow (Healthy Living Centre)		19/12/18 HW Steering Group
January 2019	04/01/19 STP DoFs and Clinical Directors meeting 15/01/19 HW Steering Group 17/01/19 Comms & Engagement Group	09/01/19 CSDDG 09/01/19 GP Forum 14/01/19 Meeting with T&SFT CEO and Medical Director 17/01/19 CSDDG 17/01/19 GP Consultation following PLANET	17/01/19 Comms and Engagement Group	22/01/18, 24/01/18 Meetings with Weston General Hospital Consultant Committee (HMAC)	31/01/19 North Somerset HOSP	21/01/19 Mendip District Council Meeting 21/01/19 Presentation to Weston Town Council	24/01/19 WAHT Patient Council		21/01/19 Somerset Engagement Advisory Group

Themes common across all types of engagement were:

- Core services should be provided as locally as possible and in a more integrated and joined-up manner.
- Focus more resources on improving access to primary care and community services to reflect the increased demand from an ageing and growing population.
- Provide clarity about a sustainable future for Weston General Hospital.
- Concerns around the temporary overnight closure of A&E in Weston.
- Collaborate with voluntary, community and social services.
- Professionals and organisations should be better at sharing information (supported by integrated IT systems and shared medical records).
- Address patient need holistically, rather than a set of individual conditions.
- Help people to understand, navigate and access the 'system' and be kept informed about what is happening, including help to support self-care.
- Before any significant decisions are made, local people must be fully involved.

The Programme developed a 'you said, we did' table to provide examples of how feedback gathered during engagement helped to shape ongoing planning (see Table 9).

Engaging with other key stakeholders

The *Healthy Weston Programme* kept North Somerset Council, Weston Town Council, Somerset Council and the local MPs informed and engaged throughout via formal meetings and informal verbal briefings, as well as with regular written information updates.

The Bristol, North Somerset and South Gloucestershire Joint Overview and Scrutiny Committee has had the Programme presented to them and has indicated that they are content that it falls under the jurisdiction of the North Somerset Health and Overview Scrutiny Panel. This Panel and the Somerset Scrutiny Panel have had regular presentations, and this will continue.

Further details about oversight by the Overview and Scrutiny Committee and Panels is described in Section 7.

Table 9: Feedback during listening and engagement phase

We heard …	Therefore we will...
"What does it mean for me? I need to hear real examples of patients, not theory"	Ensure we tell you what the changes will actually mean to patients on a day-to-day basis
"Keep it simple. Use non-medical language and helpful illustrations to explain how things are now, and how this would be different in the future"	Ensure we communicate in a way which is clear and easy to understand in the consultation documents. This particular document is for internal use and the language reflects this.
"Communicate with me in a variety of different ways. Use face-to-face events as well as communicating in newspapers, and via Facebook, and other social media"	Create a communications plan which allows people to hear information from a wide variety of sources building upon the engagement work to date
"Involve as many people as possible in the discussion; charities and the voluntary sector, patients, carers, mental health users and other members of the public"	Ensure our consultation process is engaging with the widest variety of patients, members of the public and other key stakeholder groups
"Share an overview of the whole-system for the options available"	Ensure we are giving a holistic view of the design of the models we are supporting and the impact of the different options available
"Make sure transport is considered in your discussions"	Consider transport implications in any changes being made
"Show me what bringing healthcare services closer to home will actually mean to me when I need to get support"	We will clearly explain what integrated care will mean to patients and give examples through patient stories in our consultation materials
"I'm really concerned that key services are given enough funding, especially voluntary groups, which provide key services to my area"	We recognise this concern but it sits outside the scope of this document. It will be considered via other routes within the CCG
"Could we use more technology to help access services"	We are looking at options on how to digitalise access to services where possible and appropriate (understanding that not everyone is on line) and will extend this as we progress the detailed design work of the options. We recognise that technology is a great enabler for some of the changes we wish to see and will embrace and exploit this where we can. We have already got some work underway to demonstrate this, for example our 'Intensive Support Site' work in primary care.
"There is a level of mistrust- people think they are going to get a second -class service compared to the cities"	Ensure all communications are open and transparent and there are plenty of opportunities for members of the public, patients and carers to feedback

4.2 Developing clinical models

Taking on board the feedback from pre-consultation engagement, the *Healthy Weston Programme* used a methodology to generate potential clinical models for acute care at Weston General Hospital. This comprised:

1. Building a clear **Case for Change**. This involved describing the local population's health and care needs now and into the future, setting out how services are currently provided and highlighting the challenges faced by current health and care services now and in the future as they seek to meet the needs of the local population. In addition to the summary provided in Section 2, robust analysis of a wide range of data was undertaken. These data are summarised in Appendix 14 which contains the technical data and Appendix 15 which is a public document setting out why local health services need to change. There is also an 'easy read' version of the Case for Change which can be seen in Appendix 16.

2. Defining **evaluation criteria** against which different models for the future of Weston General Hospital could be assessed. These were heavily shaped by feedback from the pre-consultation engagement phase.

3. Developing **best practice care pathways and models of care.** This first involved drawing on local, national and international exemplars. This was followed by detailed description of a range of potential new service models for Weston General Hospital, including the provision of care in conjunction with other local community services and neighbouring hospitals. These models were refined into a shortlist of potential service options for Weston General Hospital.

4. The shortlisted options were **evaluated against the agreed criteria,** including modelling of activity and financial impacts and alignment and discussion of interdependencies and preferences through a clinical working group.

5. Building on the evaluation of options, shortlisted options were **tested for feasibility**, including detailed financial and activity modelling, consideration by the *Healthy Weston* Steering Group and review by the South West Clinical Senate.

Ultimately this process led to the identification of a preferred option to be put forward for public consultation, in the context of other developments underway and a longer-term vision for the future. This section describes in brief the process for developing best practice care pathways and models of care. Further details are provided in Appendices 9 and 17-19. The process is described so that readers can be assured of the rigorous process followed to consider and assess all possibilities before focusing on a preferred option in depth.

Best practice care pathways

A set of best practice care pathways provided the building block to consider clinical models. The pathways were developed by the *Healthy Weston* Clinical Service Design and Delivery Group with reference to the clinical evidence base for each service area, 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 should look like for each of the core service areas at each stage of the patient journey. Different levels of patient need were considered for each pathway (such as patients with 'minor' or 'major' conditions requiring urgent and emergency care).

Best practice pathways were developed for: urgent and emergency care pathways for less seriously unwell (minor) and more seriously unwell (major) patients; elective care pathway (for patients requiring lower complexity surgery and those requiring high complexity surgery); acute paediatrics; maternity and people with long-term conditions and frailty. Appendix 9 contains the full set of pathways for each service area.

Developing potential models

Potential clinical models to support the delivery of each best practice care pathway were then developed based on a number of principles. It was assumed that the models of care and services should be applicable to any local district general hospital around the country. High quality, accessible out of hospital services (such as general practice and community mental health services) were assumed to exist in support of all models to better deliver optimised patient care.

The focus was on defining core acute hospital services including A&E, acute medicine, emergency general surgery, critical care, elective surgical care, paediatrics and maternity. It was expected that diagnostics, elective medicine, outpatients and a frailty service should be provided in all cases. On site access to interventional radiology was not assumed as this is a specialist service. It was expected that clinical models should be detailed enough with respect to high-level workforce requirements, conditions covered and clinical interdependencies in order to enable objective assessment of how these models might be applied at Weston General Hospital against the agreed evaluation criteria in due course.

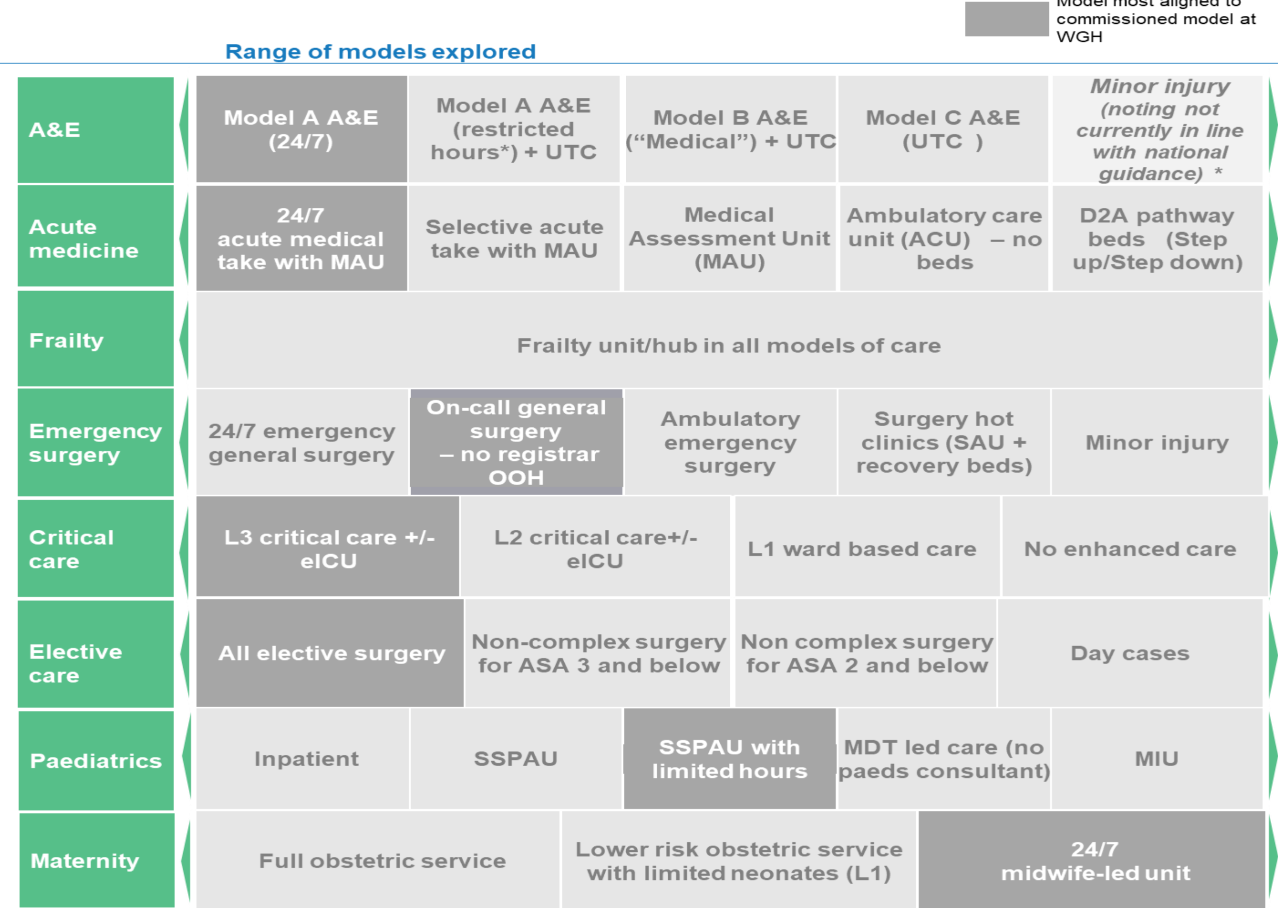
Only after each model was described was there consideration of how this might be applied at Weston General Hospital and the implications for the wider health and care system.
It was recognised that a number of common enablers needed to underpin any future model of care.

These enablers are:

- standardised care pathways
- common approaches across the whole-system
- easy access to senior decision-makers, on site or remotely
- remote advice to a specialist opinion
- mental health teams available where required
- stabilisation and rapid transfer of patients when required
- transfer back from specialist centres
- availability of step up/step down facilities
- greater use of hot clinics
- IT and technology to support improved care
- staff rotations

As a result of this model a long-list of service models were developed. Figure 7 shows the range of models explored for each service (see end of document for abbreviations list). These could be combined in various ways to lead to many different overall models. Appendix 17 provides detailed descriptions of what each service model entails.

Figure 7: Summary of potential clinical models for each best practice pathway



4.3 Evaluating clinical models

Developing evaluation criteria

Criteria for evaluating clinical service models were developed through an inclusive process, starting with the feedback gathered through public dialogue and codesign. This engagement predated the development of the potential clinical models themselves so the development of criteria was robust and not based on ideas relating to individual models. More than 2,500 people took part in engagement and codesign activities from October 2017 to early March 2018, including responding to survey questions about the things that the system should prioritise when making decisions about next steps.

The suggested criteria were further tested in a whole-system stakeholder event in April 2018, attended by more than 100 people including clinicians, partner organisations and patients and carers. The criteria of deliverability, affordability, access, workforce and quality of care were perceived to be of greatest importance. The attendees list and output of this meeting can be seen in Appendix 11.

Building on this insight, the *Healthy Weston Programme* developed a more detailed set of criteria drawing on best practice and experience from similar work elsewhere. The draft criteria were tested with the *Healthy Weston* Patient and Public Reference Group and their comments incorporated into a set of criteria that were considered by the *Healthy Weston* Steering Group. Detailed sub-criteria are outlined in Appendix 13, which also shows how comments from the Patient and Public Reference Group were reflected in the final evaluation criteria.

The *Healthy Weston* Steering Group, comprising the most senior leaders of organisations across Bristol, North Somerset and South Gloucestershire, endorsed the evaluation criteria for recommendation to the CCG Governing Body. The Steering Group proposed that the criteria should not be weighted, but rather used to help differentiate between different options.

The evaluation criteria listed in Figure 8 were approved by the CCG Governing Body on 2 October 2018. See Appendix 13 for more details.

Figure 8: Criteria for evaluating clinical models

Evaluation criteria	Defined as
1 **Quality of Care**	1.1 Clinical effectiveness 1.2 Patient and carer experience 1.3 Safety (e.g. workforce rotas)
2 **Access to care**	2.1 Impact on patient choice 2.2 Distance, cost and time to access services 2.3 Service operating hours
3 **Workforce**	3.1 Scale of impact 3.2 Impact on recruitment, retention, skills
4 **Value for money**	4.1 Forecast income and expenditure at system and organisation level 4.2 Capital cost to the system 4.3 Transition costs required 4.4 Net present value (10, 20 and 60 year)
5 **Deliverability**	5.1 Expected time to deliver 5.2 Co-dependencies with other strategies/strategic fit

Developing potential approaches to be evaluated

Combining all of the different models of care set out in Figure 7 in each possible permutation would give thousands of potential service models for a hospital. A structured process was applied to help select the combinations of services that may be most applicable and worthwhile for Weston General Hospital. The structured process included:

- examining clinical interdependencies (for models of care in general)
- high-level application of evaluation criteria to identify sufficiently differentiated models of care (for models of care in general)
- more detailed analysis of shortlisted models against criteria (applied specifically to Weston General Hospital and wider system).

Exploring clinical interdependencies

Clinical interdependencies were considered by the *Healthy Weston* Clinical Service Design and Delivery Group, made up of senior clinicians. This narrowed the number of models from more than 1,000 to about 200. This assessment was undertaken considering the generic needs of a hospital rather than the specifics of Weston General Hospital. This process aimed to reduce bias and allow consideration of a wide range of approaches, before narrowing to locally applicable models. Interdependencies included:

- **Front door interdependencies (things needed at entry):** A full A&E requires a core level of emergency surgery and critical care support in order to provide safe and timely care to acutely unwell medical and surgical patients. An Urgent Treatment Centre does not require a full set of all these services on site.

- **Acute medicine interdependencies:** A fully unselected acute medical intake that accepts all acute medical presentations of varying comorbidity and severity needs emergency surgery and critical care available for those patients who may need joint care and/or escalation of care. Overnight acute medical inpatients would require medical registrar cover overnight.

- **Emergency surgery interdependencies:** In order to provide safe inpatient emergency surgery, there needs to be both acute medicine on site as well as level 2 critical care services at a minimum, in order to support surgical patients.

- **Critical care interdependencies:** Critical care cannot be provided unless there is also an acute medicine intake. Unwell medical patients (as opposed to acute surgical patients) typically make up the majority of patients who require higher level input and critical care.

- **Elective surgery interdependencies:** Delivery of more complex elective surgery or operating on patients with multiple comorbidity requires on site emergency surgery and level 3 critical care. Non-complex elective surgery for ASA 3 or less patients requires some level of critical care support (including the potential to step up if ward-based care only).

- **Frailty service interdependencies:** In view of the fact that the local population is older than the national average and growing, a frailty service should be provided in all options, in order to specifically support both urgent needs as well as the long-term management of the frail and elderly patient contingent. Appendix 6 provides further details.

Applying high-level evaluation criteria

After interdependences were considered, the process moved from considering potential clinical models which could be applied to any hospital to considering which of these clinical models could be an option for Weston General Hospital. The generic clinical models were evaluated against the high-level evaluation criteria: quality of care, access to care and workforce criteria. The *Healthy Weston Programme* decided that:

- A 24/7 emergency surgery unit serving patients at Weston Hospital would not be in line with NHS guidance which recommends that people with the most serious and complex needs are treated in specialist centres noting the due to improved outcomes.

- For elective surgery, any clinical models including the provision of a full range of complex elective surgery were removed because the volumes of care required to maintain skills for all complexities of surgery would not be attainable at Weston General Hospital. Further, clinical interdependency with 24/7 emergency surgery meant that any model including all complex elective surgery was excluded as a viable option.

- For paediatric service models, inpatient paediatric services would not have the case mix and volume required to allow for the safe and skilled provision of this service at Weston General Hospital. It would also be a difficult model to staff, with a requirement of 24/7 consultant cover.

- For maternity service models, a full obstetric service as well as a lower-risk obstetric service with limited neonatal care (level 1) were eliminated as viable potential models of care for Weston General Hospital as the catchment population does not enable the volume and case mix required to allow for a safe service. Both models would also be challenging to staff. It was agreed that, in line with the Local Maternity Network plan, a 24/7 midwife-led unit should be retained in all potential options so the needs of local women can continue to be met. This means there would be no change in maternity services for the people of Weston. **No public consultation is thus required about maternity services**. Staff are currently being consulted on the internal staffing model as per normal business as usual management processes within the trust.

- For completeness, models of urgent care with no medical leadership but instead a stand-alone nurse-led minor injuries unit were developed in the process, but were later discounted on the basis that having this model of care at Weston General Hospital would result in large numbers of patients having to travel further for their care. This was something that was strongly opposed in public dialogue and codesign. In addition, the creation of new minor injury unit runs counter to the current direction of national policy.

Appendix 18 contains details of the combinations of models of care that remained after considering high-level evaluation criteria**.** The *Healthy Weston Programme* Clinical Service Design and Delivery Group reviewed these models to identify meaningfully distinct models for Weston General Hospital. This was done because it would not be a practical use of senior clinicians' time to evaluate a number of very similar variations on the same model. Figure 9 shows the seven models selected for more detailed analysis. The Clinical Service Design and Delivery Group added a variation to one model to incorporate increased non-complex elective surgery.

All of the models in the long list were labelled 1, 2, 3 and so on when applying high-level evaluation criteria. These notations are kept here to allow easy cross referencing to the material in Appendices 17 and 19, which shows detailed workings of how models were shortlisted and evaluated for potential consultation.

Model 1 in Figure 9 is broadly equivalent to the status quo in terms of the model currently commissioned. Model 3 is equivalent to the status quo in terms of the model being delivered during the temporary overnight closure of A&E.

Figure 9: Seven clinical models shortlisted for more detailed analysis[1]

	Option 1a	Option 3a	Option 9a	Option 12a	Option 12b	Option 27b	Option 37b
A&E	24x7 A&E + UTC	A&E (restricted hours) + UTC	Medical only A&E + UTC	UTC only	UTC only	UTC only	MIU
Acute Medicine	24/7 medical take + MAU	Selective take + MAU	Selective take + MAU	Selective take + MAU	MAU only	ACU only	D2A pathway beds only
Emergency Surgery	On call gen surg (no registrar OOH)	On call gen surg (no registrar OOH)	Amb emerg surgery only	Amb emerg surgery only	Surgical hot clinics	Surgical hot clinics	Minor injuries
Critical Care	Level 3	Level 3	Level 2	Level 1 (Ward)	Level 1 (Ward)	No enhanced care	No enhanced care
Elective care	Non-complex surgery (ASA 3 or less)	Non-complex surgery (ASA 3 or less)	Non-complex surgery (ASA 3 or less)	Non-complex surgery (ASA 2 or less)	Non-complex surgery (ASA 2 or less)	Non-complex surgery (ASA 2 or less)	Non-complex surgery (ASA 2 or less)
Paediatrics	SSPAU co-located with ED	SSPAU co-located with ED	SSPAU co-located with ED	Standalone SSPAU limited hours (GP and UCC referrals)	Standalone SSPAU limited hours (GP and UCC referrals)	Standalone SSPAU limited hours (GP and UCC referrals)	MIU with no facility for children
Maternity	24/7 midwife led unit	24/7 midwife led unit	24/7 midwife led unit	24/7 midwife led unit	24/7 midwife led unit	24/7 midwife led unit	24/7 midwife led unit

Assumes diagnostic imaging, pathology services and a frailty service exist in all options

Healthier Together

Assessing shortlisted models

The seven shortlisted models were evaluated against the agreed evaluation criteria by the *Healthy Weston* Clinical Service Design and Delivery Group and the Finance and Enabling Group. The agreed criteria were quality of care, access to care, workforce, deliverability and value for money. The *Healthy Weston* Steering Group then considered the assessments in-depth to develop a recommendation for the CCG Governing Body about options to be tested further through public consultation.

The seven shortlisted models were objectively considered based on expected delivery of the service model in 2023/24, drawing on evidence from national guidance and best

practice as well as data laid out in the Case for Change and the Commissioning Context. Each of the service models was assessed against the five pre-defined evaluation criteria.

A 5-point scale was used in which the service model under evaluation was assessed against current service provision (both commissioned and current) at Weston General Hospital. Models that would perform as well as the current status quo for each particular evaluation question assessed as neutral (●). Models which were judged by members of the CSDDG to perform differently than the status quo on an evaluation question were assessed as slightly better (+), significantly better (++), slightly worse (-) or significantly worse (- -). Appendix 19 shows the evaluation process in detail.

Table 10 summarises the assessment of seven options shortlisted options. Readers should refer to Figure 9 as a reminder of the description of each model. The assessment included a minor injury unit (option 37b) for completeness to ensure that the full range of options is described. However, it became apparent early on that this option was unlikely to meet the evaluation criteria and it was removed for practical purposes. Table 11 summarises key points from the evaluation of the seven shortlisted models. Further details of the financial and activity modelling that contributed to the evaluation are set out in Appendix 20.

As previously noted, it was assumed that a number of changes to the overall health system would be desirable under any model. These included closer integration of primary, community and social care with major acute hospital services; adoption of best practice out of hospital care in all services provided to reduce variation in quality and outcomes; development of an integrated service offering proactive care and management of frailty and long-term conditions through community services, outreach and hospital follow-up supported by robust reactive care for patients who require acute services; and local outpatient and routine diagnostic services, with point-of-care testing maximised. Other clinical enablers assumed in all models included standardised care pathways; remote advice to specialist opinions; effective stabilisation and rapid transfer for patients needing escalation; and easy step down or transfer to community or social care settings. These assumptions were also reflected in the finance and activity modelling.

Overall the evaluation by clinicians and finance leads concluded that potential benefits could be realised through three models (9a, 12a and 27b). Three models were not supported against the clinical criteria primarily on the basis of deliverability (1, 3 and 37).

An assessment completed by the Directors of Finance across the system concluded that two of the three most preferred models provided a positive contribution towards closing the financial gap and had similar levels of capital requirement (9a and 12a). The third model (27b) was higher risk in terms of accessing capital and releasing fixed costs, but had the potential for higher recurrent financial benefit.

The *Healthy Weston* Steering Group, made up of senior leaders from all partner organisations, considered the evaluation and recommendations of the Service Design and Delivery Group and the Finance and Enabling Group. The Steering Group asked the South West Clinical Senate to review the three models that received the most favourable evaluation and whether these might be each be considered as stages in a long-term development journey (implementing model 9a, followed by 12a then 27b).

Table 10: Summary of evaluation of seven shortlisted models

	Model 1 - Status quo commissioned	Model 3 - Status quo delivered	Model 9a –	Model 12a	Model 12b	Model 27b	Model 37
Quality of care							
Clinical effectiveness	Emergency care not in line with national standards. Integrated frailty model improves acute medicine. Critical care not in line with national standards. Increased quality of children's care. Less investment in out of hospital services possible as more investment needed on acute care.	Emergency care not in line with national standards. Integrated frailty model improves acute medicine. Critical care not in line with national standards. Increased quality of children's care. Less investment in out of hospital services possible as more investment needed on acute care.	Emergency care at larger hospitals in line with national standards. Integrated frailty model improves acute medicine. Critical care in line with national standards. Increased quality of children's care. Less investment in out of hospital services possible as more investment needed on acute care.	Emergency care at larger units in line with national standards. Integrated frailty model improves acute medicine. Critical care in line with national standards. Increased quality of children's care. Less investment in acute care needed, so more investment available out of hospital.	Emergency care at larger units in line with national standards. Integrated frailty model improves acute medicine. Critical care in line with national standards. Increased quality of children's care. Less investment in acute care needed, so more investment available out of hospital.	Emergency care at larger units in line with national standards. Integrated frailty model improves acute medicine. Critical care in line with national standards. Increased quality of children's care. Less investment in acute care needed, so more investment available out of hospital.	Emergency care at larger units in line with national standards. Integrated frailty model improves acute medicine. Critical care in line with national standards. Increased quality of children's care. Less investment in acute care needed, so more investment available out of hospital.
Patient and carer experience	Better continuity for frailty care.	Better continuity for frailty care.	Better continuity for frailty care.	Better continuity for frailty care. Potential to support integration between primary and hospital care. Potential to integrate primary care and frailty, with better links with the community and wider services. Improves physical environment.	Better continuity for frailty care. Potential to support integration between primary and hospital care. Potential to integrate primary care and frailty, with better links with the community and wider services. Improves physical environment.	Better continuity for frailty care. Potential to support integration between primary and hospital care. Potential to integrate primary care and frailty, so better links with the community and wider services. Improves physical environment.	Better continuity for frailty care.

	Model 1 - Status quo commissioned	Model 3 - Status quo delivered	Model 9a –	Model 12a	Model 12b	Model 27b	Model 37
Safety	Enables clinically safe transfers with minimal impact of travel time on patient outcomes.	Enables clinically safe transfers with minimal impact of travel time on patient outcomes. Reduced risk due to less reliance on consultant-led A&E workforce.	Enables clinically safe transfers with minimal impact of travel time on patient outcomes. Reduced risk due to less reliance on consultant-led A&E workforce.	Enables clinically safe transfers with minimal impact of travel time on patient outcomes. Reduced risk due to less reliance on consultant-led A&E workforce. Positive since more care for patients in larger centres.	Enables clinically safe transfers with minimal impact of travel time on patient outcomes. Reduced risk due to less reliance on consultant-led A&E workforce. Positive since more care for patients in larger centres.	Enables clinically safe transfers with minimal impact of travel time on patient outcomes. Reduced risk due to less reliance on consultant-led A&E workforce. Positive since more care for patients in larger centres.	Enables clinically safe transfers with minimal impact of travel time on patient outcomes. Reduced risk due to less reliance on consultant-led A&E workforce. Positive since more care for patients in larger centres.
Access							
Patient choice	No change to patient choice for elective care.	No change to patient choice for elective care.	No change to patient choice for elective care.	No change to patient choice for elective care. Improved choice for primary care services.	No change to patient choice for elective care. Improved choice for primary care services.	No change to patient choice for elective care. Improved choice for primary care services.	No change to patient choice for elective care.
Distance	No change in travel time.	Increased travel time for patients and carers who would no longer be able receive care at Weston General Hospital to an average of 41 minutes (peak) and 35 minutes (off peak) total travel time when travelling by private car.	Increased travel time for patients and carers who would no longer be able receive care at Weston General Hospital to an average of 41 minutes (peak) and 35 minutes (off peak) total travel time when travelling by private car	Increased travel time for patients and carers who would no longer be able receive care at Weston General Hospital to an average of 41 minutes (peak) and 35 minutes (off peak) total travel time when travelling by private car	Increased travel time for patients and carers who would no longer be able receive care at Weston General Hospital to an average of 41 minutes (peak) and 35 minutes (off peak) total travel time when travelling by private car	Increased travel time for patients and carers who would no longer be able receive care at Weston General Hospital to an average of 41 minutes (peak) and 35 minutes (off peak) total travel time when travelling by private car	Increased travel time for patients and carers who would no longer be able receive care at Weston General Hospital to an average of 41 minutes (peak) and 35 minutes (off peak) total travel time when travelling by private car
Operating hours		Reduced hours but still meeting population needed.	Reduced hours but still meeting population needed.	Reduced hours but still meeting population needed.	Reduced hours but still meeting population needed.	Reduced hours but still meeting population needed.	Reduced hours but still meeting population needed.

	Model 1 - Status quo commissioned	Model 3 - Status quo delivered	Model 9a –	Model 12a	Model 12b	Model 27b	Model 37
Workforce							
Impact on current workforce	Less impact on staff.	Less impact on staff.	Transfer of services will potentially impact primarily on staff in critical care and surgical specialities.	Transfer of services will impact on staff.	Transfer of services will impact on staff.	Transfer of services will impact on staff.	Transfer of services will impact on staff.
Workforce sustainability	Not sustainable. Insufficient complex work for staff which inhibits professional development and peak performance.	Not sustainable. Insufficient complex work for staff which inhibits professional development and performance	Reduce reliance on A&E workforce. Opportunity to use workforce 'at the top of their license'.	Reduce reliance on A&E workforce. Opportunity to use workforce 'at the top of their license'.	Reduce reliance on A&E workforce. Opportunity to use workforce 'at the top of their license'.	Reduce reliance on A&E workforce. Opportunity to use workforce 'at the top of their license'.	Reduce reliance on A&E workforce. Opportunity to use workforce 'at the top of their license'.
Value for money							
Capital costs (details within finance appendix)	No extra capital costs.	Some capital costs.	Some capital costs.	Some capital costs.	Some capital costs.	Most capital costs (£44m unmitigated).	Most capital costs (£60m).
Income and expenditure	Improves the system's income and expenditure position by an amount greater than the current CCG subsidy of £3.5 million.	Improves the system's income and expenditure position by an amount greater than the current CCG subsidy of £3.5 million.	Improves the system's income and expenditure position by an amount greater than the current CCG subsidy of £3.5 million.	Improves the system's income and expenditure position by an amount greater than the current CCG subsidy of £3.5 million.	Improves the system's income and expenditure position by an amount greater than the current CCG subsidy of £3.5 million.	Improves the system's income and expenditure position by an amount greater than the current CCG subsidy of £3.5 million.	Improves the system's income and expenditure position by an amount greater than the current CCG subsidy of £3.5 million.
Transition costs			Higher transition costs associated with activity changes.	Higher transition costs associated with activity changes.	Higher transition costs associated with activity changes.	Higher transition costs associated with activity changes.	Higher transition costs associated with activity changes.
Net present value	System NPV over 30 and 60 years improves with all options compared	System NPV over 30 and 60 years improves with all options	System NPV over 30 and 60 years improves with all options compared	System NPV over 30 and 60 years improves with all options compared	System NPV over 30 and 60 years improves with all options compared	System NPV over 30 and 60 years improves with all options compared	System NPV over 30 and 60 years improves with all options compared

	Model 1 - Status quo commissioned	Model 3 - Status quo delivered	Model 9a –	Model 12a	Model 12b	Model 27b	Model 37
	to baseline.	compared to baseline.	to baseline.	to baseline.	to baseline.	to baseline.	to baseline.
Deliverability							
Ability to be delivered in 3-5 years	Not deliverable in line with national standards because of staffing and patient volumes for some interventions	Not deliverable in line with national standards.				Move more acute services to other sites so will take longer to deliver.	Move more acute services to other sites so will take longer to deliver.
Alignment with strategy	Does not support best quality care for population.	Does not support best quality care for population.	Supports STP priorities. Depends on system transformation.	Supports STP priorities. Depends on system transformation.	Supports STP priorities. Depends on system transformation.	Supports STP priorities. Depends on system transformation.	Supports STP priorities. Depends on system transformation.

Table 11: Summary of evaluation of seven shortlisted models

Criteria	Summary
Quality	**Clinical effectiveness:** the status quo models were worse for clinical effectiveness. Other models were similar and all offered potential benefit. Model 27b was slightly less favourable for acute medicine but more favourable for critical care and A&E. **Patient experience:** the status quo models and model 9a were less favourable. Continuity of care was best in model 12a. **Safety:** models 12a and 27b were broadly similar in terms of potential benefit, with 3 and 9a less positive.
Access to care	**Impact on patient choice:** the impact was differential across elective care, primary care and non-elective care. Taken together models 12a and 27b were marginally more favourable. **Distance, cost and time:** models 9a and 12a were assessed as better than models 3 and 27b. **Service operating hours** there were no significant differences identified between models 9a, 12a and 27b.
Workforce	**Scale of impact:** More staff were affected by model 27b, other models were similar. **Recruitment, retention, skills:** model 27b had more opportunities for primary care retention, but 9a was more attractive for those working in acute medicine and emergency surgery.
Deliverability	**Expected time to deliver:** model 9a was assessed as most favourable, with 3 and 27b considered higher risk. **Co-dependencies:** model 9a was assessed as more favourable than 12a and 27b because it is closer to the current model of care and therefore the transition process would not be as complex. Model 3 was not considered deliverable.
Value for Money	**Capital costs –** all options imply some capital cost outlay, with the capital cost for models 27b and 37 being notably significant. **Income and expenditure impact –** all options improve the income and expenditure position, with more notable improvements from model 27b. **Transition cost** – models 27b and 37 have more significant transition costs. **Net present value** – 30 and 60 year net present value improves with all options compared to baseline, with greater impact (but little distinction) between models 9a and 37.

Feedback from South West Clinical Senate review panel

Based on the evaluation of shortlisted models, the *Healthy Weston Programme* sought independent clinical feedback about the three most highly evaluated approaches.

The South West Clinical Senate reviewed a draft Pre-Consultation Business Case on 20 November 2018 and received a presentation from key senior clinicians. This included an outline of three models (9a, 12a and 27b), potentially to be seen as steps in a journey.

The Senate's review panel agreed with the case for change set out by the *Healthy Weston Programme* and felt that the proposals and overall direction of travel were in line with other systems, national guidance and available evidence.

The panel were unanimous that 'do nothing' was not a safe or sustainable model and should not be considered for Weston General Hospital. The panel said that the current configuration of services at Weston General Hospital was not best for the population of Weston. They identified issues around patient outcomes and clinical quality that the workforce is working hard every day to manage.

There was unanimous support by the South West Clinical Senate review panel for consultation on and progression to implement one model as soon as possible (9a) on safety grounds. The panel were also supportive of the longer direction of travel and asked that a longer term model (27b) be worked up in more detail with a view to potentially moving forward after immediate safety issues were addressed.

The Clinical Senate advised that one shortlisted model (12a) appeared more complicated and unclear than the other shortlisted approaches and there was concern that this would be unstable as a stand-alone model. The panel advised that this could be part of a transition plan to move from model 9a to 27b, rather than a separate stage of service delivery in itself.

Thus overall, the Clinical Senate advised that the *Healthy Weston Programme* should work towards delivering a model of care for immediate change (model 9), with a longer term direction of travel in mind that had carefully planned transition points along the journey.

The *Healthy Weston* Steering Group reconsidered all of the evaluation assessments and feedback from the Clinical Senate and refined its preferred number of phases as a result, noting that the overall direction of travel and endpoint remained the same and was fully supported by the Clinical Senate. The *Healthy Weston* Clinical Service Design and Delivery Group held a workshop to further develop the longer term vision for Weston General Hospital building upon the original 27b model.

NHS England Stage 2 assurance

On 19 December 2018, CCG representatives from the *Healthy Weston Programme* met with NHS England and representatives from the Clinical Senate to present a revised two stage model (model 9a and 27b), based on feedback from the Clinical Senate. NHS England suggested that the overall vision was in line with national drivers and that there was work to do to fully develop the approach to achieving the long-term vision (model 27b). It was recognised that there was an urgent need for change at Weston General Hospital based on safety and workforce issues so it was proposed to move forward to consultation about a shorter-term solution (model 9a), whilst further work is undertaken to seek views and plan for the longer-term.

The *Healthy Weston* Steering Group considered feedback from NHS England and is proposing to the CCG Governing Body to proceed to consultation about **a preferred option** (model 9a), in the context of a broader direction of travel. At this stage there were minor amendments to the description of the model to clarify the proposed service delivery model and allow sufficient flexibility in the development of the service delivery model. These amendments were reviewed by the Clinical Service Design and Delivery Group and it was concluded that there was no material change to the evaluation of the model and therefore no need to re-evaluate 9a against the other shortlisted models. Both the original and the amended model descriptions are included in Appendix 18.

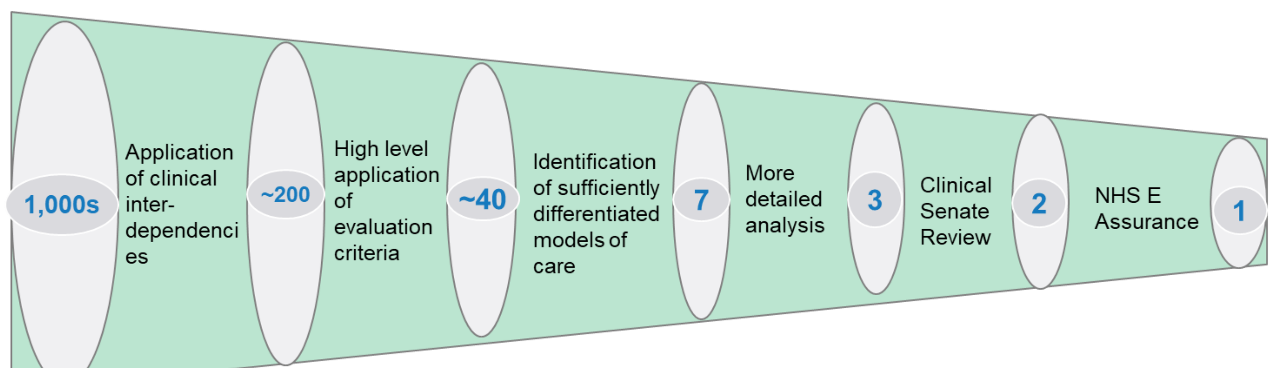
Table 12 lists the decision-making steps from the long-list to a shortlist of models, showing that the development and refinement of the proposed preferred model of care for consultation has been clinically-led and that feedback from patients, the public and other stakeholders was reflected in the evaluation criteria and decision steps.

This section has outlined the robust process used to identify and shortlist a preferred model of care for public consultation. The next section of the document describes this preferred model of care and its potential impacts.

Summary of the shortlisting process

The process to arrive at a single, preferred option for consultation is summarised below in Figure 10.

Figure 10: Clinically led process to shortlist models of care for consideration



The clinical group described best practice care pathways and clinical models to enable delivery of best practice care	By applying clinical interdependencies between different services, the potential models of care were narrowed down to ~200	High level evaluation excluded some models as being suitable for Weston on the basis of clinical quality, workforce criteria and/or access to care	Clinicians identified 7 sufficiently differentiated options to analyse	Detailed evaluation resulted in three viable options for change to be identified	Focus on 2 models following Clinical senate feedback	Move to one model for consultation following NHS E Assurance feedback

Table 12: Decision audit of long-list to shortlist of models for potential consultation

Date 2018	Event	Attendees	Objectives	Outcome
19th April	Stakeholder co-design event	Representatives from charities, homeless groups, housing, Rehab organisations, disability groups, patient representatives, members of public (150 invited in total – **Appendix 11** for full list)	To update stakeholders on feedback from co-design phase and inform them of next steps	Updated stakeholders on future development of long list of models
26th June	Newly formed Clinical Service Design and Delivery Group	Clinicians from UHB, WAHT, BNSSG CCG, AWP, NBT, NSCP, Primary Care	To agree the transition from Co-Design Phase to Pre-Consultation Business Case and role of CSDDG	Establishment of Clinical Service Design and Development Group (CSDDG)
9th & 29th August	*Healthy Weston* Clinical Workshops	Clinicians from AWP, NBT, NSCP, Primary Care, SWASFT, UHB, WAHT. Representatives from McKinsey , BNSSG CCG and STP (54 attendees in total - **Appendix 11** for full list of attendees)	Agree best practice pathways and potential clinical models for future modelling	500 models to 37 generic models “Long List” agreed
6th Sept	Clinical Services Design and Delivery Group	Clinicians from UHB, WAHT, NSCP, Primary Care, SWASFT Representatives from McKinsey, BNSSG CCG, Hood &Woolf	Review long list against service line and rationalise	Agreed to recommend 6 (including base case) potential clinical models to Steering Group: 3a, 9a, 12, 27b and 37b
20th Sept	Steering Group	CEO’s of BNSSG CCG, WAHT, NSCP and UHB. Medical Directors of NBT and WAHT, Chair of CSSDG. Representatives from CCG, NSC, McKinsey, and Hood & Woolf.	To consider recommendation from CSDDG regarding potential models – with model 12 being refined into 12a and 12b – difference is critical care	Agreed 7 models in line with CSDDG recommendations to be progressed for more detailed modelling
1st Oct	Steering Group	CEOs frrom BNSSG CCG, WAHT and UHB. Chair CSDDG, Medical Director WAHT, Representatives from McKinsey, Hood & Woolf	To consider the evaluation criteria recommended from CSDDG	Agreed evaluation criteria
9th Oct	Extended Clinical Services Design and Delivery Group Workshop	Clinicians from UHB, WAHT, NSCP, Primary Care, SWASFT Representatives from McKinsey, BNSSG CCG, Hood & Woolf plus other clinicians	Evaluation of models against agreed evaluation criteria to shortlist	Recommend 3a, 9a, 12a, 12b, and 27b as viable models, with 1a and 37b not supported
12th Oct	Finance and Enabling Group	DoFs of all Acute Trusts	Evaluation of models against agreed financial criteria	Recommend 9a, 12a, 12b and 27b as viable models (1a, 3a, 37b not supported)
18th Oct	Steering Group	CEOs from BNSSG CCG, NSCP, UHB, NBT. NSC Public Health Director, Chair of CSDDG and GP Weston Locality Lead, Medical Director WAHT, SWASFT, Somerset CCG. Representatives from BNSSG CCG, STP,	To consider the evaluations from CSDDG and FEG to make decision on models to go forward	Agreed Options 3a, 9a, 12a and 27b (with 3a for light touch). Option 12b removed as no material advantages over 12a or 27b). Requested further review of remaining models by CSDDG and FEG

Date 2018	Event	Attendees	Objectives	Outcome
		McKinsey, Hood & Woolf		
24th Oct	Clinical Services Design and Delivery Group	Clinicians from WAHT, NBT, NSCP, UHB, SWASFT. Representatives from BNSSG CCG and McKinsey.	To consider issues raised by SG and review assessment to enable clearer differentiation with focus on models 3a, 9a, 12a, 27b	Moderation of activity shift for model 27b. Recommendation to SG that models 9a, 12a and 27b be considered for consultation (with 3a as base)
26th Oct	Finance and Enabling Group	DoFs from Acute Trusts	Remodel with revised shift of activity for 27b. Bottom up validation of activity and financial modelling for 9a, 12a and 27b	To confirm support for 9a and 12a, with concerns around 27b due to levels of capital required
1st Nov	Steering Group	CEOs from BNSSG CCG, UHB, NBT and NSCP. Medical Director from WAHT, NSC Public Health, SWASFT, Chair CSDDG and GP Lead Weston & Worle Locality. Representatives from BNSSG CCG, McKinsey and Hood &Woolf	To consider the further evaluation from CSDDG and FEG to inform decision on models for PCBC	Recommended 9a, 12a and 27b be tested through consultation. Recognised that 27b represented potential long term direction of travel which may require phased approach. Agreed to explore whether phasing needed 2 steps 9a, 12a or one step (blended model between 9a and 12a)
20th Nov	Clinical Senate Review	Representatives from Steering Group, CSDDG and NHS England	Clinical Senate review of PCBC and emerging models (9a, 12a and 27b)	Senate strongly supported no change is not an model, supported model 9a for immediate implementation to address quality and safety issues, and move to 27b. did not support model 12a and was concerned that it could, in fact, introduce more risk
29th Nov	Clinical Services Design and Delivery Group	Clinicians from WAHT, NBT, NSCP, UHB, SWAFST Representatives from BNSSG CCG, McKinsey	To respond to Clinical Senate feedback and describe 27b more fully and transition steps to get there	CSDDG refined 27b more fully as shown in the following diagrams – clarity that 27b includes DAU, and MAU and step up beds and model for enhanced care step up if required.
29th Nov	Steering Group	CEOs from BNSSG CCG, UHB, NBT and NSCP. Medical Director from WAHT, NSC Public Health, SWAFST, Chair CSDDG and GP Lead Weston & Worle Locality. Representatives from CCG, and H&W	To respond to Clinical Senate feedback and describe 27b more fully and transition steps to get there	Steering group received report from CSDDG and clarification on what was included in 27b and agreed to be preferred model with 9a as first step towards it
19th Dec	NHS England Stage 2 Assurance Meeting	NHS England Assurance Panel, BNSSG CCG Executives	To seek assurance from NHS England on preferred model with 2 phases – 1st phase 9a and longer term 2nd Phase towards 27b	NHS England confirmed that they felt that Phase 1 should be framed as a fixed point, and Phase 2 as a direction of travel, rather than as a second fixed point. NHS England confirmed that they would approve going to consultation for Phase 1 (9a).

Date 2018	Event	Attendees	Objectives	Outcome
19th Dec	Steering Group	Teleconference with CEOs from BNSSG CCG, UHB, NBT, WAHT, NSCP and nominated representative for CEO T&SFT. Medical Directors from WAHT, NSC Public Health, T&SFT, Chair CSDDG and GP Lead Weston & Worle Locality. Representatives from CCG and Hood & Woolf	Update Steering Group on NHS England assurance and agree next steps to determine preferred model for consultation	PCBC to be redrafted to reflect NHS England recommendations with 9a being the model to be consulted upon within a described 5 year vision /direction of travel Clinical Assumptions around critical care and emergency surgery in 9a to be tested in CSDDG
4th Jan 2019	Joint DoFs and Clinical Directors meeting	DoFs from BNSSG CCG, NBT, UHB and STP with Clinical Directors from WAHT & NBT, Directors of Transformation UHB and WAHT Executive Director for *Healthy Weston*	To agree clinical assumptions about movement of patients under 9a and identify activity and bed implications	DoFs understood the broad assumptions that had resulted in remodeling and reduction in beds but tasked CSDDG to explore at HRG actual shift for 9a and would accept the outcome of this for PCBC. They agreed that the limited number of beds would be able to be repatriated/repurposed
9th and 17th Jan 2019	Clinical Service Design and Delivery Groups	Clinicians from WAHT, NBT, UHB and NSCP, Business and Financial Analysts from BNSSG CCG, Representatives from BNSSG CCG	To agree HRGs for patients who will be impacted under 9a around critical care and emergency surgery who will move to neighbouring hospitals to remodel with actual LOS	Actual shift of patients by HRG (by neighbouring trust) identified To revise activity and financial modelling to reflect this to be included in PCBC for 9a
15th Jan 2019	Steering Group	CEOs from BNSSG CCG, UHB, NBT and NSCP. Medical Director, NSCP Public Health, SWAFST, Chair CSDDG and GP Lead Weston & Worle Locality. Representatives from BNSSG CCG, McKinsey and Hood &Woolf	Sign-off the key messages and approach as set out in the draft Consultation Document and Pre Consultation Business Case	Agreement of key messages, ensuring that the separation of immediate changes and a potential long term future which needs more co-design work was made clear
25th Jan 2019	NHS England Stage 2 Assurance Meeting	NHS England Assurance Panel, BNSSG CCG Executives	To seek assurance from NHS England on preferred model for preferred option (9a)	Fully assured subject to conditions met on 28.01.19. Final sign off from regional director on 29.01.19.

Note: See end of document for list of abbreviations.

Key points

- The *Healthy Weston Programme* used a rigorous iterative process to identify, evaluate and shortlist potential options for consultation regarding acute services at Weston General Hospital. The process was driven by clinicians, with widespread engagement with patients, frontline staff and partners from across health, social care and the voluntary sector.

- A structured clinically-led process supported the development of potential clinical models for Weston General Hospital. This involved defining best practice care pathways using national and international guidelines and evidence, describing the potential models of care which could deliver best practice care pathways, identifying potential options for the delivery of valid clinical service models through considering clinical interdependencies, applying the clinical models to Weston General Hospital and using evaluation criteria to identify models for further evaluation and testing through public consultation.

- More than 1,000 combinations of potential clinical models were identified via reviews of national best practice and Royal College guidelines and clinical input. Reviewing clinical interdependencies helped to narrow this down to fewer than 200 models. Looking at the extent to which models would be applicable at Weston General Hospital based on workforce, access and safety constraints narrowed the models to fewer than 40. Clinicians reviewed these models in-depth using pre-selected evaluation criteria that had been tested and agreed with clinicians, stakeholders and patient and public representatives, and cross referenced with national guidelines and best practice. This led to shortlisting seven models for formal detailed evaluation, including financial and activity modelling. On the basis of the pre-agreed evaluation criteria, clinicians judged that three of the seven shortlisted models were best placed to respond to the case for change.

- The South West Clinical Senate reviewed the three shortlisted models and advised that they supported two of them for public consultation on the grounds of clinical feasibility and impact – one as an immediate safety step and one as the longer-term overall direction of travel and preferred approach.

- NHS England confirmed that the immediate safety step for Weston General Hospital can be publicly consulted upon, recognising that there is a desire to move to a longer-term solution which needs to be developed further before consultation and implementation. This is the preferred option that the *Healthy Weston Programme* puts forward to the CCG's Governing Body to consider for public consultation.

5. Preferred option for consultation

This section summarises the preferred option to be publicly consulted about.

5.1 Consultation scope

Having followed a rigorous process to identify potential service delivery models, evaluate them using evidence-based criteria and incorporate feedback from an independent group of clinicians (Clinical Senate), the *Healthy Weston* Programme proposes consulting the public about a preferred option.

The proposed scope of the consultation is:

- to formally consult about one preferred option which would provide a short-term solution to the reasons for change. The components of this option are described below, but in brief the significant variations to service delivery comprise a change in A&E, a change in emergency surgery and a change in critical care. These three components would be highest priority to collate feedback about via a consultation survey, public meetings, social media and a wide range of other consultation approaches described in Section 7

- to seek feedback during some of the engagement activities planned during the consultation period about other developments such as those related to primary and community care. These developments would not be part of the formal consultation as they do not constitute a significant variation in services, but it would be useful to share what is happening and hear people's views to support ongoing development. Such feedback would largely be collected during public meetings, discussion groups and other sessions rather than via a formal consultation questionnaire. This is to keep differentiated the things being formally consulted about and the things that are happening simultaneously as part of wider engagement

- to seek feedback during some of the engagement activities planned during the consultation period about the longer term vision for Weston General Hospital. These developments would not be part of the formal consultation as they are not yet fully codesigned. The consultation period will provide an opportunity to begin codesign of the longer-term vision and to understand where more clarity and development is needed. Such feedback would largely be collected during public meetings, discussion groups and other sessions rather than via a formal consultation questionnaire. This is to keep differentiated the things being formally consulted about and future potential plans. This also allows delving into more depth about the longer-term vision as part of open-ended discussions and to reflect changes based on feedback throughout the consultation period

5.2 Components of preferred option

The *Healthy Weston Programme* wishes to put forward for public consultation the following changes in the provision of care at Weston General Hospital:

1.

1. Urgent and emergency care

- To have a medically led A&E for urgent and emergency care open 8am-10pm seven days per week with a multi-disciplinary team (supported by overnight GP out of hours service and 24/7 direct admissions to the hospital via GP referrals). This is a change from the 24 hour service currently commissioned, but in line with the current opening hours under a temporary overnight A&E closure

2. Critical care

- To change the critical care service from an intensive care unit to a high dependency unit (including the ability to escalate to level 3 critical care for 12 hours with the option to extend on a case by case basis)
- As a result, a small number of the most complex and serious acute medical and surgery patients would be treated at neighbouring hospitals.

3. Emergency surgery

- to move a small number of the most complex emergency surgery cases from Weston General Hospital to neighbouring hospitals

Under these proposals, most patients will continue to be treated at Weston General Hospital (97% of the current hospital activity given the temporary overnight closure of A&E, or 92% compared to activity before the temporary closure).

It is proposed that a number of services will be enhanced at Weston General Hospital such as having an integrated frailty service and extending the hours for paediatric expertise (8am to 10pm) seven days per week. These changes do not require formal consultation. The majority of services across medicine and planned care would remain the same as currently.

Figure 11 summarises the components of the preferred option compared with what is currently available (commissioned and currently delivered).

Figure 11: How the preferred option differs from current services

	Status Quo Models	Preferred Option
Front Door, critical care, emergency surgery, acute medicine	▪ Predominantly A&E consultant staffing with some GP streaming at front door ▪ Full staffing for Level 3 critical care provided a restricted hours ED ▪ Emergency surgery provided in line with A&E ▪ Acute medical patient service	▪ A&E open 14 hours a day, 7 days a week, staffed by a mix of senior decision-makers (A&E consultants, acute physicians and GPs) ▪ Day assessment unit with direct GP pathways ▪ Medical admissions unit 7 days a week, with provision for direct admission pathways out of hours ▪ Ambulatory emergency surgery with consultant cover and daytime only emergency operating theatre - minimum four hours per day ▪ Level 2 critical care with ability to step up to level 3 for max of 24-48 hours
Elective planned activity	▪ Planned surgical activity as now, caring for people up to ASA level 4	▪ Planned surgical activity, caring for people up to ASA level 3 ▪ Local access to services such as breast, urology, oncology treatment supported by networks with neighbouring trusts
Frailty service	▪ Embryonic hospital based frailty service based in A&E running 5 days a week Monday to Friday ▪ No dedicated community provision	▪ Frailty Unit based in the hospital with dedicated specialist staffing ▪ Ability to admit via MAU ▪ Dedicated community provision
Paediatrics	▪ Paediatric assessment unit open 8am-8pm Monday to Friday ▪ Elective ambulatory care ▪ Outpatient services	▪ Paediatric expertise available 8am-10pm (14 hours) 7 days a week ▪ Elective ambulatory care ▪ Outpatient services
Maternity Services	▪ Midwife led birthing unit ▪ Community antenatal and postnatal care ▪ General obstetric care ▪ Day assessment ▪ Early Pregnancy Service	▪ Midwife led birthing unit ▪ Community antenatal and postnatal care ▪ General obstetric care ▪ Day assessment ▪ Early Pregnancy Service
Outpatient Services	▪ Range of hospital based outpatient services	▪ Range of outpatient services enhanced, repatriating activity from other providers ▪ Improved integration with primary care and increased outreach to community locations
Diagnostic Services	▪ Full range of hospital based diagnostic imaging and pathology services0	▪ Full range of hospital based diagnostic and pathology services with improved direct access pathways from primary care

Services included

Under the preferred approach for consultation, Weston General Hospital would include the following services:

- A&E open 14 hours a day, seven days a week, staffed by a mix of senior decision-makers (multi-disciplinary team including A&E consultants, acute physicians and GPs)
- Medical assessment unit and acute medical admissions unit seven days a week
- Day assessment unit with direct GP pathways
- Ambulatory emergency surgery with consultant cover and emergency operating theatre available for a minimum four hours per day
- Level 2 critical care with 24 hour, seven days per week acute medicine or anaesthetic cover with the ability to step up to level 3 for 12 hours with the option to extend on a case by case basis.
- Extended hours for paediatric expertise, seven days a week
- Planned surgical activity for people up to ASA level 3 (ASA is the American Society of Anaesthesiologists classification system)

Figure 12 illustrates these services.

Under this proposal, Weston General Hospital would manage most levels of severity of patients, with selected major surgical emergencies being seen in larger centres with more volume including hospitals in Bristol and Taunton. Patients requiring emergency surgery could be managed on site during the day, or via hot surgical clinics or being added to a routine list. The majority of elective care procedures would continue to be carried out at Weston General Hospital, with the potential to move some additional services from Bristol and Taunton to Weston General Hospital. The Short Stay Paediatric Assessment Unit would operate as now but with increased availability of staff to support A&E opening hours. The current model of maternity services would remain.

If, following public consultation the CCG's Governing Body decided to proceed with this approach, it could be fully implemented within one year (or as soon as practicable), subject to appropriate pathways and protocols being agreed and capacity for emergency surgery being in place in alternative centres, to keep the system safe and sustainable.

Figure 12: Services available in the preferred option

*NB – direct referrals from community GPs to MAU & SAU not included
**Skillset required at pre-hospital triage to be defined and to enable 24/7 referral

The services in the preferred option are described in more detail below:

Emergency care: medically-led A&E and Urgent Treatment Centre
A fully functioning A&E would be open 14 hours a day, seven days a week. The service would manage unwell general medical and surgical patients, as well as people with minor illnesses and injuries. The service would be supported by a high dependency unit providing Level 2 critical care as well as a medical assessment unit and an Integrated Frailty Service (to be commissioned in the year following decision). Outpatients and diagnostics would be on site as now.

Patients who need emergency surgery would be operated on in-hours in a theatre which would be available for a minimum of four hours a day, seven days a week, or could be added to an elective surgery list. Those in immediate need of emergency surgery, or those arriving at night would be transferred to an alternative hospital. This is most likely to happen as a result of triage by the ambulance service but in the instance of patients arriving at Weston, or already being there, they would be stabilised on site and then transferred.

South Western Ambulance Service has been fully involved in the development of these proposals. Protocols would be developed and agreed to support the ambulance crews to make sure that patients get to the right service first time. Any additional resource required by South Western Ambulance Service will be provided if required. The experience gained by planning and safely implementing the temporary overnight closure of the A&E at Weston General Hospital in terms of protocols and additional resourcing will help ensure that any future changes to ambulance provision are planned and managed successfully.

Acute medicine

The acute medicine service would take all patients who currently attend Weston except for those who may be in need of level 3 critical care. This means patients who are likely to have multi-organ failure or who need ventilating. These patients would be diverted by the ambulance service. In the instance of patients arriving at Weston, or already being there, they would be stabilised on site and then transferred. Patients suffering from an acute stroke or a heart attack would be transferred/ diverted to a specialist unit, as currently happens.

Patients would be managed as now in a medical assessment unit, an acute medical admissions unit or in acute medical beds.

This service requires an acute medical consultant on site during opening hours, as well as a medical registrar on site 24 hours a day, seven days a week, as now.

Day assessment unit integrated with Integrated Frailty Service

A day unit integrated with frailty service would provide care for frail people whose condition has deteriorated and needed observing, are awaiting the results of diagnostic tests or require planned infusions on a short term basis. Ideally, they would be assessed and supported to return home to avoid the risk of further deterioration but where necessary they would be admitted to the medical assessment unit for treatment. More details can be found in Appendix 6.

Emergency surgery: ambulatory emergency surgery provision

An ambulatory emergency surgery service would provide surgical interventions for patients requiring emergency surgery within 12-24 hours. This includes people with abscesses that require draining, acute uncomplicated gallbladder disease and elderly patients who present with a fractured neck of femur who do not have complications or morbidities severe enough to require them to be cared for at larger units.

Patients who need immediate emergency surgery (such as patients requiring an emergency laparotomy) would be transferred to alternative surgical centres. Patients arriving at Weston General Hospital or already there would be stabilised on site and then transferred. Patients who need emergency vascular surgery or care for major trauma would be transferred to specialist units as is currently the case.

This service requires a surgical consultant to be available seven days per week. Additional support and advice would be available from colleagues in larger surgical centres in Bristol, using technology as appropriate.

Critical care: level 2 support

Level 2 plus critical care looks after patients requiring single organ support e.g. inotrope administration and/or invasive physiological monitoring. Patients requiring multiple organ support would be transferred to a highly specialised level 3 critical care unit in Bristol or Taunton. There would be the ability to step up to level 3 at Weston General Hospital for 12 hours with the option to extend on a case by case basis

This service requires a consultant anaesthetist or acute medical consultant available 24 hours a day, seven days a week as well as a transfer team (trained anaesthetist and airway-trained nurse) and enough critical care-trained nursing staff to provide 1:2 nursing cover to patients requiring level 2 care.

Elective care: non-complex surgery for patients at ASA 3 or less risk levels

In this model, surgery would be provided on site for patients who have a physical status risk score (ASA) up to and including ASA 3. Patients would be supported by an enhanced level of care up to and including level 2, as well as a fully staffed NCEPOD theatre (operating 12 hours a day, seven days a week) and access to interventional radiology (with consultant cover 12 hours a day, seven days a week). All highly-complex procedures as well as surgery on any patient deemed to be ASA 4 would be provided elsewhere.

This model requires a specialist-level surgeon and resident anaesthetist during opening hours, along with access to a medical opinion and cross-site consultant support from larger surgical centres. Additionally, access to middle-grade surgical cover would be required out of hours.

Paediatrics: short stay paediatric assessment unit with expertise out of hours to support the A&E

A paediatric service would provide care for all children with an acute illness or minor trauma, burns or infections requiring IV antibiotics. It would also care for children being moved to be nearer their homes from Bristol Children's Hospital.

More paediatric staff would be available than now with a 14 hour per day, seven days a week service – opening the same hours as the A&E. Any child requiring an overnight stay or over eight hours of observation and/or inpatient admission for further management and care would need to be stabilised and transferred to a larger unit as happens now. Similarly, any neonate requiring neonatal ICU would also be transferred as happens now.

This service requires specialist paediatric staff to be on site whilst A&E is open. Additionally, A&E doctors and out of hours GPs with paediatric expertise would also provide care. The opportunity to co-locate with A&E will be explored as well.

5.3 How preferred option addresses the reasons for change

This section describes how the preferred option addresses issues in the Case for Change. It is based on the evaluation process outlined in Section 4.

Change is needed because the health needs of the population are changing

The preferred option helps to address the fact that the population is growing, getting older, living with more long-term conditions and there are significant inequalities amongst local communities**.** It starts to refocus the hospital on the population groups identified as priorities, with enhanced frailty services.

The enhanced paediatric offer caters for another important section of the population. During the co-design phase the idea of a paediatric hub, combing acute and community services into an integrated service was put forward by the public and this is being explored as part of the business as usual commissioning cycle. Similarly, work is underway to identify whether a larger provider or partnership of providers might be better able to manage the delivery of mental health services for children and young people and community paediatric services.

Change is needed due to variation in access to and continuity of care

The Case for Change set out in Section 2 showed that there are differences in the way care is currently provided and opportunities to offer better access and continuity of care, focusing on prevention and supporting people to maintain their independence. Opportunities to join up primary care, community care and hospital care are a key part of this.

The preferred option would see Weston General Hospital build on the acute care collaboration work already underway with other hospitals, with more complex cases being transferred to larger units. This would ensure better access to acute care for those with the most complex or rare issues.

The changes that are being consulted on would not help to reduce variation in access to or continuity of primary and community care in themselves but the proposed establishment of the Pier Health Partnership in primary care is expected to maximise the sharing of primary care staff across the system and improve access.

The establishment of the integrated frailty service should provide appropriate support to allow elderly and frail people to return to their own homes within 12-72 hours where clinically appropriate.

Moving some services from Bristol hospitals has the potential to provide better access to planned care in this model.

Change is needed because there is variation in the standards of care provided

Section 2 described how some services at Weston General Hospital are not able to consistently meet national and local clinical quality standards because of low volumes of particular cases and shortages of specialist staff. There are opportunities to use Weston General Hospital more effectively and efficiently to provide care in line with national and local standards.

With the preferred option more people who require highly specialised care would be treated in units which are more easily able to comply with national standards.

Change is needed because it is essential to ensure value for money

Section 2 showed that there is a growing gap between the cost of healthcare and available funding, with the Bristol, North Somerset and South Gloucestershire region in deficit by £86m in 2017/18. The system needs to live within its means, get best value and make sure available financial resources most effectively meet the needs of the whole population. This will ensure sustainability of the wider health and care system as a whole.

The preferred option is projected to deliver a £5.3 million improvement in net income and expenditure with a £5.2 million capital investment. The system expects that the only capital required to build capacity will be in University Hospitals Bristol critical care. This is part of existing plans and will be funded by the Trust. The small amounts of capital for the Ambulance Service and for Weston General Hospital backlog will be met through usual sources.

The ongoing financial challenges at Weston General Hospital will be fully met by any of the evaluated models and the preferred option results in a continued financial gap.

5.4 Impacts of preferred option

The preferred model of care was compared to the status quo to consider the impacts of this approach. All evaluations drew upon evidence from national guidance and best practice as well as local data. Further details of the overall options appraisal are in Appendix 19. A summary is presented here, broken down by each of the evaluation criteria used.

Quality of care

Evaluation found that the preferred option will improve the delivery of care compared to the status quo. Quality of care includes three elements: clinical effectiveness or outcomes for patients; patient and carer experience; and clinical safety. There will be benefits for quality of care with the proposed model of care in the preferred option.

Clinical effectiveness

For urgent and emergency services, the *Healthy Weston Programme* recognised that the key differentiator of clinical effectiveness is the degree to which the preferred option allows more patients to receive care from a unit which is compliant, or more compliant, with national standards for high quality care. The volume of activity is a key determinant of the ability of a hospital to meet those standards because higher volumes of care enable clinicians to build experience and maintain their clinical competencies, and also enable enough activity to justify the costs of providing a seven day a week, up to 24 hours a day service.

Safety

The preferred model of care includes A&E services at Weston General Hospital. Whilst it is an improvement on the baseline position, it would still result in a number of patients receiving care from a hospital which does not fully meet national standards for best practice care. The catchment population, and thus the number of patients, is not in line with nationally agreed best practice standards of care. This results in staff potentially having less skills and experience, and consequently being unable to offer best practice care in all cases. However there are significant improvements in quality of care as patients requiring the greatest level of acute and emergency care will be seen in high volume centres within this option.

Patient and carer experience

The preferred option has more ring-fenced elective services and is designed to result in fewer cancellations and lower waiting times.

The opportunity for greater integration between local services and the hospital to support continuity of care will be explored within this option and this will enable patients to experience a more joined up and holistic package of care, particularly in relation to the integrated frailty service and extended children services.

For a minority of patients, some aspects of their care will transfer to larger hospitals better able to meet national standards for clinical services. For other patients, they will be able to access better care, closer to home. Modelling related to travel times is presented overleaf.

Access to care

The preferred model of care would result in more patients who require emergency and complex surgery being treated in units which are more compliant with national standards for high quality care.

Table 13 shows the expected activity levels at Weston General Hospital under the proposed model.

Table 13: Predicted impact of preferred option on activity at Weston General Hospital

			2018/19			Preferred Option			
	Activity	Units	Predicted	Impact of temporary overnight closure	Normalised to commissioned Model	Retained at WAHT	Impact of Frailty	Provided Elsewhere (TONC)	Provided Elsewhere
1	A&E major	Attendances	7,700	1,766	9,466	5,599	464	3,657	1,637
2	A&E standard	Attendances	21,923	5,028	26,951	21,127	795		0
3	A&E minor	Attendances	16,439	3,770	20,209	16,166	273		0
	A&E Total	***Attendances***	***46,062***	***10,564***	***56,626***	***42,893***	***1,533***	***3,657***	***1,637***
4	Acute medicine	Spells	10,336		10,336	8,965	1,286		86
5	Emergency surgery	Spells	3,266		3,266	2,393	310		562
							0		
							0		
6	Elective medicine	Attendances	283		283	250	0		33
7	Daycase medicine	Attendances	8,518		8,518	8,518	0		0
8	Critical Care	Bed days	1,784		1,784	815	0		969
9	Elective surgery	Spells	1,255		1,255	1,176	0		79
10	Daycase surgery	Spells	4,828		4,828	4,828	0		0
	Total Planned Surgery	***Spells***	***6,083***		***6,083***	***6,004***	***0***		***79***
11	Outpatient	Attendances	108,171		108,171	108,171			0
12	Paediatrics	Spells	827		827	1,241			(414)
	Total Patient Contacts		**185,330**	**10,564**	**195,894**	**179,249**	**3,128**	**3,657**	**2,952**
			185,330	10,564	195,894	179,249	3,128	3,657	2,952
	Services as % of commissioned					91.5%	1.6%	1.9%	1.5%
	Services as % of commissioned adj. for TONC					96.7%	1.7%		1.6%
	A&E as % of commissioned					75.7%	2.7%	6.5%	2.9%
	A&E as % of commissioned adj. for TONC					93.1%	3.3%		3.6%

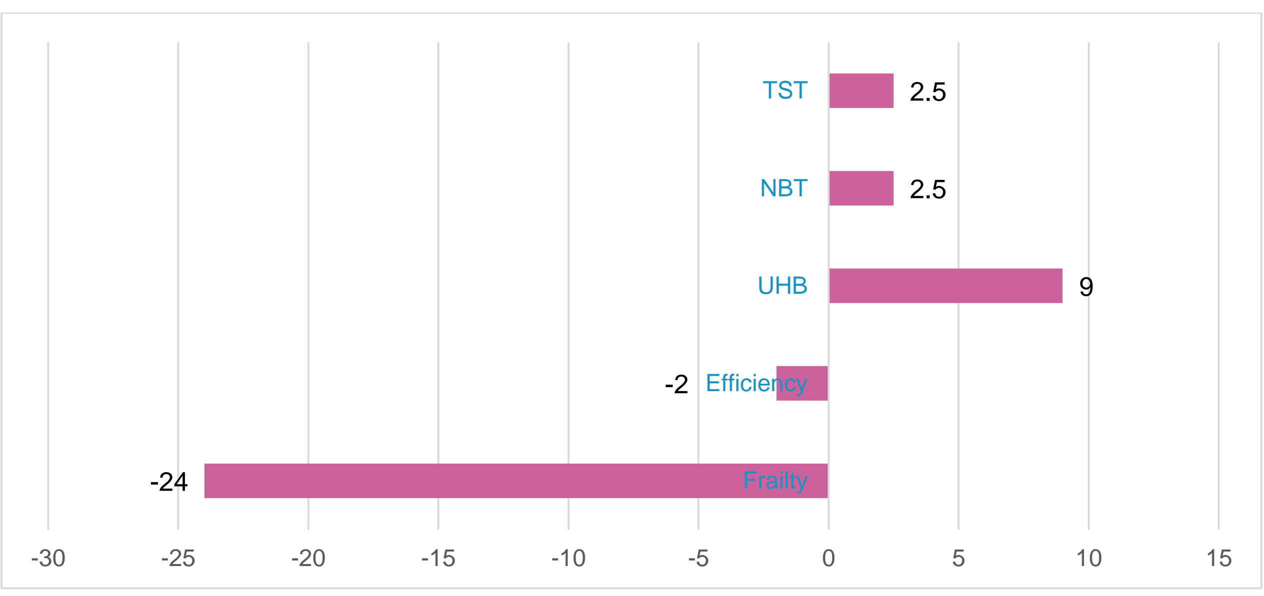
Clinically-led modelling suggests that around 80% of A&E visits for major issues, 99% of acute medicine and 83% of emergency surgical activity would continue to be managed at Weston General Hospital compared to currently commissioned services. Overall we estimate that around **92% of the current episodes of care commissioned for delivery at Weston General Hospital – and 97% of that which is currently delivered following the temporary overnight closure - would remain** in this option. When the retained activity and potential benefits from the new integrated frailty service are totalled, our modelling indicates that neighbouring hospitals would be asked to absorb around 2% of Weston Hospital's current activity.

Impact on other acute trusts

Healthy Weston's Finance and Enabling Group undertook a comprehensive assessment of shift of activity under this approach and how this would impact the various neighbouring acute trusts: University Hospital Bristol (UHB), North Bristol Trust (NBT) and Taunton and Somerset Trust (T&SFT).

Figure 13 shows that with the preferred option, the total number of beds at Weston General Hospital would reduce by 40 beds from the current bed base of 267 beds. The integrated frailty service is estimated to reduce the demand by 24 beds alongside this model of care. The major impact is expected to be on University Hospital Bristol, with an additional 9 beds being required. However, this modelling excludes the impact of the wider *Healthier Together* frailty service across the region and the impact of any elective care being transferred from Bristol hospitals to Weston General Hospital.

Figure 13: Activity impact (beds) on neighbouring trusts



Impact on travel

Patient travel and transport are important elements in planning the delivery of healthcare and are always key concerns of users of any service. The evaluation criteria for the programme reflects. The impact of the preferred option and strengthened primary and community care was modelled to understand the numbers of patients affected and the likely impact.

The modelling found:

- 3,657 people are already traveling to neighbouring hospitals currently as a result of the temporary overnight closure and this takes on average between 13 and 19 additional minutes of travel time by blue light ambulance.

- 2,472 more patients will require additional travel above the current delivered model and these are people with the most serious or life-threatening conditions, or who need complex emergency surgery or the highest levels of critical care.

- Under the preferred option 500 people (above the commissioned model) will travel to a neighbouring hospital by private car and this will take on average an additional 17 minutes at peak time and an additional 14 minutes at off peak time.

- Travel to a neighbouring hospital by public transport will take an average of an additional 18 minutes at peak and 41 minutes at off-peak times.

Table 14 shows the number of required transfers over and above the current delivered model that will require ambulance or private car / public transport transfer under the proposed option.

Table 14: Number of ambulance transfers by type of activity

				Preferred Option Travel > Current Delivery			TONC			Additional conveyances (above Commissioned levels)		
	Activity	Units		Conveyances	Travel Independently	Total People Travelling	Conveyances	Travel Independently	Total People Travelling	Conveyances	Travel Independently	Total People Travelling
1	A&E major	Attendances		1,637	0	1,637	3,291	366	3,657	4,928	366	5,294
2	A&E standard	Attendances		0	0	0		0		0	0	0
3	A&E minor	Attendances		0	0	0		0		0	0	0
	A&E Total	***Attendances***		***1,637***	***0***	***1,637***	***3,291***	***366***	***3,657***	***4,928***	***366***	***5,294***
4	Acute medicine	Spells		65	22	86		0		65	22	86
5	Emergency surgery	Spells		562	0	562		0		562	0	562
6	Elective medicine	Attendances		0	33	33		0		0	33	33
7	Daycase medicine	Attendances		0	0	0		0		0	0	0
8	Critical Care	Bed days		75	0	75		0		75	0	75
9	Elective surgery	Spells		0	79	79		0		0	79	79
10	Daycase surgery	Spells		0	0	0		0		0	0	0
11	Outpatient	Attendances		0	0	0		0		0	0	0
12	Paediatrics	Spells		(207)	(207)	(414)		0		(207)	(207)	(414)
					0			0				
	Total			2,131	(74)	2,058	3,291	366	3,657	5,422	293	5,715
	Total (excl. Paediatrics)			**2,338**	**134**	**2,472**	**3,291**	**366**	**3,657**	**5,629**	**500**	**6,129**

Most patients will continue to be treated to Weston General Hospital under this option (97% compared to the current delivery with temporary overnight closure of A&E or 92% without temporary closure). This includes through 24/7 direct access via the out of hours GP service. There will be an estimated 1,600 fewer admissions to hospital due to strengthened primary and community care including the integrated frailty service therefore enabling patients to receive care in the community and resulting in fewer journeys to hospital. This number is based on evidence from other parts of the country that have set up similar services and is dependent on the previously outlined investment in primary care and setting up the integrated frailty service.

There will be a cohort of patients who will require additional travel to neighbouring acute hospitals. This will be 1.5% of the current patients accessing commissioned services. Travel time analysis was undertaken for people travelling to the next nearest acute hospital by ambulance, private car and public transport. When considering ambulance travel times 60 minutes is routinely considered a key figure especially in the treatment of major trauma and this includes treatment at the scene of an incident. Travel time of more than 60 minutes to the next neighbouring hospital is also used as an indicator for assessing whether a hospital is classified as a remote hospital, which Weston General Hospital is not. Maximum travel times by private car and by ambulance are well within this 60-minute indicator.

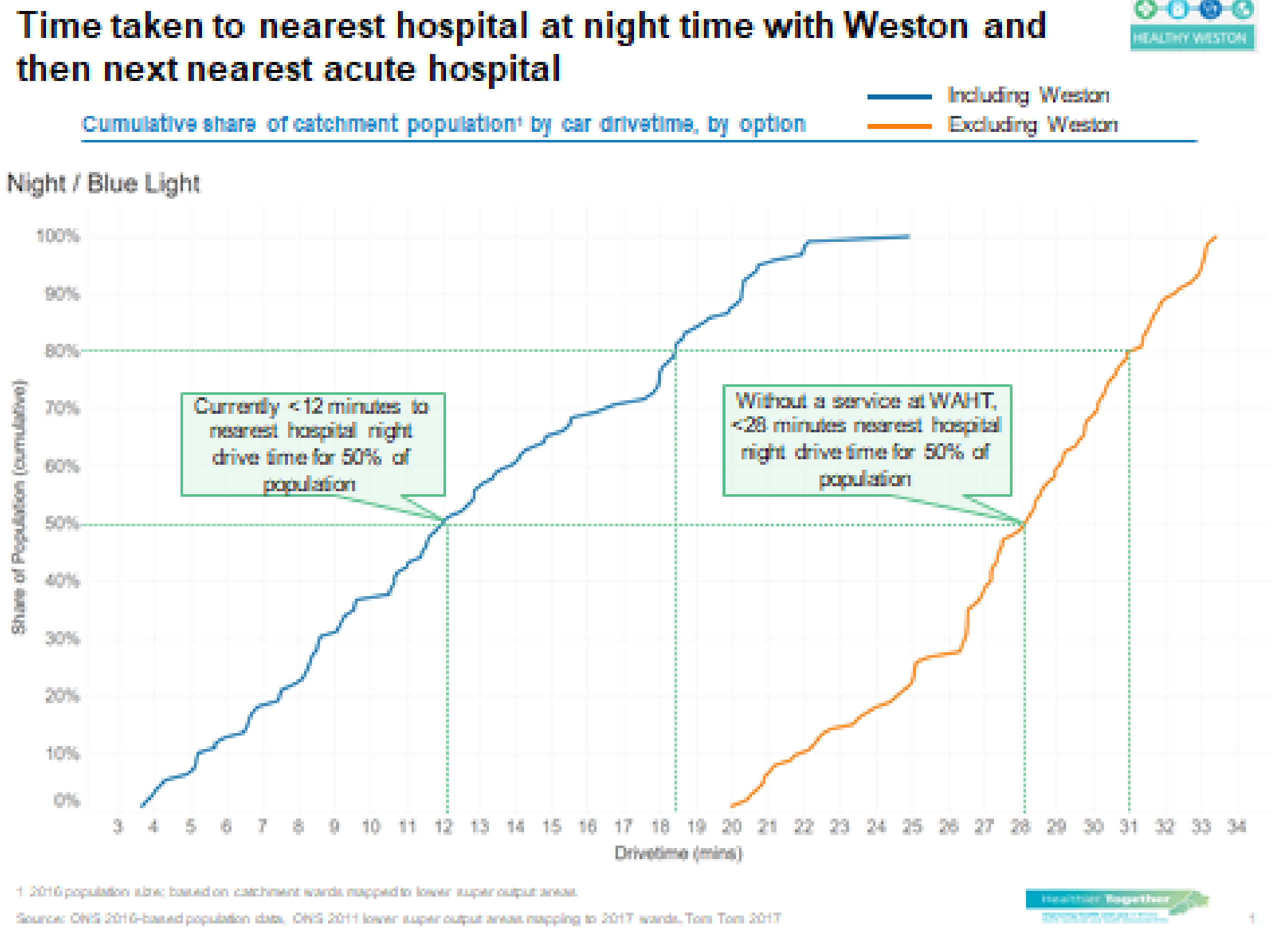
Private car and ambulance travel times used TomTom and Google maps travel time data and overlaid this information onto the Lower Super Output Areas of the catchment population of the hospital to calculate the population weighted average travel times. Public transport travel times used the TRACC specialist multi-model transport accessibly software package[2] and overlaid this information to the Lower Super Output Areas. The population sizes of the Lower Super Output Areas were calculated using data from the Office for National Statistics.

Ambulance travel time

The Ambulance Service are supportive of the preferred option. Figure 14 shows predicted blue light ambulance travel time under the preferred option. Ambulance travel time was modelled using night time private car travel time data as a proxy for ‘blue light’ time. This is an accepted proxy and across the country has been shown to be more similar to blue light times than application of a simple formula as it takes into account differences in road conditions.

2 https://www.basemap.co.uk/tracc/

Figure 14: Ambulance travel time



Since July 2017 there have been no reported incidents resulting in patient harm due to the temporary overnight closure of A&E. In advance of the temporary overnight closure, detailed planning took place with the ambulance service to model the likely impact on the availability of ambulances and the journey times to neighbouring hospitals. In order to mitigate the impact on the additional demand on the ambulance service, additional funding was provided to add two double crewed ambulances above the existing provision to manage additional and longer conveyances to neighbouring hospitals. Review after the temporary closure found the actual impact of the changes was lower than the modelled changes and therefore one double crewed ambulance stationed at Weston Station from 10pm to 8am has been found to be sufficient to mitigate the impact of the temporary overnight closure.

Ambulance conveyances during the day due to changes in emergency surgery and critical care would be in addition to the conveyances due to changes in A&E. These have been factored into plans and will require additional resources. The repatriation of these cases back to Weston General Hospital will be provided by the ambulance service, as well as patient and community transport as appropriate.

Initial modelling on any further financial impact on the ambulance service has been carried out. The "additional" ambulance conveyances are costed at £260 (which is the Ambulance Trust average cost per conveyance), £190 to reflect the additional mileage and time required to get the crew back to Weston afterwards. The additional ambulance transport cost is estimated at £1.8m per year.

Private car travel time

Journey times from a patient's normal place of residence to any hospital site were used to investigate average and maximum travel times for the population and to understand the additional travel time as a result of the proposed changes. This analysis is applicable to patients requiring treatment and for friends and relatives visiting patients in hospital. Using Office of National Statistics population data and TomTom driving time data analysis shows that 80% of the catchment population who have access to a car can currently access a hospital within 24 minutes at peak times and 21 minutes at off-peak times. If patients cannot be treated at Weston General Hospital and care is provided elsewhere, this rises to 41 minutes at peak times and 35 minutes at off-peak times, an increase of 17 and 14 minutes respectively.

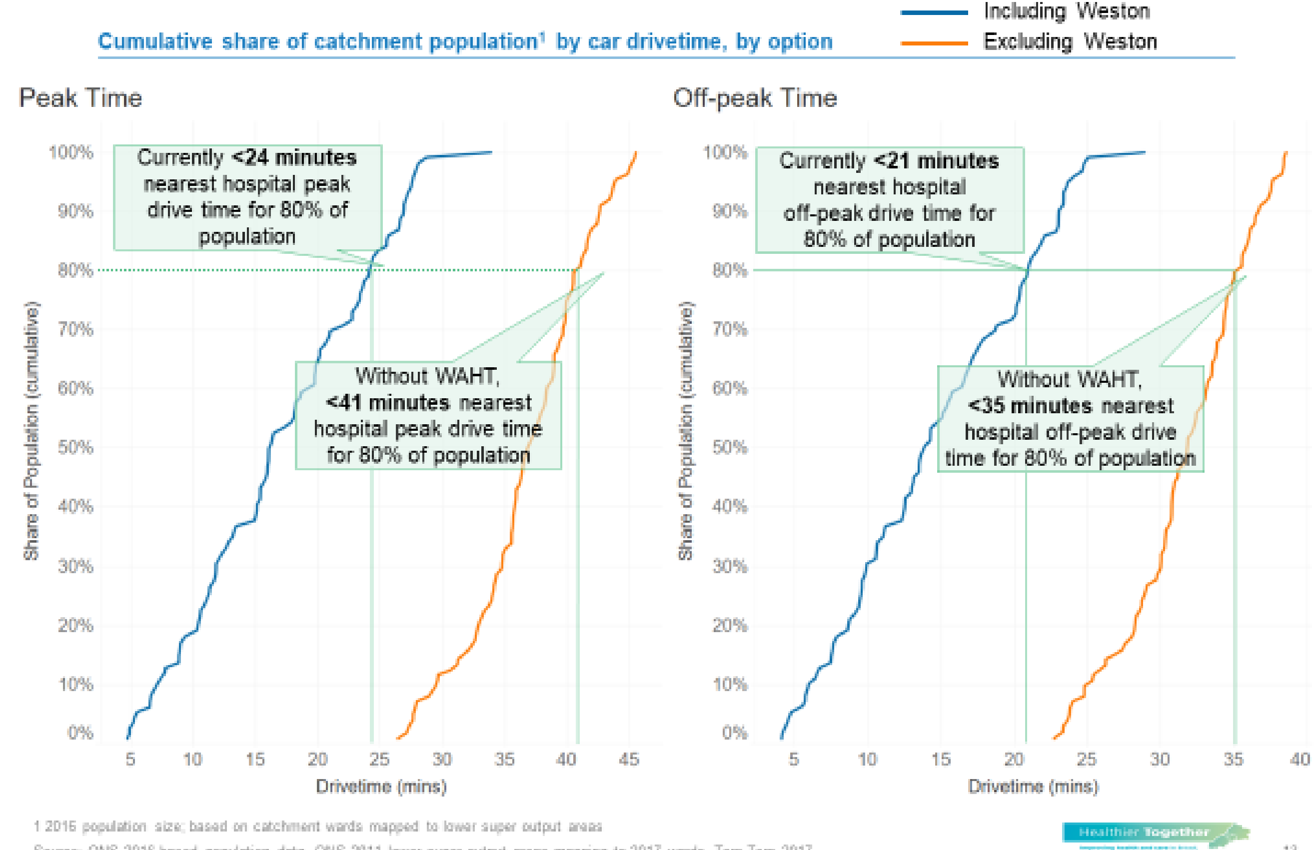
Figure 15 shows changes in the travel times for the current catchment population to reach their nearest acute hospital during peak and non-peak times by car. Travel times to major acute services by private car at peak times, inter-peak times and at night have also been quantified.

Figure 16 shows the average drive time to the nearest hospital currently and under the preferred option.

Under this analysis, it is assumed that people will travel or be taken to the closest site which provides the care they need. The population flow analysis therefore predicts what proportion of activity will take place where under the preferred option. Factoring in travelling to an alternative site, the nearest acute hospital for 75% of the Weston General Hospital catchment population is Southmead.

Adding five minutes to estimated drive times to North Bristol Trust results in significant shifts in activity, with 88% of the Weston General Hospital catchment population being able to access University Hospitals Bristol.

Figure 15: Changes in travel time by car

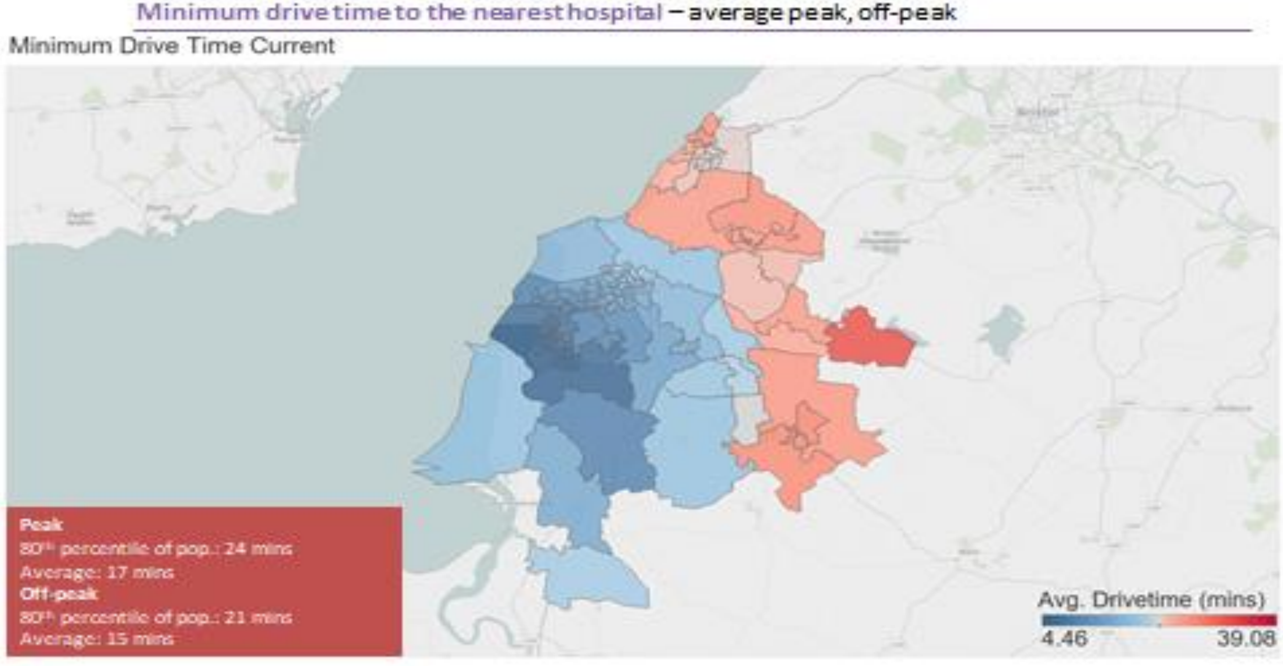


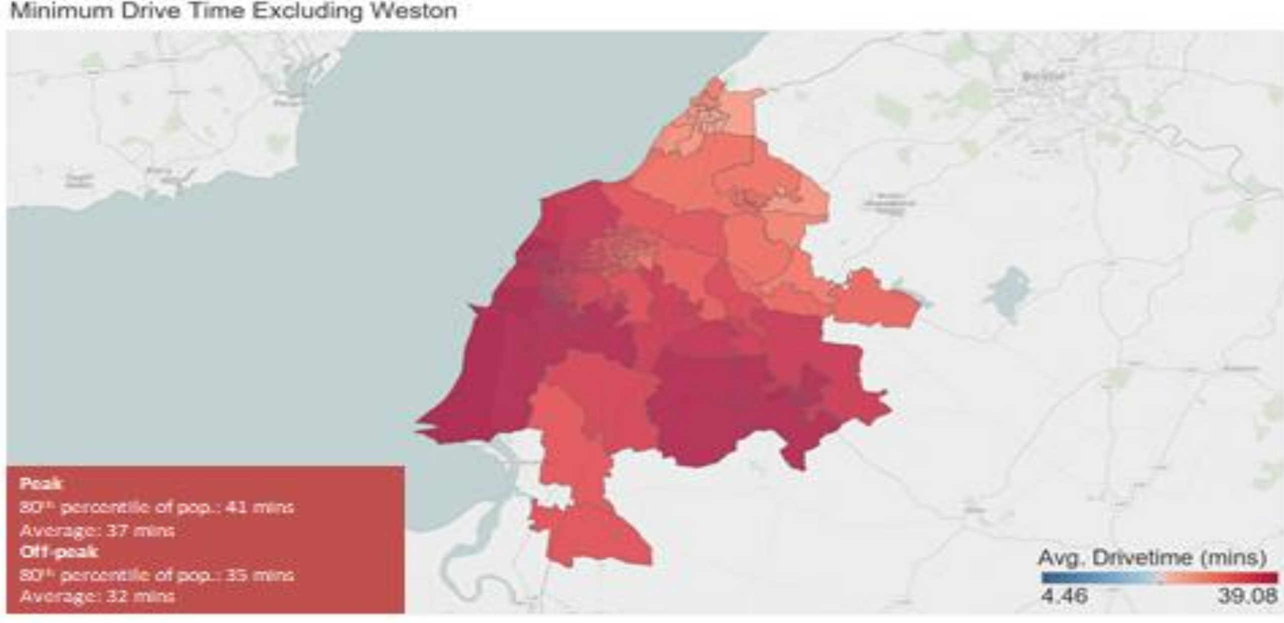
Public transport travel

The programme does not anticipate that anyone requiring emergency care will travel to hospital via public transport. However, travel by public transport is an important consideration for people traveling for elective care and for relatives and friends visiting people in hospital. Using Office of National Statistics population data and public transport modelling software showed that 80% of the Weston General Hospital catchment population can currently access a hospital by public transport within one hour and one minute at peak times and one hour and four minutes at off-peak times. If patients require treatment at an alternative site and care is provided elsewhere, this rises to one hour and 42 minutes at peak times and one hour and 31 minutes at off-peak times, increases of 41 minutes and 27 minutes respectively.

After Weston General Hospital, the quickest hospital to get to by public transport for the majority of the catchment is University Hospital Bristol. The *Healthy Weston Programme* wants to further consider access via public transport given the rural nature of parts of the area and reliance amongst some on public transport.

Figure 16: Average drive times – current and under preferred option





Additional detail about travel analysis is provided in Appendix 21.

A Travel Working Group is being established to further examine the impact of the preferred option on patient travel and to provide support in the development of mitigations to address any adverse impacts. We recognise that travel is of particular concern to people without their own transport and our plans will take this into consideration, including the implications of transferring back home from a neighbouring hospital having been conveyed by ambulance for the initial journey. The programme may recommend changes to

commissioning patient and community transport. This will include identifying opportunities to work with transport commissioners more broadly to improve patient transport across the system.

Impact on the workforce

Although the breadth of services retained in the preferred option would allow staff to utilise their skills and develop their experience, the ongoing issue of staff recruitment in A&E will remain a challenge with this model. Challenges will also remain for staffing at other hospitals in the wider health economy as this model of care requires more consultants and specialist nursing staff overall across the health economy. Health Education England have expressed concerns about the training of doctors within this model. This is a significant long-term risk for this option. Based on assessment of benefits and risks, the *Healthy Weston Programme* considers the preferred model a **short term solution**, necessary to stabilise Weston General Hospital but unlikely to be sustainable in the long-term.

The local workforce has been engaged via a series of events and workshops throughout the engagement process over the past 18 months. This will continue as the *Healthy Weston Programme* progresses.

A workforce plan is in development for the whole-system and is due for completion by April 2019. The plan will review the assumptions in every *Healthier Together* clinical workstream to ensure robust translation into workforce plans. The amalgamation of this work together with the baseline assessment of the five-year supply and demand picture within the system will give a clearer understanding of the likely workforce impact of the preferred direction of travel. We will ensure that all staff groups (e.g. doctors, nurses and allied health professionals) will be fully engaged in the consultation process and long-term codesign work going forward.

In the meantime, evaluation suggests that the preferred option reduces dependence on the A&E workforce and provides better opportunities for staff to work in new roles, thereby potentially improving the recruitment and retention rate. The preferred option can support development of the required skills in primary care in relation to emergency and frailty services, which is predicted to lead to more multidisciplinary care and cross-organisational collaboration than the status quo. However, the preferred option has a greater reliance on GPs than the status quo and therefore brings with it recruitment risks.

Deliverability

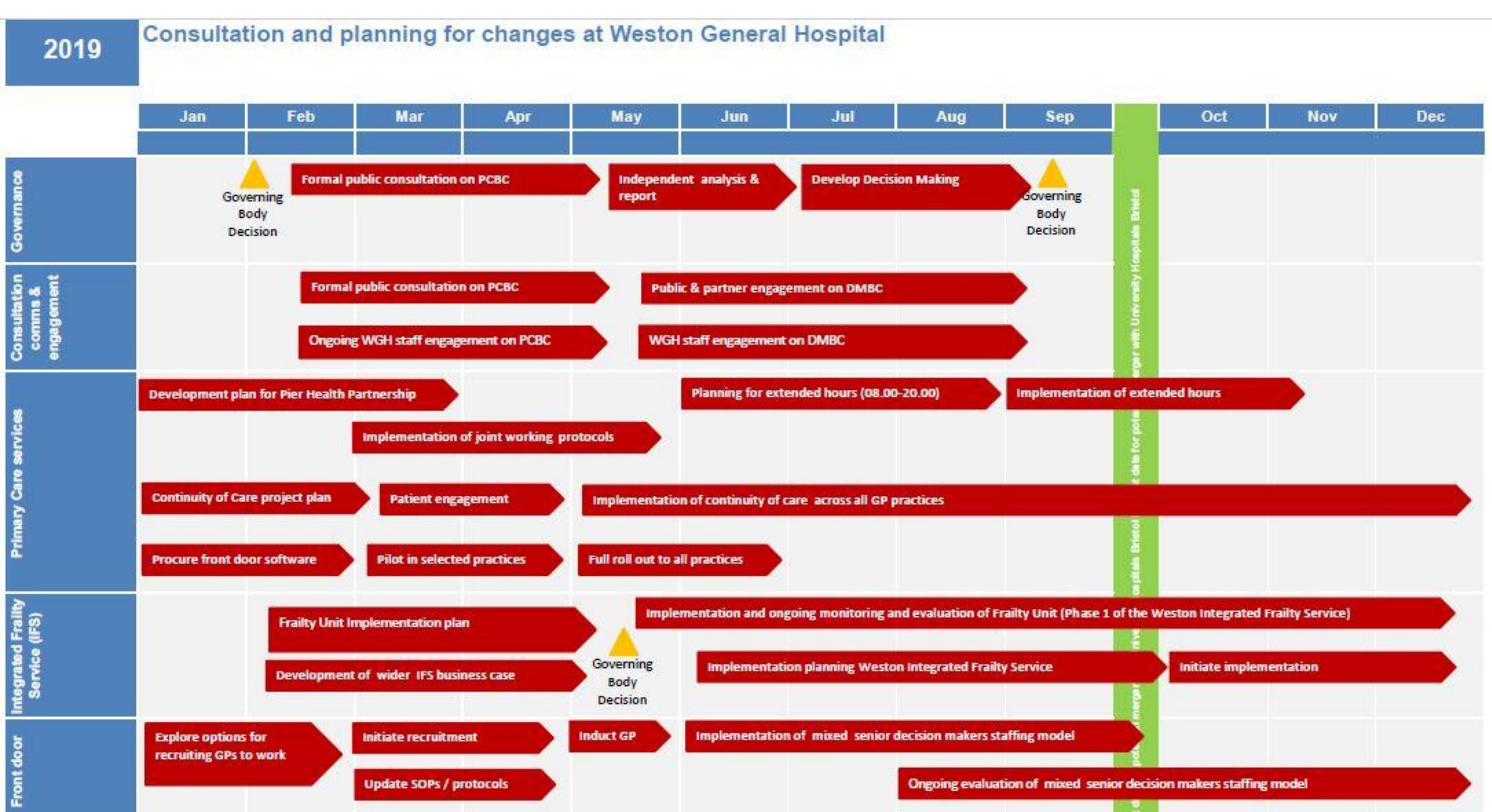
Assessment of deliverability concluded that the preferred option would be deliverable within 12-18 months. This assumes that the system has the infrastructure, capacity and capability available, as well as the will to successfully implement the changes.

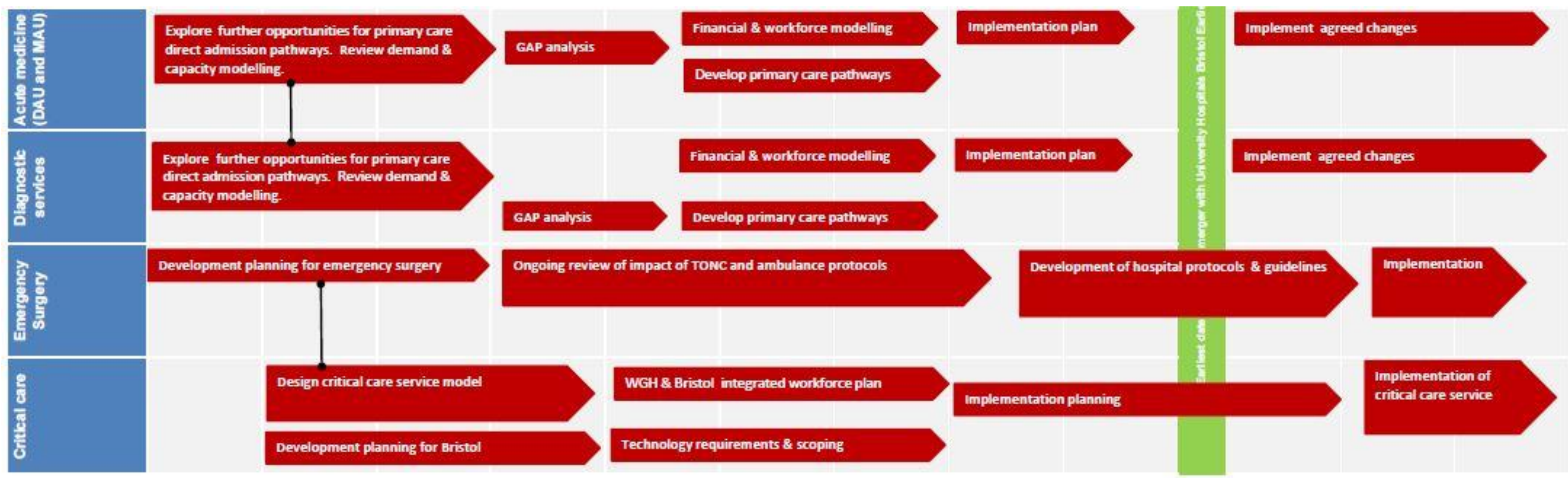
If this option was approved following consultation, it could be implemented within one year (or as soon as practicable) of approval by the CCG. It is supported for immediate implementation by the Clinical Senate. It is closely aligned to the current services offered at Weston General Hospital. Therefore, it is the model which would be easiest to deliver quickly, and cause least disruption.

All risks attached to the preferred option are balanced with the understanding that the status quo also presents significant risk of unplanned changes that cannot be fully mitigated. If implemented, a checkpoint/ gateway process will be developed so that before any future changes are implemented there will be a system-wide assessment of services' ability to safely and sustainably adapt to the impact of proposed reforms

Appendix 22 sets out initial implementation plans if the preferred option was initiated. More detail would be provided in a Decision Making Business Case, but the *Healthy Weston Programme* has started to set out key delivery milestones from the current position to implement the preferred option. Figure 17 sets out the 2019 planned actions and milestones.

Figure 17: Initial implementation plan for preferred option




Acute medicine (DAU and MAU)
Explore further opportunities for primary care direct admission pathways. Review demand & capacity modelling.
GAP analysis
Financial & workforce modelling
Develop primary care pathways
Implementation plan
Implement agreed changes
Diagnostic services
Explore further opportunities for primary care direct admission pathways. Review demand & capacity modelling.
GAP analysis
Financial & workforce modelling
Develop primary care pathways
Implementation plan
Implement agreed changes
Emergency Surgery
Development planning for emergency surgery
Ongoing review of impact of TONC and ambulance protocols
Development of hospital protocols & guidelines
Implementation
Critical care
Design critical care service model
Development planning for Bristol
WGH & Bristol integrated workforce plan
Technology requirements & scoping
Implementation planning
Implementation of critical care service
Earliest date merger with University Hospitals Bristol

Financial impact

The Directors of Finance involved in *Healthy Weston* modelled the financial impact of the proposed model against the status quo. An activity baseline was created with consistent assumptions which included a 1% demand management target. The list of service lines to be used for reconfiguration modelling was agreed and activity projections created.

A financial baseline was calculated for Weston Area Health Trust as a whole which showed that if there was no significant change to service delivery the trust would move from a recurrent deficit of £15.2m in 2018/19 to £16.6m in 2023/24.

Income and expenditure is the net of all recurrent income and all recurrent expenditure. It is an important measure of financial performance recognising that an NHS Trust is not financially viable unless it is able to generate a surplus. Appendix 20 shows that the preferred option improves the income and expenditure position by £4.5m per annum for the trust compared to the status quo. Sensitivity analyses demonstrated that the bulk of savings were driven by the integrated frailty service and reducing agency and locum premium costs.

Overall, the financial analysis found that the preferred option would be associated with a £5.3 million improvement across the system with £5.2 million capital investment (the majority of which is an existing scheme included in UHB's current capital plan). It should be noted that the BNSSG system will be developing detailed mitigating plans to avoid the need to commit significant capital to creating replacement bed capacity. One option being developed is of increasing the Elective Activity that is carried out at Weston General Hospital and so effectively moving Bed Days from the other hospitals.

In addition, the impact of a BNSSG system wide Integrated Frailty service is also expected to reduce the baseline activity at the other Acute Trusts, as is improved use of the discharge to assess (D2A) beds as a result of the procurement of Adult Community Services.

More detailed planning will be carried out to ensure that capital requirements for any reconfiguration are able to be met from individual trust capital plans and these changes will be high priority Sustainability and Transformation Partnership plans and so will have first call on capital made available through Sustainability and Transformation Partnerships.

The preferred option would see some activity (predominantly emergency activity) flowing to other hospitals in the area. The numbers of patients who would be affected each year are listed in Appendix 20.

Enablers

In order for the preferred direction of travel to proceed, a number of other changes are envisaged across the wider health and care system to support the new approach. All of these will be developed further in moving towards a Decision Making Business Case. These key enablers are described below.

- *Technology and clinical informatics:* Up-to-date technology and clinical informatics will need to be used effectively to facilitate effective communication between different health and care providers. This includes real-time communication between Weston General Hospital and other hospitals, as well as effective liaison between primary and secondary care and allied community services. Additionally, the integration of technology and health monitoring allows more patients to manage aspects of their own care effectively at home.

- *A more robust model of primary, community and social care, integrated with a new frailty service:* In order for the system as a whole to function well, there needs to be a more robust model of care in the community. Primary care needs to provide strong system leadership to support more home and community-based care along with a greater focus on healthy behaviours and wellbeing. This will support more integrated care pathways.

- *Clear transfer arrangements for patients:* The system as a whole will need to put in place robust protocols and transfer arrangements to ensure that any patients who need escalation of care are safely and rapidly transferred. Transfers need to be managed and led by the receiving unit which should take responsibility for ensuring high quality care for patients. Technology increasingly offers an alternative to patient transfer. South Western Ambulance Services NHS Foundation Trust are sharing the learning from Dorset and have been commissioned to provide detailed implementation models.

- *Coordinating the frailty offer for Somerset residents:* We are linking closely with Somerset CCG and Somerset Partnership to ensure that there is a consistent and coordinated front door/ frailty unit offer for Somerset residents accessing these services at Weston General Hospital

- *New governance arrangements:* Weston General Hospital will need to form strong links with neighbouring trusts to support staff retention and training, joint teams across sites and clear transfer arrangements. The proposed merger by acquisition of Weston Area Hospital Trust by University Hospitals Bristol NHS Foundation Trust and the increased networking of acute care across the *Healthier Together* Partnership will significantly strengthen the system’s ability to deliver these changes.

5.5 Quality impact assessment

As part of assessing the potential impacts of the preferred option for consultation, a Quality Impact Assessment was undertaken by the CCG's nursing and quality directorate. Table 15 summarises the results. Risks relating to clinical assumptions and workforce impacts are further described in Appendix 23.

Table 15: Quality impact assessment for preferred option

Is there an impact on patient safety?	**Enables clinically safe transfers with minimal impact of travel time on patient outcomes. Reduced risk due to less reliance on consultant-led A&E workforce. The full business case will model the detailed workforce requirements in terms of skills, staffing recruitment and retention.**
Is there an impact on the delivery of national standards?	More people requiring major emergency surgery would be treated in units which are more compliant with national standards for high quality of care.
Is there an impact on the providers' duty to protect people?	No change in impact.
Is there an impact on partner organisations and any shared risk?	The *Healthier Together* Sustainability and Transformation Partnership's *Healthy Weston Programme* comprises 13 commissioning organisations and health and social care delivery partners so there is whole-system ownership of the process used to develop the proposals for change.
Does the plan comply with the best evidence guidance including NICE?	More people requiring major emergency surgery would be treated in units which are more compliant with national standards for high quality of care.
Does the plan impact on the delivery of services in line with national clinical and quality standards?	Does not fully address changes in the health needs of the population, but does include the development of services for children and older people. More people requiring major emergency surgery would be treated in units which are more compliant with national standards for high quality of care.
Does the plan lead to a change in care pathways?	Weston General Hospital would manage people with needs at most levels of severity but all major surgical emergencies would go to larger centres that see greater numbers of people. Clinically-led modelling suggests that 70% of A&E visits for 'major' needs, 85% of acute medicine and 70% of emergency surgical activity would continue to be managed at Weston General Hospital compared to the current level of services.
Is there an impact on the delivery of clinical outcomes?	Emergency care at larger units in line with national standards. Integrated frailty model improves acute medicine. Critical care in line with national standards. Increased quality of children's care. Less investment in out of hospital services possible as more

	investment needed on acute care.
Does the plan promote and support the recovery model?	A range of business cases for service development are in progress as part of this wider work including a 'mental health crisis and recovery centre' to be positioned in the centre of Weston, significant new investment in local Children and Adolescent Mental Health Services and a new approach to primary care support for local nursing homes.
Does the plan impact on access to services?	Increased travel time for patients and carers who would no longer be able receive care at Weston General Hospital, with an extra 17 minutes average at peak times and an extra 14 minutes off peak. Reduced hours but still meeting population needs. Services to patients in the minor injuries unit at Clevedon Community Hospital are unaffected.
Does the plan have an impact on service user experience?	Better continuity for frailty care.
Does the plan have an impact on carer experience?	Better continuity for frailty care.
Does the plan support the choice agenda?	No change to patient choice for elective care.
Does the plan address concerns and issues raised through patient experience	People have identified that care closer to home as part of an integrated network of health and social care is a priority for them. People's feedback has directly influenced wider aspects of change, such as the planned positioning of a mental health crisis and recovery centre off-site from the hospital and the development of integrated frailty services. he full public consultation will further explore the impact on patients and their concerns in relation to the options presented
Does the plan have an impact on service user experience?	Better continuity for frailty care. Potential to support integration between primary and hospital care. Potential to integrate primary care and frailty, so better links with the community and wider services. Improves physical environment.
Does the plan have an impact on carer experience?	Better continuity for frailty care. Potential to support integration between primary and hospital care. Potential to integrate primary care and frailty, so better links with the community and wider services. Improves physical environment.
Does the plan support the choice agenda?	Potentially some minor changes to patient choice for elective care. Improved choice for primary care services.
Does the plan address concerns and issues raised through patient experience	People have already identified that care closer to home as part of an integrated network of health and social care is a priority for them. eople's feedback has directly influenced wider aspects of change, such as the planned positioning of a mental health crisis and recovery centre off-site from the hospital and the development of integrated frailty services. The public consultation will further explore the impact on patients and their concerns in relation to the options presented.

5.6 Equality impact assessment

An Equality Impact Assessment screening has taken place and this will be developed into a comprehensive assessment during the public consultation period. This screening was undertaken to understand how proposed service changes may impact on protected groups as well as people affected by deprivation. This work involved the interim Director of Public Health, North Somerset, as well as the inclusion lead for the CCG. Prior to this screening process, the programme engaged extensively with groups representing protected characteristics. Public engagement work has taken place with the local community including with groups representing the seldom heard and all the protected characteristics (see Appendix 11). In addition, the engagement work outlined in Appendices 7 and 11-12 has fed into the overall understanding of the local population and the impact of any service changes.

The impact assessment has identified key areas for enquiry during the public consultation. It has highlighted groups who could experience a negative impact as a result of the changes.

The preferred option has been evaluated against the protected characteristics of disability, ethnicity, gender, sexual orientation, transgender, age, religion and marital status as well as deprivation. Table 16 shows the scoring system used.

Table 16: Scoring system for equalities impact assessment

	Likelihood				
Impact	Rare 1	Unlikely 2	Possible 3	Likely 4	Certain 5
Significant negative impact - 2	-2	-4	-6	-8	-10
Moderate negative impact -1	-1	-2	-2	-4	-5
No significant effect	0	0	0	0	0
Moderate positive impact +1	1	2	3	4	9
Significant positive impact +2	2	4	6	8	10

Where the preferred option was considered to potentially have both positive and negative impacts (such as access to services and the impact on people with frailty), or to affect different groups differently within one protected characteristic (such as younger people and older people) then these were each scored and the scores added to create a single score.

The overall score for the currently commissioned model was -40. This demonstrates a significant negative impact on people with protected characteristics and those experiencing deprivation, reinforcing that doing nothing is not an option. Particular areas that have been highlighted that are also covered in the Case for Change are age and deprivation. A key stimulus in developing the preferred option has been to tackle the health inequalities that are currently not addressed by the existing model.

The overall score for the preferred option was +3. This is a marginal positive impact overall but one that is substantially better than the currently commissioned model. The integrated frailty service, greater availability of paediatric services and improved community and primary services were particular areas of strength in the preferred option that resulted in an improved score.

The full Equality Impact Assessment is contained in Appendix 24.

Local groups representing the protected characteristics and other vulnerable patients have been identified for further discussion about this during the formal consultation process. As well as the local groups already identified, an independent organisation will undertake discussion groups with people who may experience a negative impact of some of the changes resulting from the preferred option. This feedback will be used to plan appropriate mitigations.

5.7 Longer-term vision

The *Healthy Weston Programme* recognises that the preferred option provides an immediate potential solution for urgent issues. However, there is a requirement for a longer-term vision for building a sustainable and vibrant future for Weston General Hospital. The preferred option for consultation addresses immediate staffing and safety concerns but does not go far enough to develop a truly sustainable service for the long-term.

The longer-term vision of care to be provided from Weston General Hospital recognises a genuine desire on behalf of service providers to break down organisational boundaries and work together in new and radically different ways to support people, help them stay well and live happy and healthy lives in their community. The key principles underpinning this longer-term vision are more integrated primary, community and acute care services, maintained bed base for acute emergency care at Weston General Hospital and appropriate step up enhanced care to enable elective surgery if ASA level deteriorates.

This is in line with the NHS Long Term Plan which talks about ‘triple integration’ of services, namely GPs working closely with hospitals and other specialist care services, physical and mental health services being delivered together and health and social care coming together. The way to achieve this is through the development of “Integrated Care Systems” which means individual services working together seamlessly, rather than operating as separate organisations.

The Integrated Care System model has the potential to significantly further improve local services, but this will entail further change. These changes will be part of a national work programme that will affect every hospital and local health care system in England. It is too early to know the precise details of the changes needed, but the following areas are of high priority:

- a different way of providing outpatient care. The NHS Long Term Plan estimates that with redesigned hospital support, up to a third of hospital outpatient appointments could be avoided
- more of the sickest patients being treated at larger hospitals instead of Weston General Hospital, as indicated by the forthcoming national Clinical Standards and guidance on Smaller Hospitals. To support this there would need to be closer cooperation between Weston General Hospital and other local hospitals. These relationships are already strong and developing, but will be underpinned by the new “duty to collaborate” trailed in the NHS Long Term Plan
- transfer of more patients needing specialised treatment will provide even more scope for Weston General Hospital to become a focus for planned surgery within the region
- asking GPs to take an even more prominent leadership role in the delivery of urgent care, prevention of hospital admissions and reducing the need for outpatient services. Again the NHS Plan provides for this by announcing a new “shared savings scheme”. This means Primary Care Networks (i.e. groups of GP practices working together at scale) can benefit from actions they take to reduce avoidable demand on Weston General Hospital, which currently suffers from often having a higher bed occupancy rate than is recommended as best practice
- better use of digital technology to make patient consultations easier, but also allowing professionals from other hospitals to support Weston General Hospital staff in the diagnosis and treatment of their patients

There are also opportunities to repatriate work that is currently being done in Bristol for the population served by Weston General Hospital as outlined below:

- **Additional inpatient elective care –** in specialties such as breast, urology, gynaecology, oncology and orthopaedics
- **Enhanced day case activity** – more planned day case activity including laparoscopic day cases and planned infusions
- **Endoscopy and diagnostics** – more upper and lower endoscopy procedures, more diagnostic activity (e.g. CT and MRI)

There are a variety of similar models already operating across England that are able to take the best elements of local acute care whilst harnessing the potential presented by local community services. This future direction of care would also be supported by acute providers in the surrounding area, meaning that services best delivered at scale can be offered in this manner, making room for other services such as cancer treatment that local people value and need to be offered more locally.

Figure 18 gives an indication of how Weston General Hospital services may be organised by 2025, with a consistent focus on providing care that local people need most.

The *Healthy Weston Programme* recognises that this future vision of care is highly reliant on whole system transformation, in particular the developments in primary and community care locally, the ability of neighbouring acute hospitals to accommodate the shift of patients and the establishment of the frailty hub (as part of the wider integrated frailty service). The programme is therefore beginning to develop these plans concurrently with consulting about immediate changes to Weston General Hospital.

Figure 18: Broad vision for acute services at Weston General Hospital by 2025

A potential model for 2025

Service	Vision
A&E and urgent care	Urgent access 8am to 10pm 7 days a week to a medically led team of healthcare professionals with a range of different clinical skills
Unplanned inpatient care	Patients who are very sick and likely to need longer unplanned inpatient care may be treated elsewhere There may be longer term beds available for frail/older people
Care for frail/ older people	Improved frailty service with a team of healthcare professionals working closely with the hospital medical team and other NHS and social care professionals to appropriately assess and treat patients.
Emergency surgery and critical care	Daytime emergency surgery for patients who are otherwise fit and well. Access to ward-based critical care with stabilisation and transfer of patients needing Level 2/3 critical care
Children's urgent care	Children's' urgent care provided by specialist paediatric staff extended to 8am to10pm 7 days a week
Planned Care	Planned surgery for people who are otherwise fit and well. Further expansion of planned care, for example other cancer treatments

6. Assurance of process

This section describes the assurance and scrutiny that the *Healthy Weston Programme* has undergone, both internally and externally.

6.1 Internal assurance

The *Healthy Weston Programme* is overseen by the *Healthier Together* Sustainability and Transformation Partnership and Bristol, North Somerset and South Gloucestershire CCG. Regular reports have been taken to the CCG Governing Body which are held in public, and also to the CCG Commissioning Executive, the CCG Strategic Finance Committee and the CCG Patient and Public Involvement Forum. Table 17 provides examples of key CCG internal assurance milestones, in addition to regular Governing Board updates from the Chief Executive.

6.2 External assurance

NHS England has been involved in the *Healthy Weston Programme*, with regular meetings to share progress and secure input. In accordance with best practice guidelines, NHS England will undertake assurance of the plans for consultation and the models of care for the future. This process consists of:

- **A strategic sense check** which examines the Case for Change and the level of consensus for change (completed).

- **Review of feedback from South West Clinical Senate.** The Senate provides independent, strategic clinical advice and leadership to all commissioners across the South West geographical area. It is a non-statutory advisory body with no executive authority or legal obligations and it therefore works collaboratively and objectively across the health system. The South West Clinical Senate will provide NHS England with an independent review of clinical elements of the plans for service change.

- **Stage 2 assurance** is NHS England's formal assurance of proposals for consultation, including review of the consultation plan and draft consultation document.

Table 17: Examples of internal CCG assurance of the *Healthy Weston* process

Date	Meeting	Purpose
4 June 2018	Governing Body Seminar	To provide overview of programme in context of Board Assurance Framework
3 July 2018	Governing Body AGM	To provide overview of the *Healthy Weston Programme*
4 September 2018	Governing Body Seminar	Seminar discussion on programme approach and Case for Change
18 September 2018	CCG PPI Forum	To seek assurance on approach to public and patient involvement
2 October 2018	Governing Body Seminar	Discussion on evaluation criteria, best practice pathways and clinical models
2 October 2018	Governing Body Meeting (Open)	Approval of Evaluation Criteria
2 October 2018	Governing Body (Closed)	Review of technical and summary Case for Change and agreed delegation for sign off to CCG Commissioning Executive and CEO
11 October 2018	CCG Commissioning Executive	Review of best practice pathways, clinical models and approach to options development
25 October 2018	CCG Strategic Finance Committee	Review of the financial and modelling assumptions
6 November 2018	Governing Body Seminar joint with Weston Area Health Trust Board	Discussion on emerging options for consultation and next steps
6 November 2018	Governing Body (open)	Received technical and summary Case for Change
6 November 2018	Governing Body (closed)	Agreed in principle options for consultation subject to further review by Commissioning Executive
8 November 2018	CCG Commissioning Executive	Full review of options recommended by *Healthy Weston* Steering Group and draft proposals agreed
4 December 2018	CCG Governing Body (closed)	Receive Pre-Consultation Business Case and consultation plan for approval in principle
13 December 2018	CCG Commissioning Executive	Review of Pre-Consultation Business Case in context of Clinical Senate feedback
5 February 2019	CCG Governing Body (public)	Decision on Pre-Consultation Business Case and consultation document

NHS England's *Planning, Assuring and Delivering Service Change for Patients* (updated in October 2015), describes how proposals for service change must demonstrate that they satisfy the five tests of service reconfiguration and are affordable in capital and revenue terms. The tests are:

- **Clarity around the clinical evidence base:** The Case for Change must be widely understood and there should be clear, clinical evidence of the benefits of the proposals being consulted on.

- **Support from GP commissioners:** must be clear and unequivocal and there should be involvement and 'ambassadorship' of the programme by them throughout.

- **Promotion of genuine patient choice**: must be able to demonstrate that patients, residents and other stakeholders have understood how and why the proposals will benefit them and offer a better way forward for their healthcare needs.

- **Genuine engagement with the public, patients and local authorities:** working to reach as many people as possible, put the proposals forward in a clear and comprehensible way and listen and respond to people throughout the process.

- Assurance with regards to any changes to **inpatient bed numbers**.

The extent to which this Pre-Consultation Business Case addresses each of these criteria is briefly described in turn.

Clear clinical evidence base

There is a clear clinical evidence base about why we think services need to change. This is set out in Section 2 and Appendices 5, 14 and 15. The case for change has been reviewed by the South West Clinical Senate, NHS England, the *Healthy Weston* Steering Group, the CCG Patient and Public Involvement Forum and other stakeholders. All have noted that there is clear evidence for change.

The robust process and clear clinical evidence is strengthened because clinicians have led the *Healthy Weston Programme* throughout, working with wider stakeholders to develop models of care. As part of diagnostic work, clinicians undertook a detailed review of care models to identify good practice nationally and locally. Feedback from the National Institute for Health and Care Excellence field team has been received and incorporated into the best practice pathways.

As clinical models were developed there was continuing discussion with the South West Clinical Senate and written feedback from the Senate informed how models were conceptualised and assessed. A formal Senate Panel Review on 20 November 2018 confirmed that the case for change was easy to understand and compelling, and that there was robust clinical evidence supporting the preferred option for consultation and longer term direction of travel.

There is clear clinical evidence about the benefits of the preferred option. This is outlined in Sections 3 and 4 as well as Appendices 3, 17 and 19. The evidence shows that the new model of care will help to address the case for change.

Support for proposals from commissioners

The preferred option and longer term direction of travel is fully supported by GP commissioners and all other stakeholder organisations that are part of the *Healthy Weston Programme*. The CCG's Governing Body, the GP members of the Governing Body and the Weston and Worle Locality GP Membership Group have been involved in the Programme throughout and have expressed support for the models of care proposed. In December 2018, the CCG Governing Body provided approval in principle to move forward to consultation, pending NHS England review.

GPs and other clinicians have been ambassadors for *Healthy Weston* throughout, leading the development and refinement of the proposals. The Medical Director of NHS Bristol, North Somerset and South Gloucestershire CCG, a GP, chairs the group that developed all clinical models. This group has also involved wider primary, community and secondary care clinicians in the review and evaluation of options and via a number of workshops. The *Healthy Weston* Steering Group also has representation from the Director of Public Health and the CEO of North Somerset Council.

Consistency with patient choice

The *Healthy Weston Programme* recognises the need to consider patient choice and ensuring patients have access to the right treatment, at the right place at the right time. Feedback through extensive engagement and codesign with local communities has reinforced the need for a balance between providing a range of choices and the system's ability to deliver the best possible quality of care. This is particularly the case in rural populations where travelling times are a key factor in patient experience. People have already identified that care closer to home as part of an integrated network of health and social care is a priority for them. People's feedback has directly influenced wider aspects of change, such as the planned positioning of a mental health crisis and recovery centre off-site from the hospital and the development of integrated frailty services.

Patient choice and patient experience were included in the criteria that the *Healthy Weston Programme* used to evaluate the potential options for consultation. These factors will also be explored further through the consultation period which will help to determine the final configuration of services.

The *Healthy Weston Programme* has developed a consultation plan to ensure that patients, residents and other stakeholders have understood how and why the proposals will benefit them and offer a better way forward for their healthcare needs. Ongoing engagement activities undertaken in November and December 2018 are shaping how to present the preferred option and longer term direction of travel in a way that is meaningful and easy to understand.

Strong patient and public engagement

Section 3 and Appendices 11 and 12 describe the extensive engagement at the heart of the *Healthy Weston Programme*. Stakeholder engagement started at the beginning of the Programme and this continues. The Programme has undertaken an extensive amount of work to reach as many people as possible, put the proposals forward in a clear and comprehensible way and listen and respond to people throughout the process. More than 3,000 people have been involved in events, surveys and ongoing discussions throughout the programme.

The programme has developed a consultation plan to ensure that a wide range of people continue to be reached, including those that may be less likely to take part in consultation activities such as those from ethnically diverse committees, travellers and the gay, lesbian, bi and queer communities.

North Somerset Health Oversight and Scrutiny Panel is responsible for assuring the consultation process locally on behalf of other oversight and scrutiny committees. The Panel has been engaged informally and formally throughout the process, noting that *Healthy Weston* should focus on consulting about changes to acute services at this stage. They convened a meeting in December 2018 to formally comment on the *Healthy Weston* consultation plan and consultation document. The Panel has agreed in principle that there can be some overlap with local election Purdah, allowing consultation to start in February 2019 and finish in May/June 2019.

Somerset Health Overview and Scrutiny Committee has been kept appraised of consultation plans. Bristol, North Somerset and South Gloucestershire Joint Health Oversight and Scrutiny Committee has been kept informed of the progress both within the *Healthier Together* briefings and separate *Healthy Weston* briefings.

Bed modelling

Appendix 20 contains details of work undertaken to assess the impact of proposed changes in activity on bed capacity. *Healthy Weston* is not proposing a reduction in total beds across the Bristol, North Somerset and South Gloucestershire system (apart from about 24 beds being released following successful implementation of an Integrated Frailty Service and two beds following improvements in productivity as a result of moving activity).

Table 18 shows the overall bed impact.

Table 18: Estimated impact on inpatient beds (2019.20) of preferred option

	Modelled Impact Beds	Critical Care	Part Spell Repatriate to WGH	Net Bed Impact
Surgery				
General	8.11	(0.42)	(1.59)	6.10
Trauma and Orthopaedic	3.74		(2.24)	1.50
Surgery Sub-Total	***11.85***	***(0.42)***	***(3.83)***	***7.60***
Acute Medical	4.78	(0.88)	(3.68)	0.22
Critical Care Beds		1.30		1.30
Total Bed Impact	**16.63**	**0.00**	**(7.51)**	**9.13**
Changes to make				
Impact of move on lengthening stay *(481 patients at 2 day LOS increase)*	2.60			2.60
Increase critical care due to clinical caution *(double the number of critical care patients)*	1.30			1.30
Proposed total	**20.53**	**0.00**	**(7.51)**	**13.03**

General surgery

A list of HRGs that could not be supported without level 3 critical care was drawn together and reviewed by surgeons from Weston General Hospital and other trusts. The number of spells for 2017-18 for each of these HRGs was multiplied by the University Hospitals Bristol length of stay (as this trust would be receiving most patients) to calculate a bed day requirement. HRGs associated with NBT specialities were also included in the impact analysis.

This resulted in a 2,960 bed days required (extra 8.1 beds) at other hospitals before mitigation.

This shift in activity is of a relatively low number of spells (518) that have a proportionally long length of stay so repatriation was discussed. The programme agreed that after five days at the receiving hospital, 90% of patients would be transferred back to Weston General Hospital as the likelihood of them needing critical care level 3 or above was low after that period. This would see repatriation of 1.6 of the above beds.

Trauma and orthopaedic

The proposed clinical model would allow surgery up to ASA 3+ (as long as there was the ability to mechanically ventilate for 12 hours, or longer on a case by case basis). The Weston General Hospital Operating Theatre system (Opera) was used to identify which patients from 2017-18 would not have been able to be operated on if this model was in place at the time. This identified 91 patients with an average length of stay of 15 days. This generated a requirement for 3.7 beds. A similar repatriation assumption was agreed as above O which reduced the bed requirement by 2.2 beds.

Acute medicine

A list of HRGs that could not be supported without level 3 critical care was drawn together and reviewed by clinicians from Weston General Hospital. The number of spells for each of these HRGs was then multiplied by the Weston General Hospital length of stay to take into account age profile/ length of stay and calculate a bed day requirement. Almost half of the patients that may need to be transferred were coded to 'viral pneumonia' at one level or another. Weston General Hospital clinicians agreed that these patients were a core patient base for Weston General Hospital and that as long as there was step up access to level 3 critical care support for 12 hours with the option to extend on a case by case basis then the vast majority of these patients could still be received and treated at Weston General Hospital. This resulted in a 1,745 bed days (4.8 beds) requirement at other hospitals before mitigation.

This shift in activity is of a relatively low number of spells (96) that have a relatively long length of stay so repatriation was discussed. It was agreed that after five days at the receiving hospital, 90% of patients would be estimated to transfer back to Weston General Hospital as the likelihood of them needing critical care level 3 or above was low after that period. This would see repatriation of 3.7 of the above beds.

Patients that deteriorate once at Weston General Hospital would be stabilised and then transferred another hospital, the impact of these is covered within the critical care section below.

Critical care

WGH had 1,749 critical care bed days in 2017-18. Of these 475 were at level 3 or above with a split of 2/3rd medical and 1/3rd surgical cases. This implies a critical care requirement of 1.30 beds. These beds should be included within the main spell length of stay and so do not result in a net increase in beds but simply a reclassification between bed types.

Additional adjustments

It is recognised that moving a patient can have an impact on the date of their eventual discharge from hospital. There are 481 spells being moved to alternate hospitals, assuming a 2 day LOS increase and that this increase will occur at the receiving hospital (not Weston General Hospital) this would increase beds needed by 2.6 beds.

It is recognised that the non-availability of a service locally can result in clinicians becoming more cautious and so an adjustment has been made to reflect that a higher proportion of patients may transfer that the retrospective HRG analysis has indicated. A proxy to estimate this is that for every patient transferred under critical care, a patient who "may" need critical care but does not eventually need this is also transferred. This has been estimated at 1.3 bed days and their pathway is modelled in the same was as if a patient did need critical care (e.g. they go to the receiving hospital for 5 days than return to WGH).

Summary of bed impact

The table below lays out the impact:

Table 19: Estimated level of activity 2019/20

	Modelled Impact Beds	Critical Care	Part Spell Repatriate to WGH	Net Bed Impact
Surgery				
General	8.11	(0.42)	(1.59)	6.10
Trauma and Orthopaedic	3.74		(2.24)	1.50
Surgery Sub-Total	***11.85***	***(0.42)***	***(3.83)***	***7.60***
Acute Medical	4.78	(0.88)	(3.68)	0.22
Critical Care Beds		1.30		1.30
Total Bed Impact	**16.63**	**0.00**	**(7.51)**	**9.13**
Changes to make				
Impact of move on lengthening stay *(481 patients at 2 day LOS increase)*	2.60			2.60
Increase critical care due to clinical caution *(double the number of critical care patients)*	1.30			1.30
Proposed total	**20.53**	**0.00**	**(7.51)**	**13.03**

The system is working on further mitigation to remove the need for any additional bed capacity to be developed; a sub-group of the CSDDG and STP DoFs is exploring what

elective activity could potentially move from UHB, NBT and TST to transfer into WGH which would release capacity for them to absorb the above small movements in beds.

Please note the above model is using current year activity, when this is put through the McKinsey model it walks the activity forward by 5 years and so the additional demographic growth adds an additional bed being transferred.

6.3 Public sector equality duty

The requirements of the Public Sector Equality Duties as set out in the Equality Act 2010 are integral to the *Healthy Weston Programme* approach. To inform the programme there has been extensive engagement and communications activity seeking to gather the views of seldom heard groups. The planned consultation will continue with this approach, and is underpinned by an Equality Impact Assessment. The Equality Impact Assessment will be updated iteratively and used to inform decision making as the Programme progresses.

6.4 Emergency preparedness resilience and response

All NHS organisations are required to have in place robust plans and procedures which enable them to respond to major incidents or business continuity incidents. This requirement is set out in the Civil Contingencies Act (2004). Additionally, NHS England Emergency Preparedness, Resilience and Response assurance outlines 37 core standards that NHS providers must have in place. In continuing to develop plans for Weston General Hospital, consideration will be given to ensuring that the local healthcare system has the flexibility and ability to support business continuity. Plans and processes will be developed in line with the proposed option implementation approach.

Key points

The *Healthy Weston Programme* has undergone robust assurance from the CCG, South West Clinical Senate, NHS England and Oversight and Scrutiny Panels.

The programme has met the NHS England five tests of change:

- **Clarity around the clinical evidence base:** The case for change is widely understood and supported and there is clear clinical evidence of the benefits of the proposals to be consulted about. The Clinical Senate has said there is clear clinical evidence and that no change is not an option.

- **Support from GP commissioners:** There is clear and unequivocal support from GP commissioners about the need to change and the proposed option. GPs and other clinicians have been involved as ambassadors and leaders throughout. The preferred direction of travel is fully endorsed by the CCG.

- **Promotion of genuine patient choice**: Patients, residents and other stakeholders have been involved in sharing their priorities and perspectives through extensive pre-consultation engagement. A consultation plan has been developed to hear people's views about the preferred option. The preferred option allows more choice, with the potential for some additional planned activity to be moved to Weston General Hospital.

- **Genuine engagement with the public, patients and local authorities:** The *Healthy Weston Programme* has involved more than 3,000 local people, clinicians and other stakeholders in shaping proposals and considering the advantages and challenges. A consultation plan has been developed to reach as many people as possible during formal consultation, including seldom heard groups. Local authorities are involved in the *Healthy Weston* Steering Group and also providing oversight for the consultation.

- Modelling has been undertaken to show changes to **inpatient bed numbers**. No overall reduction in inpatient beds across the system is planned, apart from a small number as a result of an integrated frailty service – which would be a result of successful demand reduction rather than precipitative closures.

7. Proposed public consultation

This chapter describes proposed next steps for public consultation.

7.1 Consultation focus

The Healthy Weston Programme has developed a draft consultation document which focuses on three key changes to acute services at Weston General Hospital, as well as outlining other supporting developments and the longer-term vision. The three core acute care elements to be consulted on are:

1. **A&E and urgent care**

- Making the temporary changes to A&E opening hours permanent, i.e. A&E at Weston General Hospital would be open from 8am to 10pm, seven days a week
- Adding GPs to the A&E team
- Providing continued 24-hour access to emergency admissions to the hospital through direct referrals from GPs (and in the future potentially paramedics as well)

2. **Critical care**

- Providing critical care for patients whom doctors have assessed as needing a high dependency unit (up to level 2 critical care)
- Ability to escalate to level 3 critical care to stabilise and transfer (level 3 can be provided for up to 12 hours with the ability to extend on a case by case basis)
- Patients who are assessed as likely to need more intensive critical care support i.e. the most serious and complex cases, would be transferred to other hospitals

3. **Emergency surgery**

- Providing emergency surgery in the day time for patients whom doctors have assessed as suitable for up to level 2 critical care on a high dependency unit following surgery (i.e. not for the most serious or complex surgical patients who would instead be stabilised and then transferred by ambulance and operated on at neighbouring hospitals in Bristol or Taunton, if not already taken directly there)

7.2 Consultation process

Legal requirements

In recommending public consultation to the CCG, the *Healthy Weston Programme* is clear about the statutory duties and responsibilities associated with consultation, which are summarised below:

- **Section 242** of the NHS Act 2006 places a duty on NHS providers to make arrangements to involve patients and the public in planning services, developing and considering proposals for changes in the way services are provided and decisions to be made that affect how those services operate.

- **Section 244** requires NHS bodies to consult relevant local authority Overview and Scrutiny Committees on any proposals for substantial variations or substantial developments of health services. This duty is additional to the duty of involvement under section 242 and 14Z2 (which applies to patients and the public rather than to Overview and Scrutiny Committees).

- The NHS Act 2006, **Section 14Z2** places a duty on CCGs to make arrangements to ensure that individuals to whom the services are being or may be provided are involved (whether by being consulted or provided with information or in other ways) in the development and consideration or proposals by the group for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals or the range of health services available to them; in the planning of the commissioning arrangements by the group; in decisions of the group affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.

Consultation principles

The *Healthy Weston Programme* recommends launching a public consultation about one preferred option, noting that no change is not an option and summarising the longer-term vision.

There are some principles surrounding appropriate consultation which *Healthy Weston* has been mindful of when developing its consultation plan:

- **Proposals must still be at a formative stage:** Public bodies need to have an open mind during a consultation and decisions cannot already be made. *Healthy Weston* has not made any decisions and has engaged with people throughout the development stage.

- **There must be sufficient information around proposals to permit 'intelligent consideration':** People involved in the consultation need to have enough information to provide intelligent input into the process. *Healthy Weston* has an extensive amount of information to share.

- **There must be adequate time for consideration and response:** Sufficient time should be given to enable people to make an informed response and there must be enough time to analyse the feedback. The proposed consultation period is 12 weeks.

- **Consultation feedback must be conscientiously taken into account:** Decision-makers should be able to evidence how they have taken consultation responses into account. At least one month has been allocated for compiling consultation feedback after the end of the consultation period. This will be taken into account in creating a Decision Making Business Case. The *Healthy Weston Programme* and CCG has committed to considering all feedback, including alternative options put forward.

The planned public consultation for *Healthy Weston* is also guided by the following priorities:

- *Consulting with everyone who may be impacted by our proposals*: Reaching out across the geography, demography, including the working well, silent majority, seldom heard and those with protected characteristics, to gather a fair representation of views and feedback.

- *Consulting in an accessible way*: Making sure information is consistent and clear; written and spoken in 'plain English' avoiding jargon and technical information; accessible to everyone and available on request in a range of languages and formats; reaching out to people where they are, in their local neighbourhoods and in local networks, physically and digitally.

- *Consulting well through a robust process*: Ensuring people have confidence in the consultation process; ensuring the process is open, transparent and accessible; being clear and up front about how public views can influence decision making, explaining it will not be possible to do everything everyone wants and why difficult decisions have to be made; making sure people are aware of the consultation even if they choose not to participate; making sure the consultation runs for a sufficient length of time to allow people to give their views, providing regular reminders about the closing date; ensuring locally and nationally we are acknowledged to have undertaken a meaningful and effective consultation process.

- *Consulting collaboratively*: Working together to reach out to as many people as we can in a meaningful way across North Somerset and the surrounding area. Ensuring information is relevant to local groups; being clear about what the proposals mean for each geographical area and for each group of people taking account of their interests, diverse needs and preferences.

- *Consulting cost-effectively*: Making sure the consultation budget is spent wisely and used effectively in terms of reach and response, delivering good value for money throughout.

- *Consulting for feedback*: Monitoring and evaluating the consultation process consistently and in a systematic way, including capturing feedback and comments from events, meetings, discussions and individual responses; ensuring independent analysis of the feedback received; considering and using the feedback to inform decision making; and sharing the feedback with local people including publishing a final feedback report.

Consultation methods

A variety of consultation methods will be used to reach a wide range of people, in particular seldom heard groups. Table 20 summarises the planned consultation methods. Appendix 25 includes the detailed consultation plan with timetable and draft consultation document, following receipt of confirmation from NHS England that this Pre Consultation Business Case is fully assured against all relevant conditions (please see appendix 26).

It is proposed that the consultation runs from February to May/June 2019 (to account for limited activity allowable during the purdah period for local authority elections).

The consultation plan aims to offer the same level of information to people attending events and/or who ask to be given updates; be clear how proposals have been developed including why some have been discounted and others preferred; put as much information as possible in the public domain including showing the clinical and demographic evidence behind the need for change and for planned proposals; provide regular updates to everyone in the local health and care system about progress and next steps in the programme and enable clinicians and other key programme decision-makers to have wide-ranging discussions which enable challenge and debate.

A working group of the North Somerset Patient and Public Reference Group and the CCG Patient and Public Involvement Forum have been asked to review the consultation plan and monitor delivery.

A consultation team has been set up comprising members of the CCG, Weston General Hospital and an external communications agency. The consultation team will meet regularly with communications colleagues from across the CCG geography and Somerset to update them about progress. They will work with groups such as Healthwatch and local patient groups to ensure the patient voice is heard in discussions and decisions. The consultation team will be accountable to the *Healthy Weston* Steering Group and be staffed by the programme, but draw on advice and support, and some resource from local trust teams.

The *Healthy Weston* communications team will continue to work with the communication teams at each of the different providers in Bristol, North Somerset, South Gloucestershire and Somerset as appropriate. Communication leads from each of the providers will continue to be involved in regular Steering Group meetings and will be able to use standard communications materials such as slide decks and leaflets at any internal meetings or events they may be holding. The communication leads from providers are leading the setting up of the ‘hospital site events’.

Table 20: Planned consultation methods

Consultation method	Approach
General publicity – advertising in local media, posters and postcards, support on social media, as well as via NHS organisations and established stakeholder channels such as Healthwatch and local voluntary group networks	• Information about consultation and public events available in GP waiting rooms, hospital waiting rooms, libraries, town hall and other civic and community centres • Publicity in local papers to promote specific local events • Website and Freephone telephone line advertised widely to drive responses
Public meetings – an effective way of engaging with a wide range of interested parties in the local health economy as well as patients and the general public	• Any invitation to attend a public meeting (whether campaign group or community group) to be considered and, within reason, accepted
Drop in sessions – to provide an opportunity for detailed conversations with the public, local commissioners and acute trusts about their specific priorities and interests	• Drop in / market stall events held in areas most affected by proposals • Include static and interactive elements including the ability to fill-in the consultation questionnaire
Focus groups will be held to target identified heard to reach groups, in conjunction with the Equality Impact Assessment work	• Focus groups during consultation, with numbers and frequency are being planned with the support of Health Watch in accessing key hard to reach groups
Staff engagement	• Trust-specific events to engage with staff, supported by the programme. Key clinicians supported to lead this process
One to one or small group meetings – for key individual stakeholders such as MPs and councillors	• Key stakeholders will be written to proactively and meetings offered • All requests for meetings and briefings to be considered and, within reason, accepted
Website / online media – for all stakeholders to access information and provide further background information	• Website with comprehensive guide to consultation, events and activities, regularly updated • Including information to help the public to understand the impact of the proposed changes on them individually
Telephone and freepost – the consultation team will be directly accessible via telephone and post mechanisms in addition to online contact information	• To support open communications between the programme and interested parties

Consultation materials

The core consultation material will be a consultation document, which has been developed to encourage maximum participation in the process. It includes a core narrative, associated messages, and questions and answers. The consultation document and all other materials have been written as clearly, simply and in as compelling a way as possible, avoiding jargon and complex technical language. All core materials will be tested for accessibility with key user groups, including the North Somerset Patient and Public Reference Group.

The consultation document and associated materials will be published on a dedicated section of the *Healthier Together* website under the *Healthy Weston* section. This will be clearly signposted from the CCG website. It will host general information about the programme and consultation, including structure charts and maps; meeting papers and other key decision documents; clinical evidence and data used to inform decisions; documents and data relating to *Healthy Weston;* the consultation questionnaire. This will enable people to easily visit and respond to the consultation online.

Documentation will be made available in various formats including hard copy and online. Special versions such as audio or translated versions will be made available on request. Graphics and video material will be used to make the concepts and information more accessible to audiences.

It is vital that patients, the public, staff and other interested parties feel that their feedback is valued and that they can give feedback easily and directly. The mechanisms for response will include a Freepost address, a dedicated email address and an online response form.

A dedicated response unit will be in place for the consultation period. The response unit will work closely with the communications team to ensure that responses that require a reply will be actioned in good time. A protocol will be in place to govern this process.

News and media

News media will be kept informed and press releases and interviews provided as appropriate. Media enquiries will be handled as swiftly and accurately as possible and inaccuracies challenged and rebutted, based on a set of agreed and updated questions and answers. Local newspaper adverts may be considered as a way of providing information about events.

Specific media handling plans will be created for significant milestones throughout the consultation, including in each case key messages, detailed questions and answers, targeted media, arrangements to offer broadcast interviews and photograph/filming opportunities, a record of who has been approached and briefings offered.

A media strategy will be put in place to cover the launch, proactive public relations activity and reactive communications. A bank of stories and case studies that illustrate the case for change and the benefits of the proposals will be developed. An efficient and effective approvals process will also be important in terms of reacting quickly to negative or inaccurate articles.

A number of proactive approaches to engage more closely with the media are being considered to ensure an open and transparent approach. The principle is that the Programme has nothing to hide and that it can only benefit by providing access to the media and showing, as objectively and transparently as possible, the current challenges facing healthcare, how the proposals are being driven by local clinicians, and how the proposals will ultimately benefit local communities.

Consultation events

A number of different events will be held to ensure that the consultation can be shaped by early feedback, for example on format and language and that responses are encouraged from the communities and populations potentially most affected by the plans. It will also be important to include health and care staff Bristol and Somerset so they are aware of, and can get involved in, the consultation. The consultation team will therefore provide briefing materials and information to local trusts and other partner organisation communications teams so they can lead the staff engagement process from within their individual organisations. It will also ensure copies of hard copy materials are available at relevant staff sites and digitally on appropriate websites.

The consultation plan in Appendix 25 outlines the types of meetings and events planned. Table 21 outlines some of the meetings that have been scheduled to date.

A series of public meetings has been planned in a range of locations, on different days of the week, and both during the day and in the evening, to make them as accessible as possible to as many people as possible. Dates, times and venues will be advertised through a range of channels.

There will also be a programme of outreach to seldom heard groups throughout the consultation period. In addition, the programme will seek to attend existing meetings and fora to talk about the preferred option and direction of travel with local people and stakeholders and invite invitations from community and other groups for this purpose.

The Programme will review the activity regularly throughout the consultation period. If there are significant requests to host additional public meetings, these will be considered where time, resource and logistics allow.

Table 21: Already scheduled consultation events and locations

Consultation weeks	Week beginning	Meeting type	Locality
1	w/b 11/2/19	Staff round table event	Weston
3	w/b 4/3/19	1st listening event – for invited stakeholders	Weston
3	w/b 4/3/19	1st public listening event	Weston
3	w/b 4/3/19	Public listening event	Bournville
4	w/b 11/3/19	Public listening event	Kewstoke
4	w/b 11/3/19	Drop in event with stands and subject experts	Weston
5	w/b 18/3/19	Public listening event	Villages (Banwell, Parklands)
5	w/b 18/3/19	Public listening event	Locking
12	w/b 6/5/19	Public listening event	Worle
12	w/b 6/5/19	Public listening event	Burnham on Sea
13	w/b/ 13/5/19	Public listening event	North Sedgemoor
13	w/b 13/5/19	Public listening event	Mendip
14	w/b 20/5/19	Public listening event	Woodspring
14	w/b 20/5/19	Public listening event	Weston

7.3 Summary of planned next steps

Table 22 summarises key milestones for the consultation. Pending final review by the CCG's Governing Body and NHS England, it is proposed that the consultation would launch in February 2019. During the consultation period, the *Healthy Weston Programme* would continue work to refine the proposals, taking into account public, clinical and other stakeholder feedback.

Following the close of the consultation in May/June 2019, the CCG Governing Body will consider the responses to the consultation, which will be compiled by an independent team, and a Decision Making Business Case will be prepared to help decide about next steps.

A robust programme management and governance structure will implement whatever final decision is made by the CCG Governing Body, overseen by the *Healthier Together* Partnership to reflect the system ownership of change. The Programme will follow formal project management principles and have sufficient resource allocated to support delivery. This will include a clear governance and delivery structure from operational workstreams through to the *Healthier Together* Oversight Board; a structured relationship between programme management and delivery and a comprehensive approach to risk management.

Table 22: Planned next steps for public consultation

Milestone	Date
CCG Governing Body considers Pre-Consultation Business Case, including consultation plan (closed meeting)	4 December 2018
Publication of HOSP papers to determine whether proposals **constitute a substantial variation in services**	5 December 2018
North Somerset HOSP Meeting	11 December 2018
NHS England Stage 2 Assurance Meeting	19 December 2018
CCG Governing Body papers published	2 January 2019
C**onsultation plan considered by the CCG Governing Body**	8 January 2019
Pre-Consultation Business Case published with CCG Governing Body papers	29 January 2019
CCG Governing Body considers Pre-Consultation Business Case	5 February 2019
Consultation begins, with full programme of events and engagement straddling purdah and running for total of 14 weeks	13 February 2019
Consultation ends	24 May 2019
Independent analysis of consultation feedback	May - June 2019
Development of Decision Making Business Case	July - August 2019
Share Decision Making Business Case with NHS England	August/Sept 2019
CCG Governing Body makes decision about next steps	September 2019

To summarise, this Pre-Consultation Business Case has shown that there is an overwhelming case for transforming health services in Weston, Worle and the surrounding areas to improve the care available for local people, population outcomes and system efficiencies. The *Healthy Weston Programme* includes a wide range of service improvement initiatives focusing on primary and community care but these are not the subject of consultation as they constitute 'service improvement' rather than a 'substantial variation' to services. North Somerset Council's Health Overview and Scrutiny Panel has suggested that the out of hospital service improvements do not require public consultation at this stage so this Pre-Consultation Business Case has focused specifically on the substantial variations to service at Weston General Hospital needing public consultation.

More than 3,000 people have contributed to developing or reflecting on the case for change and the options for the future. The work has been clinically led throughout, drawing on best practice standards, Royal College guidelines and robust methods for engaging with patients, the public and health and care staff. The proposed consultation will seek people's views about the preferred option for acute care at Weston General Hospital and begin to seek views about the longer-term direction of travel.

The *Healthy Weston* proposals provide an exciting opportunity to not only address an urgent and long-standing issue at Weston General Hospital, but also to improve the entire

health and care system for local people. All commissioners and providers support the approach and champion this whole-system change.

Abbreviations

A&E	Accident and Emergency
AES	Ambulatory Emergency Surgery
AGM	Annual General Meeting
ALOS	Average length of stay
ASA	American Society of Anaesthesiologists
AWP	Avon and Wiltshire Partnership NHS Foundation Trust
BNSSG	Bristol, North Somerset, South Gloucestershire
CAMHS	Children and Adolescent Mental Health Services
CCG	Clinical Commissioning Group
COPD	Chronic Obstructive Pulmonary Disease
CSDDG	Clinical Service Design and Delivery Group
CQC	Care Quality Commission
D2A	Discharge to Assess
DAU	Day Assessment Unit
DMBC	Decision Making Business Case
DoFs	Directors of Finance
ED	Emergency Department
EIA	Equality Impact Assessment
FEG	Finance and Enabling Group
GP	General Practitioner
HOSC	Health Overview and Scrutiny Committee
HOSP	Health Overview and Scrutiny Panel
HRG	Healthcare Resource Group
HW	Healthy Weston
H&W	Hood and Woolf
ICU	Intensive Care Unit
I&E	Income and Expenditure
IFS	Integrated Frailty Service
ISS	Intensive Support Service
IT	Information Technology
JHSC	Joint Health Scrutiny Committee
LOS	Length of stay
MAU	Medical Assessment Unit
McK	McKinsey & Company
MIU	Minor Injury Unit
NBT	North Bristol NHS Foundation Trust
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
NHSE	NHS England
NICE	National Institute for Health and Care Excellence
NPV	Net Present Value
NSCP	North Somerset Community Partnership

NSC	North Somerset Council
ONS	Office of National Statistics
PCBC	Pre-Consultation Business Case
PLANET	Protected Learning and New Educational Training
POD	Point of Delivery
POPP	Partnerships for Older People Projects
PPI	Patient and Public Involvement
PPRG	Patient and Public Reference Group
QIA	Quality Impact Assessment
SSPAU	Short Stay Paediatric Assessment Unit
SWASFT	South Western Ambulances Services NHS Foundation Trust
STP	Sustainability and Transformation Partnership
T&O	Trauma and Orthopaedics
T&ST	Taunton and Somerset NHS Foundation Trust
TONC	Temporary overnight closure of Weston General Hospital A&E department
UTC	Urgent Treatment Centre
UHB	University Hospitals Bristol NHS Foundation Trust
VANS	Voluntary Action North Somerset
VCSE	Voluntary Community and Social Enterprise
WAHT	Weston Area Health NHS Trust
WTE	Whole Time Equivalent

Glossary of terms

24/7 – 24 hours, seven days a week.

14/7 – 14 hours, seven days a week.

Ambulatory Assessment Unit – provides assessment, observation, diagnosis and treatment with the aim of getting patients home safely within a few hours, without the need for an overnight stay or admission to hospital.

A&E (accident and emergency) – hospital-based service available urgent medical care and surgical emergencies that are likely to need admission to hospital. This includes severe pneumonia, diabetic coma, bleeding from the gut, complicated fractures that need surgery, and other serious illnesses.

Acute care – short term treatment, usually in a hospital, for patients with any kind of illness or injury.

Acute Frailty Unit – unit which provides care for acutely unwell frail patients with the aim of avoiding admission from A&E or to reduce length of stay for admitted patients.

ASA physical status classification system – for assessing the fitness of patients before surgery.

Care pathway – the spectrum of services for a particular condition or disease. This starts with prevention and includes primary care, diagnosis, and rehabilitation. For example, for maternity, the care pathway can run from pre-conception care, education and advice; antenatal care during pregnancy; labour and delivery; and postnatal care. It could also include mental health services at any point. A pathway can feel very disjointed for a patient, who might find themselves repeatedly having to give information to different healthcare professionals, or trying to negotiate a pathway that involves different organisations, such as the NHS and the local council. An 'integrated care pathway' aims to make the passage from service to service as smooth as possible for the patient.

Clinical Commissioning Group or CCG – organisation made up of GPs which is responsible for identifying and securing most NHS health services for a particular area. They replaced primary care trusts (PCTs) in April 2013. Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group (CCG) was established in April 2018, bringing together NHS Bristol CCG, NHS North Somerset CCG and NHS South Gloucestershire CCG. It is responsible for commissioning services for the whole of Bristol, North Somerset and South Gloucestershire.

Clinical interdependencies – some services need to be in the same place, or supported by other services through a network arrangement. For example, an A&E department would normally have to have blood testing and X-ray facilities on site. A cardiothoracic unit – which treats heart and lung disease – would usually need critical/intensive care support in the same place.

Continuous Positive Airways Pressure – a form of positive airway pressure ventilator, which applies mild air pressure on a continuous basis to keep the airways continuously open in people who are not able to breathe spontaneously on their own.

Clinical Services Design and Delivery Group – group of clinicians from hospitals and primary care as well as other clinicians (nurses, paramedics?) who have reviewed the services and models of care at Weston General Hospital to ensure the provision of resilient and sustainable acute hospital services. They have developed and evaluated options for acute, urgent and planned care services provided in Weston.
CQC – Care Quality Commission, the independent regular of health and adult social care in England. The CQC inspects all hospitals, GP practices and care homes in England to make sure they are meeting national standards, and to share their findings with the public.
Discharge to Assess – service which funds and supports people to leave hospital, when safe and appropriate to do so, and continuing their care and assessment out of hospital.
eConsultant – consultants who assess and monitor multiple patients' clinical parameters without the need to be directly on site to provide on-call expertise as and when required.
electronic Intensive Care Unit - a form of telemedicine that uses state of the art technology to provide an additional layer of critical care service.
Elective Care – see Planned Care.
Equality and Quality Impact Assessment – a process designed to ensure that a policy, project or scheme does not discriminate against any disadvantaged or vulnerable people.
Financial Deficit – when spending is greater than income.
Financial surplus – when income is greater than spending.
Foundation Trust (FT) − NHS Foundation Trusts are non-profit making public sector corporations. They are part of the NHS but have greater freedom to decide their own plans and the way services are run. Foundation Trusts have members and a council of governors. The aim is that eventually all NHS trusts will be Foundation Trusts. All three acute hospitals in North Somerset are Foundation Trusts.
Frailty Hub – unit that provides proactive care (and rapid assessment) for the 'frail' population with the aim of keeping this population well enough to avoid hospital attendance and admission.
Governing Body – the decision making group on behalf of the GP membership of the Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group.
GP locality – a smaller group of GP practices within the BNSSG CCG area. There are six localities in BNSSG, able to bring more detailed, local knowledge to BNSSG CCG.
Health and Wellbeing Board (HWB) – were formed as part of the NHS restructure in April 2013. They bring together the local NHS, public health, adult social scare and children services to plan how best to meet the needs of local people, and tackle health inequalities. They are hosted by the local authority and members include elected Councillors and Healthwatch. There are one health and wellbeing boards in North Somerset.
Health Overview and Scrutiny Committee (HOSC) or Health Overview and Scrutiny Panel (HOSP) – committee of the relevant local authority, or group of local authorities, made up of local Councillors who are responsible for monitoring, and if necessary challenging, health plans. They decide whether consultation is needed, depending on the scale of proposed change, and they also agree some other aspects of consultation, such as the length of the consultation period. North Somerset has a HOSP and Somerset a HOSC.

Healthwatch – replaced LINks, the public involvement networks, as part of the restructure of the NHS. North Somerset Healthwatch provides information to service users, carers and the public about local health and care services and how to find their way around the system. And it represents the views and experiences of service users, carers and the public on health and wellbeing boards. It can also raise any concerns with the national body Healthwatch England, which can in turn recommend that the CQC takes action.

Hub and spoke model – setting for care outside hospital, based on a central community site and serving as a support 'hub' to local healthcare teams. The services offered vary depending on local needs, from bases for multi-disciplinary teams to 'one-stop' centres for GP services, diagnostics and outpatient appointments.

Integrated frailty service – an integrated and partnership across commissioning and provider organisations, to better support our elderly and frail population to remain independent, confident, and in control of their care, for as long as is possible We will improve services for our frail elderly population by working much more intensively with patients with complex, chronic and disabling conditions, aiming to reduce their need for emergency, and often lengthy, bedded care.

Inpatient – a patient who is admitted to a hospital for treatment or an operation.

Integrated care – care which is coordinated around the patient, making sure all parts of the NHS and social services work more closely and effectively together.

Intensive care − units provide support for patients after complex surgery, or patients needing multiple organ support such as ventilation and dialysis.

Intensive Support Scheme (ISS) – a NHS England initiative to support significant change and transformation, including new organisational arrangements that will deliver primary care at scale to improve access and continuity of care for those who need it most.

Joint Strategic Needs Assessment – Enables the local NHS, in partnership with local authorities and other public sector partners, to work collaboratively to understand the current and future health and wellbeing needs of its local population and identifies future priorities.

LGBT+ – Lesbian, gay, bisexual, transgender, queer, questioning, intersex, asexual.

Locality Transformation Scheme – investment in primary care at locality level for transformation and improvement.

Long-term conditions – medical condition that cannot be cured, but can be managed by treatment such as medication and other therapies. Examples include diabetes, heart disease and dementia.

Maternity − relating to pregnancy, childbirth and immediately following childbirth.

Medical Assessment Unit – an acute medical ward which admits (from A&E and GPs) patients requiring short term assessment (e.g. 48-72 hours) before discharge or admission to a ward.

Minor Injury Unit – walk-in clinic service provided in some hospitals in the United Kingdom. Units are generally staffed by emergency nurse practitioners (ENPs) who can work autonomously to treat minor injuries such as lacerations and fractures

Models of care – approach by which care can be provided to a population, for example, an A&E which supports patients with all types of conditions.

Multidisciplinary team − groups of professionals from primary, community, social care and mental health services who work together to plan a patient's care.
NHS England – An executive non-departmental public body of the Department of Health. It oversees the budget, planning, delivery and day-to-day operation of the commissioning side of the NHS in England as set out in the Health and Social Care Act 2012. It holds the contracts for primary care services and specialised services.
NHS Mandate – mandate from the Government to NHS England that provides direction and ambitions for the NHS. The Mandate is published every year to make sure it is up-to-date, but it also sets long-term ambitions.
Non-elective surgery – see urgent and emergency care.
Integrated community services care – care that takes place outside of hospital, in a community setting. This could be a patient's home, GP practice, community hospital or community health centre.
Outpatient – patient who attends an appointment to receive treatment without needing to be actually admitted to hospital (unlike an inpatient). Outpatient care can be provided by hospitals, GPs and community providers and is often used to follow up after treatment or to assess for further treatment.
Paediatric services – healthcare services for babies, children and adolescents
Parity of esteem – the principle by which mental health must be given equal priority to physical health.
Patient and Public Reference Group – a group of patients, carers and the public, set up to provide input into the Review. It consists of a range of people who use or have contact with health services across North Somerset and who between them bring a wide and diverse range of experiences and perspectives to feed into the discussions. In addition, they are able to feedback information and progress on the work of the review to their own networks and are supporting North Somerset CCG with its information sharing and gathering around the review.
Planned care (also known as elective care or elective surgery) **–** a planned operation or medical care. This can be relatively straightforward (hernia repairs, knee replacements), and not require a stay in hospital. Or it may be complex, either because the procedure itself is complex or because the patient has other health problems, and require a stay in hospital whilst the patient recovers.
Primary care – services which are the main or first point of contact for the patient, usually GPs.
Provider – an individual or an organisation that gives a service in return for payment.
Secondary care – hospital or specialist care that a patient is referred to by their GP or other primary care provider.
Short Stay Paediatric Assessment Unit – assesses and treats children and young people referred by their GP or who have an open access arrangement.
Specialist care – hospital or secondary care that a patient is referred to by their GP or other primary care provider.
Stakeholder – anyone with an interest in a business. Stakeholders are individuals, groups or organisations that are affected by the activity of the business.

Surgical Hot Clinic – introduced in various specialties, including surgery to provide quick access to specialist services to avoid delay and reduce the burden on the emergency department.
Third sector – charitable or voluntary organisations.
Trauma, as in major trauma centre or trauma centre **–** designated centres that treat patients who have complex injuries – either one very serious injury or a number of injuries – which make managing these patients very challenging. They need expert care from a large number of different specialties to give them the best chance of survival and recovery.
Urgent and emergency care – surgery or medical treatment that is not planned and which is needed for urgent conditions. Examples include surgery for appendicitis, perforated or obstructed bowel, and gallbladder infections. It is also known as non-elective care.
Urgent Treatment Centre – unit at the front door (entry point) of a hospital which is staffed by primary care (e.g. GPs) and a multi-disciplinary team to provide urgent and emergency care to a population.
Whole-system – commissioners and providers in a local area acting as a single system to deliver effective and efficient services across all aspects of health and/or social care.
Weston Area Health Trust (WAHT) - the acute Trust which manages Weston General Hospital and ensures provision of high quality health care within an efficiently deployed financial envelope.
WTE – whole time equivalent: the number of staff required to carry out a particular function assuming that they all work full time.