Joint Health Overview and Scrutiny Committee

Agenda

Date: Friday, 25 October 2019
Time: 1.30 pm
Venue: The Council Chamber - City Hall, College Green, Bristol, BS1 5TR

Distribution:

Bristol City Council Members
Councillors: Brenda Massey (Chair), Eleanor Combley, Harriet Clough, Paul Goggin, Gill Kirk, Celia Phipps, Chris Windows

North Somerset Council Members
Councillors: Caroline Cherry, Ruth Jacobs, Geoffrey Richardson, Timothy Snaden, Mike Solomon, Roz Willis, Richard Tucker

South Gloucestershire Council Members
Councillors: Sarah Pomfret, Matthew Riddle, Robert Griffin, Trevor Jones, John O'Neill, Shirley Holloway, April Begley

Issued by: Dan Berlin, Scrutiny Advisor
City Hall, PO Box 3176, Bristol, BS3 9FS
Tel: 0117 3525232
E-mail: scrutiny@bristol.gov.uk
Date: Thursday, 17 October 2019

Agenda

1. Welcome, Introductions and Safety Information

2. Apologies for Absence

3. Declarations of Interest

4. Chair's Business

5. Minutes of the Previous Meeting

(Pages 4 - 9)

6. Public Forum

The total time allowed for this item is 30 minutes. **(Page 10)**

Members of the public and members of council may participate in Public Forum. The detailed arrangements for so doing are set out in the **Public Information Sheet** at the back of this agenda.

Public Forum items should be emailed to scrutiny@bristol.gov.uk and please note that the following deadlines will apply in relation to this meeting:-
Petitions, Statements and Questions – must be received no later than the working day prior to the meeting.

For this meeting, your submission must be received in this office, no later than **12.00 noon on Thursday, 24th October 2019**.

7. Healthier Together 5 Year System Plan

(Pages 11 - 48)

8. Adult Community Health Services Procurement

(Pages 49 - 65)

9. Specialised Neonatal Intensive Care

(Pages 66 - 84)

10. Mental Health Services

(Pages 85 - 92)

11. Healthy Weston: Future Services at Weston Hospital

(Pages 93 - 115)

Joint Health Scrutiny Committee

Wednesday, 26th September, 2018 at 10.00am

held at the Civic Centre, Kingswood, South Gloucestershire

Present

South Gloucestershire Council:
Councillors: Marian Gilpin (Chair), Janet Biggin, Shirley Holloway, Sarah Pomfret, Matthew Riddle and Ian Scott
Apologies: Cllrs Keith Burchell (replaced by Matthew Riddle) and Sue Hope

Bristol City Council:
Councillors: Brenda Massey (Vice-Chair), Eleanor Combley and Celia Phipps
Apologies: Cllrs Paul Goggin and Gill Kirk; also Cllr Helen Holland (Cabinet Member for Adult Social Care)

North Somerset Council:
Councillors: Roz Willis (Vice-Chair), Ruth Jacobs and Deborah Yamanaka
Apologies: Cllrs Mike Bell (replaced by Deborah Yamanaka), Andy Cole, David Hitchins, Reyna Knight and Ian Parker

In Attendance

South Gloucestershire Council:
Sara Blackmore, Director of Public Health
Karen King, Democratic Services Officer
Gill Sinclair, Deputy to the Head of Legal, Governance and Democratic Services

Bristol City Council:
Louise de Cordova, Democratic and Scrutiny Manager
Jacqui Jensen, Executive Director Adults, Children and Education

North Somerset Council:
Andrew Burnett, Interim Director of Public Health
Julia Parkes, Democratic and Registration Officer
Leo Taylor, Scrutiny Officer

Health Service Representatives:
Rebecca Balloch, Communications & Engagement Lead, Healthier Together Office
Deborah El-Sayed, Director of Transformation, BNSSG CCG
Stephen Lightbown, Director of Communications, North Bristol Hospitals NHS Trust
Lisa Manson, Director of Commissioning, BNSSG CCG
Laura Nicholas, STP Programme Director BNSSG CCG
Julia Ross, Chief Executive, BNSSG CCG
David Soodeen, Clinical Lead for Mental Health, BNSSG CCG

Apology: Robert Woolley (Chief Executive, UHBristol)

1 WELCOME AND INTRODUCTIONS (Agenda Item 1)

The Chair welcomed everyone to the meeting.

2 EVACUATION PROCEDURE (Agenda Item 3)

The Chair drew attention to the evacuation procedure.

3 DECLARATIONS OF INTEREST (Agenda Item 4)

There were no declarations of interest.

4 MINUTES OF THE LAST MEETING HELD ON 27TH FEBRUARY 2018 (Agenda Item 5)

Upon a proposal by Cllr Roz Willis, seconded by Cllr Brenda Massey, it was

AGREED: To approve the minutes of the meeting held on 27th February 2018 as a correct record for signing by the Chair.

5 PUBLIC FORUM (Agenda Item 6)

5.1 Submission by Viran Patel – Waiting List backlogs

A written public submission had been received, however the member of the public was not present at the meeting. The Chair indicated that a written response would be prepared and sent.

6 REPORT OF THE HEALTHIER TOGETHER TEAM (Agenda Item 7)

The Chair indicated that the part of agenda item 9 entitled 'Community Services Re-procurement' would also be considered as part of the main Healthier Together report under item 7, rather than in exempt session as shown on the agenda.

6.1 Healthier Together Update

Julia Ross introduced the Healthier Together update report. Since the Healthier Together Conference in June 2018, much progress had been made. A significant step had been to secure support to deliver a citizens' panel to gather the views of around 1,000 members of the public across the BNSSG area. The Healthier Together Panel would be surveyed on a range of health and care topics. Further progress included the establishment of 6 localities within the BNSSG area, being 3 localities in Bristol, 2 in North Somerset and 1 GP led locality in South Glos which contained a number of clusters. GPs were leading the work and vision of the localities and the ambition was that localities would be the default place of care with secondary (hospital) care being accessed only when there was real need.

The Clinical Commissioning Group (CCG) was on a journey to integrated care and to achieve this, 6 areas of change had been identified to focus upon:

- Integrated community localities
- Networked general hospital care
- Regional centre of excellence for specialised services
- Clinically and financially sustainable services
- Staff enabled to deliver excellent care every day
- Digitally enabled care

To deliver this vision of integrated care, there would be 10 priority areas of work:

- Integrated Community Localities
- General Practice Resilience and Transformation
- Mental Health Strategy
- Prevention
- Acute Care Collaboration
- Maternity
- Urgent Care
- Digital
- Workforce
- Healthy Weston

Members asked questions about the information presented and noted the following:

- No reduction in services was anticipated over the next 12 months and the intention was that waiting times would get no worse
- Social Care was part of the integrated community localities and local authorities were fully engaged with the Sustainability and Transformation Partnership (STP) plans
- There was a national direction on workforce planning post Brexit (withdrawal of the United Kingdom from the European Union), however local planning would take place
- Ways of maximising collaborative working across the BNSSG in order to provide the population with health and care services in the best way, were being explored; examples included deciding who would deliver specialist services currently available at more than 1 hospital; a BNSSG wide approach to tackling difficulties of recruitment and retention of staff to Weston Hospital; and aiming to have a BNSSG wide focus for clinical teams, work on which was already exemplified by the Maternity Services Team
- The voluntary sector played an integral part of community localities; the CCG worked with umbrella organisations such as the Care Forum, but also directly with discrete organisations such as BS3 Community; however, ways of funding the voluntary sector were as yet unclear; a planned engagement event would start to address ways of working under the 6 community localities
- Plans for an aspirant Integrated Care System were at an early stage

- The need to avoid duplication of work undertaken by the local authorities was acknowledged, for example in the area of meeting the mental health and wellbeing needs of the population.

6.2 Urgent Care Strategy

Deborah El-Sayed presented an update on the Urgent Care Strategy which gave details of work that had been done to identify what people wanted from urgent care and gave details of the vision for integrated urgent care and how this could be achieved. Members gave some examples of using the current 111 urgent care and 'out of hours' telephone system, which indicated a mixed experience.

6.3 Developing Strategic Plans for Mental Health

David Soodeen and Deborah El-Sayed addressed the Committee on the need to develop access to equitable mental health services across the BNSSG area, whilst respecting locality needs. A listening event had taken place to gauge views on gaps in services and as a result IAPT (Improving Access to Psychological Therapies) services were particularly being reviewed. Planning was also underway to improve crisis response, access to CAMHS (Children and Adolescent Mental Health Services) and work to reduce suicides and self-harm.

Members asked questions about the information presented and noted the following:

- Access to CAMHS services for children could involve lengthy waiting times; there had been many years of under-investment in providing CAMHS but the CCG had committed to additional investment
- The CCG had regular meetings with University leaders in the BNSSG, to work together to address the mental health of students; there had been a cluster of suicides by students in Bristol which was of concern; a pilot had been set up to establish integrated mental health staff within GP practices and it was planned to extend this to the university
- Work under the CCG mental health strategy and Public Health prevention programmes was linked and the workstreams were operating collaboratively
- Mental Health workstreams in schools related to areas such as self-harm and cyber bullying; most work took place within secondary schools but this did not rule out more work in primary schools in the future. A useful resource was suggested by Cllr Janet Biggin who recommended the book 'The Cyber Effect' by Dr Mary Aiken, which explained how human behaviours changed online

6.4 Communications and Engagement

Stephen Lightbown updated the Committee on the ways the STP was being shared with the Public and methods of engaging the Public in the re-design of services. As outlined earlier in the meeting, the Citizens' Panel would be a key part of the engagement plans. Rebecca Balloch added that there would be other engagement opportunities with a public facing event planned for November 2018 with a second Member workshop planned for January 2019.

Members asked questions about the information presented and noted the following:

- The issue of a lack of transport to healthcare facilities, particularly to the hospitals, affected many residents and this was something that the CCG and local authorities needed to work together on
- The CCG would make contact with the local authorities' communications teams to promote involvement in the Citizens' Panel and other engagement opportunities
- Patient Participation Groups were being included in engagement work through the area teams
- It was important to promote the good work already completed by the CCG as well as including the public on new initiatives

6.5 Capital Bids

Julia Ross reported on the list of capital bids currently underway. Key items noted were a bid for £9.40m for the Thornbury Primary and Community Health Care Hub and a bid for £18.32m for 3 frailty hubs across the BNSSG area. Information about the outcome of bids would be shared in due course. It was also noted that there was a bid for a combined heat and power cost efficiency scheme, which would be in the North Bristol area. The bid for Community Children's Health Partnership IT would require collaboration with the local authority children's social service departments.

6.6 Community Services Reprocurement

Lisa Manson and Deborah El-Sayed reported on the reprocurement of Community Health Services across the BNSSG area. Currently services were provided by 3 separate organisations, Sirona care & health, Bristol Community Health and North Somerset Community Partnership, each with its own service specification. Market testing of the services was required and this would be set against a BNSSG wide specification to align services with the CCG area. The intention was that the CCG Governing Body would make a decision on the specification and formally start the procurement exercise at its meeting in January 2019, with the aim of a new service being in place and operational from April 2020. Wide public engagement would take place, details of which were given.

Members asked questions about the information presented and noted the following:

- It was important to involve cultural groups in the engagement activities, noting that these differed from faith groups; local authority contacts could provide details of which ones operated within their area
- Weighting for local needs would be part of the procurement process and would be taken into account as the specification was developed and evaluated
- It was hoped that there would be a single community services provider across the BNSSG area, possibly with some separate specialisms

The Chair thanked the CCG for their informative presentation.

7 EXCLUSION OF THE PUBLIC (Agenda Item 8)

Upon a proposal by Cllr Roz Willis, seconded by Cllr Janet Biggin, it was

RESOLVED: That the public be excluded during consideration of the following item on the grounds that is likely, in view of the nature of the business to be transacted or the nature of proceedings, that if members of the public are present during consideration of the exempt item, there will be disclosure to them of exempt information as defined under Section 100(1) of the Local Government Act 1972.

8 REPORT OF THE HEALTHIER TOGETHER TEAM - CONTINUED (Agenda Item 9)

Representatives of the CCG reported on Estates Rationalisation Plans for the Avon & Wiltshire Mental Health Partnership (AWP) and answered further questions about the reprocurement of community services which related to commercially sensitive details. The information reported is contained in a separate confidential minute (see Appendix 1)

Cllr Ian Scott raised an objection to receiving this part of the Healthier Together report in a closed session because he felt that scrutiny items should be heard in public. He suggested that the information would be better delivered in a briefing session for Members until the point at which the details could be made public. Cllr Scott left the meeting at this point.

OPEN SESSION

9 DATE OF NEXT MEETING (Agenda Item 10)

AGREED: To hold the next meeting in March 2019, to take place after the second Members' workshop planned for January 2019.

The meeting closed at 12.40pm

Chair _____

Date_____

Joint Health Overview and Scrutiny Committee
Public Information Sheet

Petitions, Statements and Questions

Members of the public and members of council, provided they give notice in writing or by electronic mail to the proper officer of the host authority (and include their name and address and details of the wording of the petition, and in the case of a statement or question a copy of the submission), by no later than 12 noon of the working day before the meeting, may present a petition, submit a statement or ask a question at meetings of the committee. The petition, statement or question must relate to the terms of reference and role and responsibility of the committee.

The total time allowed for dealing with petitions, statements and questions at each meeting is thirty minutes.

Statements and written questions, provided they are of reasonable length, will be copied and circulated to all members and will be made available to the public at the meeting

There will be no debate in relation to any petitions, statements and questions raised at the meeting but the committee will resolve;

(1) "that the petition / statement be noted"; or
(2) if the content relates to a matter on the agenda for the meeting:
"that the contents of the petition / statement be considered when the item is debated";

Response to Questions

Questions will be directed to the appropriate Director or organisation to provide a written response directly to the questioner. Appropriately redacted copies of responses will be published on the host authority's website within 28 days.

Details of the questions and answers will be included on the following agenda.

Joint Health Overview and Scrutiny Committee

25 October 2019

Report of: Bristol, North Somerset, South Gloucestershire Healthier Together

Title: Developing our Five Year System Plan

Ward: Bristol, North Somerset, South Gloucestershire (BNSSG)

Officers Presenting Report: Julia Ross, Chief Executive BNSSG CCG /
Sebastian Habibi, Programme Director Healthier Together

Contact Telephone Number: 0117 900 2583

Recommendation
To receive an update from Healthier Together on the 5 Year Plan and the focus on improving health and wellbeing for our local populations.

Summary
The presentation sets out the approach to developing the 5 year plan for Bristol, North Somerset and South Gloucestershire (BNSSG). It is still being developed, with the final plan due for submission on 15 November 2019.

Context
The 5 year plan will set out local ambitions for the future of health and care provision, including acute hospital services, mental health, cancer, maternity care and end of life. It will also establish the workforce, financial commitments and partnership working required to deliver on these ambitions for patients and the public.

The plan will reflect the national priorities set out in the overall NHS Long Term Plan, which was published in January 2019, and every area of the country is required to submit their local plan to the national regulator NHS England and Improvement.

Healthier Together is a partnership approach, with the plan being developed in close collaboration with all the Healthier Together partners. Further information about Healthier Together can be found on our website www.bnssghealthiertogether.org.uk

Proposal
The members of the JHOSC are asked to review the information presented in the plan and provide any feedback or comment to the Healthier Together team on bnssg.healthier.together@nhs.net

Healthier **Together**

Improving health and care in Bristol,
North Somerset and South Gloucestershire

Developing our Five Year System Plan

Sebastian Habibi
Programme Director
Healthier Together

Contents

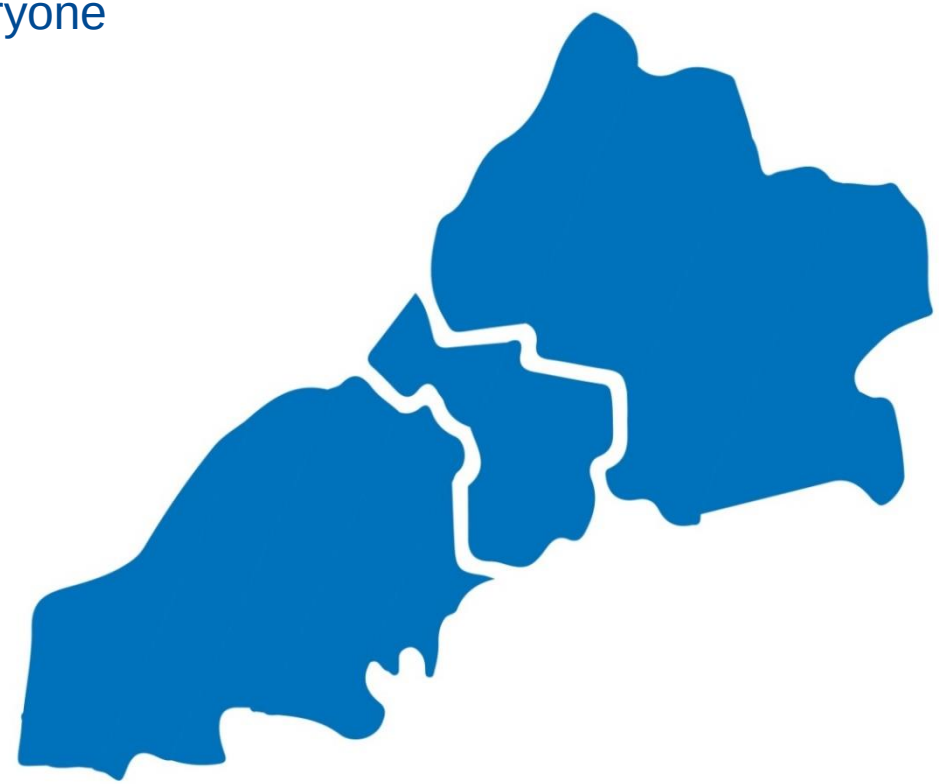
1. Approach to developing our 5-year plan

Our five year plan will focus on improving health and wellbeing for our populations

Vision - healthy, fulfilled lives for everyone

Goals

- Reduce inequalities in healthy life expectancy
- Release and reallocate resources from low value to high value activity
- Optimise people's independence
- Ensure our system deliver compassionate and high quality care
- Build a healthy and fulfilled workforce



Our starting point is to understand our populations better….

We have agreed design principles to guide our approach

Focusing on population, people and place – focusing on population health and wellbeing, identifying the outcomes that matter to people and understanding place from a resident's perspective

Targeting interventions to address inequality – tailoring approaches to address variation and under/over representation, and to take account of geography and cultural diversity

Addressing wider determinants of health and inequalities – working in partnership to give children the best possible start in life; improve education and employment outcomes; and contribute to inclusive growth

Reducing our impact on the environment – assessing the environmental impact of developments; reducing our carbon footprint and promoting better air quality

Investing in localities and neighbourhoods and in community capacity building to support health and wellbeing – devolving accountability and decision making as close to the community as possible

Applying data, intelligence and resources in a value based approach to understand population health, focus on outcomes that matter to people and ensure best possible use of all our resources

Identifying what matters to people – measuring outcomes, promoting independence and personalising care

Focusing on hearts and minds to drive change – facilitating cultural shift, embracing innovation and adopting best practice

Evidencing committed ownership of all partners – agreeing credible plans and timelines for delivery and embedding them in our organisational plans

We are developing a framework for our 5-year plan that reflects local and national priorities and strategies…

Ambitions

Improve Population Health and reduce gap in healthy life expectancy

Systematic delivery of value-based care

Shift to personalised, integrated, proactive and preventive care

Rebalance resources

Our Population

Local needs

Inequalities

Outcomes focus

Targeted interventions

Architecture

Strengthen primary care

Build integrated care partnerships at a locality level – including building healthier communities

Network acute care, deliver consistent standards and integrate access to specialist care closer to home

Develop further our specialist services to lead regionally, nationally and internationally

Promote research and innovation

Priority Care Programmes

- Prevention
- Children and Families
- Mental Health
- LD and Autism
- Frailty
- End of Life
- Maternity
- Diabetes
- Respiratory
- Cancer
- CVD
- Stroke
- Planned care
- Outpatients
- Urgent care/SDUC
- Medicines Optimisation

Key Enablers

- Digital
- Workforce
- Estates

Delivery Plans

Locality Plans

Performance management

Finance narrative

Roadmap for delivery

Activity Plan

Financial Plan

Workforce Plan

Performance trajectories

Strategic narrative

Delivery plans and numerical returns

Healthier Together

2. Our Population & Outcomes

Our approach to population health & population health management

Taking a population health approach means that we are collectively responsible for improving the physical and mental health outcomes and wellbeing of the people of Bristol, North Somerset and South Gloucestershire, while reducing health inequalities.

In doing so this approach guides us to prevent ill health, deliver quality health and care services and impact on the wider determinants of health. We believe this will only be achieved though working as a health and care community, which includes our patients and public.

A key enabler of our value based population health approach is the Population Health Management (PHM) programme, which aims to improve population health by data-driven planning, delivery and evaluation of care. Operationally this has involved the construction of a linked dataset across primary, secondary, community and mental health care, which is then used to facilitate analysis of a single longitudinal person record to enable more sophisticated intervention planning.

Through our involvement on Wave Two of the National Population Health Management development programme, we expect to expand our capability to broaden the breadth and depth of the linked dataset and over time bring together our data and intelligence assets to enable our system to deliver better value for our population.

We are already working with our frailty programme to improve the modelling of integrated locality hubs, urgent and emergency care where we have identified that 1% of users of those services use 50% of resource and are comprised of a frail and multimorbid cohort, and developing a targeted approach to improving the early diagnosis of cancers.


BNSSG
as
100 People
Diet
8 use pre-prepared food
21 prepare simple meals or use pre-prepared ingredients
69 prepare meals from scratch
Age
17 aged 0-4
65 aged 15-64
17 aged 65+
Adult weight
61 overweight or obese
Child weight
32 overweight or obese
Adult Smoking
16 current smokers
Area
48 in Bristol
23 in North Somerset
29 in South Gloucestershire
Geography
86 in urban areas
14 in rural areas
Ethnicity
90 are White
4 are Asian
3 are Black African/Caribbean
2 are of multiple ethnicity
1 is of another ethnicity
Main language
95 English
2 European
1 Polish
2 Asian
1 Arabic or African
Deprivation
16 most deprived
26 least deprived
Alcohol
23 report binge drinking
Childhood immunisation
14 not completed MMR by 5 years old

We know that we need to address the wider determinants of health to improve health and have a sustainable system. We can address these as a partnership.

46% of Bristol secondary school leavers are not achieving five GCSEs grade A*-C including mathematics and English

North Somerset 42%; South Gloucestershire 43%

27% of children across BNSSG are not considered to have achieved a good level of development at the end of reception.

5.1% of mortality in Bristol and South Gloucestershire is attributable to air pollution

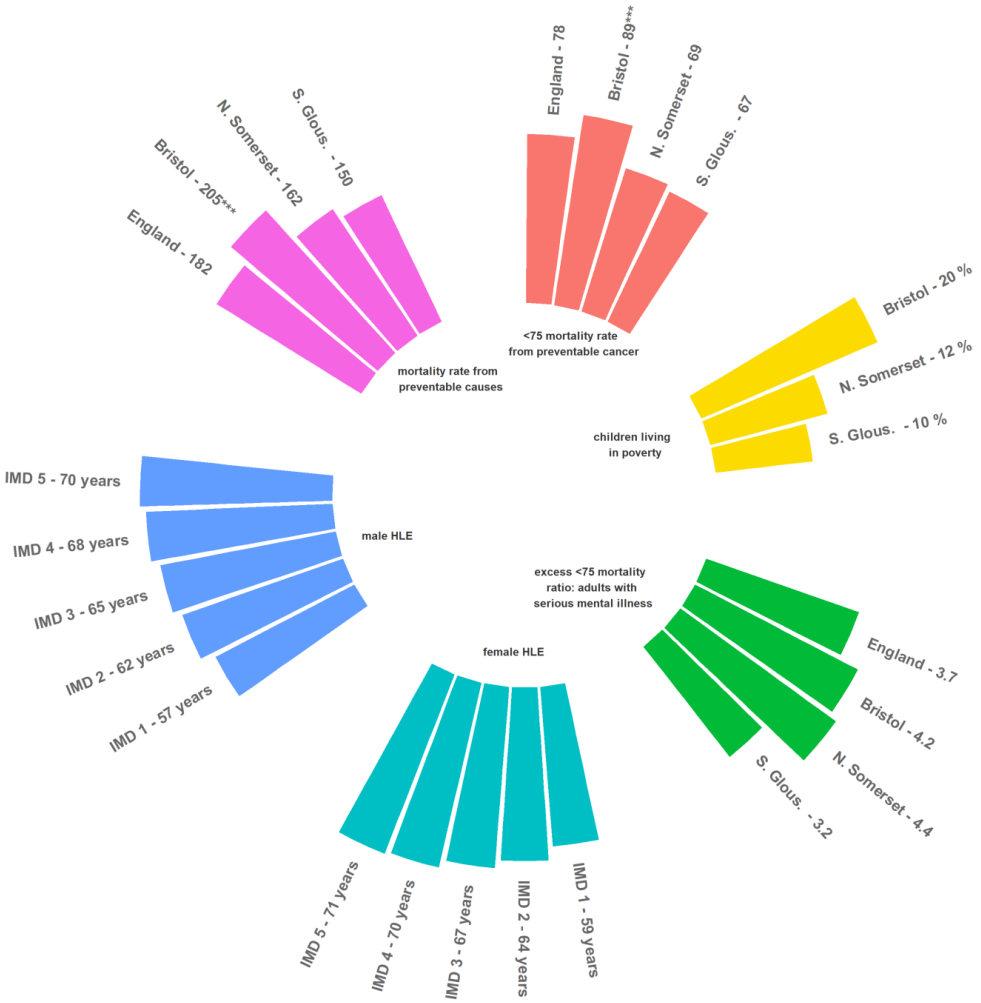
North Somerset 4.3%

21% of people aged 16-64 in North Somerset are unemployed

Bristol 22%; South Gloucestershire 21%

We also know that health inequalities play a large part in the demand for health and care services

The inequalities in health outcomes that we observe in the system are the result of the current state of the wider determinants of health, how people manage their own health and the function of the health system.



Guidance Notes

HLE: Healthy Life Expectancy.

IMD 1: most deprived population quintile by index of multiple deprivation.

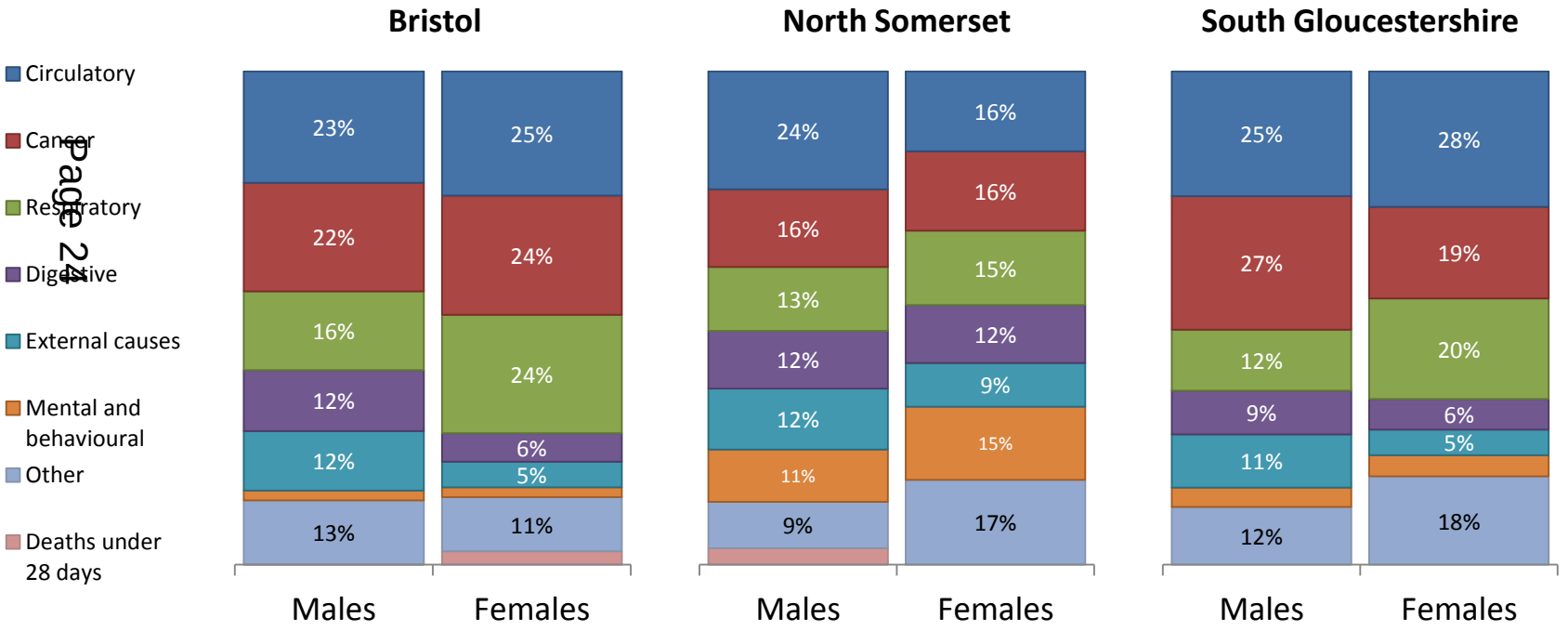
Excess <75 mortality ratio is the number of times greater than the background population.

Mortality rates are directly standardised per 100,000 population.

Outliers with statistically significant differences from the England average are denoted ***.

Our approaches to reducing inequalities are determined through local insight about population health

This insight is generated through local engagement with communities and stakeholders, as well as data from population health management to enable us as a system to develop a common understanding of the complex causes and costs of health inequalities and what we can do to address them. We will use national tools and guidance such as such as the PHE Place-based approaches for reducing health inequalities to support us in this work.

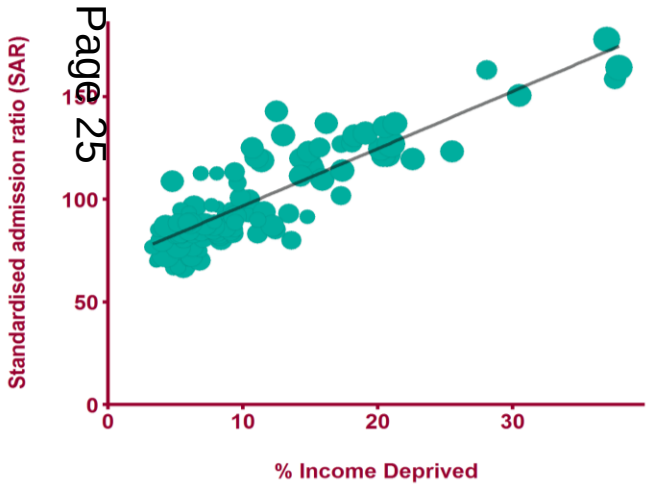


between most deprived quintile and least deprived quintile, 2015-17

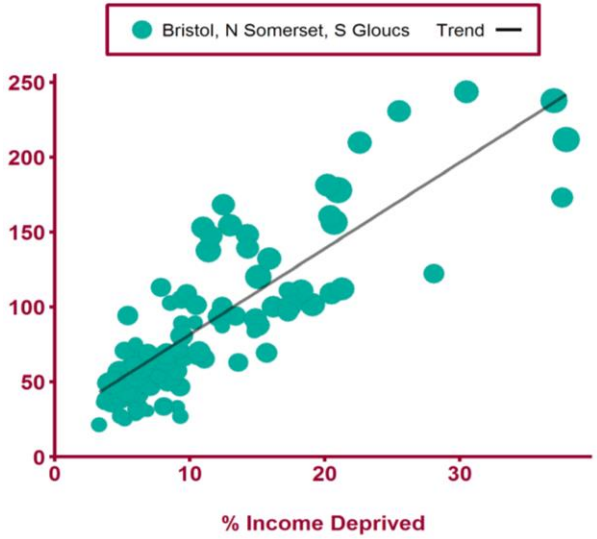
Health inequalities are not only bad for the people who experience them, but there is a strong correlation between deprivation and demand on the health system, and in particular the acute system

Across a range of indicator conditions, health inequalities have a significant impact on acute hospital activity.

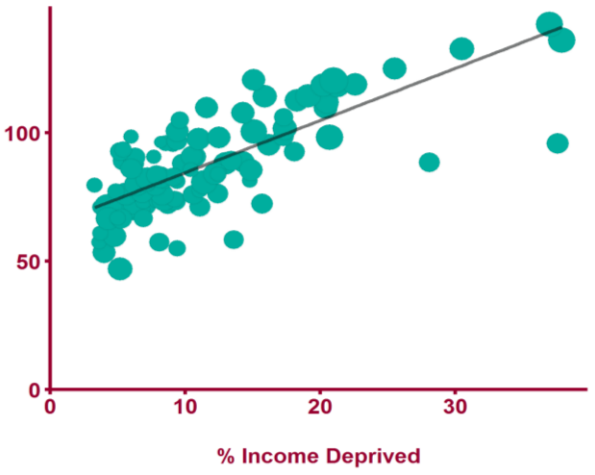
Alcohol related harm



COPD



Coronary Heart Disease



We know that people living with mental health problems, learning disabilities and/or autism have poorer access and outcomes

Bristol autistic spectrum service for adults
292 people waiting, average wait 8 months

Autistic Spectrum Diagnosis Pathway for children and young people
463 people waiting (January 2019)

Child and adolescent mental health services
260 children waiting for access (December 2018)

Improving access to psychological therapies (IAPT)
Estimated by September 2019 there will be 3400-3840 people waiting for their second treatment

Completeness of the GP learning disability register (BNSSG prevalence 1.7%, England prevalence 1.5%)
0.46% of population on a register (6th/11 CCG peers; 104/195 in England)

Proportion of people with a learning disability on the GP register receiving an annual health check
51.9% (5th/11 CCG peers; 72/195 in England)

Self-harm
2,200 emergency admissions annually, predominantly females and Bristol more than other areas

In line with the global Value Based Healthcare movement we are taking a value based approach to population health

For us this means following three core principles:

- Firstly it means that the outcomes we are trying to improve are outcomes that matter to people and our population. We need to understand and respond to these outcomes from the level of the clinic to the board room.
- Secondly it means delivering quality, cost-effective services based on the best available evidence to the people who will benefit; avoiding both under and overuse of healthcare.
- Thirdly it means taking both a ‘bottom up’ and ‘top down’ approach to analysing and planning the allocation of resources across our system in order to achieve the greatest overall benefit.

Healthier Together has developed a Value Programme, working with the Aneurin Bevan University Health Board and Professor Sir Muir Gray’s Oxford Centre for Triple Value Healthcare. Although in the early stages we have trained a clinically led, cross-system multidisciplinary group of 25 leaders, worked with programmes to develop whole system outcome sets in co-production with people with lived experience, and we are engaged in a procurement process to secure a digital platform to enable our system partners to systematically measure patient reported outcomes measures.

Our 5 year plan will be define value in terms of our ambitions for improving outcomes that matter to people in BNSSG and how we will measure progress…

We have started a discussion, working with our Directors of Public Health, on what overarching outcomes our system will direct its efforts at achieving. These outcomes will be ones that can only be achieved using the efforts of all partners, the community's assets and individual people.

We'll be working with public health, wider local authority and other partners over the next few weeks to finalise a set of outcomes

Our overarching aim is to:

Improve the overall health of everyone in BNSSG and improve the health of the poorest fastest

Outcomes we will monitor include:

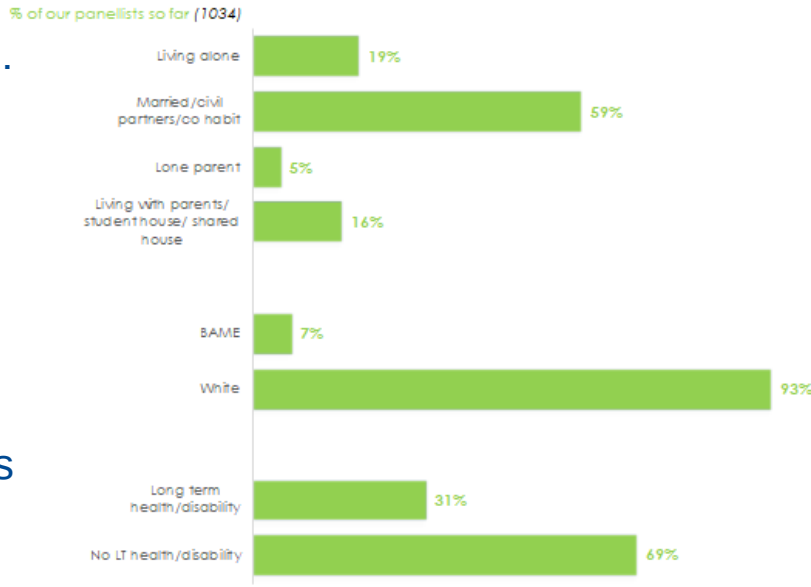
- Healthy life expectancy
- Premature mortality
- Mental health and wellbeing
- Educational attainment
- Inequalities in outcomes

We are also having meaningful conversations with our population to understand their needs and wants further

In 2018, we established the Healthier Together Citizen's Panel. Our vision is to have a detailed understanding of the needs and wants of the population of BNSSG, and use this insight to connect to the behavioural insights gained through Population Health Management to ensure we have a thorough understanding of the key drivers which lead to the behaviour we observe.

This will allow us to make more sophisticated and effective decisions on how we allocate resource and plan services.

The Citizen's Panel has completed 3 waves of research. We have recruited a total of 1,034 panellists, carefully calibrating our recruitment to ensure that we have a panel which is robust and representative of the population we serve.



We will continue to explore key areas of focus from our 5 year system plan using the full panel, and are also conducting deliberative research with smaller subgroups within our population to ensure that our plans are developed through meaningful conversations with our

These insights are already shaping our decisions

73% of BNSSG residents report that they are feeling healthy

65% of BNSSG residents currently feel in control of their lives

Only 62% of BNSSG residents currently feel happy

If BNSSG residents were in control of the health and care budget, 28% of it would be split equally between adult and children's mental health

They would split a further 30% of the budget equally between hospital care and General Practice

The remaining 42% of the budget would be shared relatively equally between services for older people, learning disabilities, end of life care, children's social care and adult social care

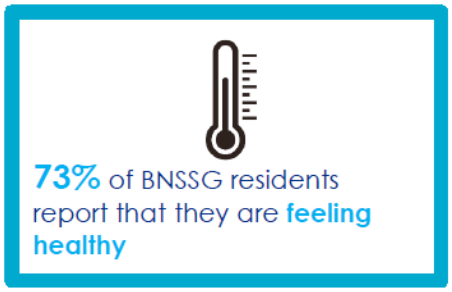
11% of BNSSG residents report that they have had an outpatient or clinic appointment that they considered to be a waste of their time

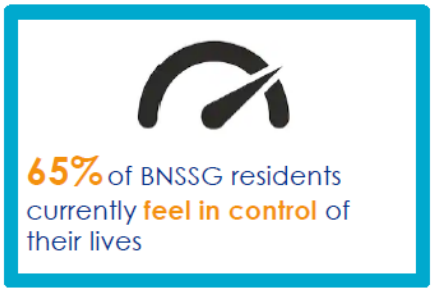
13% of BNSSG residents report that they have had surgery or treatment that they later regretted (or know someone who has)

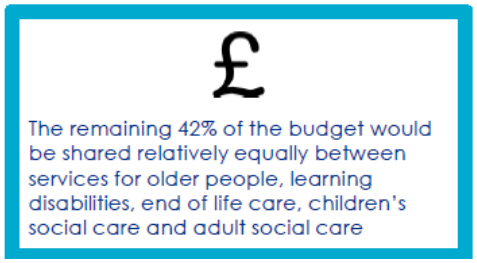
Between one half and two thirds of BNSSG residents would travel (up to 3 hours on average) to receive specialist care with better results, rather than stay close to home


BNSSG
as
100 People
Diet
8 use pre-prepared food
21 prepare simple meals or use pre-prepared ingredients
69 prepare meals from scratch
Age
17 aged 0-4
65 aged 15-64
17 aged 65+
Adult weight
61 overweight or obese
Child weight
32 overweight or obese
Adult Smoking
16 current smokers
Area
48 in Bristol
23 in North Somerset
29 in South Gloucestershire
Geography
86 in urban areas
14 in rural areas
Ethnicity
90 are White
4 are Asian
3 are Black African/Caribbean
2 are of multiple ethnicity
1 is of another ethnicity
Main language
95 English
2 European
1 Polish
2 Asian
1 Arabic or African
Deprivation
16 most deprived
26 least deprived
Alcohol
23 report binge drinking
Childhood immunisation
14 not completed MMR by 5 years old

And we are engaging people through our Stakeholder event (17 Oct), Citizens Panel and deliberative sessions…







We have been engaging Health & Wellbeing Boards in developing design principles to guide our approach…

Focusing on population, people and place – focusing on population health and wellbeing, identifying the outcomes that matter to people and understanding place from a resident's perspective

Targeting interventions to address inequality – tailoring approaches to address variation and under/over representation, and to take account of geography and cultural diversity

Addressing wider determinants of health and inequalities – working in partnership to give children the best possible start in life; improve education and employment outcomes; and contribute to inclusive growth

Reducing our impact on the environment – assessing the environmental impact of developments; reducing our carbon footprint and promoting better air quality

Investing in localities and neighbourhoods and in community capacity building to support health and wellbeing – devolving accountability and decision making as close to the community as possible

Applying data, intelligence and resources in a value based approach to understand population health, focus on outcomes that matter to people and ensure best possible use of all our resources

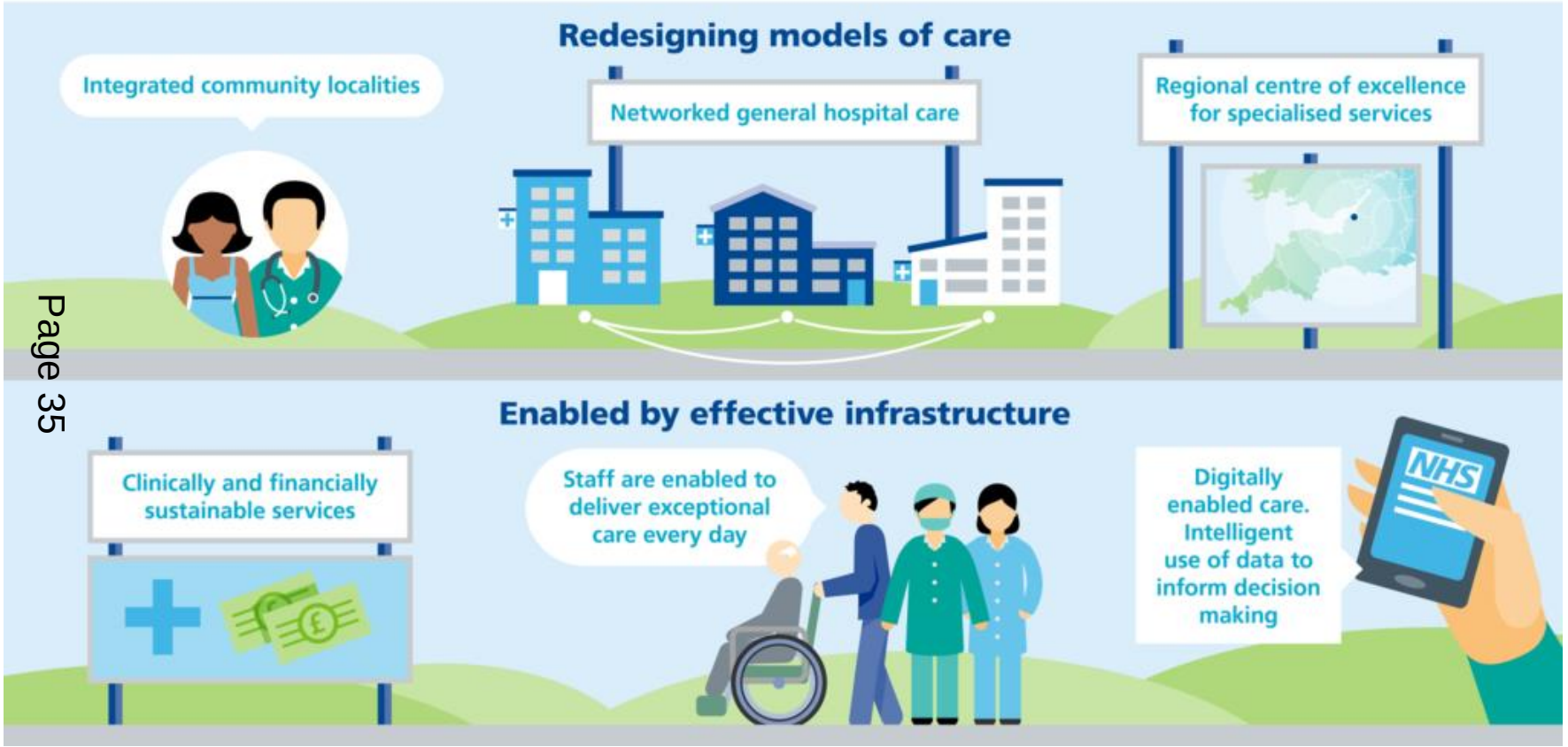
Identifying what matters to people – measuring outcomes, promoting independence and personalising care

Focusing on hearts and minds to drive change – facilitating cultural shift, embracing innovation and adopting best practice

Evidencing committed ownership of all partners – agreeing credible plans and timelines for delivery and embedding them in our organisational plans

3. Key themes within our 5-year plan

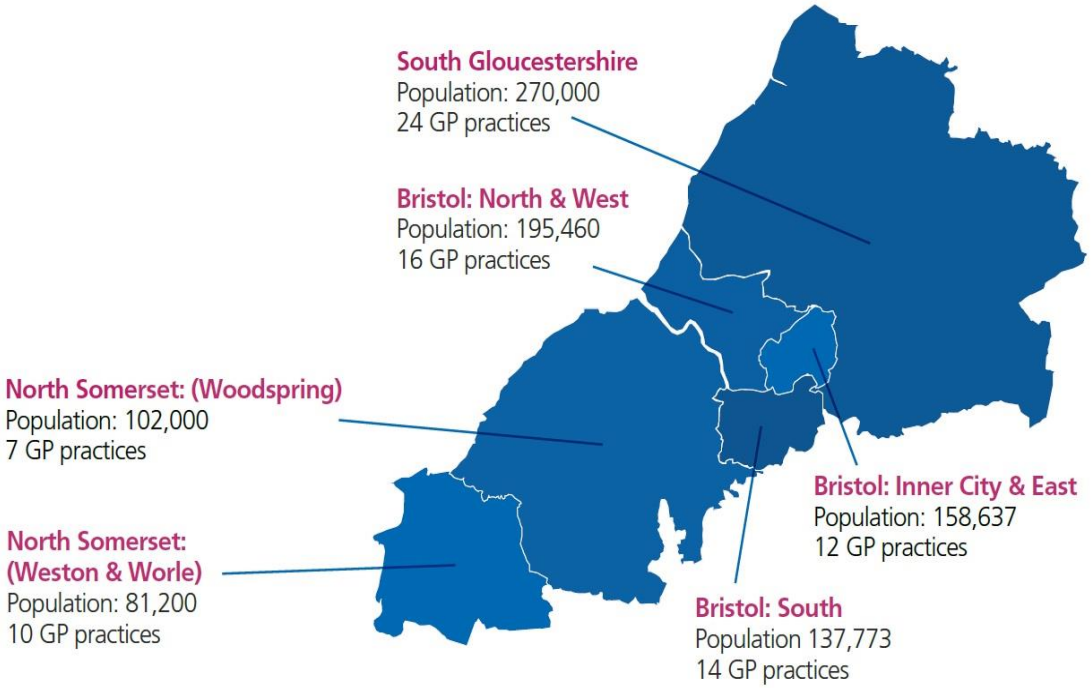
We will build on our vision for redesigning care and support to improve outcomes that matter to citizens, service users and staff



The foundation of our strategy is to build integrated care partnerships at locality level...

We have six localities across BNSSG, each with a population of between 100-250k

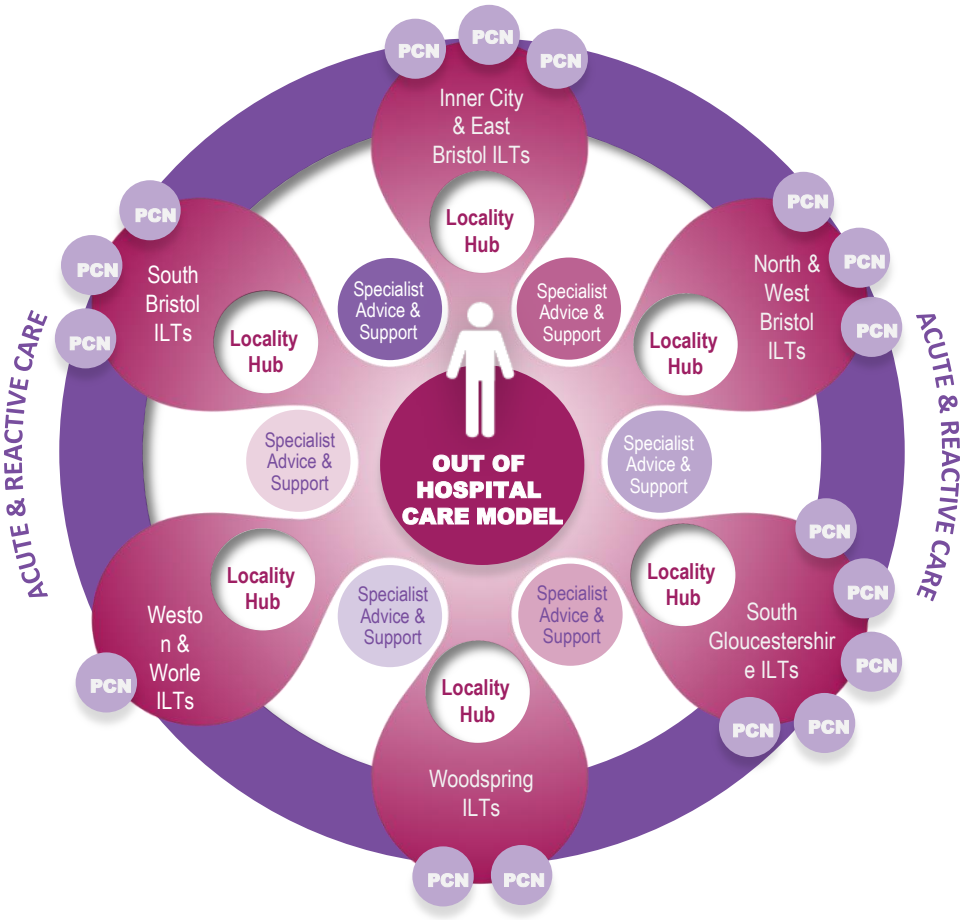
- Natural geographies based around GP practice populations
- GP clinical leadership within a provider alliance, moving towards full Integrated Care Partnerships from 2021
- Large enough to impact on system and delivery of successful integrated model of care in the community
- Able to accommodate smaller units within the locality e.g. 30-50k model to deliver MDT working



Our new single BNSSG wide community services model is designed to accelerate progress towards fully integrated localities as a key enabler of ICPs

These teams will be able to focus more on prevention and proactive, anticipatory care, providing continuity of care for people with varying needs.

They will expand the range of services available from core teams in the community, reducing the need to refer people to new services when they are most vulnerable and the need for specialist referrals, reliance on emergency and crisis services and avoidable admission of people to hospital in-patient wards in acute or mental health hospitals.



Specialist care and support will be integrated within localities and hospital services will be delivered through networks…

We will increasingly use the specialist staff in our hospitals to support the locality teams, in addition to caring directly for their patients, so that generalist teams can deliver technically excellent as well as holistic care to people with more severe health conditions. These changes will reduce the number of people attending urgent care and specialist hospital services who could be better supported in the community, allowing hospital consultants to give direct care to people who most need their support.

One example of closer integration is the proposed model for outpatient services. This model is based on enhanced links between named specialists and locality teams who will work together in a virtual integrated team to support more delivery of care out of hospital, fewer deteriorations of care, ability to manage higher acuity locally and reduce duplication and low value activities for patients and staff.

Our hospitals will work together in a network to improve the quality of all our general hospital services through sharing scarce resources such as particular consultants, working together to benchmark performance and on improvement projects. We will deliver exceptional quality and outcomes through consistent and aligned services. We will reduce cost through better use of estate and reduced service duplication. We will improve clinical sustainability and the experience of our staff by working as one network

Collaborating for excellence specialist hospital services - making best use of specialist skills and facilities

Our hospitals will continue to develop as regional, national and international centres of excellence delivering highly specialist services for people across the south west of England, building on the progress we have already made in cancer treatment, cardiac surgery and paediatrics amongst others.

Our 5-year plan will set out our ambitions for further development and expansion of some of our most specialist services, working in partnership with our local Universities in promoting research, innovation and education.

We will agree our plans with NHSE Specialised Commissioners so that this work is aligned at a regional and national level. the South West and beyond.

Genomics is an example of the potential opportunities in BNSSG. We have one of only seven genomics laboratory hubs in the country, a genomics medicines service and whole genome sequencing and we want to continue to be at the forefront of supporting more personalised medicine for patients with cancer and rare diseases.

Digital transformation offers an opportunity for us to make these changes within the context of limited workforce supply

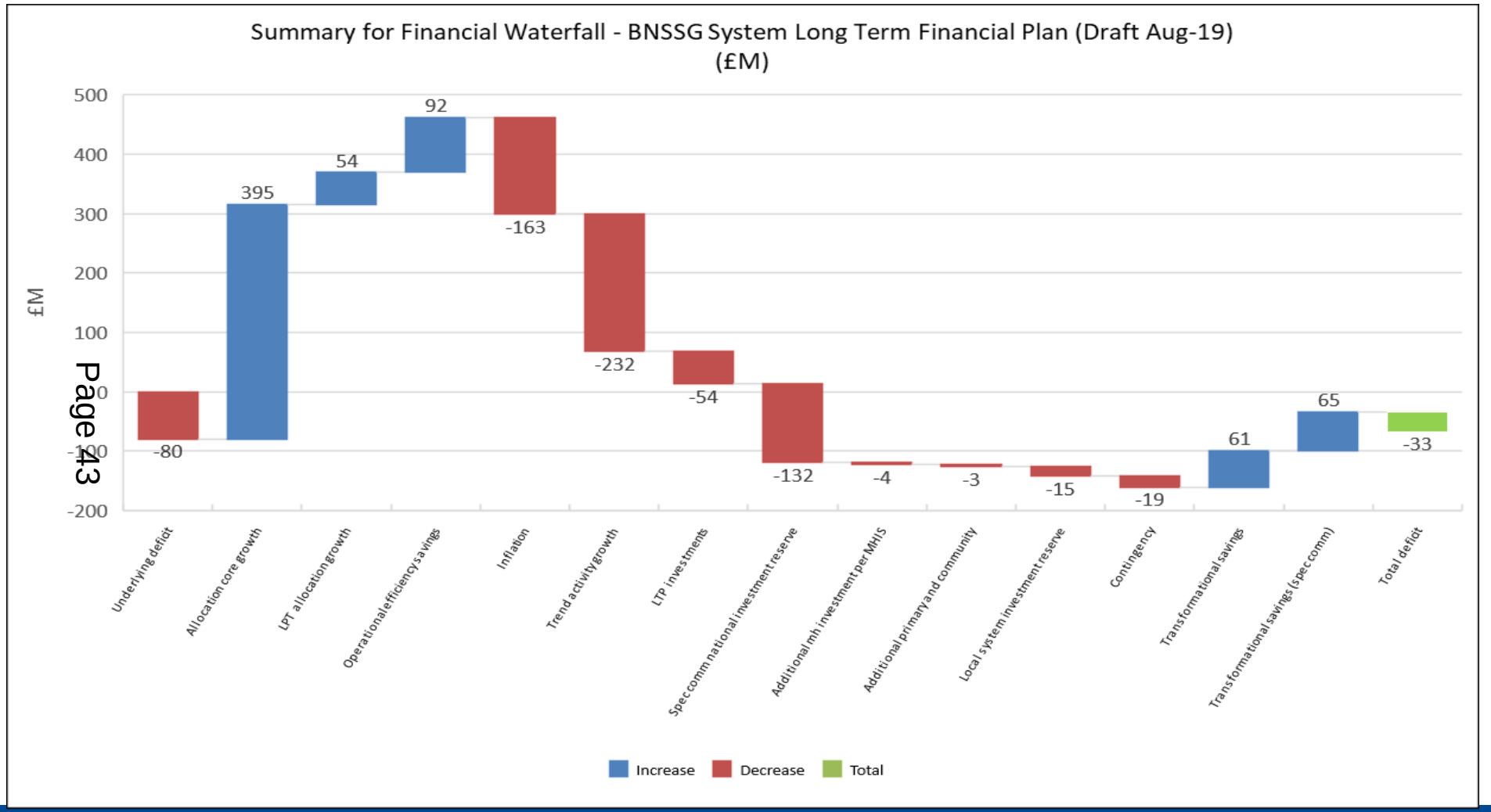
We will build on our significant progress to date on delivering digitally enabled health and care in the next five years. Our Connecting Care integrated digital care record has been in use across all partners since 2013 and is paving the way for delivering digital innovation as a partnership by 2024.

- Digital information captured at the point of care
- Reliable and prompt communication between staff through integrated digital records and messaging systems
- People will be able to access and interact with their records
- Automation of low value transactions such as booking appointments, ordering prescriptions and receiving test results
- Digitally enabled health and social care including assistive technology that builds on our asset-based model
- 24/7 access to advice, guidance and support across different services
- Involvement of the public and staff in developing digital systems and applications

4. Rebalancing resources to achieve financial sustainability

We will set out plans for progressing towards financial balance by improving efficiency and reducing unsustainable growth

Summary planning assumptions

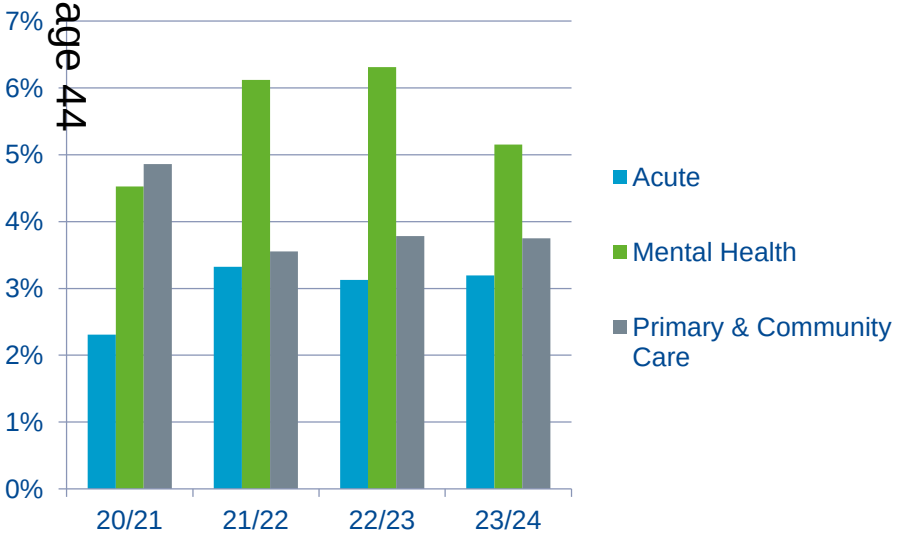


To enable the changes we will set out commitments to invest in primary and community care and mental health

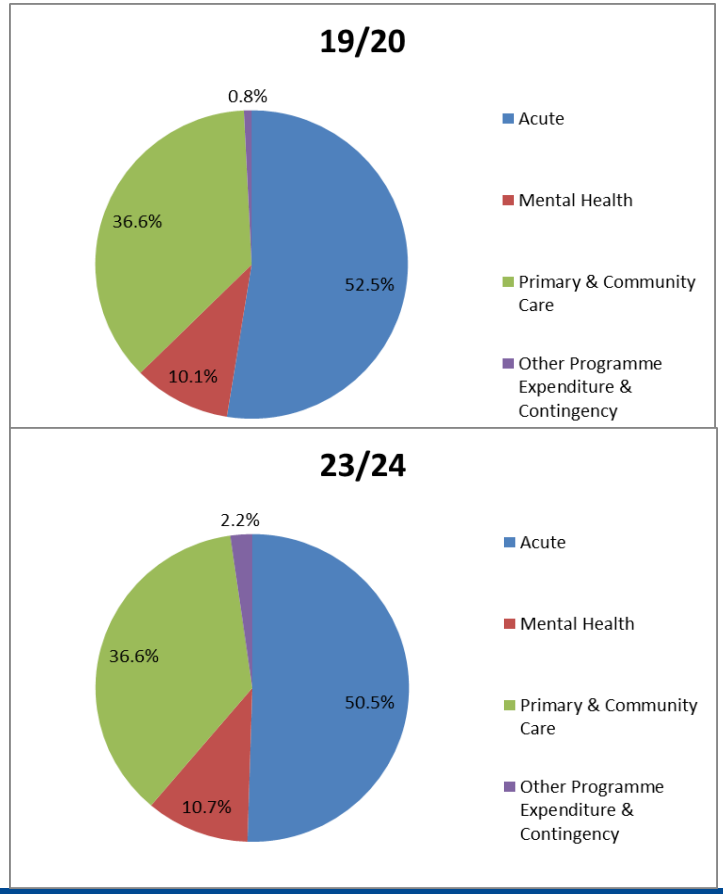
BNSSG will increase investment in Primary & Community Care and Mental Health each year…

…to support improvements in population health and to reduce growing pressures on hospital services

Boosting investment in out of hospital care each year



Reducing growth in acute care



5. Next Steps

We are engaging with system leaders, staff and citizens in developing our plan …

Key Activities to Date

- Citizens panel deliberative workshop – 3 October
- System leaders workshop – 9 October
- Whole system stakeholder event – 17 October
- System leaders workshop – 24 October

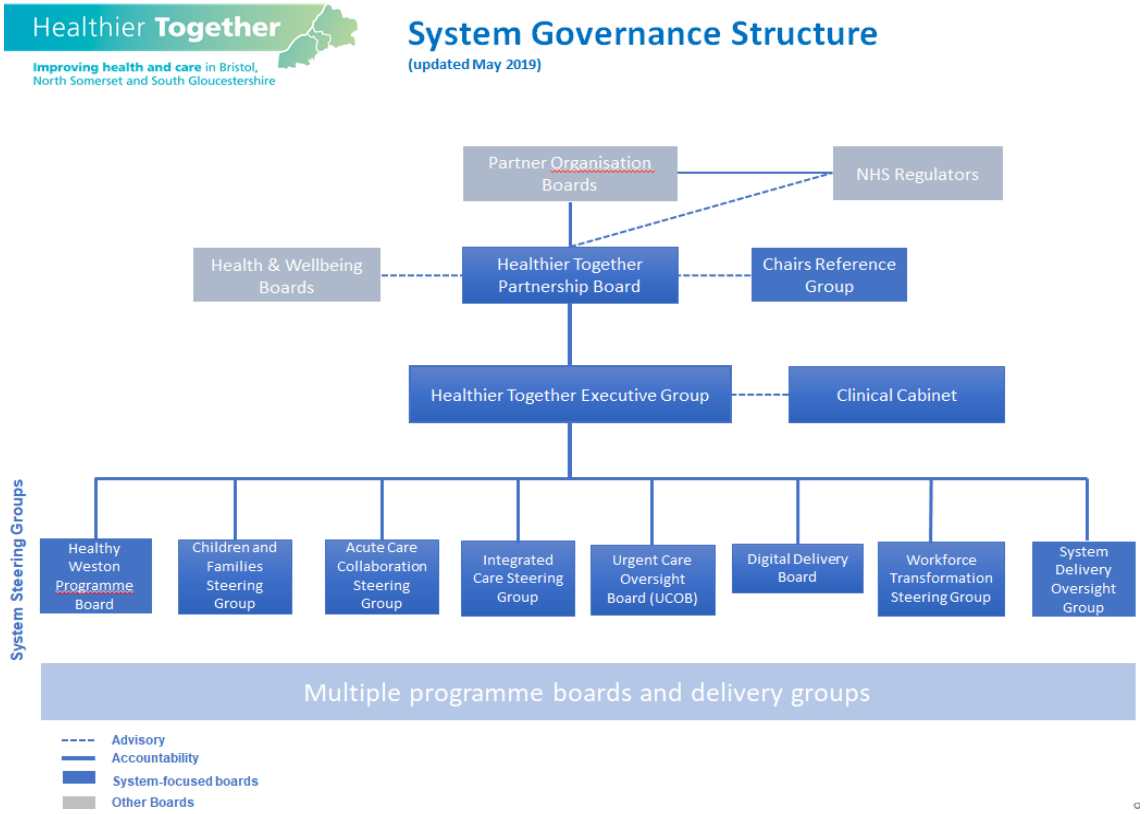
Upcoming Milestones

- Draft plan circulated to BNSSG Partnership Board and submitted to NHSE/I – 1 November
- Partnership Board sign-off – 14 November

Our Partnership Board will oversee delivery of our 5-year plan as BNSSG continue to mature as an Integrated Care System

From April 2020, our system will comprise of ten partner organisations:

- Avon & Wiltshire Partnership NHS Foundation Trust
- BNSSG CCG
- Bristol City Council
- North Bristol NHS Trust
- North Somerset Council
- One Care
- Sirona care & health
- South Gloucestershire Council
- South West Ambulance Services Foundation Trust
- UH Bristol NHS Foundation Trust



All organisations form part of the system's governance structure, with a Partnership Board comprising chairs, chief executives and elected members leading the system.

Healthier **Together**

Improving health and care in Bristol,
North Somerset and South Gloucestershire

Contact us:

Healthier Together Office, Level 4, South Plaza, Marlborough Street, Bristol, BS1 3NX

0117 900 2583

Bnssg.healthier.together@nhs.net

www.bnssghealthiertogether.org.uk

@HTBNSSG

Joint Health Overview and Scrutiny Committee
25 October 2019

Report of: Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group.

Title: Adult Community Health Services Procurement

Ward: Bristol, North Somerset, South Gloucestershire (BNSSG)

Officer Presenting Report: Dr Kate Rush, Associate Medical Director, NHS Bristol, North Somerset & South Gloucestershire CCG

Contact Telephone Number: 0117 947 1556

Recommendation

That the Panel note this report and comment/ask questions as required.

1 Summary

This paper provides an update on BNSSG CCGs procurement of Adult Community Health services and is for information only.

2. Background

On 10 January 2019, NHS Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group (CCG) began advertising the procurement of Adult Community Health services, following approval from the Governing Body.

There are currently three main providers of Adult Community Health services in the CCG area: one in Bristol, one in North Somerset and one in South Gloucestershire. The contracts for these services end in 2020 and 2021. As part of routine work, the CCG is procured Adult Community Health services to ensure these remain available for the population.

The CCG took the opportunity to build consistency across the CCG geography, and advertised for a single provider of Adult Community Health services. More than 500 people, including service users, carers and clinicians, helped to develop the model of care and specifications for future Adult Community Health services and these people emphasised the importance of having consistent high quality care, no matter where people lived.

The contract is for a period of ten years, with an indicative contract value of approximately £106m per annum.

Bids were submitted in accordance with the CCGs Request for Proposals and all were deemed to be of high quality.
On 29 July 2019, Sirona care & health Community Interest Company was announced as the high scoring bidder.

The CCG undertook due diligence during August 2019 to ensure that the bid was accurate, feasible and based on sound assumptions.

The CCG Governing Body approved signing the contract at the Governing Body meeting on 3 September 2019.

3. Input from local people

Adult Community Health services are available for the almost one million adults across Bristol, North Somerset and South Gloucestershire CCG. They include services offered in people's homes or local communities such as community nursing, speech and language therapy, physiotherapy, specialist diabetes support and many more. They do not include primary care such as general practices or dentists.

The CCG has worked with local authorities, GPs and other frontline staff, provider organisations, the voluntary sector, mental health services, patients and carers, hospitals and others to develop a model for care outside hospital and service specifications to support this.

Between September and November 2018, the following activities took place to gain feedback from the public, patients and carers to help develop community services:

- surveys, both online and physical, completed by 196 people
- over three hours of filming with patients
- four specification development workshops
- one engagement planning workshop
- one carer's workshop
- review of existing data held by the CCG about patient opinions

The main things that those providing feedback said should be prioritised when developing and delivering adult community services were as follows.

Independence

- Patients wanted to be listened to by the workforce, including when a carer is present.
- Patients wanted to have a choice regarding the frequency and intensity of follow-up / aftercare
- Patients and carers said it was important to enable self-care.
- Stakeholders said it was important that patients felt empowered after experiencing community health services.

Consistency

- Stakeholders said that services should provide consistent quality across Bristol, North Somerset and South Gloucestershire.
- A system where a service is offered in one locality but not another was thought to be unfair.
- If a service does not exist in their own locality, patients and carers wanted to be able to access that service in a different locality if it exists.

Integration

- Having services which are integrated and 'working together' was a key priority.
- Stakeholders were positive about the idea of a physical 'locality hub', believing that referrals would be smoother if services co-locate
- Clinicians and patients said that the referral process needs to smooth and signposting should be offered to ensure joined up working.
- Those from the voluntary sector sought greater integration between Third Sector organisations, community services and primary care

Access

- People said that patients should be able to access services within a week even if their issue was not urgent.
- Stakeholders said that it is important for patients and carers to know which services exist nearby. 'Making health services visible' was seen as a key priority.
- Patients and carers said services should be located in an area which is relatively easy to access, for instance near public transport.
- There was mixed opinion about online access. Some people were positive about being able to book appointments online, have access to their own medical records and 'virtual appointments', but as a supplement to other approaches.
- Stakeholders said that people should not need to have a medical condition to access a locality hub, as the focus should be on prevention and proactive care.

Continuity

- It was felt that patients should have continuity of care, preferably from the same worker each time.
- It was felt that patients should have a care plan which contains clear, agreed outcomes and goals

Clear communication

- Stakeholders said that community health professionals should communicate effectively with each other and with other services.
- People felt strongly that patients should be asked what they want.
- People said that patients and carers should be asked how they prefer to be communicated with.
- It was stated that any changes to care plans should be discussed and communicated to patients.
- People noted that communication can break down when patients transfer between different parts of the care pathway so steps should be in place to address this.
- Patients and carers said they do not want to repeat themselves when they visit different services.

- It is appreciated when the workforce shows empathy, compassion and clear communication.

Meeting the needs of local people

- People said that the CCG should work with organisations that 'show they know what local people need'.
- Although there was a desire to take into account the needs of specific communities, consistent access to services across each locality was also important.

Signposting

- People said that better community outreach may be necessary to reach 'seldom heard' individuals and communities.
- Clinicians, patients and carers said that GPs should work with the Third Sector and know about organisations they can signpost people to.
- It was suggested that an up to date list of services should be created which people could be referred to.
- It was felt that appropriate signposting would empower patients and improve self-care.

Supporting relatives and carers

- There were repeated comments that it was important to support carers and relatives.
- Carers said they need support to access services themselves and feel able to leave the person they care for safely whilst they do so.
- It was reported that community enablement teams help carers and relatives live well.
- People said that supporting families should be considered within a patient's long-term care plan.
- Carers said they would like the opportunity to feed back about services to help improve them.

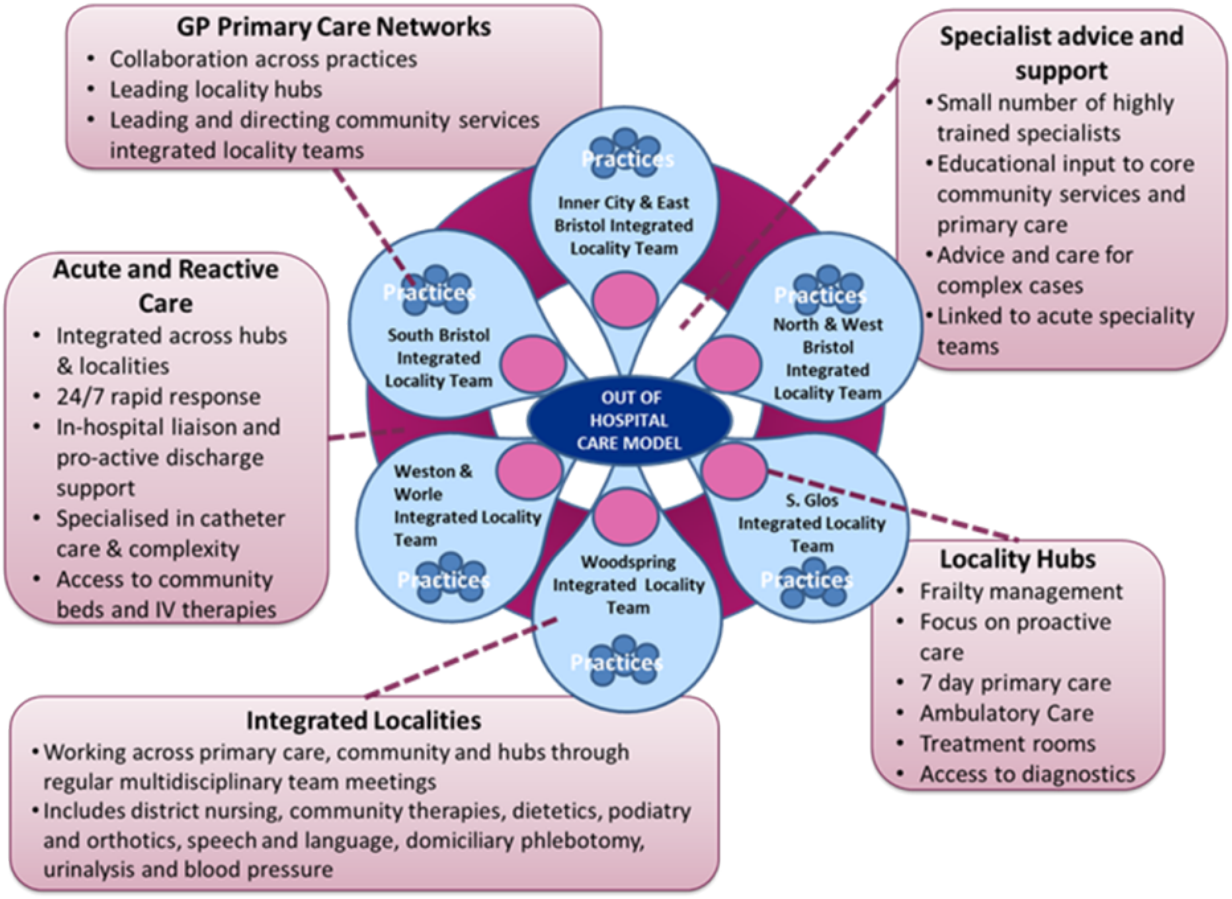
A 'you said, we did' document and summaries of workshops have been prepared so stakeholders can see what people said and how their feedback was used to shape the services that will be available in future.

4. Overarching vision for adult community health services

All feedback was used to develop the model of care and the service specifications. Specifications are the formal requirements that the CCG is asking a community services provider to fulfil. The CCG published the draft contract on its website, which incorporated the feedback received directly into the service specifications.

Figure 1 sets out the model of care for out of hospital care. . The vision is that Adult Community Health services should be seamlessly integrated with Primary Care, providing care based on need and managing complexity and risk tailored to the person. An overarching principle is to enable people to support themselves as much as possible through a 'home first' approach. The home first principle aims to keep people living and supported in the community.

Figure 1: Adult community services model of care



The model outlined in Figure 1 groups services according to the level of need and complexity of people they support, all designed to help people to stay in the community. The service groupings are:

- **Integrated locality teams** focusing on relationships with primary care to support people who have relatively stable needs to manage and reduce the risk of acute worsening of their condition. This incorporates multidisciplinary team meetings with the community services, primary care, social care and mental health to identify patients who need proactive support to maintain their health and wellbeing. Access to adult community services will be through a single point of access located within the integrated locality teams that will respond in a timely manner to patient needs and develop a consistent care plan agreed with the patient and named contact for the person being referred, keeping patients central to decisions about their care.

- **Acute and reactive care teams** work across localities and hubs to manage patients who have acutely worsening conditions and are at risk of a hospital admission/attendance. These teams will provide a timely response to prevent admission, including rapid response. The teams will have links to secondary care and community beds to help patients remain in a community setting and enable prompter

discharge from hospital. An integrated care bureau and a falls service sit within this specification to enable the home first principle of working.

- **Specialist advice and support** has clinical staff knowledgeable about specific conditions such as diabetes and heart failure. There is an expectation that community services will strengthen links between secondary care specialist knowledge and primary care support and ensure patients, carers and professionals within the community are empowered and educated to better understand and manage the specialist clinical condition. This should support the adult community services staff to increase their generalist skills so patients with multiple health care needs do not have to see too many people, enabling continuity and more holistic care.

- **Locality hubs** are a range of service models that are provided through physical building(s) and/or virtual connections of professionals within a locality that give people and professionals across a larger area access to multiple services with a focus on proactive care. We expect the community service will work with other partners across health and social care and the third sector to have services available to our population in a setting that brings organisations together in the same place to meet population need and focus on proactive care and a holistic approach to improve health and wellbeing.

5. Procurement process

The CCG has ensured that the process used to award the contract for Adult Community Health services is fair, transparent and proportionate. The Public Contracts Regulations 2015 require that a competitive procurement process is followed for contracts of this scale. The CCG used of a bespoke process akin to a competitive procedure with negotiation.

The procurement launched in early 2019 with two rounds of negotiation meetings and proposals to secure the most advantageous bid. The broad milestones were:

- January-March 2019: Release of the Request for Proposals and Round 1 negotiation meetings and proposals submitted

- April-June 2019: Release of updated Request for Proposals and Round 2 negotiation meetings and proposals submitted by shortlisted bidders

- July-September 2019: Due diligence, Governing Body review and NHS England assurance prior to contract award

Negotiation meetings were held with the CCG and meetings also took place between bidders and neutral partners (stakeholders from across BNSSG, including Local Authority representatives), as well as meeting with a patient and carer panel. Patient and carer representatives and neutral partners also sat on the Adult Community Health services Programme Board, with the Governing Body being responsible for overall decision making.

A Public Reference Group made up of patients and carers also met throughout the process to ensure patient and carer views were taken into consideration, as well as providing advice about how to engage with patients, the public and carers.

6. Next steps

Work has begun with Sirona care & health to mobilise ready for service commencement on 1st April 2020. This will involve engaging with service users, stakeholders and the valued community services workforce. Meetings and engagement with existing Adult Community Health service providers is also underway to ensure a smooth transition and safe transfer.

The benefit the Programme has received from involving neutral partners will continue through mobilisation in the form of a Partnership subgroup, where stakeholders across BNSSG will focus on delivering the model of care and furthering integration across the system. A representative of each Local Authority will be a member of this group.

Going forward, the CCG and Sirona care & health will present attend HOSC meetings across BNSSG for the first three months following contract award. From that point onwards, attendance will be as and when required.

AUTHOR
Dr Kate Rush
Associate Medical Director
Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group

NHS
Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Group

Adult Community Health services

Janet Rowse, Chief Executive, Sirona care & health

Kate Rush, Associate Medical Director, BNSSG CCG

Integrated Network Teams

- Multi-disciplinary teams working with Primary Care to identify people who need support to remain well
- Teams include mental health and social care
- Team members should adapt to local peoples needs
- Access to therapies e.g.: physiotherapy
- Single point of access including self-referral
- Care co-ordinators who know the person and their circumstances
- Working closely with care homes

Locality Hubs

- Geographical locations within localities providing proactive and reactive care
- Includes frailty services in the community
- Minor injury units, walk-in centre and urgent treatment centres
- People can access third sector and other services to keep themselves healthy, well and independent
- Transport solutions to reduce social isolation and improve access
- Links to 7 day access to Primary Care

Acute and Reactive Care

- Access to urgent care – 2 hours for those at risk of admission, 4 hours for urgent needs
- Access to step-up and step-down community beds across localities
- 24/7 rapid response service across BNSSG
- Integrated Care Bureau to actively support people to return to the community from hospital
- Access to intravenous therapies in the community

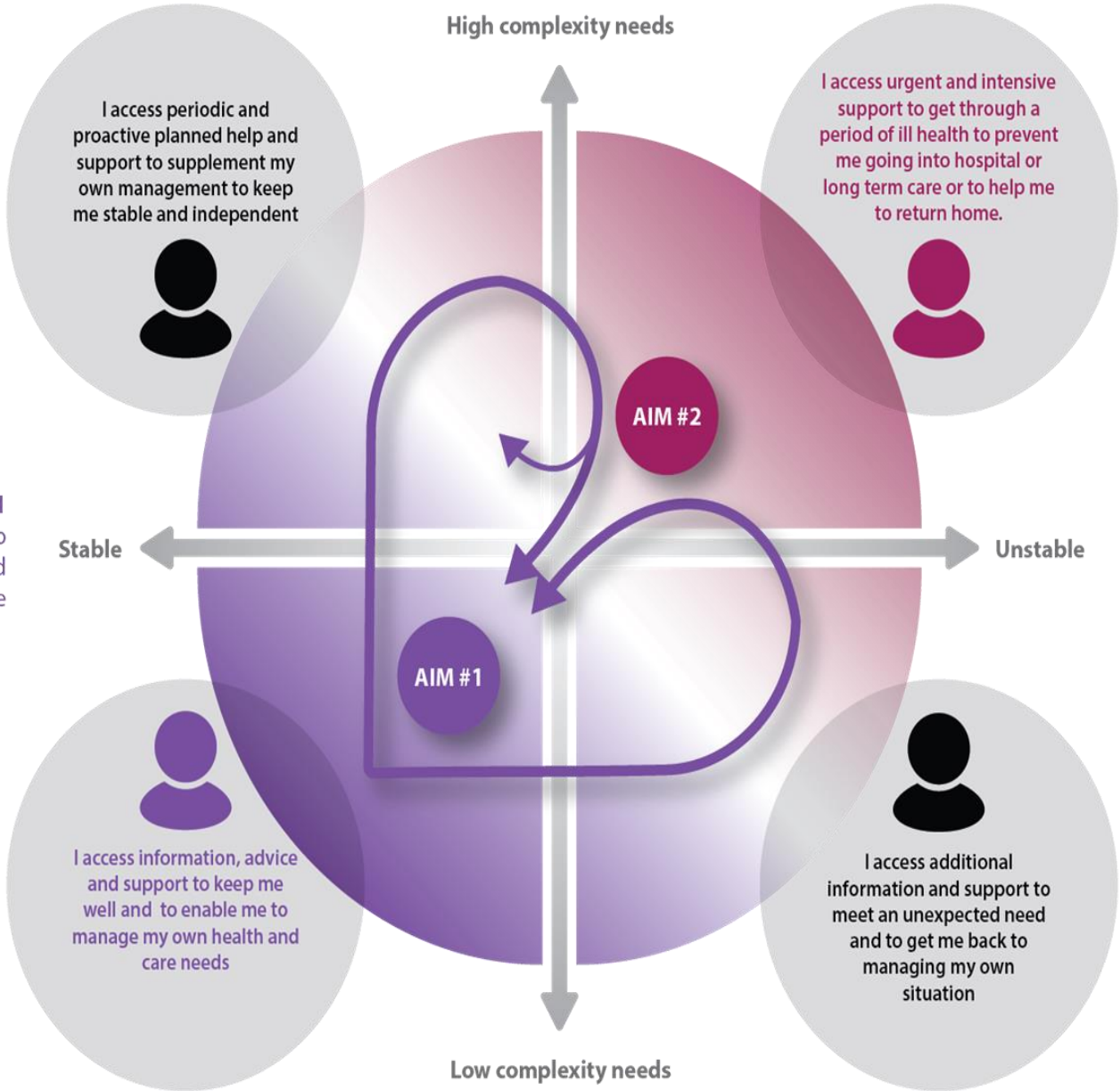
Specialist Advice & Support

- All services will have a BNSSG offer
- Includes refugee and translation services
- Diabetes, respiratory, heart failure, musculoskeletal conditions included
- Includes education to up-skill professionals and people about how to best manage their condition to stay healthy, well and independent
- We expect strong links with hospitals to support specialist care in the community e.g.: clinics near home

Contract award

- Single contract awarded for BNSSG
- 10 years in length
- £100m+ per year
- 3% of contract to support Third Sector
- Awarded to Sirona care & health
- Service starts 1st April 2020
- Mobilisation underway
- Services will transfer from North Somerset Community Partnership and Bristol Community Health

Integrated Care Approach

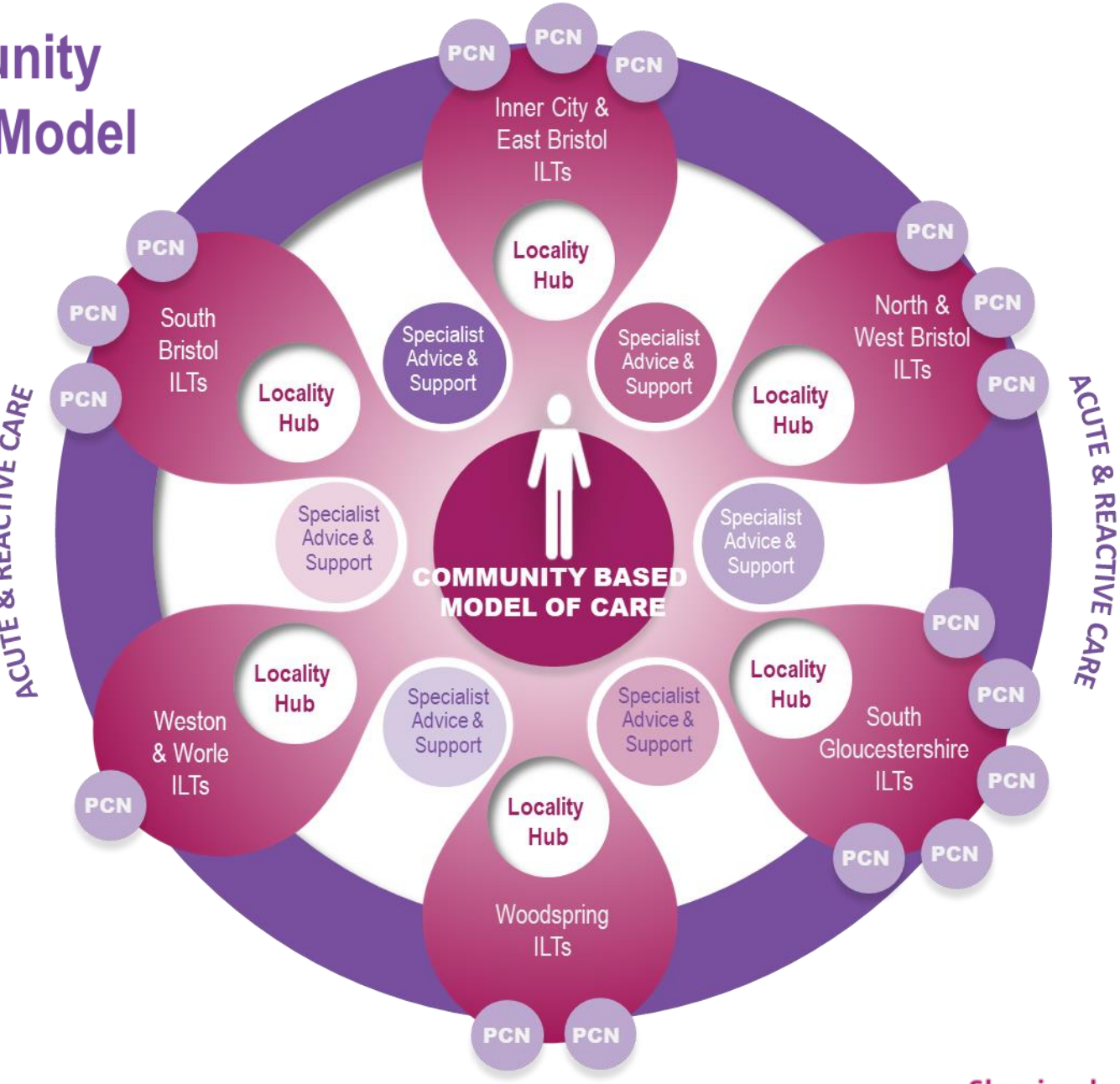


AIM #1
Support people to stay healthy and self care

AIM #2
Reduce the number of emergency hospital admissions; A&E attendance and admissions into long term care

Shaping better health

Community Based Model of Care



Commitments to Improvement

- Building on Strengths
  - Individual
  - Communities
  - Existing Services and Providers
- Simplifying
  - No wrong door
  - Care Navigators
  - Care Co-ordination for those with complex needs
- Consistency and Fairness
  - Targeting Resources/Level Up
  - Consistency of approach
  - Local Autonomy
- New Ways of Working for Some - Digital
- Community Outcomes Framework

Strong local governance

- Structure is based around 6 Localities
  - One in South Gloucestershire
  - Three in Bristol
  - Two in North Somerset
- Active and Visible in local communities
  - Locality operational structure – Associate Director for each Locality
  - Locality Engagement Groups x 6
- Joined up Working
  - Physical and Mental Health
  - Health and Social Care
  - Wider determinants of health – housing; education; employment

Joint Health Overview and Scrutiny Committee

25th October 2019

Report of: Specialised Commissioning - NHS England and NHS Improvement South West

Title: Bristol, North Somerset and South Gloucestershire Joint Health Scrutiny Committee briefing on proposed reconfiguration of Specialised Neonatal Intensive Care

Ward: All

Presenting report: Dr Lou Farbus, Head of Stakeholder Engagement, Specialised Commissioning - NHS England and NHS Improvement South West

Contact Telephone Number: 0779 694 7074

Recommendation

Members of Bristol, North Somerset and South Gloucestershire Joint Health Overview and Scrutiny Committee are respectfully asked to:

- Note the improvements in patient outcomes and family experience the proposed model is expected to deliver;
- Note the support and involvement of local people, experts and clinical leaders in the option development and appraisal processes that identified the recommended model of care;
- Note the intention to increase NICU capacity and family accommodation in Bristol;
- Note the commitment to ensure sustainability of services through reconfiguration, relevant to the clinical workforce and estate of both organisations;
- Endorse the proposal to integrate the neonatal services at Southmead and St Michael's by concentrating level 3 NICU at St Michael's, with families still able to access level 2 neonatal services at Southmead.

Context and Summary

The purpose of this report is to brief members of the Bristol, North Somerset and South Gloucestershire Joint Health Overview and Scrutiny Committee on the options appraisal process that has led to the recommendation to bring the services of the two units into a single functioning unit across the two sites and to concentrate the babies requiring level 3 intensive care onto the St Michael's site with families still able to access level 1 and level 2 neonatal services at Southmead.

The proposed new clinical model is supported by clinical and management teams at both North Bristol Trust (NBT at Southmead) and University Hospital's Bristol Foundation Trust (UHB at St. Michael's) and NHS England and Improvement (NHSE/I).

Scrutiny members' endorsement of this proposal will enable more detailed planning work to develop a Full Business Case and outline implementation plan for the proposed reconfiguration to progress.

Bristol, North Somerset & South Gloucestershire Joint Health Scrutiny Committee briefing on the review of Neonatal Intensive Care

NHS England and NHS Improvement

North Bristol NHS Trust

University Hospitals Bristol NHS Foundation Trust

Bristol, North Somerset and South Gloucestershire Joint Health Scrutiny Committee briefing on proposed reconfiguration of Specialised Neonatal Intensive Care

1. Introduction: What happens now?

Every year over 11,000 women have a baby in Bristol and the majority can choose where to deliver their baby.

Women with low-risk pregnancies can have their babies at home or in hospital under the care of a midwife. Women with pregnancy-related health concerns will be cared for by a consultant and will have their babies in hospital.

A small number of babies, usually around 10%, will need extra, more specialised care in hospital each year. Special care for ill or premature babies should be provided by specialised 'neonatal services' in acute hospitals in line with a national service specification. The service specification describes what is required in each of three levels of neonatal unit to ensure that people receive the same level and quality of service regardless of where they have their baby delivered in England.

Each level of neonatal care requires increasing speciality (described below):

Level One – Special Care Unit (SCU)

SCU is for babies who need short-term care such as continuous monitoring of their breathing and heart rate, treatment for jaundice and for those who are convalescing from other care. Generally premature babies who are over 32 weeks gestation will be cared for in a SCU.

Level Two – Local Neonatal Unit (LNU)

LNU is for babies who have a higher dependency and need short-term intensive care. Generally premature babies who are over 27 weeks gestation will be cared for in a Local Neonatal Unit.

Level Three – Neonatal Intensive Care Unit (NICU)

NICU provides very specialist intensive treatment for the very smallest and sickest babies. Generally, neonatal intensive care is for babies needing respiratory support weighing less than 1,000g, born at less than 28 weeks gestation and needing significant continuous positive airway pressure. Babies with severe respiratory disease who also require surgery may need this level of care too.

All 3 levels of care are currently provided in neonatal units at Southmead (North Bristol Trust - NBT) and St Michael's (University Hospital Bristol Trust - UHB) hospitals in Bristol.

The neonatal unit at Southmead cares for around 770 babies each year and the neonatal unit at St Michael's cares for around 750 babies each year. Both units function independently and provide care to babies within the Bristol, North Somerset and South Gloucestershire (BNSSG) region as well as to babies from the wider South West Operational Delivery network (SWODN) as and when needed.

2. Proposal to integrate neonatal services in Bristol

Neonatal services at both sites provide excellent care to the large number of babies they care for and have some of the lowest mortality figures in the UK (MBRRACE 2015). Nevertheless, in line with recommendations made following national and local clinical reviews, local clinical experts at both hospitals agree that changes need to be made now to ensure they can continue to deliver a safe, resilient and sustainable service for years to come.

This is because neither service is currently able to meet the staffing requirements set out in the national service specification, which makes both services less resilient and less able to be flexible when responding to staffing pressures or sudden increases in demand. Moreover, in attempting to meet the national service specification's staffing requirements for two separate NICUs that are located four miles apart, both Trusts are competing to recruit an already limited, highly specialised workforce. Consequently, attempts to achieve staffing targets at both sites have been repeatedly unsuccessful.

In addition, there is strong clinical agreement locally, nationally and internationally that babies needing neonatal intensive care (level 3) receive better quality care and have better clinical outcomes when they are treated by specialists who deal with a higher number of patients (please see Research section). Indeed, British Association of Perinatal Medicine (BAPM) research recently found that extremely preterm babies (below 27 weeks gestation) who are cared for in neonatal units that treat greater numbers of patients have approximately twice the survival rates as babies cared for in units that treat fewer patients. However, spreading activity across two sites that work independently makes it more difficult for either Bristol NICU to receive and treat the number of babies needed to maintain the highly specialist skills that are associated with these higher survival rates.

We also know that babies born at less than 32 weeks will often need other paediatric specialist treatment such as cardiac surgery. However, since paediatric services were centralised at the Bristol Royal Hospital for Children some years ago, Southmead has had no paediatric surgery, cardiology, radiology and neonatal trained pharmacy on site, and has

limited input from paediatric physiotherapy, speech and language therapy and dietetics. As a result, 35-40% of NICU babies born at Southmead have to be transferred to St Michael's at some point after they have been born in a specially equipped and staffed neonatal ambulance to receive care from paediatric specialists that are unavailable at Southmead. Moving from one hospital to another ex-utero at such a vulnerable time in a small baby's life can be challenging both for the baby and their family and poses substantial clinical risks.

3. Reconfiguration option development and appraisal

To address these concerns specialised commissioners and a project team from the two NICU units in Bristol have listened to a range of clinical experts, patient representatives and their families to develop and appraise options for how neonatal services could be arranged differently to ensure all babies born in Bristol are delivered in the right place at the right time with the right level of staffing within the following parameters.

- The neonatal service must operate as a single managed service, with a clear line of day to day clinical and operational accountability;
- There is a strong preference for the entire service to be based on a single site where this is deliverable within logistical and operational constraints;
- If the service is based across more than one site, the level 3 (NICU) element of the service must be delivered entirely on one site, with a level 1 or level 2 service delivered on the second site.
- The level 3 (NICU) element of the service must have direct and seamless access to the full range of paediatric co-dependencies and specialist clinical support.

Moreover, both Trusts and Specialised Commissioners are keen to ensure that any proposed change to current provision meets the following objectives.

- Minimise transfers of small high-risk babies
- Improve access for all neonatal babies to paediatric specialities
- Improve access for all neonatal babies to paediatric support services i.e. paediatric radiology, paediatric pharmacy, speech and language therapy, physiotherapy, dietetics
- Support provision of a safe and sustainable neonatal workforce
- Have minimal impact on the existing maternity provision at each hospital

Having consulted a wide group of paediatric and obstetrics clinicians, CCG maternity commissioners, patient advocacy groups both locally and nationally, and the South West Neonatal Operational Delivery network a long list of options were developed (please see Table 1).

After assessing each of the above options against the previously mentioned criteria options 2 and 5 were rejected for the reasons given in Table 1. Hence, the three options that were selected to be taken forward for further targeted engagement were:

1. **Do nothing option**

   St Michael's and Southmead to both remain level 3 (Neonatal Intensive Care) Units.

3. **LNU option**

   St Michael's to remain a level 3 (Neonatal Intensive Care) Unit, with Southmead to be re-designated as a level 2 (Local Neonatal) Unit

4. **SCU option**

   St Michael's to remain a level 3 (Neonatal Intensive Care) Unit, with Southmead to be re-designated as a level 1 (Special Care) Unit

Table 1. Long list to short list of clinical model options

Long of options	Shortlisting Criteria	Result
1. Do Nothing	• Delivers Project Objectives • Feasibility & deliverability	Standard to include in short list
2. Minimum change/enhance existing service at Southmead (NBT)		Not shortlisted as does not achieve project objective to minimise transfers of small high risks babies
3. Neonatal Intensive Care (level 3) at St Michael's (UH Bristol) and Local Neonatal Unit (Level 2) at NBT		Shortlisted
4. Neonatal Intensive Care (level 3) at UH Bristol and Special Care Unit with short term non-invasive ventilation at NBT		Shortlisted
5. All neonatal services centralised on one site		Not shortlisted as currently not feasible or deliverable
6. Option 4 with maternity workload redistribution		Not shortlisted as significant impact on maternity services

Public and Patient Feedback

To ensure the options appraisal was informed by the views and ideas of local people in ways that are proportionate to the proposed change and targeted at the people most likely to be impacted by it, support groups that were already involved and engaged in either maternity or neonatal services were asked to attend a public meeting and/or complete a questionnaire.

This included local Maternity Voices members, South West Neonatal Operational Delivery Network parent representatives, and Bliss volunteers (Neonatal Charity for families with sick and premature babies).

This was undertaken through existing groups led by the clinical teams at both hospitals, with input and oversight from Specialised Commissioners to obtain a wider group of people's views on the shortlist.

In addition, a public engagement meeting held on 6th November, 2018 was attended by 11 people and a further three people provided feedback on the proposals online. The invitation to this event was widely circulated to the parent representative organisations listed above. It was also placed on Facebook. The numbers who attended the public meeting reflects the very small user population for this service and what we have found to be wide support for our efforts to protect the sustainability and resilience of neonatal provision in Bristol for years to come.

Patient representatives and local clinical experts who shared their views on the above options identified Option 3 (that level 3 activity should be consolidated at St Michael's and that the Southmead facility should be re-designated as a level 2 unit) as the preferred option because it balances clinical improvements against the need to maintain access and choice of birthing location for all but the most premature births and enables level 3 babies to be repatriated to Southmead for step down care as soon as they are well enough.

A summary of the things that were said in response to the public and patient engagement and how these have influenced commissioners' plans and actions (in italics) is summarised (in no particular order) below.

1. Initially, a few people were opposed to any change, especially changing the level of the Southmead unit, but once they learned about the reasons for changes and the benefits for mothers and babies, they understood why the change was being considered and were supportive.

2. **Parking, facilities for parents, access to food** were all raised as important factors for families that need to be taken into consideration when thinking about concentrating NICU services at St Michael's.

   The project team have modelled the parental accommodation that would be needed for the preferred option, details of which are included in an outline business case that has been approved by both Trusts and NHS England/Improvement (available on request).

3. **Communication:** The need for clear and consistent communication throughout the maternity and neonatal pathway was emphasised both as an everyday part of quality delivery as well as something that would need to be carefully considered when

informing people about any service change. Mothers would want to know what was happening and why so that they and their families could prepare properly.

Communications and engagement colleagues from both hospitals and NHS England/Improvement are currently working on this with a view to producing an information leaflet to help people navigate the system and know what to expect.

4. **Bereavement and Palliative care**: People suggested that bereavement and palliative care at St. Michaels would need to be enhanced and expanded to cope with the greater numbers of very sick babies.

   Bereavement and palliative care services are available at both sites. As we change the way that the teams at each hospital work together we will review the distribution of bereavement and palliative care services that currently exist and respond as needed.

5. **Perinatal mental health** was raised as a general current concern and discussed at length as people stressed the importance of ensuring mothers' physical and mental health needs are provided for as well as babies.

   Although perinatal mental health services were beyond the scope of this NICU review, NHS England and NHS Improvement's South West Specialised Commissioning team have listened to these concerns and are working to secure an additional seven perinatal beds in the South West by April 2021.

6. **Capacity:** Concerns were raised about St. Michaels' ability to cope with any additional workload when babies and mothers are already being sent out of Bristol due to occasional lack of capacity at St Michael's.

   The St. Michaels unit will be expanded to accommodate the additional workload, with improved cot occupancy to increase capacity. If Option 3 is endorsed by scrutiny colleagues then we are committed to increase capacity at St Michaels to be a 41 cot unit (from a 31 cot unit). Southmead would retain 26 cots which would achieve an average daily occupancy of 90% (cot modelling available on request). However, we cannot rule out the possibility that there may be (albeit fewer) times when mothers and babies are sent out of area as happens currently even if the number of cots is increased.

7. **Continuity of care:** Some people stressed the need for continuity of care for women and babies who need to be transferred between different services.

   Having the same clinical guidelines, governance structures and policies implemented across both units will support continuity of care for babies by enabling both teams to collectively plan and provide care as one team. Further work is being carried out with the local maternity system for Bristol, North Somerset and South Gloucestershire to look at how continuity of care for mothers can also be enhanced.

8. **Choice:** People asked whether women would feel that they still had choice in terms of place to birth, and whether they would feel supported in their choice if possible.

   The recommended changes do not impact on the choice of most mothers as it is only the sickest babies that would need to go to St Michael's, where many babies are already being transferred shortly after birth. As such these cases are treated as an

emergency where choice is not applicable. Nevertheless, choice was one of the criteria the appraisal team considered when scoring options and the option that was given the highest score (Option 3) enables 98% of mothers to still be able to deliver in their booking hospital of choice as Southmead will continue to provide maternity services and Level 1 and 2 neonatal unit care as currently.

9. **Transitional Care:** Concerns were raised about the provision of transitional care and "rooming in" and at times the poor experience of mothers coming from neonatal units into transitional care. It was hoped that the proposed changes for neonatal service may be an opportunity to iron out some of the existing issues with transitional care.

   In line with the recommendations of the national review of neonatal services (soon to be published) specialised commissioners will be looking at transitional care models across all providers to identify best practice so that learning can be shared across all neonatal units.

10. **Parent Accommodation**: people were concerned that this would need to be increased if the proposal to deliver all NICU babies at St Michael's was actioned.

    Provisional plans for expansion at St. Michaels include the recommended increased provision of parental accommodation, including rooms for parents to stay in on the unit, for each of the options (available on request) to ensure there is sufficient accommodation to cope with the increase in activity at St Michaels.

11. **Neonatal /parents timeline**: Parent representatives that attended the event agreed the planned development of a roadmap for parents may be a useful resource in the future to address some of the confusion parents can feel and wanted to know when this would be available.

    Communications and engagement colleagues from both hospitals and NHS England are currently working on this with a view to producing an information leaflet to help people navigate the system and know what to expect as soon as all of the work to ensure the carefully managed centralisation of NICU at St Michael's is completed.

12. **Clinical reputations:** Some were concerned that mortality numbers may increase at St Michael's relative to current figures if the NICU starts receiving greater numbers of the very sickest babies that have a low chance of survival even with the best intervention. Hence, people stressed the need for steps to protect the unit's reputation.

    We asked the options appraisal team to specifically consider each of the options in terms of their ability to protect and enhance the reputation of both services. Of all the options that were considered the recommended model (Option 3) scored highest for clinical reputation (please see Table 2 below).

    Table 2

Framework for decision making	No.	Criteria	Option 1 "Do Nothing"	Option 3 NIC/LNU	Option 4 NIC/SCU
4. Reputational	4a	The option protects and offers opportunity to enhance the reputation of neonatal services delivered by both organisations.	569	942	796
		Total	**569**	**942**	**796**

13. **"De-skilling" of staff, governance issues:** Some asked whether the change in service provision at Southmead would result in de-skilling of staff and whether, if there was integration and staff rotation to prevent this deskilling, if there would be any governance issues with staff working across two hospitals.

    The recommended changes would give clinical staff access to a wider range of cases by working on a shared rota and to a single set of governance and clinical protocols. This will provide increased opportunities to share learning and expertise across both teams and help staff develop and maintain their skills at the highest level.

Staff Feedback

Throughout the lifetime of the project there have also been a number of staff engagement sessions held in both hospitals both before and after the public and patient engagement described above. These staff engagement sessions, run by the clinical lead for the project and/or the NICU Project Manager, have included neonatal nurses, neonatal staff, midwifery staff, neonatal consultants and obstetric consultants.

After providing staff with updates on progress with the project to date, staff have been asked to raise:

1. Any concerns they have
2. Any positive outcomes/opportunities that making a change might bring

Key issues raised by staff were consistent with the feedback and concerns that people shared during the public and patient engagement already described above. Additional benefits of reconfiguring neonatal services in Bristol that local clinical experts identified were:

- Improved clinical quality of care by reducing transfers of very sick small high-risk babies across the city.
- Excellence and good clinical outcomes at both Southmead and St. Michaels so bringing both units closer together will offer opportunities to share best practice across both sites.
- Highly trained and skilled staff on both sites, presents opportunities to share learning, to increase exposure of staff to both medical and surgical neonatology to improve the service overall.
- Larger pool of both medical and nursing staff to pull from.
- Improved recruitment and retention of both medical and nursing staff across both units.
- Common sense to have intensive care at St Michael's who manage almost all the paediatric services.
- Could improve continuity of care for families if the same clinical guidelines and policies are implemented across both units. This could be further improved if both units had the same patient administration system.
- Improved educational and research opportunities across both units.
- Larger service could improve support for staff and benefit the babies.

- Positive for babies in Bristol as may mean fewer transfers out of area if there is increased capacity/occupancy across the units.
- Co-ordinated cross-city working, improved cohesiveness between both units.
- Focusing on what's best for the baby, placing the baby at the center of designing the potential future neonatal service- aiming for a service that is both safe and sustainable has to be good.

A detailed engagement report that describes the patient, public and clinical stakeholder engagement that was conducted is available to download at https://www.england.nhs.uk/south/team/direct-commissioning/specialised-commissioning/

Scoring Process

All of the stakeholder feedback was included in the options appraisal supporting information pack that was given to the scoring team to ensure any recommended option that emerged was influenced by local people's views.

Across all evaluation criteria, Option 3, that level 3 specialised support should be concentrated at St Michael's and that the Southmead facility should be re-designated to provide care as a level 2 unit (see Table 3), emerged as the preferred option. This balances clinical improvements against the need to maintain access and choice of birthing location for all but the most premature births and enables level 3 babies to be transferred back to Southmead for step down care as soon as they are well enough.

Table 3 Option Appraisal Results

Framework for decision making	Option 1 "Do Nothing"	Option 3 NIC/LNU	Option 4 NIC/SCU
1. Strategic Alignment	2067	2899	2310
2. Operational	6754	10,458	9,732
3. Clinical and quality	3321	4531	3795
4. Reputational	569	942	796
Total	**12711**	**18830**	**16633**

4. Impact Assessment

Doctors and midwives agree that the safest way to transport a baby that is likely to need higher levels of care is in the mother's womb whilst she is still pregnant. Whilst the vast

majority of women (98%) due to give birth would see no change at all, there would be a small number of women who would move to St Michael's to give birth.

In the new model of care, with a Level 3 service at St. Michael's and a LNU at Southmead, we would expect based on historical data (2016/17: 23, 2017/18: 28, 2018/19: 22) that less than 30 women a year would deliver at St. Michael's instead of Southmead, excluding women who transfer into the area from outside of Bristol, North Somerset and South Gloucestershire.

The distance between Southmead (NBT) and St Michael's (UHB) is approximately four miles, making it closer to the homes of some of these women and slightly further for others. NHS England/Improvement and local clinical experts believe the clinical benefits to babies and mothers far outweigh any potential negative impact of any additional mileage. Moreover, a free hospital shuttle bus operates between hospitals in Bristol and free accommodation for families at both St Michael's and Southmead that is being increased to ensure there is sufficient capacity to meet the anticipated increase in demand for family accommodation. Therefore, we do not believe the proposed change will disadvantage people on low incomes or contribute to health inequalities.

Families will still be able to access level 1 and level 2 neonatal services at Southmead to enable babies to receive as much of their care as possible in the hospital that mothers originally chose as their place of delivery. NHS England/Improvement and local clinical experts believe these considerations collectively mitigate and minimise the potential negative impact on families who would have otherwise chosen to give birth at Southmead.

Under current arrangements, 40% of babies born at Southmead before 32 weeks are subsequently transferred to St Michaels for surgical interventions and so a significant proportion of the women who would be affected by the proposed change will have earlier transfer to the most appropriate care setting for their babies, thereby removing the clinical risk to both mother and child that is incurred when having to move them.

There will be more paediatric clinicians with the right specialist skills (including cardiology and surgical specialties) available to treat NICU babies through this integrated service, with multidisciplinary teams working across both hospitals jointly caring for sufficient numbers of babies to maintain their skills at the levels needed to deliver the safest, highest quality neonatal services 24/7 (in accordance with the recommendations of the British Association of Perinatal Medicine and South West Neonatal Operational Delivery Network). This should also support research and development activities at each hospital, again increasing the skills and knowledge of both teams.

Funding additional cots will also reduce the number of mothers who need to be sent out of the area to deliver their baby. Any reduction in transfers would improve the patient and family experience, staff morale as well of the financial benefits to the local health economy of retaining activity in Bristol.

Local clinical consensus is that the integration of the Southmead and St Michaels specialised neonatal services in this way will create a centre of excellence for neonatal care in Bristol that is more resilient and sustainable.

5. The benefits of the proposed reconfiguration

To summarise, we anticipate the proposed model of care will have the following benefits.

Improved clinical quality outcomes and patient safety

- It places the most at risk small vulnerable babies at St Michael's with the paediatric specialists co-located, ensuring that they are in the right place at the right time with the right staff to care for them
- It minimises ex-utero transfers of these small high-risk babies
- A centralized NICU is endorsed by the research evidence that has shown improved mortality and morbidity in NICU's that care for higher numbers of babies
- A key component of any partnership agreement between the Trusts would be a firm commitment from St Michael's to ensure systems are in place to improve referral pathways from Southmead to St Michael's to paediatric specialists and improve access for babies to paediatric support services
- It improves patient safety by integrating the units and agreeing clinical guidelines, rotation of staff and maintenance of neonatal skills across sites, professional advice and shared learning

Improved long term sustainability of the service

Integrating both units would significantly improve the long-term sustainability of the service:

- Southmead NICU would no longer be a standalone unit, instead it would be bolstered and supported via integration with St Michael's, with better access to paediatric specialists and paediatric support services, and together provide excellent, high quality tertiary neonatal care across the region
- Integration of medical staffing would enable greater flexibility of medical workforce to cover rotas across both sites due to a larger medical staff pool
- Improved recruitment and retention for nursing and medical staff**;** Integration of the units provides more scope for teaching and training, better exposure to a wider range of neonatal problems. This breadth of exposure would be attractive to potential incoming staff

- Will allow the establishment of an integrated neonatal service with increased research capabilities which in turn will help to attract staff for training and fellowships

Additional benefits include:

- Improved patient and family experience; It is recognised that the transfer of new-borns at such an early vulnerable stage of their life often causes both the new-born and their family stress and concern. Reducing these transfers will help improve families' experience as well as the clinical outcomes of neonatal care in Bristol
- Minimal impact on current maternity services as 98% of women will still deliver in their maternity unit of choice
- It meets the Specialised Commissioner intentions for all intensive care to be provided on one site and it steps towards the intentions for a single managed neonatal service in Bristol

In other words, there will be one neonatal service jointly delivered across two sites that is more flexible and resilient to pressures related to demand and staffing gaps. No resources will be lost as concentrating NICU for the very sickest level babies at St Michael's will also enable specialised commissioning to increase the number of NICU beds that is able to deliver a 24/7 service that meets the requirements of the national service specification and gives these very sick babies the very best chance of survival based on current evidence.

6. The risks if we do not implement the proposed reconfiguration

There is universal support for the proposed changes because both services are unable to meet the standards set out in the national service specification and are vulnerable to increasing demand and staffing challenges, which undermines their sustainability and resilience.

7. Next steps

Before the recommended changes can proceed the proposal to centralise NICU at St Michael's must be supported by the organisations that need to commit the resources needed to implement the reconfiguration (University Hospitals Bristol, North Bristol Trust and NHSE England). Consequently, an outline business case has been developed with stakeholders and approved by the relevant organisations.

Detailed work is now needed to develop a full business case, including the shared management model, which can then go for final approval to Trust and NHSE/I boards to commit the necessary resources in Spring 2020. Endorsement by members of the Bristol, North Somerset and South Gloucestershire Joint Overview and Scrutiny Committee (at the

end of October 2019) is sought for the progression of this work, with ongoing engagement as the full business case is developed.

In line with recommendations from the national review of neonatal services to concentrate NICU activity in a single centre in Bristol by 2022 we anticipate commencing implementation by mid to late 2021 once the additional clinical facilities, family accommodation, management model and staffing arrangements are in place.

8. Recommendations

Given the sound evidence-based reasons for the proposed development; that the national service specification is mandatory and has itself already been subjected to impact assessment and public and clinical engagement and; the balancing of choice against clinically optimal service considerations, members of Bristol, North Somerset and South Gloucestershire Joint Health Overview and Scrutiny Committee are respectfully asked to:

- Note the improvements in patient outcomes and family experience the proposed model is expected to deliver;
- Note the support and involvement of local people, experts and clinical leaders in the option development and appraisal processes that identified the recommended model of care;
- Note the intention to increase NICU capacity and family accommodation in Bristol;
- Note the commitment to ensure sustainability of services through reconfiguration, relevant to the clinical workforce and estate of both organisations;
- Endorse the proposal to centralise level 3 NICU at St Michael's, with families still able to access level 2 neonatal services at Southmead.

References

Marlow N, Bennett C, Draper ES, Hennessy EM, Morgan AS, Costeloe KL. Perinatal outcomes for extremely preterm babies in relation to place of birth in England: The EPICure 2 study. *Arch Dis Child Fetal Neonatal Ed.* 2014 99(3): F181-8 doi: 10.1136/archdischild-2013-305555

Watson S, Arulampalam W, Petrou S, Marlow N, Morgan AS, Draper ES, Santhakumaran S, Modi N; Neonatal Data Analysis Unit and the NESCOP Group. The effects of designation and volume of neonatal care on mortality and morbidity outcomes of very preterm infants in England: Retrospective population-based cohort study. BMJ Open (in press) 2014

Watson SI, Arulampalam W, Petrou S, Marlow N, Morgan AS, Draper ES, Modi N; Neonatal Data Analysis Unit (NDAU) and the Neonatal Economic, Staffing, and Clinical Outcomes Project (NESCOP) Group. The effects of a one-to-one nurse-to-patient ratio on the mortality rate in neonatal intensive care: a retrospective, longitudinal, population-based study. Arch Dis Child Fetal Neonatal Ed. 2016 Feb 9. pii: fetalneonatal-2015-309435. doi: 10.1136/archdischild-2015-309435.

Fenton AC, Ainsworth SB, Sturgiss SN. Population-based outcomes after antenatal transfer. Paediatric & Perinatal Epidemiology 2002; 16: 278-285

Mohammed, M. A., Aly, H. Transport of premature infants is associated with increased risk for intraventricular haemorrhage. Archives of Disease in Children – Fetal and Neonatal Edition 2010:95:F403-F407

Almadhoob, A., Ohlsson, A. 2015. Sound reduction management in the neonatal intensive care unit for preterm or very low birthweight infants. Cochrane Database of Systematic Reviews.

Harrison, C., McKechnie, L. 2011. How comfortable is neonatal transport? Acta Paediatrica. Feb:101(2):143-7.

BLISS. 2016. BLISS Reports and Publications. [ONLINE] Available at: https://s3.eu-west-2.amazonaws.com/files.bliss.org.uk/images/Transfers-of-premature-and-sick-babies.pdf?mtime=20180404114256. [Accessed 5 November 2018].

Mulaney, D. M., Edwards, W. H., DeGrazia, M. 2014. Family Centered Care During Acute Neonatal Transport. Advances in Neonatal Care. Vol. 14 (5S) p S16-S23

Appendix A – Glossary

Apnoeic attacks	Apnoeic attacks refer to cessation of respiratory movements for more than 10 seconds.
BLISS	A charity that supports families with babies born premature or sick.
Continuous positive airway pressure	Continuous positive airway pressure is 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.
Dietetics	Applying the science of nutrition to regulate food intake and provide advice on healthy diets.
Jaundice	Jaundice is when your skin and the whites of your eyes turn yellow. It is common in new born babies but in some cases requires intervention with investigations and treatment.
Maternity Voices	A forum to engage with patient populations in respect of changes to maternity services in Bristol, North Somerset and South Gloucestershire.
NBT	North Bristol Trust – neonatal unit at Southmead often referred to as NBT
Operational Delivery Network	ODNs coordinate patient pathways between providers over a wide area to ensure access to specialist resources and expertise. South West Operational Delivery Network (for neonatal care) is made up of neonatal services at

	Gloucester, Swindon, Bristol, Bath, Taunton, Yeovil (Northern Sector) and Barnstaple, Torbay, Exeter, Plymouth and Truro (Southern Sector).
Phototherapy recovery	Phototherapy in the newborn is a treatment for hyperbilirubinemia and jaundice in the newborn that involves the exposure of an infant's bare skin to intense fluorescent light.
Tertiary services	The NHS is divided into primary care, secondary care, and tertiary care. Primary care is often the first point of contact for people in need of healthcare, and may be provided by professionals such as GPs, dentists and pharmacists. Secondary care, which is sometimes referred to as 'hospital and community care', can either be planned (elective) care such as a cataract operation, or urgent and emergency care such as treatment for a fracture. Tertiary care refers to highly specialised treatment such as neurosurgery, transplants and includes specialised neonatal services such as NICU. As of March 2017 there are 233 NHS providers of secondary and tertiary care.
UHB	University Hospitals Bristol NHS Trust – neonatal unit often called St. Michael's

Joint Health Overview and Scrutiny Committee
25th October 2019

Report of: Mental Health Services in Bristol, North Somerset and South Gloucestershire

Title: Update on Mental Health Services in BNSSG

Ward: Citywide

Officer Presenting Report: Deborah El-Sayed, Director of Transformation, BNSSG CCG

Recommendation

It is recommended that the Joint Health Overview & Scrutiny Committee note the report for information.

Summary

This report provides the JHOSC with an overview of 3 key strategic processes that are currently underway to improve mental health provision – the delivery of the Mental Health Strategy, the Review of Adult Mental Health Services commissioned by the CCG and the implementation of the Long Term Plan. In addition it provides an update on three newly commissioned CCG services – Improving Access to Psychological Therapies (IAPT), Sexual Violence Therapies Service and the Crisis Café in Weston.

Context

Mental Health is a significant priority for BNSSG CCG and the STP and work is being delivered at pace, to understand the need in the area, the existing offer and the focus of future provision. There is currently a challenged picture within BNSSG including high numbers of people being placed out of area, significant numbers of people on the wards who are under Section, a fragmented and geographically inequitable pathway, and CAMHS services offering different levels of provision. However alongside this, there is real opportunity – there is system wide agreement that Mental Health is a priority and that changes are required to really improve people's experiences and therefore lives. There is also national recognition of the issues, which are welcomed locally, which is leading to significant investment in services locally, via the Mental Health Investment Standard.

The discussion below outlines the work that is currently in delivery across BNSSG.

Strategic Context

Mental Health Strategy

The CCG has worked with partners across BNSSG to develop an STP wide all age Mental Health and Wellbeing strategy which sets out what changes will need to be made to local services, identifies support to address current and emerging need, and which responds to feedback and insights from people with lived experience, carers, clinicians and our wider population. It is also aligned with national policy direction such as the NHS Long Term Plan and recognises the need to make our services efficient, affordable and sustainable.

The draft strategy has been co-produced with users, clinicians, stakeholder and wider population through a significant number of engagement events and a structured insights process. A Healthier Together mental health strategy steering group facilitates oversight and the involvement of all system partners with a commitment to embed the insights from those with lived experience in all aspects of the design.

The strategy has been built upon four common themes in the context of the life course; promoting mental wellbeing and preventing ill health; access; integration and sustainability.

The draft strategy will presented to STP partner organisations for their views before final approval is sought from the STP Partnership Board. It is anticipated that the strategy will be presented for sign off in December 2019.

Mental Health Review of Adult Services

This review of adult Mental Health Contracts is an internal CCG review, to fully understand the position for all Adult Mental Health Contracts commissioned by the CCG in BNSSG.

BNSSG CCG is in a position where a number of contracts within the Bristol area have previously been procured. In 2013 Bristol PCT tested the market and awarded contracts to multiple Providers – awarding to different organisations and moving away from one Provider (in this case AWP) providing services to the whole of the pathway. This re-commissioning also included a 'system leadership' function designed to co-ordinate the many different providers in place in Bristol. However, this function was decommissioned in 2017 as it was challenging to evidence the value of the function and in some respects duplicated the role of commissioners. In comparison South Gloucestershire and North Somerset CCG's did not market test their services and continued to have AWP providing the vast majority of the services. This, coupled with varying levels of investment in predecessor organisations has meant that there was inconsistency in the type and level of services commissioned across BNSSG. Alongside this each area also had a number of historic small value contracts which also required review.

As BNSSG CCG we recognise that there is now a fragmented pathway across the area, with different organisations providing services in different ways. We know that we need to modernise, rationalise and develop services and that we need to do this at pace.

Contracts within the Bristol area have been extended until September 2021, the maximum extension that is permitted under the contract terms. With this in mind, it was the opportune time to move towards further scoping of the options for adult mental health services to work towards a consistent approach across BNSSG.

The review has enabled the CCG to fully understand the existing services in greater detail in order to take decisions around the future direction of travel. It has included:

- An overarching assessment of the current performance and outcomes of all adult mental health contracts across BNSSG including both those formerly market tested under the 'Bristol Mental health' commissioning exercise and statutory and voluntary sector services which have never been market tested.
- Identify where there are gaps in knowledge and understanding of services.
- Begin to think about next steps for adult mental health contracts

NHS Long Term Plan

Mental Health is at the forefront of the Long Term Plan, of which there are a number of outcomes that BNSSG will be required to achieve over the next 5 years. The following sets out the national requirements, many of which we have already made strides to deliver.

The national outcomes for the Mental Health Long Term Plan can be grouped into 7 themes, as described below.

For people requiring perinatal mental health care to have:

- improved access to evidence-based care for women with moderate to severe perinatal mental health difficulties and a personality disorder diagnosis, provided by specialist perinatal mental health services, from preconception to 24 months after birth
- expanded access to evidence-based psychological therapies within specialist perinatal mental health services so that they also include parent-infant, couple, co-parenting and family interventions
- for fathers/partners of women accessing specialist perinatal mental health services, an offer of an assessment of their mental health and where required signpost to other services
- an offer of evidenced based maternity outreach clinics that provide combine maternity, reproductive health and psychological therapy for women experiencing mental health difficulties.
- increased access to evidence-based psychological support and therapy, including digital options, in a maternity setting.

For children and young people requiring mental have support to have improved:

- access to community based mental health services

- access to services more quickly for eating disorders
- access to services when they are in crisis with 100% coverage of 24/7 crisis provision for CYP which combines crisis assessment, brief response and intensive home treatment functions
- support in schools and colleges via Mental Health Support Teams
- support during transition.

For people with a "common disorder":

- to be able to access IAPT, which includes a focus on long term conditions.

For people with severe mental health problems:

- to be supported by new and integrated models of primary and community mental health care.

For people who require "emergency support" to be able to:

- access crisis services, with a 24 hour community response available
- have 24/7 access to Mental Health liaison in hospitals
- be able to access support with a single point of access via 111
- have alternative support available when in crisis
- have access to a mental health professional working in the ambulance control centre to reduce inappropriate ambulance conveyance
- have the ability to access a Mental Health vehicle to reduce inappropriate ambulance conveyance.

For people who require Inpatient Care:

- to be treated near home and not be placed out of area
- to have an improved therapeutic offer to improve patient outcomes and experience of inpatient care, and reduce average length of stay in all in adult acute inpatient mental health settings.

To ensure that as a system we focus on Suicide Prevention

- reducing the number of suicides and developing suicide bereavement support.

The STP are currently working to deliver a submission to NHS England, outlining how they plan to address all the elements of the Long Term Plan (Mental and Physical Healthcare). This submission is due in late November, with a workshop planned for all partners and members of the Public on 17th October, to discuss the priorities and the plans.

Newly Commissioned Services

Alongside the Strategic work, BNSSG CCG has tendered 3 services in the past 12 months.

Improving Access to Psychological Therapies (IAPT)

Mobilisation update

As JHSOC will be aware, the CCG tendered the three IAPT contracts that were in existence and specified one new service. The tender was won by Vita Health in partnership with Bluebell Care Trust and Windmill Hill City Farm. An accelerated mobilisation period took place, and the new Provider took over on 1st September 2019.

It cannot be underestimated how significant the task was to implement this service at pace, winding down 3 contracts and starting up a new one. This service already has nearly 5000 people who require treatment and there has been a huge volume of calls coming in with queries and referrals. The CCG are working with Vita on a daily basis to address any issues as they arise, as it is inevitable with a change of this magnitude that there will be some initial concerns. Embedding any new service is always a challenge, when people have been used to working with a certain Provider in a certain way and it is common in transition to have a higher than average number of queries and concerns raised during this phase- the CCG will be closely monitoring this and working with Vita Health to deliver the excellent service that has been commissioned.

An update on mobilisation and implementation, that was discussed at the project group, which meets fortnightly, is summarised below.

Workforce

The Workforce work-stream was focused on two key points: ensuring a smooth transition for staff between providers for the individuals being TUPED across to Vita and monitoring staff that left or were placed in a different role within Avon and Wiltshire Mental Health Partnership Trust. There were a number of specific actions relating to staff and trade union consultation, policies, procedures, pensions and educational training which Vita/AWP and BNSSG CCG were actively involved in. There were a number of last minute changes to the number of people who were TUPEing and there is now an active recruitment process underway.

Estates

The Estates work-stream was focused on ensuring the Estates Vita had identified as fit for purpose were handed over in co-operation with AWP. Those estates that Vita had chosen not to use were included within AWP decommissioning plan. There was a delay in getting the estates confirmed, however, the estates were confirmed in the 2/3rd week of august 2019. The three main hubs have been confirmed as Newminster (for Bristol), Coast Resource Centre (For North Somerset) and Station Road, Yate (For South Gloucestershire). Alongside the three main hubs, there are a number of additional estates across the BNSSG area which will be used for therapy.

Finances

The finance work-stream was focused on two priorities: ensuring a smooth transition between the providers and proactively managing any potential financial issues. First, in June, a joint meeting between AWP, Vita and BNSSG CCG took place to review a number of potential actions related to the transition of services. It quickly became apparent that with the nature of the transition, there was limited engagement required, since none of the assets, liabilities or obligations were transferring between providers. Second, Vita was asked to provide regular financial forecast during the mobilisation to highlight any potential future financial issues. All financial performance

reporting mechanisms used during the mobilisation phase will continue to be applied as part of an ongoing contract monitoring

Operation Governance
The Operation Governance work-stream focused on providing BNSSG CCG with the assurance that Vita had appropriate Governance and constitution arrangements in place for go live on the 1st of September. This included reviewing and gaining assurance that Vita had clear information governance processes in place. There are no outstanding actions or risks in relation to the operational governance.

Data Protection
The Data protection work-stream focused on ensuring Vita were GDPR compliant and followed data protection guidelines appropriately. The review of the data protection was overseen by the Information Governance Manager with the CSU.

Under GDPR guidance, all service users on the waiting list were contacted by AWP advising their data would be transferred on the 1st of September unless they advise otherwise. Service users were contacted by letter and phone. This did see a number of individuals dropping out of accessing the service – this could be a for a number of reasons including people no longer needing help, or having sourced help from elsewhere. There are no outstanding actions or risks in relation to the operational governance.

Freedom of information
Vita are not subject to freedom of information requests and therefore any requests will be processed by BNSSG with ongoing support.

Information, Communication and Technology (I.C.T)
The I.C.T work-stream focused on ensuring Vita had secure email addresses and the appropriate technology in place for when the service went live on the 1st of September 2019. Despite the short time frame for the mobilisation, Vita worked through the I.C.T challenges at pace ensuring there would be no issues for go live. All of the estates were confirmed to have the right internet connection bar 1. As a result of delay in getting the estate defined and agreed there was a risk that the necessary data links from the sites to Vita infrastructure would not be in place before Service start and this would result in degradation to the Service. Vita developed a work round for the one estate where it had not been possible to make the internet connection. All telephony systems were in place and running from the 1st of September 2019.

Contracts
The Contracts work-stream focused on ensuring all contracts were in place. BNSSG CCG and Vita formally signed the contract on the 12th of July 2019. Vita have decided to subcontract Bluebell and Windmill City Farm, both of whom formally signed off contracts with Vita by the 31st August 2019.

Sexual Violence Therapies Service

This service was one that had been previously commissioned by NHS England and was passed to BNSSG CCG in April 2019. The CCG's approach to developing the new service was to work

collaboratively with NHS England, Avon and Somerset Police and Crime Commissioner and B&NES and Somerset CCGs, to agree the service specification and model of care. In the absence of any national guidance on the detail of the service and in the absence of any significant concerns with the existing service, the approach was to mirror current service provision, with some minor changes, to support best practice.

The service is all-age and is to support survivors of rape and serious sexual assault and is available to all genders. The service provides therapeutic interventions and counselling to:

• Adults (aged 18years +) who have experienced rape and serious sexual assault within the last 12 months (The CCG commissions a separate service for victims of historic abuse).
• Children regardless of when the assault or abuse took place

The service offers a comprehensive assessment to ensure that people are referred into the most appropriate model of intervention and support. Where indicated in the assessment, this includes support for families and friends of the survivor.
The successful bidder was Somerset and Avon Rape and Sexual Abuse Support (SARSAS) working as a consortium in association with Womankind and The Green House. The contract commenced on 1st June 2019, for 3 years.

North Somerset Crisis and Recovery Centre

The idea for a North Somerset Crisis and Recovery Centre came out of initial scooping of the Healthy Weston model at the start of 2018. During public engagement and co-design workshops, discussions specifically focussed around a 'crisis café' style model which would allow people access to out of hours mental health support. The model is also referenced in the NHS Long Term Plan as an appropriate model of care for vulnerable people which CCGs are expected to commission as part of their crisis offer. The service specification was co-produced with AWP, Lived Experience Representatives, SWASFT, GPs and voluntary sector providers during winter 2018/19.

There are two key purposes; to provide a safe, welcoming and comfortable place for people in immediate acute emotional distress and for those seeking to prevent the onset of a crisis, and to work with the individuals to create plans and strategies for managing their mental health and wellbeing and preventing future crisis. The service will have a very close working relationship with the local AWP Intensive Support Crisis Team and blue light services.

The CCG was very pleased to announce last month that local mental health charity Second Step, is the preferred bidder for the new service. We are currently working through the due diligence process and the contract is due to be signed. The new service will commence late Spring 2020.

Next Steps

As a system we are now working through the prioritisation of mental health pathways to establish the order in which workstreams should be addressed. This will enable the work that is taking place within the Strategy, the Review and the Long Term Plan to converge with an agreed set of priorities, and associated timelines to be finalised.

The work on the crisis pathway, which is a key area of focus has already commenced. The first of three workshops has been held with partners from across BNSSG, to understand what the future offer is for people in a mental health crisis. The next workshop is in plan for November and a blue print for the crisis offer is being developed.

When priorities have been agreed, work will continue at pace to deliver the agreed outcomes.

Conclusion

As described above there is a significant amount of work underway to address the variation and challenges that currently exist with mental health services across BNSSG. As a system we will continue to focus on these to deliver the best possible care for our population and further updates can be provided to JHOSC as appropriate.

Joint Health Overview and Scrutiny Committee

25th October 2019

Report of: Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group.

Title: Healthy Weston: Future Services at Weston Hospital.

Ward: Weston-super-Mare and surrounding area.

Officer Presenting Report: Rebecca Dunn

Contact Telephone Number: 0117 900 2184

Recommendation

To receive an update on the future service model at Weston Hospital following approval of the Healthy Weston Decision-Making Business Case (DMBC) by the CCG Governing Body and consultation with the North Somerset Health Overview and Scrutiny Panel (HOSP).

Summary

On 1st October 2019 the CCG Governing Body approved the recommendations of the Healthy Weston Decision-Making Business Case (DMBC) to make the following changes to services at Weston Hospital:

- To keep A&E at Weston Hospital open 8am to 10pm, seven days per week, making the temporary overnight closure of the A&E permanent.
- To make specialist children's urgent care provision available 7 days a week instead of 5, and extending the mid-week opening hours at the Seashore Centre to match those of A&E.
- Continue to provide emergency surgery at Weston Hospital 7 days a week, closing theatres from 8pm-8am.
- Continue to provide up to Level 3 critical care for people who need single organ support at Weston Hospital.

The CCG has formally consulted with the North Somerset HOSP regarding the Healthy Weston Programme as per the delegation of duties agreed when the JHSOC was established. On 15th October the North Somerset HOSP agreed a motion to work together with the CCG to review the implementation of the service change one year after implementation (April 2021).

Context

The Healthy Weston Programme was established in October 2017 to address long standing issues with the delivery of health care services in the Weston-super-Mare area. The Commissioning Context, published in October 2017, outlined the vision for healthcare services in the area and highlighted the issues that needed to be addressed.

Following a period of public and stakeholder engagement, in October 2018 the CCG published the Healthy Weston Case for Change that focussed on four main reasons why health services need to change in Weston and the surrounding area:

1. Our changing health needs
2. Variation in care and access to primary and community care
3. Meeting national clinical quality standards
4. Delivering value for money.

Between February and June 2019 the CCG consulted with more than 3,000 members of the public, workforce and stakeholders about proposed changes to the Weston Hospital model of care. The CCG published a detailed consultation document that was heavily promoted throughout the region. In August 2019, the CCG published an independent review of the responses to the consultation.

The consulted proposals were developed and enhanced to form the full DMBC that was approved at the CCG Governing Body on 1st October.

Proposal

Meeting national clinical quality standards to ensure high quality and safe care has been the primary driver in the development of the service change recommendations that have subsequently been agreed at the CCG Governing Body. The development of the service model has been clinically led and is supported by senior doctors from across the region.

The recommendations that have been approved are detailed below:

Urgent and Emergency Care and A&E

- To keep A&E at Weston Hospital open 8am to 10pm, seven days per week, making the temporary overnight closure of the A&E permanent. The A&E would be staffed by a multi-disciplinary team of hospital and primary care clinicians working together. The overnight closure of A&E would be supported by 24/7 direct admissions to the hospital via referrals from GPs, paramedics and other healthcare professionals.

Critical Care

- Provide up to Level 3 critical care for people who need single organ support at Weston Hospital. This includes short stay post-operative recovery at Level 3 and longer term intubation, where the lungs are the organ requiring support.
- Transfer people requiring critical care for two or more organs at Level 2 or 3 or people who would benefit from proximity to UHB's specialist clinical services via dedicated transfer team to UHB.
- Establish a critical care service that is digitally linked to UHB to provide oversight and monitoring from the larger unit of the people who remain at Weston Hospital.
- Repatriate people following treatment in UHB when care needs can be met at Weston Hospital.

Emergency Surgery

- Provide emergency surgery in the daytime only at Weston Hospital. Theatres will close overnight from 8pm-8am.
- People requiring an emergency operation overnight (those who deteriorate on the ward or present to A&E in the evening) will be stabilised and transferred to Bristol for surgery.
- A small number of people who require more complex surgery will also be transferred to Bristol to receive support from specialists unavailable at Weston Hospital.
- Ambulatory pathways for emergency surgery, including rapid access to daily clinics Monday to Friday and a dedicated afternoon emergency theatre session, will be established to improve the quality and responsiveness of the surgical service.

Acute Paediatrics

- Specialist children's staff will be available at Weston Hospital seven days a week from 8am-10pm.
- This includes extending the hours of opening of the Seashore Centre from 8am to 10pm, Monday to Friday in Weston with paediatric expertise over the duration of its opening hours on Saturday and Sunday.

The changes that were agreed will enable more than 2,000 additional people to receive care at Weston Hospital than is currently the case as well as providing a more stable platform for the hospital to meet national clinical quality standards.

The recommendations made in the DMBC are supported by key stakeholders across the area including University Hospital Bristol NHS Foundation Trust (UHB), Weston Area Health NHS Trust (WAHT), North Bristol NHS Trust, Taunton and Somerset NHS Foundation Trust, South Weston Ambulance Service NHS Foundation Trust, North

Somerset Community Partnership, Avon and Wiltshire Mental Health Partnership Trust, local GPs and Somerset CCG.

NHS England and the South West Clinical Senate (a regional body of independent experts that assess NHS change programmes from a safety and quality perspective) have assured the recommendations.

The success of changes agreed at the CCG Governing Body is also interdependent with the WAHT and UHB merger. The decision on the hospital model of care will form the baseline of UHB's Full Business Case that is being considered at the UHB Board in November. Closer working between the two hospitals is a critical enabler of some of the service changes proposed, for example, those relating to critical care.

The implementation of the recommendations, coupled with the organisational merger between WAHT and UHB, will provide a stronger platform from which to continue to redesign the local health service to better meet the needs the local people and continue to address the case for change.

The CCG engaged and consulted with the North Somerset HOSP throughout this period dating back to March 2017. The period of statutory consultation began in February 2019 and included a briefing in private and detailed discussions in public in September 2019. Following a meeting in public on 30th September 2019, the North Somerset HOSP requested additional detail on specific items related to the proposals. Additional information was provided in writing, and on 15th October the CCG presented the additional information to the HOSP members. Two votes were held: HOSP members voted against making a recommendation to the full council to immediately refer the programme to the Secretary of State for Health; HOSP members voted unanimously to support the proposals to move forward with a full review of the impact of the changes made at 12 months following implementation. The review will have the following components:

1. The staffing position for urgent and emergency care and the prospect of sustainably staffing a return to a 24/7 rota
2. Progress in recruiting primary care staff for the new front door model for the A&E
3. Evaluation of the impact and outputs of the mental health community crisis and recovery centre following the setting up of the new service in Spring 2020
4. The number of people transferring to care elsewhere in the health system and their experience and outcomes

Approximately 20% of patients using Weston Hospital are from the north Sedgemoor area of Somerset and therefore the CCG provided a briefing to the Somerset Scrutiny for Policies, Adults and Health Committee on September 11th 2019. Formal written support for the proposals and consultation process undertaken was subsequently provided by the Chair on behalf of the Committee.

The CCG will commission these changes through contractual processes, and work with system partners to deliver the new service model. Implementation will largely be driven by the provider organisations, UHB and WAHT, with commissioning support where necessary.

HEALTHY WESTON

NHS

Weston as a dynamic hospital at the heart of the community

BNSSG JHOSC
25th October 2019

Background and the Case for Change

There is a compelling body of evidence around WGH to support the case for change

Clinical

- **"Inadequate"** - 2019 CQC report rated WAHT inadequate for Urgent & Emergency Care services.
- **Potentially harmful errors** – 40% of WAHT respondents said that they'd witnessed potentially harmful errors, near misses or incidents in the last month in the 2018 staff survey (2nd highest in the country).
- **Current model "potentially unsafe"** - SW Senate, 2018
- **Fewest critical care & emergency surgery standards met of any hospital in the SW**

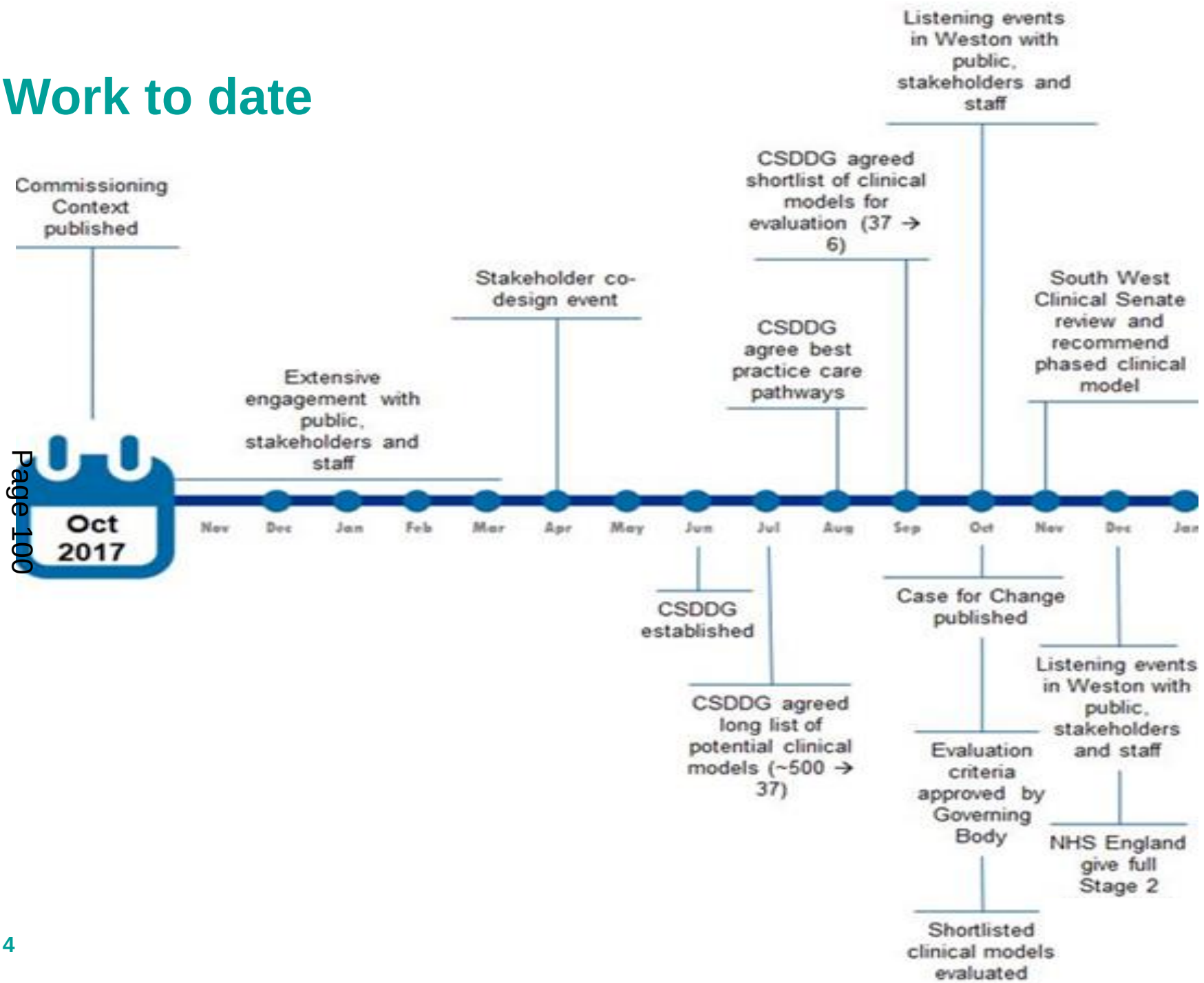
Workforce

- **"Very High" Risk** - WAHT corporate risk register rates 'difficulties in recruiting substantive medical staff with an adverse impact on patient care' as a 'Very High Risk' with 'Inadequate' controls.
- **Significant gaps in staffing** – 23% consultant vacancy rate and 25% vacancy rate in nursing in July 2019.
- **Issues with medical training** - Training of junior doctors at WAHT overall has been under enhanced monitoring since 2015 due to having poorest GMC feedback nationally.

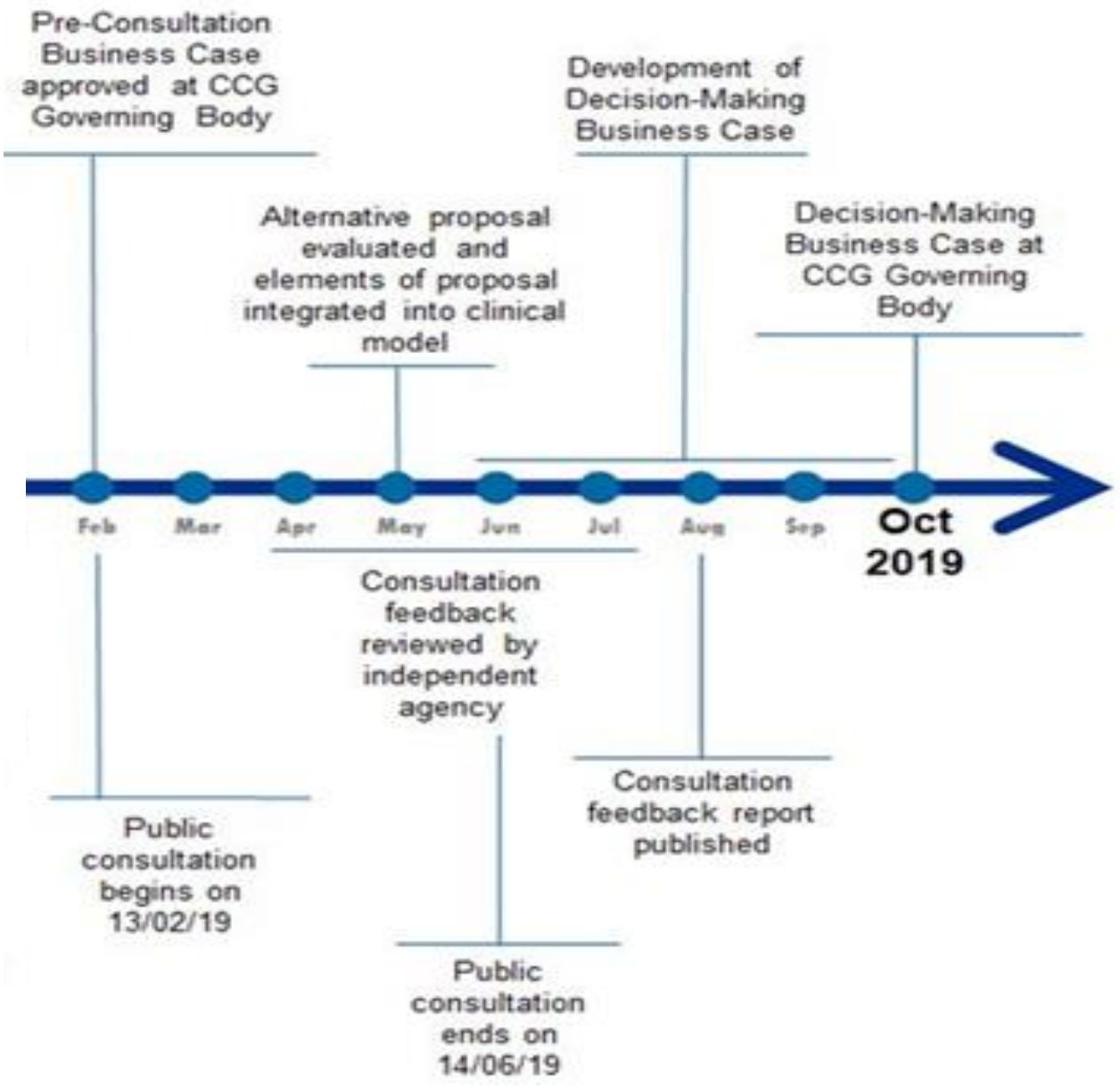
Financial

- **Challenges resulting from scale** due to coastal geography and proximity to other hospitals
- Despite a CCG subsidy the Trust **overspent by £17.5m in 2018/19**.
- Latest forecasting gives a **recurrent deficit of £30m by 2024/25**.
- **Proportionally highest agency spend in England**. Audited accounts show this has deteriorated between 2017/18 and 2018/19 by £2m.

Work to date

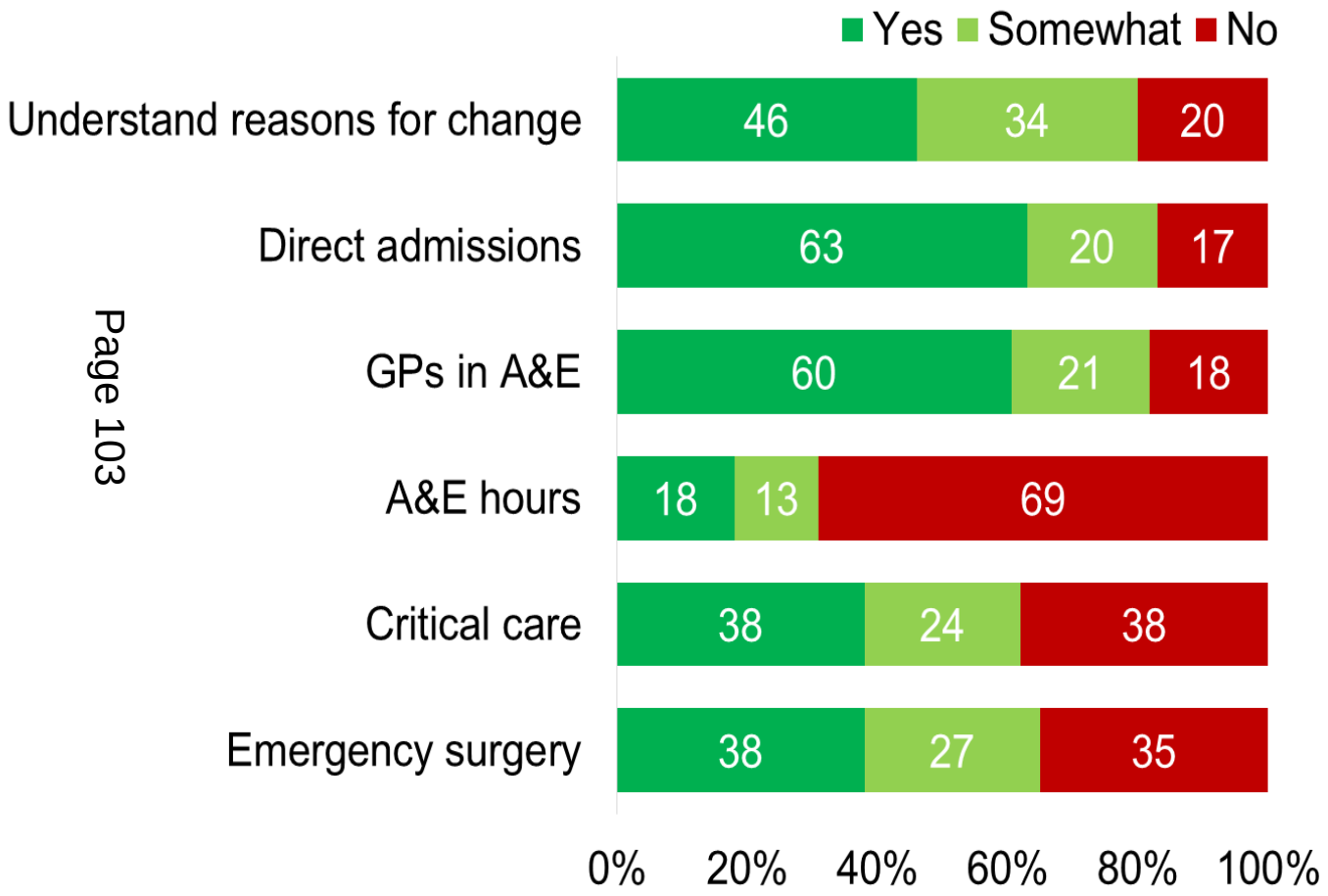

Commissioning Context published
Extensive engagement with public, stakeholders and staff
Stakeholder co-design event
CSDDG established
CSDDG agreed long list of potential clinical models (~500 → 37)
CSDDG agreed shortlist of clinical models for evaluation (37 → 6)
CSDDG agree best practice care pathways
Listening events in Weston with public, stakeholders and staff
Case for Change published
Evaluation criteria approved by Governing Body
Shortlisted clinical models evaluated
South West Clinical Senate review and recommend phased clinical model
Listening events in Weston with public, stakeholders and staff
NHS England give full Stage 2
Oct 2017
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan

Work to date


Pre-Consultation Business Case approved at CCG Governing Body
Development of Decision-Making Business Case
Alternative proposal evaluated and elements of proposal integrated into clinical model
Decision-Making Business Case at CCG Governing Body
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct 2019
Consultation feedback reviewed by independent agency
Public consultation begins on 13/02/19
Consultation feedback report published
Public consultation ends on 14/06/19

Public Consultation and Feedback

We ran an extensive public consultation between 14th Feb – 14th June



Over 2,300 responses, representing over 3,000 people

8/10 people understood the need for change

We listened & worked to address the concerns we heard:

Travel	Investment in a dedicated critical care transfer team, reduced the number of people needing to travel elsewhere, increased awareness of existing travel support
Capacity of other services	Worked with ambulance services and GPs to identify more people who could benefit from direct admissions, reduced the number of people needing to travel for surgery
Population demographics	Worked closely with local authorities to understand latest population changes, supporting changes to primary and community care to address the needs of older people and vulnerable groups
Accuracy of evidence	Worked with individual experts and national regulators to verify assumptions, evaluated the hospital consultants' model and incorporated their ideas into the proposals

Proposals for Weston Hospital

Proposals for Weston Hospital: A&E and urgent care

- To keep A&E at Weston Hospital open 8am to 10pm, seven days per week, making the temporary overnight closure of the A&E permanent.

- The A&E would be staffed by a multi-disciplinary team of hospital and primary care clinicians working together.

- The overnight closure of A&E would be supported by 24/7 direct admissions to the hospital via referrals from GPs, paramedics and other healthcare professionals.

900 more people will receive their care in Weston through overnight direct admissions than is possible today under the temporary overnight closure

Proposals for Weston Hospital: critical care

- Provide up to Level 3 critical care for people who need single organ support at Weston Hospital. This includes short stay post-operative recovery at Level 3 and longer term intubation, where the lungs are the organ requiring support.
- Transfer people requiring critical care for two or more organs at Level 2 or 3 or people who would benefit from proximity to UHB's specialist clinical services via dedicated transfer team to UHB.
- Establish a critical care service that is digitally linked to UHB to provide oversight and monitoring from the larger unit of the people who remain at Weston Hospital.
- Repatriate people following treatment in UHB when care needs can be met at Weston Hospital.

This proposal would affect around 130 people per year

Proposals for Weston Hospital: emergency surgery

- Provide emergency surgery at Weston Hospital, 8am-8pm, 7 days a week.
- Stabilise and transfer people requiring an emergency operation overnight (those who deteriorate on the ward or present to A&E in the evening).
- A small number of people who require more complex surgery will also be transferred to Bristol to receive support from specialists unavailable at Weston Hospital.
- Ambulatory pathways for emergency surgery, including rapid access to daily clinics Monday to Friday and a dedicated afternoon emergency theatre session, will be established to improve the quality and responsiveness of the surgical service.

This proposal would affect around 80 people per year

Proposals for Weston Hospital: paediatric urgent care

- Specialist children's staff will be available at Weston Hospital seven days a week from 8am-10pm.
- This includes extending the hours of opening of the Seashore Centre from 8am to 10pm, Monday to Friday in Weston with paediatric expertise over the duration of its opening hours on Saturday and Sunday.
- Once implemented, these changes mean over 1,100 more children will be treated for emergencies locally at Weston Hospital.
- A further 570 children will receive their planned care at Weston instead of travelling further afield.

This proposal would mean around 1,600 more children per year would receive their care in Weston

Out-of-hospital initiatives to support the changes

Integrated Frailty Service

Mental health crisis and recovery centre

Strengthened primary care

Integrated localities

Workforce modelling and plan

Merger of WAHT with UHB

Summary & Next Steps

Summary

- The **vast majority** of care currently provided at Weston Hospital remains under these proposals
- Major trauma, heart attacks, vascular care and care for very sick children is **already provided in neighbouring hospitals** as Weston does not have the specialist provision required
- The final proposal changed following consultation as a result of clinical partnerships formed across the system, and **reduced the number of people transferred** out of Weston
- The system has worked together to **safely maximise the hospital offer in Weston**; there is more we can and will do to increase services provided locally as part of the Healthier Together Partnership

North Somerset Health Overview and Scrutiny Panel

Engagement and Consultation
Consistent engagement since March 2017 on Healthy Weston Programme
Formal consultation under statutory guidance since February 2019
Meeting on 15th October 2019 agreed **not to refer the programme to Central Government** and to **review the programme one year after implementation**. Review areas to include: • The staffing position for urgent and emergency care and the prospect of sustainably staffing a return to a 24/7 rota • Progress in recruiting primary care staff for the A&E • Evaluation of the impact and outputs of the mental health community crisis and recovery centre • The number of people transferring to care elsewhere in the health system and their experience and outcomes

Next Steps

- A decision to go ahead has been made by the CCG Governing Body
- Frailty service establishing between now and April 2020
- Mental health crisis service operational from April 2020
- Pier health recruitment is underway – positive early responses including people wanting to work at Weston Hospital
- Implementation of the hospital proposals planned from April 2020
- **Full review of that decision at 12 months post implementation**

HEALTHY WESTON

NHS

Questions