

**NHS Bristol, North Somerset and South Gloucestershire**

**Clinical Commissioning Groups**

**Healthy Weston:**

**Joining up services for better care in the Weston area**

**A Commissioning Context for North Somerset**

**2017/18 to 2020/21**

# Contents

PREFACE .....	3
EXECUTIVE SUMMARY .....	4
1 Introduction & Background.....	8
PART 1: WHERE WE ARE TODAY .....	15
2 Our Local Population and their Needs .....	15
3 Supply-side Analysis - local provider landscape & key challenges .....	19
4 The Financial Challenge .....	21
5 Commissioning Principles .....	30
6 Priority Areas of Focus.....	32
PART 2: VISION FOR LOCAL SERVICES .....	33
7 A New Model of Care for Weston.....	33
8 Primary Care (General Practice) at Scale & Providing System Leadership .....	36
9 Stronger, More Integrated Community Services & 'Care Campus' .....	38
10 A Stronger, Focused Acute Trust & Acute Care Model at Weston Hospital .....	45
11 Key Enablers for our New Approach.....	49
PART 3: DELIVERING THE CHANGE .....	50
12 Critical Building blocks for Delivery .....	50
13 Proposed Commercial Model.....	51
14 Next Steps .....	52
APPENDICES .....	57
APPENDIX 1: Note on Population Figures .....	58
APPENDIX 2: Population and Needs Analysis .....	59
APPENDIX 3: Supply Side Analysis .....	68
APPENDIX 4: Additional Finance Information .....	82
APPENDIX 5: Key Priority Population Groups .....	84
APPENDIX 6: Key Priority Speciality Groups .....	88
APPENDIX 7: How Will These Changes Meet the Identified Priorities? .....	94
APPENDIX 8: Recognising and Responding to Public & Staff Views .....	97
APPENDIX 9: Developing the Commissioning Context.....	100
APPENDIX 10: 'You said... and your views have influenced the CCG to...' .....	103
APPENDIX 11: Glossary .....	114

## PREFACE

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

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

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

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

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

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

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



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

A handwritten signature in black ink, appearing to read 'Julia Ross'.



**Dr Mary Backhouse**  
Clinical Chair  
North Somerset CCG

A handwritten signature in black ink, appearing to read 'M Backhouse'.

## **EXECUTIVE SUMMARY**

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

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

### **Local population need & key priority groups**

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

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

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

### **Challenges in service delivery**

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

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

## **Financial challenge**

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

## **Vision for local services & a new model of care**

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

- 1. Primary Care (General Practice) working at scale & providing strong system leadership:** Over 95% of the patient contacts with the NHS take place in primary care, but primary care only accounts for 7% of the NHS's budget. Although people rightly want to know that there is a strong and resilient acute hospital system around where they live, the CCG wants to recast the conversation with residents to focus on the bigger picture. Therefore, we want to think about how we can support primary care to be more robust, working together more effectively with each other, the wider community system and secondary care services at WGH to proactively help people to stay well, independent and at home wherever possible. This includes assessing opportunities to reconfigure and enhance the primary care estate and exploring the opportunities for integration and co-location offered by the One Public Estate Programme. A significant dimension of this work will also be improving our messaging and support for patients to enable them to choose self-care options wherever appropriate.
- 2. Stronger, more integrated community services supported by a 'Care Campus' model at the WGH site:** A key objective of the new model of care is to "defragment" the many community services and resources that are already in place. There is a clear need to develop a more integrated and efficient community provider landscape and service model, centred around closer collaboration between primary care and the wider community system as a whole. This would be supported by best practice integrated care pathways that proactively focus on keeping people well and at home, with the aim of ensuring that patients get the right service, in the right place, first time.

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

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

### **Delivering the change**

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

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

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

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

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

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<sup>1</sup> <https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf>

## **Next steps**

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

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

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

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

# 1 Introduction & Background

## 1.1 Intended audience

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

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

## 1.2 Purpose & scope

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

The purpose of this document is threefold:

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

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

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

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



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

### 1.3 North Somerset CCG & BNSSG CCGs

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

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

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

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

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

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<sup>2</sup> For a description of specialised services see <https://www.england.nhs.uk/commissioning/spec-services/>

<sup>3</sup> <https://www.northsomersetccg.nhs.uk/news/statement-merger-proposal/>

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

## 1.4 Our vision and ambitions for local residents

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

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

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

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

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

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

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

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

## 1.5 Weston Sustainability Programme: "Healthy Weston"

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

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

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

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

In response to recent engagement activities at WGH, Healthwatch North Somerset published a report that summarised the feedback received from both the public and local staff. Their report clearly

showed that while many people understood the need for change (83% of respondents said they recognised the need to change), there was a public appetite for more detail on what was being proposed. It was also apparent that the options to reconfigure WGH's emergency department needed to be better communicated within the wider context of a series of interrelated changes to the acute care model.

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

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

## 1.6 Why 'the place' of Weston is an opportunity

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

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

The key drivers for local service change in Weston are:

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

- The population of Weston is both ageing and growing, and doing so at a higher rate than the England average. These demographic changes will place a significant burden on local health services that are already overstretched and struggling to meet demand. As the town centre regenerates, there are likely to be changes in the socio-economic profile of residents. This presents a challenge for commissioners to plan for future needs.
- The level of health inequality in Weston is particularly marked and is often hidden behind more generalised health and care statistics for North Somerset, which mask the true underlying problems. The IMD2015 deprivation scores show North Somerset has the 3rd largest range of scores in the country; and the gap in life expectancy between the most and least deprived Wards in North Somerset is one of the highest in the country (~18 years), with the most deprived Wards being Central and South Wards in Weston-super-Mare.

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<sup>4</sup> [The Kings Fund – Placed-based systems of Care.](#)

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

- There are challenges in meeting not only current need, but the growing and ageing population as described above. Improving local resilience and capacity to deliver improved access to primary care services is a key priority locally. We want GPs to take on a clinical leadership role, orchestrating the healthcare system in the community, seeing only the patients that their skill set requires and supporting other disciplines to provide a more prominent role in patient care as appropriate.
- This greater use of other staff groups will allow GPs more time to focus on the most complex patients. For certain groups of patients (e.g. frail and older people) the evidence suggests that continuity of care with a specific GP can reduce the chance of an unplanned hospital admission. By the same token, there are other groups of patients who use primary care infrequently who do not need to see a particular GP. As a system, we think we can do more to differentiate the needs of these different cohorts.
- We also need to ensure that the skills possessed in primary care are maximised across the locality. For example, if a particular GP has a special interest in a certain condition, it does not make sense that only patients who happen to be registered with his/her practice benefit. How can we share the range of special interest and knowledge local GPs have to the maximum benefit of the population?
- There is a need to ensure that the primary care estate in the Weston area (e.g. Central Weston and Worle) is fit for purpose in order to help resolve the resilience and capacity issues and to deliver services in the appropriate place.
- The new build housing at the Weston Villages' Airfield site will require careful analysis as to whether there is a case to rationalise and/or build new primary care estate to meet the developing population's need.
- There is a requirement to work more collaboratively across GP Practices, to both improve the resilience of clinical services (given an ageing workforce and recruitment issues), and drive greater efficiencies from economies of scale (such as working more collaboratively to deliver clinical pathways and by sharing estate, back office functions, processes and systems).

## **3) Improve the sustainability of Weston General Hospital:**

The CCG believes there is a great opportunity to use Weston General Hospital more effectively and efficiently, putting it at the heart of a local, integrated care system. Furthermore, we want to build WGH's reputation as a place where great care is provided for particular groups of patients; for example frail and older adults, outpatient cancer treatment and people needing the most common types of elective surgery. In taking this opportunity, there are a number of long standing issues that need to be addressed:

- The STP's projected "do nothing" annual deficit for WAHT will be £20.6m by 2020/21 (£7.4m if fully mitigated).
- The provision of A&E services is a high profile local issue. We must look carefully at population need to identify the most effective long term solution for local urgent care provision.
- The ability to recruit to key clinical specialties; and issues with trainee doctor placements (supervision and satisfaction) are significant challenges, putting service delivery at risk. This is

compounded by the continued delay in finding a longer term solution for the sustainability of WGH.

- The local Midwife led maternity service at WGH is not chosen by enough women to make it clinically or financially viable in its current form. The number of deliveries is currently ~170 per year, but the minimum level for a clinically appropriate unit of this type is considered to be ~ 500.
- There are questions as to whether other services may be more appropriately delivered elsewhere at scale, such as emergency general surgery and Level 3 ICU.
- Given the issues listed above, the CCG currently makes a number of premium payments, in addition to normal activity related payments, to support specific services that otherwise would struggle to be financially viable. e.g. A&E and critical care. This is clearly not sustainable and will need to change.

The following section describes '*Where we are today*'. It provides a summary of local population need, an overview of the local provider landscape, details of the financial challenge and projected financial envelope, sets out our key priority areas of focus from a population and specialty perspective, and lays out a set of Commissioning Principles to inform the transformation of local services.

## PART 1: WHERE WE ARE TODAY

### 2 Our Local Population and their Needs

Based on ONS 2016 mid-year estimates, the population of North Somerset is approximately 212,000 (versus ~219,000 based on July 2017 GP Registered data) and is served by three Acute Trusts: Weston Area Hospital Trust (WAHT) in the south on the border with Somerset, and University Hospitals Bristol (UHB) and North Bristol Trust (NBT) in the north. Twenty-seven miles to the south of Weston General Hospital (WGH) lies Musgrove Park Hospital in Taunton, which is part of Taunton and Somerset NHS Foundation Trust (TSFT) and is commissioned by Somerset CCG. There is also a small community hospital and minor injuries unit (MIU) in Clevedon and another small community hospital and MIU at Burnham on Sea War Memorial Hospital, which lies just to the south of WGH. More detailed information on the local provider landscape, key challenges and service constraints can be found in Section 3.

Figure 1 below provides some key facts about North Somerset. Throughout this document and its appendices, we have used recognised data sources to describe the population, although different data sets (e.g. ONS and GP lists) are not always coterminous and samples taken from different points in time. Please see Appendix 1 for further information.

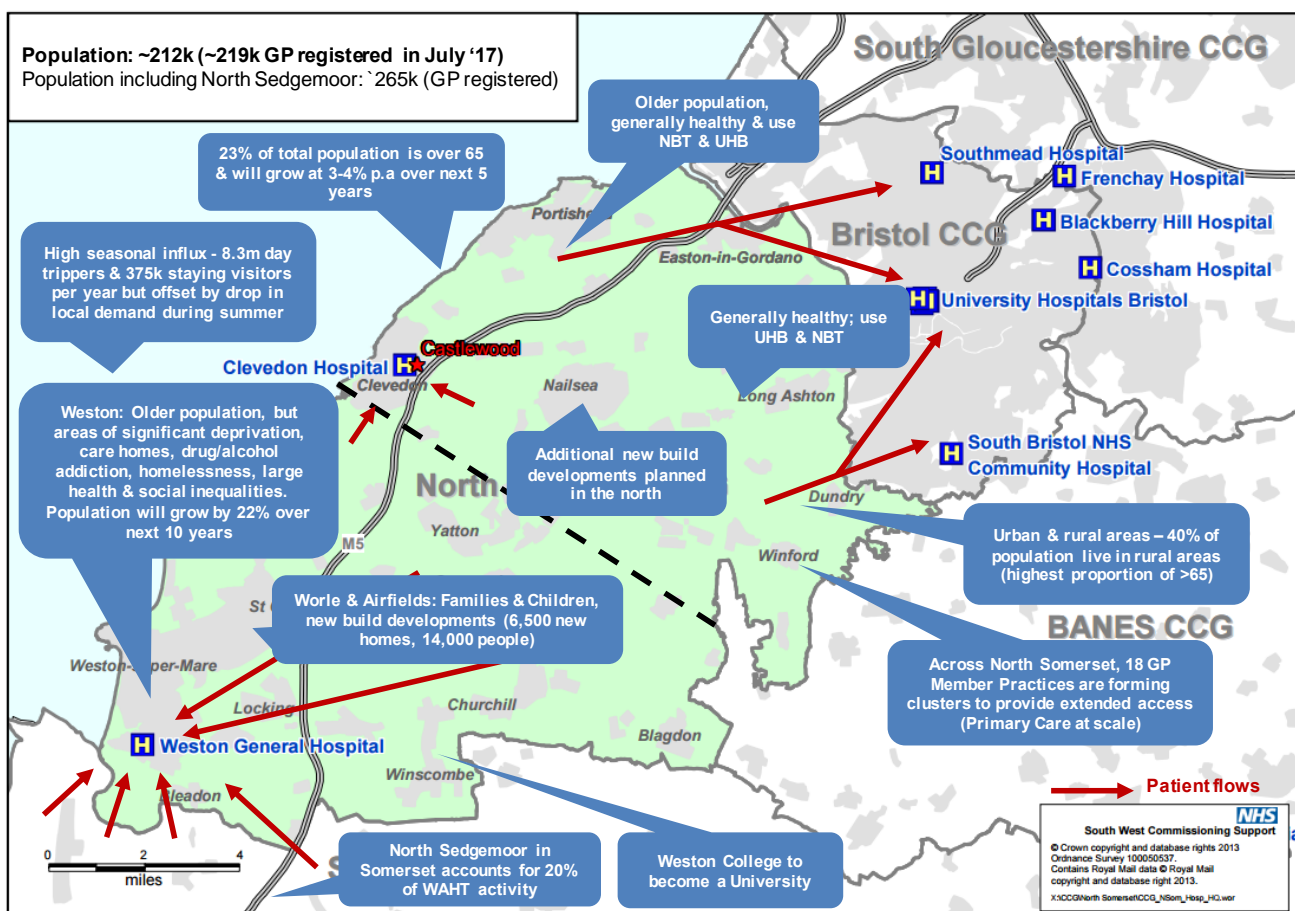


Figure 1: Key facts on North Somerset

Broadly speaking, there are two discrete health economies in North Somerset:

1. **The North** - the northern half of the patch has a total population of approximately 102,000 people centred around the towns of Clevedon (population: ~21,000), Nailsea (population ~15,500) and Portishead (population: ~22,500); and the top half of the GP locality known as 'the Rurals' (43,000). Residents of these areas tend to be healthier than residents in the south, and this population commonly look to UHB and NBT for their acute care needs.
2. **The South** - the south centres around the town of WsM; which according to 2015 ONS data has a population of ~81,200, the adjoining villages of Worle, Winscombe and the surrounding villages that make up the southern half of the Rurals locality (total population ~110,000); where residents typically look to WGH for their secondary care needs. WsM currently has an older demographic, with fewer young people under 20. However, this disguises some key differences across Wards, as South Ward has a younger demographic than the North Somerset average and 1-in-10 residents are from non-white backgrounds. The population of Worle, which lies on the north-eastern edge of WsM, is younger compared with the average for North Somerset, and has the lowest percentage of people aged over 65 and 85 years (17.7% and 2.4% respectively).

If specialised commissioning (currently commissioned by NHS England) is excluded, around 64% of secondary care activity for North Somerset residents living in the south is provided by WAHT (with the remainder largely provided by UHB, NBT and TSFT). This percentage reduces to 20% for those residents living in the north.

There is a third area known as North Sedgemoor, which lies to the south of WsM and is within the boundaries of Somerset CCG. North Sedgemoor has a GP registered population of ~48,000, which accounts for ~20% of WAHT activity. It is a bespoke local area defined for commissioning purposes, and this document references specific North Sedgemoor data wherever possible. It should be noted that Somerset CCG has been fully involved in the development of this Commissioning Context and are supportive of the direction of travel.

Whilst North Somerset and North Sedgemoor effectively form the catchment area for WAHT services, this area is geographically wide-spread, and a high proportion of residents travel to neighbouring hospitals for treatment. So, although the combined GP registered population is approximately 265,000, the effective population currently using WAHT services is estimated circa 160,000 to 180,000 (Source: WAHT commissioned GE Fynamore Report, 2016). In addition to the local population, WsM attracts 8 million day trippers and ~500,000 staying visitors<sup>5</sup> each year and in peak season; up to 10% of emergency department attendances are by out-of-area tourists.

Although WsM has an older population demographic, with pockets of significant deprivation and large health inequalities, it is in the process of undergoing an exciting and major transformation programme, with significant new build housing developments at Winterstoke Village and Parklands Village in Central Weston; many of which will be for younger families, with implications for local services including primary care, maternity and children's services. Weston College has recently been granted University status; and so the demographic and fabric of the town is likely to change over the coming years to accommodate the increase in student numbers. Additional new build developments are also expected near Nailsea, Yatton and Portishead and between Long Ashton and Bristol.

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<sup>5</sup><http://www.n-somerset.gov.uk/wp-content/uploads/2015/11/economic-impact-figures-2004-2014.pdf>



Across North Somerset, the 18 GP Member Practices<sup>6</sup> have formed into four distinct clusters (Weston, Worle, Gordano and the Rurals). A 'cluster' is a term used to describe a number of geographically close practices working together, to generate sufficient resilience and scale to be able to cope with the increasing demand for primary care services, and to work together in more integrated ways to provide more locally relevant services in the community and closer to home.

This change in the way primary care services are delivered is especially important in Weston, given the expected growth in population and where services are already stretched. There is no existing real estate within the Weston Village development for any community provision, and the surgeries surrounding the development area do not have the physical capacity to deliver the required services. Central WsM faces the challenges of both a growing population and an aging estate. To address these challenges, a number of practice groups in Weston have formed a new organisation / alliance to provide the organisational form that will support delivering services differently and at the scale required to make a difference.

The key challenges that we have identified from a population needs perspective are summarised below. Further analysis of population need can be found in Appendix 2:

- The long-term projections based on ONS data suggest the population of North Somerset (and North Sedgemoor) will increase over the next decade at an annual rate of 1% across all age groups. These figures take into account planned housing developments, and are the same figures used by North Somerset Council's Planning Department.
- However, estimates obtained from Hampshire Council's small area population forecast<sup>7</sup> service, which takes into account housing development, suggests growth in the Weston locality in the 10-year period from 2014-2024 will be 22% (i.e. 2.2% per year on average), compared to background growth across the whole of North Somerset of 13%.<sup>8</sup>
- The largest increase in population over the next ten years is set to be in the 75-84 age group (50% vs. 36% in England), followed by the over 85s (~46% vs. 42% in England).
- In respect of the younger age groups, the population is projected to rise in the 0-14 age group by ~12% (vs. ~8% in England), which equates to an additional ~4,000 children in total within the next 10 years.
- Life expectancy varies considerably across North Somerset. WsM Central Ward has the lowest life expectancy, where the respective figures are 67.5 years for males and 76 years for females. Conversely, Clevedon Yeo has the highest life expectancy for both males and females, at 86.1 years and 92.5 years respectively. A gap in male life expectancy therefore between these wards of 18.6 years; the equivalent gap for females in this example is 16.5 years.
- The main causes of the gap in life expectancy are circulatory diseases (such as coronary heart disease (CHD) and stroke), cancers and respiratory disease (COPD).

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<sup>6</sup> Note that further mergers are expected in the future.

<sup>7</sup> Hampshire Council. Small area population forecasts <http://www3.hants.gov.uk/factsandfigures/population-statistics/pop-estimates/small-area-pop-stats.htm>

<sup>8</sup> Comparisons between the towns of Weston-super-Mare and Bath are sometimes made in terms of population growth. The City of Bath has a population of around 89,000 and growing, compared to the WsM town population of between ~81,000 (based on 2015 ONS figures).

- Using data from Public Health England, it is estimated that 46% of male deaths and 36% of female deaths in the most deprived areas were considered 'excess'; in other words, these deaths would not have occurred if all areas in North Somerset had the same mortality profile as the least deprived areas<sup>9</sup>. Standardised Mortality Ratios range from 57% in Clevedon Yeo to 161% in Central Ward – much better and much worse than England respectively.
- The leading causes of premature mortality in North Somerset are circulatory diseases, respiratory diseases (COPD), cancer and liver disease. These are also the leading causes of premature mortality and years of life lost in North Sedgemoor.
- The potential years of life lost from treatment amenable cancers, i.e. cancers that could possibly be prevented through early detection and treatment (including breast, colorectal and skin cancer) in North Somerset, have been increasing and are above national figures. Treatment amenable cancers are now the primary cause of years of life lost from amenable causes in North Somerset, representing more than a third of total years of life lost.
- Across North Somerset, the leading causes of disability adjusted life years (DALY) lost are cancer (neoplasms), mental health and behavioural disorders, musculoskeletal conditions and cardiovascular disease.
- Compared with 2015, it is estimated that by 2030 in North Somerset, there will be over 1,700 more people living with CHD; around 750 more people will have had a stroke; over 10,000 more people will be living with hypertension; 6,000 more people will have diabetes; and around 6,000 people will be living with COPD.

### **Population summary**

As a result of the projected population growth rate across North Somerset; and in Weston in particular, coupled with the ageing profile of the local population, there will be a proportionally much greater rate of growth in people likely to need tailored and effective frailty services, including care home support and end of life care.

The growth in the numbers of children and young people is also significant and higher than the England average; and will therefore require proactive planning to ensure sufficient access to appropriate services.

Also, there are significant health inequalities in North Somerset, with the great majority of premature mortality and preventable morbidity centred around Weston. Therefore, in addition to developing new models of care to help address these inequalities, there is a need to be promoting healthier lifestyles and choices and specifically supporting the most vulnerable groups.

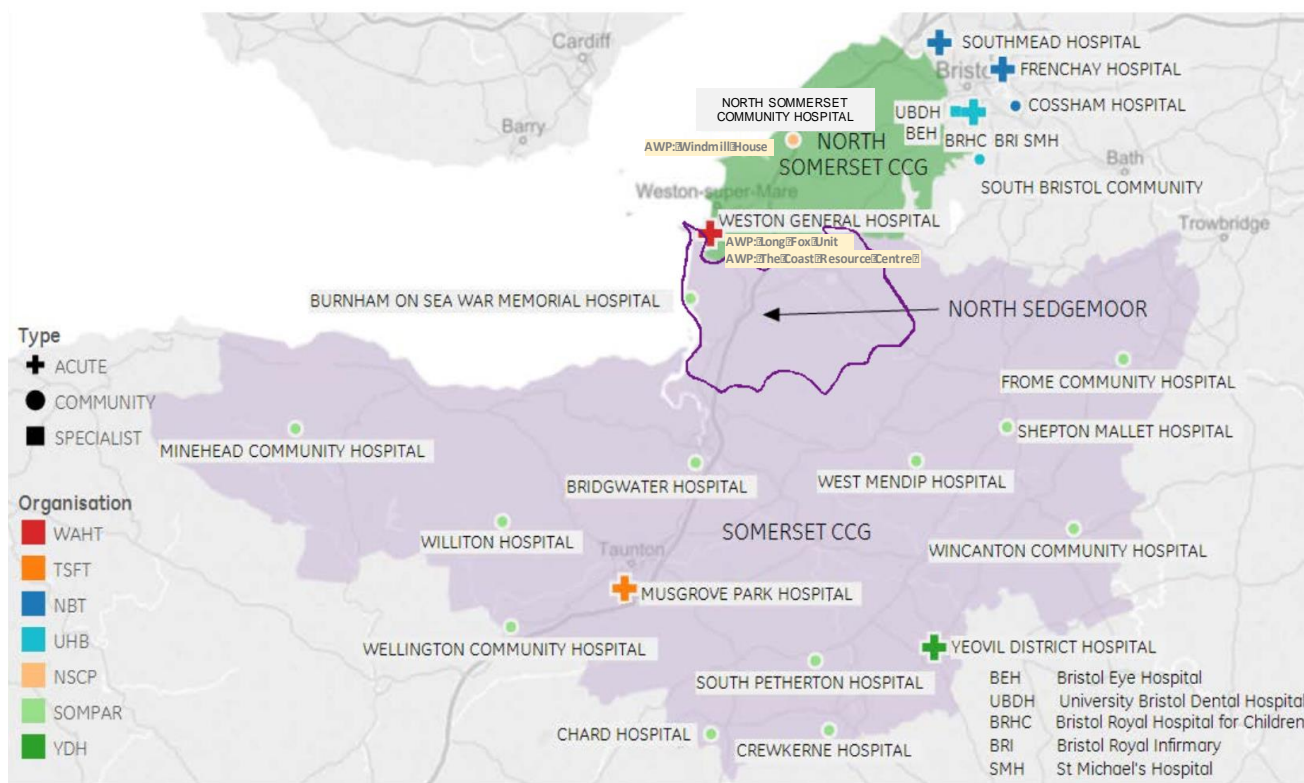
This situation, coupled with the imperative for reform of certain provider services, are some of the main reasons why BNSSG is focussing the work to reform services, and build a strengthened integrated community and acute care model in Weston as a priority.

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<sup>9</sup> Public Health England: Longer Lives data tool: Available from <http://healthierlives.phe.org.uk/topic/mortality>

### 3 Supply-side Analysis - local provider landscape & key challenges

Figure 2 below provides an overview of the local acute and community hospital landscape. The North Somerset CCG footprint is highlighted in green, whilst the Somerset CCG footprint is highlighted in purple. Hospitals in Bristol are also shown for reference.



**Figure 2: Acute and community hospitals in North Somerset, Bristol & Somerset**

Our detailed analysis of the supply side situation, can be found in Appendix 3. It provides a set of short summaries of current service provision arrangements, overviews of current quality and performance against targets, and service delivery challenges (including workforce & capacity constraints) for key providers in North Somerset.

The key local providers include:

- **The local BNSSG Acute Trusts** - WAHT, UHB and NBT.
- **The Ambulance Service** - South Western Ambulance Service Foundation Trust (SWASFT).
- **Primary Care (General Practice).**
- **Primary Care (Out of Hours)** – BrisDoc Healthcare Services.
- **Community Services** – North Somerset Community Partnership (NSCP).
- **NHS 111** - (Urgent care by phone) – Care UK.
- **Mental Health** – Avon & Wiltshire Mental Health Partnership NHS Trust (AWP).
- **Musgrove Park Hospital** - Taunton and Somerset NHS Foundation Trust (TSFT).
- **Local Authority** - North Somerset Council.
- **Voluntary Sector** – Various local providers and services.

The key supply-side challenges that have been identified are summarised as follows:

- The supply side issues at WAHT are well understood locally; with challenges to clinical recruitment and retention in specific specialities (e.g. emergency medicine, acute medicine and gynaecology) creating long standing difficulties in providing the full range of services that have been historically delivered.
- In primary care, the recruitment and retention of GPs and other primary care clinicians such as nurses, is also a challenge (both in North Somerset and nationally) for both local practices and the out-of-hours provider. The primary care workforce is ageing with ~28% of local GPs and ~41% of primary care nurses aged over 55 and approaching retirement age. In addition to increased GP recruitment, and more collaborative working arrangements across GP Practices, alternative workforce models and the greater use of new and innovative roles are required to help address the gap. Refer to Section 11 for further information.
- Recruitment and retention is also a common issue across other providers and other local workforces: NSCP has challenges with regards to community nursing roles in specific localities and some specialist clinical roles such as community matrons. AWP also face challenges around clinical recruitment; particularly with regards to staffing on acute mental health in-patient wards. SWASFT has specific challenges with the recruitment and retention of specialist paramedics, paramedics and clinical hub call takers and clinicians. Many care homes have inadequate staffing levels and inappropriate skill mixes to meet resident's nursing and care needs; and domiciliary services also struggle to retain staff.
- There are some specific estates challenges in the primary care sector (e.g. ageing estate), particularly in the Central Weston areas, as well as a potential imbalance of provision as the population expands in certain parts of the patch – particularly Weston Villages.
- There is an imbalance between demand and capacity for planned surgery at NBT. This has necessitated sending significant numbers of patients with non-complex elective needs to services outside of the NHS. There are opportunities to repatriate some of this activity to WGH as part of a revised acute model, as the hospital has recently refurbished its theatres with Laminar Flow capability.

### **Supply-side summary**

With regards to the supply side issues at WAHT, there is consensus amongst the North Somerset Sustainability Board that there is no “stand alone” solution for WAHT, hence the developing Partnership Agreement with UHB, the need for broader acute care collaboration with NBT, and the need to work in a more integrated way with the wider community system.

The CCG also believes that by bringing together disparate and fragmented services into a more integrated model of care; using the provider workforce across settings; involving a greater mix of skills (for example support from volunteers and non-professional staff to free up clinical capacity); and eliminating duplication (including sharing of back office functions and the use of trusted assessor models); many of the recruitment and workforce challenges above could be addressed by optimising the use of resources across the system.

The ability to move more flexibly across provider settings and organisational boundaries is also an attractive proposition for staff who would be able to get a much greater exposure to different aspects of the system without necessarily having to move employer.

## 4 The Financial Challenge

### 4.1 The Financial Gap 2017-2021

Over the next 4 years, the BNSSG health community as a whole faces the major financial challenge of recovering a substantial financial deficit and building a resilient and affordable health and care system for the future within the increasingly tight constraints on NHS funding. The only solution to this challenge is to transform the way healthcare services are organised and delivered.

The BNSSG community as a whole, including acute and primary care providers, has had difficulty containing expenditure within available resources for a number of years, over which time the underlying deficits in the system have been growing.

Based on current income and growth projections, the underlying BNSSG system deficit (which includes provider organisations) is expected to be, before any corrective action is taken, in excess of £300m by 2020/21. The current BNSSG System Transformation Plan (STP) has identified savings plans, but even if these are fully delivered, there remains an unfunded gap of £100m. North Somerset Council has seen year-on-year reductions in government funding, with particular pressures on budgets for social care which have been significantly over-spent in recent years.

In North Somerset, successive commissioners have been unable to contain expenditure within their allocated funding, while the gap between local acute provider costs and tariff income has continued to increase. The CCG carried an underlying deficit of £13.3m into 2017/18, which based on current income and growth projections and before any corrective action, is expected to rise to more than £40m by 2021. North Somerset CCG is also carrying a £25.3m cumulative deficit which will need to be repaid in the future.

Projected population growth in North Somerset of 1% each year equates to a cost increase closer to 2% each year, as the largest increase is in the population aged over 75 who are the highest users of healthcare services. Demographic growth of 1% per annum will therefore add some £5m-£6m of cost each year.

To be financially sustainable, North Somerset CCG needs to not only plan for demographic growth, but also to create sufficient financial headroom to ensure future resilience. NHS business rules expect commissioners to have at least 2.5% of funding uncommitted at the start of each year, of which 0.5% must be available to support the wider NHS system and to plan for an annual surplus of 1%.

In recent years, commissioners have also become increasingly exposed to external service pressures, largely generated by national policy imperatives which do not carry additional funding (e.g. Funded Nursing Care rates, changes to tariff and taking on additional unfunded commissioning responsibilities). Based on recent experience, commissioner plans should allow a further 1% headroom to meet continuing pressure from this source. The overall cost of providing this headroom is circa £4m per annum.

When headroom and debt repayment are factored into demographic growth projections, the CCG's income and expenditure gap before any corrective action, is expected to reach the £40m mark by 2021. Figure 3 below shows the CCG's overall financial gap associated with funding projected growth and providing the CCG with financial resilience.

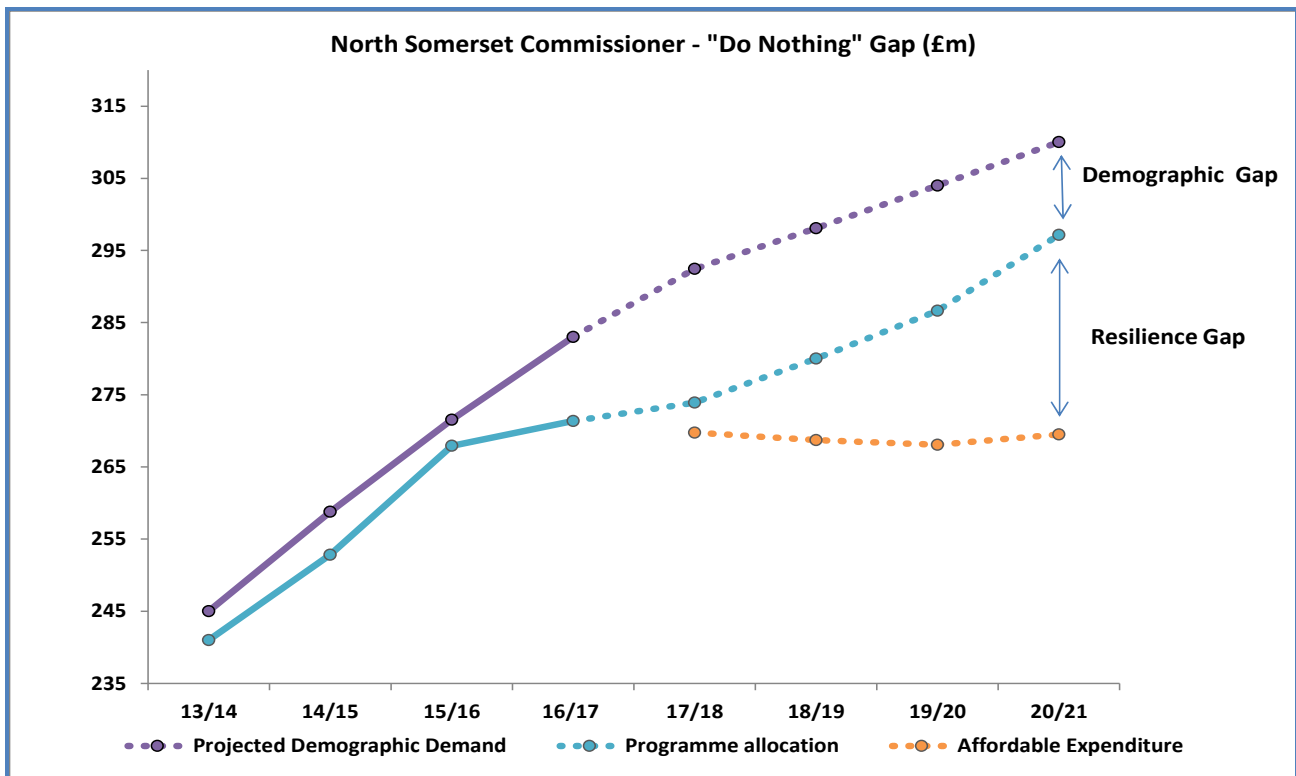


Figure 3: North Somerset CCG “do nothing” financial gap 2017-2021

Previous efforts to bring the system into financial balance have failed, largely because they were unable to overcome the structural and behavioural barriers to achieving savings at the scale and pace required. Recent developments in the local health and care system, including closer commissioner collaboration and an emerging system wide approach to transforming services, are beginning to successfully break down these barriers, but the system needs to go further and faster.

## 4.2 Affordable Services 2017-2021

### 4.2.1 Affordable spend 2017-2021

Figure 4 below indicates the level of affordable service expenditure for North Somerset CCG which is compatible with longer term financial resilience, moves the CCG from an underlying deficit of £13.3m to a 1% surplus, and starts to repay the cumulative deficit.

1% headroom is provided under NHS rules which consists of 0.5% available for non-recurrent use by the CCG and 0.5% to support the wider NHS system subject to NHSE direction. In line with NHS business rules, a 0.5% contingency is provided each year with a further 1% available to meet unfunded service pressures as required.

After providing for headroom, debt repayment and an annual surplus, funding of £269m-£270m is available to support service expenditure plans in each year. In effect, the CCG needs to reduce expenditure from £284m in 2016/17 to £269m-£270m and plan to hold expenditure at this level up to 2021. 1% will be available to meet unfunded service pressures as required, but should not be assumed in initial plans.

	Actual	Projected			
	16/17 £m	17/18 £m	18/19 £m	19/20 £m	20/21 £m
Programme Allocation	270.30	273.9	280.0	286.7	297.1
<b>Less:</b>					
1.0% headroom		2.8	2.8	2.8	2.8
0.5% contingency		1.4	2.8	4.3	5.9
1.0% unfunded service pressures		0.0	2.8	5.7	8.9
Surplus/Deficit	13.30	0.0	0.0	2.9	3.0
Repayment of cumulative deficit		0.0	2.9	2.9	7.0
<b>Service expenditure</b>	<b>284.00</b>	<b>269.8</b>	<b>268.7</b>	<b>268.0</b>	<b>269.5</b>

Figure 4: Affordable expenditure for North Somerset CCG (2017-2021)

Figure 5 below shows projected “do nothing” increase in costs over the 4 years to 2020/21 compared with the growth in funding over the same period. A “do nothing” deficit of £22.7m in 2017/18 increases to £40.5m by 2021 based on building financial resilience as described above and allowing for annual growth rate in cost of 2% per annum.

	Actual	Projected			
	16/17 £m	17/18 £m	18/19 £m	19/20 £m	20/21 £m
Baseline 2016/17	284.0	284.0	284.0	284.0	284.0
1.0% headroom		2.8	2.8	2.8	2.8
0.5% contingency		1.4	2.8	4.3	5.9
1.0% unfunded service pressures		0.0	2.8	5.7	8.9
Surplus/Deficit		0.0	2.9	2.9	3.0
Repayment of cumulative deficit		0.0	0.0	2.9	7.0
Demographic growth 2%		5.8	11.5	17.4	23.4
Non-demographic growth		2.6	2.6	2.6	2.6
<b>Total projected demand</b>	<b>284.0</b>	<b>296.6</b>	<b>309.4</b>	<b>322.6</b>	<b>337.7</b>
Funding	270.7	273.9	280.0	286.7	297.1
Surplus/(Deficit)	(13.3)	(22.7)	(29.4)	(36.0)	(40.5)
<b>Annual increase in deficit</b>		<b>(9.4)</b>	<b>(6.7)</b>	<b>(6.6)</b>	<b>(4.6)</b>

Figure 5: Comparison of affordable expenditure with projected demographic growth impact to 2020/21

#### 4.2.2 Affordable spend at locality level 2017-2021

As described in Section 2, the North Somerset area falls broadly into two discrete health economies: one in the north looking to Bristol (UHB & NBT) for acute hospital services and one in the south looking to Weston (WAHT). Each area also falls broadly into three geographical localities based around General Practice populations (note that these locality definitions vary slightly from the definition of GP Practice localities in use today). Figure 6 below shows how funding to support the affordable expenditure described above might be distributed across the local health economy based on relative health need. This distribution would form the basis of funding provider catchment areas and provide the basis for a capitated payment model as described in Part 3 of this document.

The distribution is based on the registered practice populations weighted for health need, which are used in the national formula to set CCG funding targets (which takes into account factors such as deprivation). Comparison of capitation shares with 2016/17 actual expenditure shows a significant reduction in expenditure, falling more heavily on the south than the north.

Locality	Outturn	Affordable Service Expenditure			
		2016/17 £m	2017/18 £m	2018/19 £m	2019/20 £m
Gordano	38.8	38.7	38.5	38.5	38.7
Tyntesfield	37.3	35.9	35.8	35.7	35.9
Clevedon	31.5	29.6	29.5	29.4	29.6
<b>North</b>	<b>107.6</b>	<b>104.2</b>	<b>103.8</b>	<b>103.6</b>	<b>104.1</b>
Worle	46.7	41.9	41.8	41.7	41.9
Rural South	39.1	38.8	38.7	38.6	38.8
Weston	90.6	84.8	84.5	84.3	84.7
<b>South</b>	<b>176.4</b>	<b>165.5</b>	<b>164.9</b>	<b>164.5</b>	<b>165.4</b>
<b>Total</b>	<b>284.0</b>	<b>269.8</b>	<b>268.7</b>	<b>268.1</b>	<b>269.5</b>

Figure 6: Allocation of available resources to localities.

#### 4.2.3 Affordable spend at provider level 2017-2021

Figure 7 below shows how the allocation of affordable expenditure to CCGs in Figure 4 would flow into provider baselines. The allocation is based on the 2017/18 planned expenditure profile and no change in 2016/17 patient flows compared with CCG 2016/17 expenditure.

The total for each provider is indicative of the funding that would be available to support services in the current catchment population under a capitated funding model.

Affordable Expenditure 2017/18 Allocated to Providers								
Provider	2016/17 Outturn	Clevedon	Gordano	Tyntesfield	Rural South	Weston	Worle	Total
	£m	£m	£m	£m	£m	£m	£m	£m
Weston	68.8	4.5	1.3	1.6	10.4	29.6	15.5	62.9
UHB	42.6	3.7	6.5	11.7	5.2	7.5	4.6	39.2
NBT	34.1	6.0	12.8	5.0	3.0	3.8	2.3	32.9
ISTC	5.8	0.4	0.6	0.5	0.5	0.6	0.6	3.1
AWP	17.0	1.8	2.0	1.8	2.1	7.0	2.4	17.0
NSCP	24.6	2.6	3.6	3.3	4.1	7.5	3.5	24.6
Reserves	0.0	0.4	0.6	0.5	0.7	1.3	0.6	4.2
Other	91.1	9.9	11.3	11.4	13.5	27.5	12.3	86.0
<b>Total</b>	<b>284.0</b>	<b>29.2</b>	<b>38.7</b>	<b>35.9</b>	<b>39.5</b>	<b>84.7</b>	<b>41.8</b>	<b>269.8</b>

Figure 7: Allocation of available resources to locality and providers based on 2017-18 plan



### 4.3 Current Spending: factors that are driving the CCG deficit

Current spending patterns in North Somerset are characterised by a number of features which have contributed over time to the CCG's deficit and made it more difficult to achieve financial balance including:

- Lack of financial resilience.
- Over reliance on acute hospitals.
- Fragmented provision.
- Fragmented commissioning.
- Dis-economies of scale.
- Imported costs.

#### 4.3.1 Lack of Financial Resilience:

North Somerset inherited a £11.7m underlying deficit in 2013/14. Over the following 3 years, £34m of above average growth funding was fully committed each year while total CCG expenditure over this period increased by £37.6m, leaving no financial flexibility to manage a series of substantial and unexpected cost pressures in 2016/17 and making no inroads into the deficit. As a result, an underlying deficit of £13.3m and a cumulative deficit of £25.3m were carried into 2017/18.

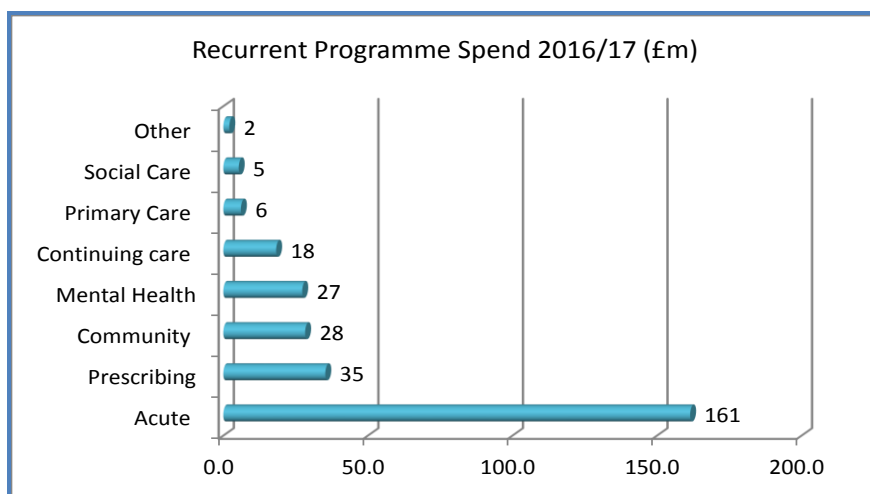
#### 4.3.2 Over reliance on Acute Hospitals

The allocation of CCG resources to individual programmes in Figure 8 below shows 57% of funding allocated to acute care.

Comparison of programme budget spend across CCGs is made difficult by the inconsistency in the reporting of spend against individual programmes and the lack of robust benchmarking data for non-acute services. However, the comparisons that are available all indicate, to varying degrees, above average spend on acute hospital care in North Somerset.

Comparisons include:

- **National programme spend 2014/15:** Acute spend accounts for 57.3% of total spend in North Somerset compared with 52.9% nationally amounting to £11.6m of additional acute spend locally.
- **Comparison with commissioning for value peer CCGs 2016/17:** Acute spend per weighted capita is 7%-9% higher than peer average amounting to additional acute spend locally of £9.7m - £13.6m when compared with Commissioning for Value top 10 peers.
- **RightCare Opportunities 2016/17:** The potential reduction in acute expenditure from a reduction in admissions only totals £9.9m.



**Figure 8: Programme spend 2016/17**

Although varying in degree, all three comparators indicate above average expenditure in the acute sector ranging from £9.7m to £13.6m which equates to a reduction in 2016/17 acute spend of 6%-8%.

Local analysis of activity covered by the Payments by Results (PbR) tariff, indicates that much of the additional cost is related to higher unit costs rather than higher overall volumes of demand driven activity.

Benchmarking of non-acute services, mental health and community and continuing care, is more problematic because of a lack of standardisation in the reporting against individual programmes. A high level comparison of 2016/17 reported spend by our 10 commissioning for value peers indicates higher acute spend as described above, but also indicates higher levels of spend on mental health /community services offset by an underspend on continuing healthcare (CHC). A more detailed comparison would need to be conducted with each individual CCG. Individual placements, often high cost, are variously reported as community, mental health or CHC so drawing conclusions around individual programmes may be misleading. Overall the CCG spend per capita on these three areas was 2% higher than peers equating to some £1.8m of additional cost per annum.

Whilst all the indicators point to over use of acute services, the 2016/17 comparison with peers suggests that there are also inefficiencies in non-acute services, albeit on a smaller scale, that should be taken into account in the funding of any service reconfiguration.

Further benchmarking detail is provided at Appendix 4.

### 4.3.3 Fragmented Provision

Whilst the northern half of North Somerset looks broadly to UHB and NBT for acute services, and the southern part looks to WAHT, there is a significant flow from Clevedon to Weston. All localities look to UHB and NBT for more complex care. Whilst the south looks to WGH for urgent care, the north has access to an MIU service in Clevedon. In addition, patients have access to 5-6 independent sector providers for elective care. All adult patients look to AWP and NSCP for mental health and community services respectively, whilst WAHT provide children's community services including CAMHS and community paediatrics.

The number of organisations not only adds to the complexity of managing contracts and controlling costs, but also allows patients to “bounce” around the system leading to unnecessary duplication and increased cost. Whilst commissioning from a number of organisations, North Somerset is the lead commissioner only for WAHT and North Somerset Community Partnership (NSCP). This has historically reduced the influence that the CCG has been able to exert over the full range of commissioned services.

#### **4.3.4 Fragmented Commissioning**

The financial gap described above only relates to CCG commissioned services and excludes specialised commissioning and primary care provider costs. However, the fragmentation of commissioning since 2013/14 has made it more difficult for individual commissioners to manage commissioning costs across BNSSG prior to the engagement of all commissioners in the STP process.

#### **4.3.5 Diseconomies of Scale**

WAHT is the main acute provider for North Somerset providing 46% all non-specialised acute services delivered locally, but is also one of the smallest acute hospitals in the country making it extremely challenging to deliver the economies of scale achieved by larger hospitals, and upon which national payment tariff assumptions are based for all providers. Consequently, the commissioner is currently paying a premium each year to subsidise the current configuration of services on this site, most notably A&E and critical care services. Similarly NSCP, as a small community provider, will struggle to achieve the same economies of scale as their larger counterparts. As one of the largest mental health providers in the south west, AWP brings advantages in terms of economies of scale.

#### **4.3.6 Imported Costs**

The number of care homes in North Somerset providing care mainly for older patients with multiple morbidities and clients with learning difficulties, is one of the highest in the country attracting clients from out of area, who then become the responsibility of the North Somerset commissioner for both funded nursing care and for health services more generally. There is also a significant inflow of patients with alcohol and drug related mental health needs, in large part due to the high number of residential treatment facilities concentrated in Weston. Many of these patients subsequently stay in the local area following treatment.

### **4.4 Closing the Financial Gap (2017-2021)**

#### **4.4.1 Overview**

North Somerset CCG’s funding gap of ~£41m over the 4 years to 2021 is made up of:

- The current £13.3m underlying deficit brought forward from 2016/17.
- Additional £9.7m of unfunded costs in 2017/18.
- Additional unfunded costs of £17.8m from 2018/19 and 2020/21.

#### 4.4.2 Closing the current financial gap (2017/18)

The 2017/18 financial gap of £22.7m is being addressed through the Turnaround process which is required to deliver an £82.3m saving after growth across BNSSG to meet the control total of £8m set by NHSE. Delivery is now being managed and measured on a BNSSG wide basis.

The North Somerset element of the BNSSG financial plan includes savings of £20.7m to be delivered in 2017/18 with a full year effect of £27m in 2018/19. The full year planned reduction in expenditure includes £19.3m (acute), £4.4m (non-acute) £2.8m (prescribing) and £0.4m (running costs). Most of the planned savings will impact on local provider income and require significant reductions in the provider cost base across North Somerset.

Comparison with peer spend in 2016/17 indicates that most, if not all, of the £20.7m savings target for 2017/18 could be met by matching current peer performance.

#### 4.4.3 Closing the future financial gap (2018/9-2020/21)

To close the future financial gap, North Somerset will need to look beyond matching current best performance to meeting the challenging ambitions set out in the 5 Year Forward View. Over the next 5-10 years, the main pressures on services in North Somerset are expected to come from:

- A significant increase in the number of frail and older people over age 75.
- An expected increase in the demand on children’s services in the south.
- Better meeting the needs of vulnerable groups within the population.

Based on the above assessment of what is affordable, the local system needs to work together to design and deliver a new model of care that better meets the needs of the local population within the available financial allocation. All providers will need to play their part, and hard choices will need to be made.

The population aged 75 or over currently accounts for 30% of all admissions, 60% of beds and 40% of admitted patient costs. The rate of hospital admission increases significantly with age so that 1 in 3 people aged over 85 were admitted to hospital as an emergency in 2016/17 compared with 1 in 13 aged 65-74.

By far the largest pressure on services and costs is expected to come from growth in the older population living longer with long term conditions and increasing frailty. Figure 9 below shows the expected population growth from 2017/18 to 2020/21. Whilst the population aged 65 or over is expected to increase by less than 1%, the over 75 population is expected to grow by 14% to 16% over the period. Translated into absolute numbers, this represents an estimated increase of 3,522 adults over the age of 75.

Age Group	Population Increase	North	South	% Growth
65-74	154	66	88	0.6%
75-84	2489	1090	1400	15.8%
>85	1033	445	588	14.4%
<b>Total</b>	<b>3676</b>	<b>1601</b>	<b>2076</b>	<b>7.4%</b>

**Figure 9: Population growth to 2021(Source: ONS projections applied to Registered Population of North Somerset over 4 year period (2017/18 to 2020/21)**

The impact of projected growth in the older population is illustrated in Figure 10 below. Overall, this represents an additional 20 hospital beds based on current lengths of stay with an estimated £2m increase in cost related to emergency admissions alone. If this is projected into the future, an additional 65 beds would be required over the next 10 years. Even if we could afford the beds there may be insufficient clinical staff to service them.

Other costs related to elective admissions, outpatient attendances, community nursing and therapies, continuing and dementia care provision as well as GP prescribing, will put further pressure on an already unaffordable health system.

Age	Population Growth	Emergency Admission Rate 2016/17	Projected Increase in Emergency Admissions	Projected Increase in Beds	Projected Increase in Costs £000s
65-74	154	7.7%	12	0.3	98
75-84	2489	15.7%	390	9.4	1,176
>85	1033	31.7%	328	10.0	1,058
	<b>3676</b>		<b>730</b>	<b>19.6</b>	<b>2,234</b>

**Figure 10: Impact of population increases on activity and costs to 2021**

Whilst hospital admission rates for the older population in North Somerset are currently among the lowest in the south, they are almost certainly not sustainable into the future in the context of reduced funding and constrained capacity. Therefore, we need to focus our efforts and resources in supporting people to stay well and out of hospital wherever possible. We also need to work together to reduce the length of time people who are admitted to hospital stay. North Somerset residents currently spend longer in hospital (for both elective and non-elective spells) than residents in comparable CCG areas.

## 4.5 Summary

In summary, to achieve an affordable and sustainable service model for the North Somerset population, it will necessitate a radical transformation of the way in which health and care services are provided for local people. This will mean:

- A significant reduction in both commissioner spend and therefore provider income.
- Developing service models and provider configurations that address the weaknesses in the current system.
- Developing contracting models that are fit for purpose and incentivise both commissioners and providers to reduce costs and allow the money to follow the patient. This will help incentivise the movement of resource around the system where it can have the greatest impact for patients.
- Committing commissioner resources to building financial resilience and the non-recurrent flexibility to support transition costs.
- More “place” based commissioning cutting across organisational boundaries.
- Maximising the opportunities afforded by the Resilience, Transformation, and Improved Access allocations from the GP Forward View (GPFV) funding.

## 5 Commissioning Principles

To underpin the development of this Commissioning Context, a set of Commissioning Principles were produced which have been tested and refined with local partner organisations.

These principles are as follows:

1. **Driven by a systematic and evidence based assessment of population and patient need** – the Commissioning Context should be driven by the needs of the local population (both physical and mental health) and conclusions drawn from a thorough analysis of the data as opposed to organisational interest.
2. **Be commissioned at a scale that maximises the most effective use of resources** to deliver the required outcomes and to enable providers to develop workable systems of care - suggested to be at least 100k population.
3. **“Do Nothing” is not an option** – given the financial position of the CCG and the wider BNSSG system, “Do Nothing” is simply not an option. The CCG must go well beyond the current in-year financial recovery plan to achieve longer term clinical and financial sustainability across the health and care system.

What this means in practical terms in North Somerset is:

- Sustainable primary care and other constituent community organisations.
  - A sustainable Acute Trust that is ‘right sized’, and doing the work that only it can do.
  - Acknowledging and accepting the inescapable constraints of funding and staff shortages in some key areas and re-designing services accordingly.
  - A willingness of all providers and stakeholders to change the current model of care.
4. **Focus on the few priority areas where change is potentially most impactful** – we must focus scarce resources on those priority areas that will have the most impact from both a health outcomes and financial perspective. These priorities are based on a review of local population need and an analysis of local spending patterns benchmarked against the CCG’s local and national peers (RightCare packs and associated analysis).
  5. **A balance between community care and secondary care** – as described in Section 7, the vision for local services is built on the creation of an organised, coordinated and effective community provider environment that is seen as the main conduit for meeting a person’s health and care needs. Within this vision, the community provider environment will work equally with high quality, specialist services in the main Acute Trusts, to develop seamless cross system pathways, build clinical networks and share expertise and advice to the ultimate benefit of patients.

Figure 11 below summarises the spectrum of options that providers will need to consider to realise the vision of moving from an acute dominated, reactive service to a more balanced system blending both community and acute services.

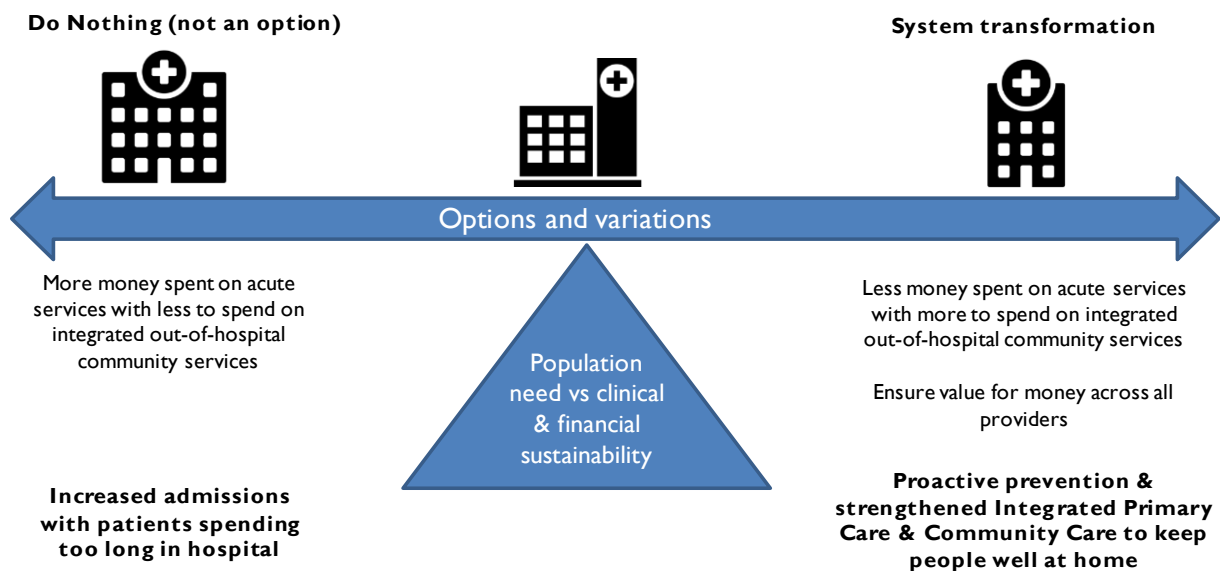


Figure 11: Rebalancing the system

6. **Greater cohesion and partnering across the community setting** – the vision is for General Practice to be at the very heart of the community system. This will involve:
  - Cluster-based working of GPs, coordinating patient care across the system.
  - Strong GP leadership to build an integrated primary & community capability.
  - Providers spanning multiple settings of care.
7. **Greater collaboration across Acute Trusts** – working under the guidance of the Acute Care Collaboration workstream of the STP and further enabled by greater partnership working between UHB and WAHT and collaboration with NBT.
8. **Greater involvement of the Voluntary Sector** in the provision of local services.
9. **Maximise the use of technology and encourage and respond to patient and public digital literacy.**
10. All parts of the system, with the aid of the Voluntary Sector, actively supporting **self-care and health promotion** to keep more people safe and well at home.
11. Integration of **mental and physical** wellbeing at all levels and settings of care.
12. **Maximise the use of the existing estate** – the aim is to make best use of existing assets, including working with partners through initiatives such as One Public Estate where it is appropriate to do so. It makes financial sense to make best use of the assets we already have before looking to build new facilities to support the development of the community system. We should explore opportunities for co-location with partners, which could free up redundant estate for re-development – providing that long term revenue requirements can be met. The CCG is already leading a piece of work to assess the strategic estate options for primary care in Weston. However, it is expected that further work will be required to look at a broader range of strategic options to consolidate and optimise the use of provider and local authority owned estates.

## 6 Priority Areas of Focus

When considering the current population need in North Somerset as set out Section 2, we can see rising demand driven by age demographics, more people living with long term conditions and general population growth.

As set out in Section 4, the CCG is spending more per head of population than similar areas elsewhere in the country. This is compounded by supply side capacity constraints driven largely by staffing pressures across the system and rising costs of provision that are outstripping the level of funding available. Whilst this picture would be familiar to many health systems across England there are a number of key drivers impacting North Somerset and Weston in particular (refer to Section 1.6), that require a materially different response.

At the same time, the North Somerset Sustainability Board is agreed that some services delivered at WGH are not clinically or financially sustainable and are therefore in need of reform. While the Partnership Agreement between WAHT and UHB will help to improve the resilience and delivery of some aspects of service, overall there is a need for significant service transformation and whole system working to develop a new, more sustainable model of care that better meets the needs of the local population.

In developing this Commissioning Context, the local system came together in a series of workshops to review the population need, the demand for services, patient outcomes, service constraints, current spend and future need, and used this information and data to identify a number of key priority areas of focus where the need for service transformation is most urgent. The three key priority population groups that were identified are:

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

Appendix 5 summarises the data and analysis behind the identification of these priority population groups. The local system also identified the following key specialities as priorities:

- **Urgent & Emergency Care** (including Emergency Surgery)
- **Planned Care**
- **Cancer**
- **Stroke**
- **Liver Disease**
- **Musculo-skeletal conditions (MSK)**
- **Dementia**
- **Maternity**
- **Critical Care**
- **Mental Health**
- **Circulatory Disease**
- **Respiratory (COPD)**
- **Frailty**
- **Diabetes**
- **End of Life**

Appendix 6 summarises the data and analysis behind the identification of these priority specialty groups, which has also been tested with a range of stakeholders during this work.



## PART 2: VISION FOR LOCAL SERVICES

### 7 A New Model of Care for Weston

The North Somerset health and care system is currently on a journey to shift the balance from a fragmented and dis-jointed out-of-hospital community provider environment, with minimal focus on proactive health management, to a model where the broader community based system and the secondary care system are more in-balance and working together in a more integrated and cohesive way, with strong central leadership and a focus on proactive health management across the entire system.

#### We're on a journey to shift the balance

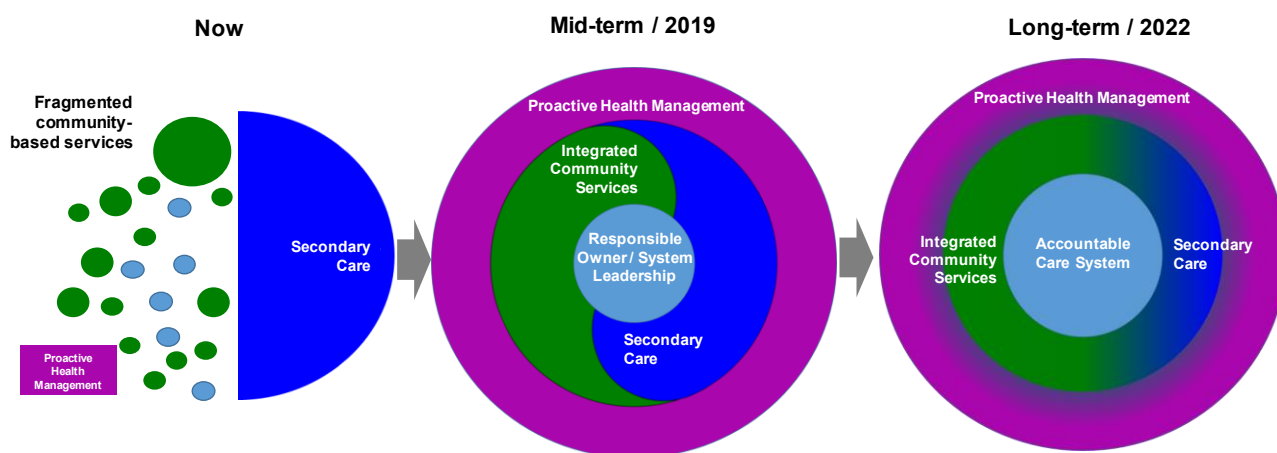


Figure 12: Shifting the balance

Over the next two years, the CCG, working in close collaboration with local providers, key stakeholders, service users and the public, will deliver a new and innovative model of care for the local population in Weston that will transform the way services are delivered and provide a framework for other areas across BNSSG.

This new and innovative model of care will not only be designed to better meet the needs of the local population, but it will also help to address the significant clinical and financial sustainability challenges that the CCG, and the system as a whole, currently faces.

The new model of care will also provide a better, and more cohesive, way of working for the local workforce by providing exciting and more varied job opportunities, including a stronger role for the voluntary sector, through the creation of new roles and the ability to work more fluidly across organisational boundaries.

At a summary level, the new model of care consists of three integrated elements as summarised below:

- **Primary Care (General Practice) working at scale & providing strong system leadership** – GP Practices working more collaboratively in locality based ‘clusters’ to improve practice resilience, deliver improved access to a broader range of services, and benefit from improved economies of scale. Cluster-based working will provide a stronger platform on which to deliver a more integrated community services model as summarised below. This includes exploring opportunities to make the most of the opportunities for integration and co-location offered by the One Public Estate Programme.
- **Stronger, more integrated community services supported by a ‘Care Campus’ model at the WGH site** - this will include the creation of a more integrated and multi-disciplinary community-based service model wrapped around clusters of local GP Practices and will develop the WGH site into an integrated ‘Care Campus’ with a co-located primary care led Community Hub providing integrated primary, community and acute services supported by a revised and more integrated acute care model.
- **A stronger, more focused Acute Trust and acute care model at WGH** – this will deliver a revised set of acute services to better meet the needs of the local population. This new acute care model will be delivered by working in closer collaboration with other Acute Trusts across BNSSG as part of a wider Acute Trust Network and will integrate closely with the co-located Primary Care led Community Hub.

These key elements of the new model of care are closely aligned with the BNSSG STP vision as shown in Figure 13 below.

The STP’s vision is to deliver ‘whole system’ integrated service delivery covering a geographical area providing high quality, affordable, community care. This includes prevention and self-care, providing alternatives to A&E and hospital admission, supporting hospital discharge and keeping patients well at home, as well as general medical services in and out-of-hours, covering seven days a week.

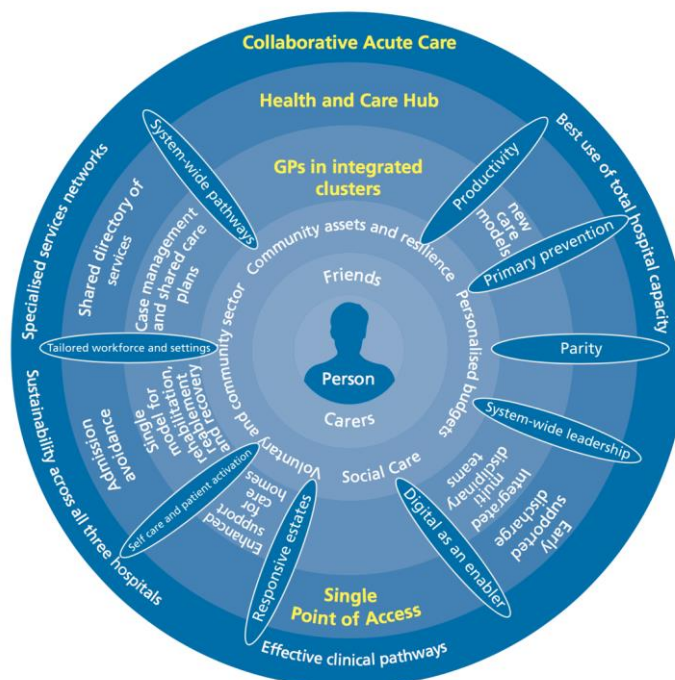


Figure 13: BNSSG STP vision for integrated delivery

In thinking about how this new model of care will address the needs of the three identified priority groups, this will mean:

- **Frail and older people:** a re-balanced system, with the Weston 'Care Campus' at its heart, will provide both proactive and reactive services to a clearly defined group of patients to keep them well and at home, with more of the services they need provided locally with less need to travel long distances out of area. If an individual is appropriately admitted to a hospital bed, the system will react quickly to pull them through the hospital system and will provide excellent rehabilitation and support services to help them get home as soon as possible.
- **Children, young people and pregnant women:** a more resilient integrated community and acute paediatric service will be able to offer more expert support and advice to the local urgent care system and address issues such as capacity and waiting times with an improved and more attractive service model, that is better able to recruit and retain expert staff; a comprehensive and appropriate maternity service that most efficiently meets the needs of the local population.
- **Vulnerable groups:** the 'Care Campus' approach offers an opportunity to provide more joined up packages of care, treating patients as individuals rather than thinking about their mental and physical health separately. This will aid sustainable recovery and protect against the risks to physical health that people with mental health and substance misuse problems are disproportionately at risk from.

The following sections describe the various elements of the new model of care in more detail and provide a set of key design principles to support future planning and design.

## 8 Primary Care (General Practice) at Scale & Providing System Leadership

With over 95% of the patient contacts with the NHS taking place in primary care, primary care is, and should continue to be, the foundation of the local NHS system.

As described in Section 3, local primary care in North Somerset is facing a number of significant challenges in the delivery of core primary care to patients such as estates challenges, an ageing workforce, workload, an ageing and growing population with complex medical needs and an expectation to deliver more care in the community. These challenges are particularly acute in Weston.

BNSSG CCGs' have developed a Primary Care Strategy that sets out a vision and direction of travel for local primary care services. The aim of the strategy is to ensure the sustainability of General Practice building on existing strengths and ensuring safe, effective and high quality care. The BNSSG Primary Care Strategy was developed in line with the General Practice Forward View (GPFV) and sets out, at a high level, how General Practice will be enabled to better support the delivery of the BNSSG STP Vision for Integrated Delivery as shown in Figure 13. The strategy has been shaped by discussions across the wider BNSSG system, not only between the respective BNSSG CCG member practices, but also with the public, GP Practices, their area representative bodies and partner services.

The strategy describes how GP Practices will address the challenges outlined above by working at scale in 'clusters'<sup>10</sup> and across larger geographical areas called 'localities'. While formal locality-based cluster-based working is still developing, the transition from today to this new way of working will require strong local GP leadership to deliver the required changes.

BNSSG CCGs are already working with NHS England to ensure that the funding that is available centrally from the GPFV, which includes estates, technology and transformation funding (ETTF), Improved Access funds, Resilience and Transformation funds, are utilised locally to maximise the benefit in supporting GP Practices to achieve the stepping stones necessary to deliver the vision. Provisional plans for the BNSSG Transformation Scheme (i.e. £3 per head funding over two years of 2017/18 and 2018/19) are being designed to support the development of GP Practice locality working.

Each GP Practice 'locality' has different population needs and priorities, and is at different stages of development. Whilst not intending to be prescriptive, nor to suppress entrepreneurship, the expectation is that practices will need to develop local services under a number of key design principles as outlined below:

### 8.1 Key Design Principles for local Primary Care Development

- GP Practices working together at scale to better enable collaborative working with the rest of the health and care system. By joining up with other providers locally, this will help to optimise resources to create a step change in care delivery and patient experience/wellbeing. This could manifest itself, for example, in a more consistent and effective service to local care homes.

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<sup>10</sup> Defined here as the registered population of a specific group of General Practices based on a geographical location where different services work in an integrated way for the population. These clusters are likely to be for a population of 30,000 to 50,000, but could be higher. In contrast, Primary care 'Localities' will be between 100-150,000 population.

- Primary care operating at scale delivering consistent, resilient, high quality and safe care with all patients having access to a range of core services, but allowing sufficient flexibility to develop services that meet the specific needs of their local populations. Instead of a 'one size fits all' model, practices will work together to determine the best solution based on local need and circumstances.
- Multi-disciplinary primary care teams - increasingly General Practice teams - will be supported by specialist nurses, mental health workers, pharmacists, physicians' associates, healthcare assistants and other healthcare professionals. Building on the tradition of hosting services such as the diabetic retinal screening and mental health services, these teams will be capable of offering more services locally to better meet the needs of their local populations – such as DVT services, for example.
- A greater level of collaborative and integrated working between General Practice teams and the wider community and social services system.
- Address public concerns over the availability and resilience of primary care services in the town centre, especially in the context of existing need and likely future population growth.
- GP leadership for the rest of the community system to enable the provision of higher acuity services in the community and allow the sector to 'punch its weight' with the acute sector by keeping people in, or quickly returning them, to their normal place of residence.
- Where it can be demonstrated that funding will be freed up, and it will deliver safe and quality care more efficiently, appropriate work and resources could shift from the acute hospital to the community – for example, certain services that are currently provided in an acute hospital setting could be more appropriately provided in a primary care led Community Hub, or other community setting.
- The implementation of the BNSSG GP Primary Care Strategy will provide the framework to support the required changes, and in addition a General Practice Sustainability Plan will be developed in line with the detail contained in the national GP Forward View.

## **8.2 Weston Primary Care Transformation Programme**

Within the locality of Weston and Worle, local GPs have been progressing a programme of work over the last few months to address the challenges described above. The Weston Primary Care Transformation Programme has been looking into primary care estate solutions, alternative models of provision for extended access appointments and urgent care appointments as well as looking into the consolidation of back-office systems and processes. It has also been looking at developing new cluster-based clinical models for the improved management of long term conditions, frailty, care homes and mental health in primary care. This work will now be incorporated into the Weston Sustainability Programme as part of the Enabling Primary Care and Integrated Community Services workstreams and will move forward in a more integrated way, working in close collaboration with the delivery of the other elements of the model.

## **8.3 Non-GP Primary Care**

Other contractors within primary care have a key role to play in patient's health and wellbeing. Using the principle that patients should be seen by the most appropriately skilled health care professional at the right time; dentists, optometrists and community pharmacists could play a larger part in the proposed integrated system. This will be fully explored as the programme of work develops.

## 9 Stronger, More Integrated Community Services & 'Care Campus'

### 9.1 Integrated Community Services

Central to the new model of care is the development of excellent integrated community services, working in conjunction with local primary care working at scale in clusters and wider localities, to provide a holistic health and care response that is genuinely tailored to the needs of the local population.

Figure 14 below, which is taken from the BNSSG Primary Care Strategy and aligns with the work of the BNSSG STP's Integrated Primary and Community Care (IPCC) workstream, aims to outline the types of services that might be provided across clusters and localities of GP Practices. Work is already underway locally in Weston to deliver this model.

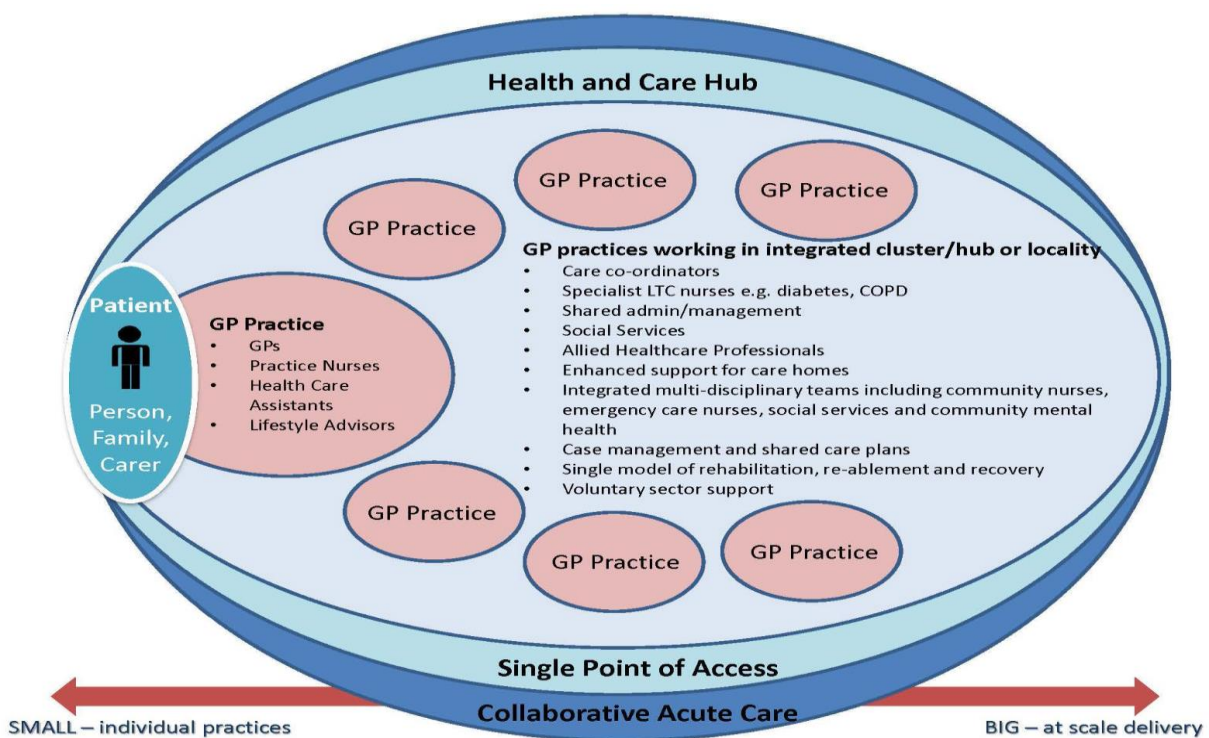


Figure 14: Integrated community services wrapped around GP Practices

### 9.2 'Care Campus' Model

The new model of care also focuses on the creation of a more organised, coordinated and effective community provider environment that is seen as the main conduit for meeting a person's health and care needs. This new community provider environment sees primary care, out-of-hours primary care, community services, mental health, the ambulance service and local authority all working much more collaboratively with each other, and more collaboratively with secondary care, around a single, person centred care plan. Strengthened and more comprehensive partnership working with the community and voluntary sector will be particularly valuable in this new model.

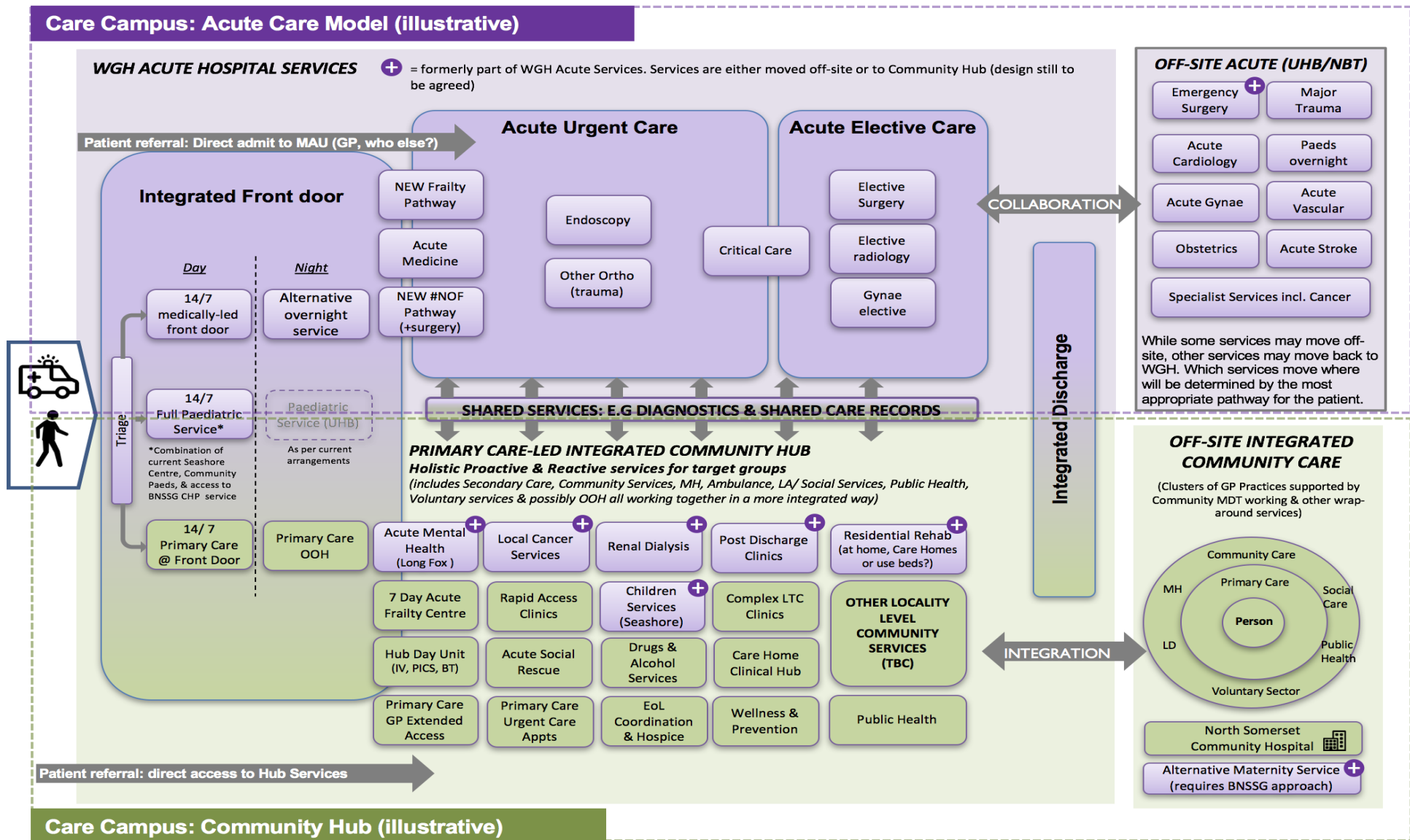


Figure 15: Example of 'Care Campus' Model: WGH providing selected acute services with a co-located Primary Care led Community Hub

Different levels of collaboration will emerge across the system. For example, certain services will be provided at a local GP Practice level, while for other services it will make more sense to provide them at a cluster (30 to 50,000+ population) or locality level (100 to 150,000+ population). A number of key services will need to be provided at a local authority or BNSSG level.

While the exact design of which service is provided where is being taken forward by the STP at a locality level, the direction of travel is clear. For Weston, the emerging consensus amongst local providers and stakeholders is to explore the possibility of turning the WGH site into an integrated 'Care Campus' that can be used by an alliance of providers (supported by strong GP leadership) to provide a wider range of integrated services and become a focal point for the local community system.

Within this 'Care Campus' model, the community provider environment will work with high quality, acute services at WAHT to develop cross-system pathways, build clinical networks and share expertise and advice to the ultimate benefit of the patient. Figure 15 above gives an illustrative example of the vision for the 'Care Campus' model and its two central component parts: 1) a co-located primary care led Community Hub that is integrated into the wider 'out of hospital' community system (green elements) and 2) a re-designed Acute Care Model (purple elements). It was shared through the system-wide engagement work to support the development of this document. In response to this Commissioning Context, providers will be expected to work in partnership to develop the design for both parts of the 'Care Campus' model to ensure the two components of the Campus model work together in an integrated and cohesive way. This will include ensuring that the estate – which is owned by WAHT – can have overheads appropriately met.

The following section provides a brief overview of what the Community Hub might provide in terms of example services. It should be noted that the information provided in the following sections is indicative and further work is required to turn this into a workable service model. In addition, the public will play a key role in helping providers to co-design the final solution. Section 10 provides further detail on the Acute Care Model.

### 9.3 Overview of Primary Care led Community Hub

As shown in Figure 15, the primary care led Community Hub will be supported by an alliance of providers (including WAHT) all working together to provide a variety of integrated services focused around the needs of key target patient groups. The Community Hub will be co-located at the WGH site and will work in an integrated way with both the wider community based system (referred to in the diagram as Off-site Integrated Primary and Community Services) and a redesigned WGH Acute Care Model.

The 'Care Campus' will have an Integrated Urgent Care Front Door service, with clear triage criteria that will support streaming to re-direct patients to the most appropriate service for their particular needs. This could include the patient's local GP, a particular service in the community, a service in the Community Hub or a service in the hospital. The 'Care Campus' will also provide an Integrated Discharge Service to proactively pull patients through the hospital system and ensure they are well supported on discharge from hospital. Community Hub services will also benefit from access to expert advice and support from on-site secondary care clinicians.

Although the design still needs to be developed, the Community Hub could contain the following types of services:

- **Additional GP urgent care and extended access appointments** to improve 7 day access to GP appointments to cope with current and forecast increases in demand.



- **A 7 Day Frailty Centre** providing proactive and reactive services to a clearly defined group of patients to keep them well and at home. If an individual is appropriately admitted to a hospital bed, the system will react quickly to pull them through the system and will provide excellent rehabilitation and support services to help them get home as soon as possible.
- **A Day Unit** providing services such as intravenous (IV) therapy in the community, management of peripherally inserted central catheters (PICC lines) and blood transfusions in a more comfortable environment so patients don't have to be admitted to hospital.
- **Rapid access to diagnostics** to provide access to a range of diagnostic tests for those patients whose symptoms are non-specific, but are concerning, and who need a diagnosis so that a treatment plan can be put in place. The service could offer patients further investigation of symptoms they may have discussed with their GP through additional tests. These could include: imaging tests such as MRIs, CT scans, endoscopy or other tests such as blood gases. The expectation is that this would be a shared service with the hospital, thereby driving economies of scale through increased activity volumes.
- **Multi-specialty Long Term Conditions Clinics** for high acuity patients, focused on key priority conditions such as CHD, Stroke, hypertension, COPD, and Diabetes etc. Given the integrated nature of the services in the Community Hub, these clinics could be multi-specialty allowing patients to be seen for multiple conditions at the same time thereby avoiding repeat visits, multiple appointments and repeating the same information multiple times.
- **Rapid Access Clinics** – for example for COPD and chest pain.
- **Mental Health services** supported by clinicians from AWP's Long Fox unit which is co-located at WGH. This will help to better manage patients with both mental and physical health needs. Services could include in-patient or crisis teams, IAPT and community mental health.
- **Rapid access to Social Services** to cope with patients attending with complex social issues requiring rapid intervention to avoid admission to hospital. The Community Hub would also use well established trusted assessor models to avoid duplication.
- **Integrated children's services** including combining the current Seashore centre, community paediatrics and wider BNSSG Partnership services into an integrated service.
- **Local cancer services** so more patients can be treated closer to home and don't have to travel to Bristol for treatment.
- **A care home support service / integrated care home delivery model** to better support local GPs and community providers in managing patients in local care homes to avoid admission – could also include an AWP specialist mental health care home liaison resource and improved medicines management.
- **Rehabilitation / reablement** – the definition and provision of a clear and robust model for rehabilitation and reablement to better support people on discharge from hospital.

Other examples of the types of services the Hub could provide include:

- **Other clinical services** - drug and alcohol services, end of life and hospice coordination, renal dialysis, post discharge clinics.
- **Other types of services** - wellness and prevention services, public health services, voluntary sector services, social prescribing, care navigation, signposting, crisis café, dementia café.
- **Support services:** Consolidation of back-office functions and process for local primary care.

Local clinicians have developed and tested a number of simple but common scenarios, comparing patient journeys in the current model to the potential benefits of the new integrated system. For example, this early work has identified a range of opportunities to help prevent unplanned admissions. Four examples are provided below.

### Scenario: Frail older adult requiring rapid access to diagnostics

- Ann is 82 and lives with her husband, who has arthritis.
- He is more dependent on her than the other way around, but she doesn't consider herself his 'carer'.
- Over 3 days Ann has a couple of unsteady episodes and becomes a bit confused.
- Her husband calls the GP concerned and requests a visit.
- GP visits and Ann has a NEWS score of 2 - slightly raised pulse and slightly low saturations.
- GP is worried about pneumonia, or an infection elsewhere, or that she has a metabolic disturbance and needs more investigations.
- GP ideally wants bloods to ensure that she hasn't got low sodium or raised calcium, and a chest x-ray
- GP also wants her to have some Intravenous fluid (IV) fluids as she seems a little dehydrated.

#### What is the preferred outcome for this patient?

<b>Today</b>	<ul style="list-style-type: none"> <li>• GP arranges for Ann to be admitted to Weston Hospital under 'medical expected'.</li> </ul>
<b>Future</b>	<ul style="list-style-type: none"> <li>• GP calls the Community Hub's frailty service to coordinate the response and investigations.</li> <li>• Ann attends the Community Hub for bloods, a chest x-ray and IV fluids.</li> <li>• The Hub has access to Ann's medical records in EMIS.</li> <li>• Ann is given a comprehensive assessment and is sent home – updates to her care record are shared with her GP.</li> <li>• GP follows up with Ann.</li> <li>• The Hub follows up in a few days to check-up on Ann and her husband.</li> </ul>

### Scenario: Combination of mental & physical health

- Trevor is 64 and had a psychotic episode 25 years ago.
- He is not really on any meds other than a statin and a BP med.
- Trevor's partner calls GP and describes him as acting strangely over the last week and becoming increasingly agitated and paranoid.
- GP is uncertain as to whether this is a psychotic episode again or a physical cause.
- GP identifies that Trevor needs both a physical work up and a psychiatric review to get to a better understanding of the diagnosis – it's unclear who completes which stage.
- GP refers Trevor to Weston General Hospital.

#### What is the preferred outcome for this patient?

<b>Today</b>	<ul style="list-style-type: none"> <li>• Trevor attends Weston Hospital's emergency department.</li> <li>• Given his psychiatric history and that he's a bit unwell - it's unclear whether he should be admitted under 'psychiatry' or 'medicine'.</li> <li>• There's a 50:50 chance that he'll end up being admitted for his physical condition - which is not ideal.</li> </ul>
<b>Future</b>	<ul style="list-style-type: none"> <li>• GP calls the Community Hub for a holistic approach to get to the answer quickly.</li> <li>• Trevor is assessed by an appropriately skilled Urgent Care practitioner and an Acute Mental Health professional.</li> </ul>

## Scenario: Carer falls ill, but spouse has dementia

- Tomacz is 73 and has type 2 diabetes.
- He has high a blood glucose level, is dehydrated and has a high temperature - possible infection.
- He calls an ambulance.
- Ambulance brings Tomacz and his wife Gloria to Weston Hospital.
- Gloria has dementia and Tomacz is her main carer (no cover).
- There is no safe place for Gloria to go while Tomacz remains in hospital.

### What is the preferred outcome for this patient?

<b>Today</b>	<ul style="list-style-type: none"> <li>• Tomacz and Gloria are both seen in the hospital's emergency department.</li> <li>• Tomacz is admitted into hospital through acute medicine.</li> <li>• Gloria is admitted to a hospital medical bed until alternative arrangements can be made with social services (depending on demand, this may take some time)</li> </ul>
<b>Future</b>	<ul style="list-style-type: none"> <li>• Tomacz and Gloria attend through the 'Care Campus' Integrated Urgent Care Front Door service.</li> <li>• Tomacz is streamed and admitted into hospital through acute medicine.</li> <li>• Gloria is streamed to the Community Hub where she is attended to by the onsite social services team and dementia team.</li> <li>• The Community Hub rapidly assesses Gloria's needs and arranges for an appropriate care package to get her back home as soon as possible.</li> </ul>

## Scenario: Care home resident

- Colin is 83 and lives in a residential care home.
- He has a fall at 10am and bangs his head.
- His carers are worried.
- He doesn't have DNAR or a TEP, or much advanced planning in general.

### What is the preferred outcome for this patient?

<b>Today</b>	<ul style="list-style-type: none"> <li>• Colin's carers call the GP.</li> <li>• GP visits Colin at 3pm and decides to admit him to hospital as they feel he needs a CT scan.</li> <li>• Colin is admitted to Weston Hospital.</li> <li>• Given the time of day, Colin stays overnight and is discharged the next day.</li> </ul>
<b>Future</b>	<ul style="list-style-type: none"> <li>• Colin's carers call a central line and are taken through a set of questions to triage the call.</li> <li>• Rapid Response is dispatched to the home.</li> <li>• Rapid Response liaise with the Community Hub who has visibility of Colin's medical record in EMIS.</li> <li>• Rapid Response and the Community Hub both agree that Colin needs a CT scan.</li> <li>• Colin attends the Community Hub and has the scan.</li> <li>• CT scan is normal and he's back at home by 7pm.</li> <li>• Community Hub follows up with the care home to discuss/help with advanced planning.</li> </ul>

## 9.4 Key Design Principles for Integrated Community Services

The delivery of more integrated community services to realise this ambitious model of care will take place in line with a number of underlying design principles:

- Integrated working i.e. breaking down the boundaries and organisational silos that exist between primary, community, and secondary care, mental health, and the local authority to build strong day-to-day working relationships across teams and GP Practices.
- Development of integrated multi-disciplinary teams from a variety of providers organised around clusters of GP Practices to work directly with primary care professionals on a day-to-day basis.
- The inclusion of memory services and dementia enhanced support teams working alongside primary and community care to reduce admissions.
- Robust care coordination and the use of named staff to coordinate seamless and timely access to different parts of the community system.
- A stronger role for the voluntary sector to support care coordination, sign-posting, social prescribing and provision of services.
- A much higher level of generalist skill across community nursing, including high quality self-management support, capable of managing multiple co-morbidities rather than an overreliance on specialist teams to manage a single condition.
- A single point of access for referral (SPA) and telephone contact; shared information management and telephony (IM&T) systems and information governance processes.
- Interoperability with primary care IT systems and streamlined, efficient methods of referral and information sharing; particularly important is the ability to provide direct interoperability with the prevailing clinical systems i.e. EMIS for both primary care and community care (note that NSCP already use EMIS) and inter-operability with secondary care and social care systems.
- Work with primary care, WAHT and other providers to explore the development and financial feasibility of creating a 'Care Campus' and primary care led Community Hub at the WGH site working closely with WAHT on the design of both the Community Hub and Acute Care Models.

It is through the delivery of these design principles and this overall vision for a new way of integrated working across the community provider environment that we will provide the highest standard of service to the people of Weston.

Through this work, the CCG also wants to explore whether the Community Hospital at Clevedon is being put to best use in the context of the wider community model. We want to explore the potential use of other sites that are available, most notably Mill Cross in Clevedon. Again, this is the sort of opportunity that could potentially be relevant to the One Public Estate initiative. The CCG will work with the Council to explore such options as part of the implementation of this Commissioning Context across the rest of BNSSG.

## 10 A Stronger, Focused Acute Trust & Acute Care Model at Weston Hospital

### 10.1 Redefining the role of Weston General Hospital

As commissioners, we support the view of Weston Area Health Trust's Board that WAHT needs to redefine its role and the role of Weston General Hospital (WGH) both within the place of Weston and across the wider BNSSG system. WGH is, and will remain, a vital part of the service infrastructure, but for a number of years the hospital has found it harder and harder to preserve the full range of services that a small District General Hospital (DGH) of its type might have provided in the past.

The CCG is working closely with WAHT, who have been long term champions of the 'Care Campus' model, to ensure we can bring to the hospital site a wider range of services that will continue to benefit the local population. This will allow us to move towards a more optimal, and less duplicative, model of service provision by coordinating services with those provided by UHB and NBT as part of a wider BNSSG Acute Services Plan.

This new and unique potential role for WGH opens up a range of exciting opportunities to put the hospital at the heart of an integrated and more responsive local system. For example, the potential exists for Weston to become a recognised regional centre for innovative and effective support of frail and older adults, at scale provision of great routine elective care, and the strengthening of local cancer outpatient treatment options.

Increasingly with modern medicine, more complex and specialist services are centralised into larger regional or sub-regional centres as the evidence demonstrates that this is better for patient outcomes. Clinicians are clear that the evidence for the treatment of many life-threatening emergencies is that it's the level of specialist knowledge and skills at the receiving hospital, rather than ambulance journey times, which drive improved outcomes. There are a growing number of examples around England where the role and scope of small DGHs is being re-evaluated, with a stronger emphasis on routine, planned care and the rarer, more complex and life threatening conditions being treated at larger local centres.

The CCG's view therefore is that WAHT needs to redefine the role of WGH within the BNSSG landscape and we must collectively take this opportunity to address long-standing issues of clinical and financial sustainability for a number of different services. From the range of different benchmarking indicators included in the financial analysis section (Section 4) of this document, it is clear that North Somerset CCG spends a disproportionate amount of funding per head on acute services when compared to its peers. This Commissioning Context does not set out in detail a final model, preferred option or target configuration state for WGH. Based on the information in this Commissioning Context, and the design principles laid out below, the CCG will work with WAHT, UHB and NBT to develop and appraise the possible options for service delivery and define where the balance should lie between "local" vs "at scale" services.

As a system, we must be honest with the public and ensure that we present options that are realistic, rather than implying that any combination of services is possible. Where there are clinical, workforce or financial limitations that make certain options unsustainable or unrealistic, we need to be open about this. However, the emphasis should be on the positives, setting out clearly what new opportunities for improved and more coordinated care this new approach will bring, rather than focussing exclusively on what services may need to be provided elsewhere in order to make the new system work.

In addition, the CCG's assessment is that WAHT and WGH would be able to operate much more effectively and sustainably if it was part of a larger organisation. This would improve the prospects of attracting both activity and staff. The CCG's expectation is that Acute Trusts will work together across BNSSG to organise services more efficiently for the effective delivery of both urgent and planned care, thereby optimising capacity and affordability for the whole system.

The transformation of services at WGH, to develop a new acute care model will take place in line with a number of underlying design principles:

## 10.2 Key design principles for a new Acute Care Model

- Quality is the overriding consideration for the new model that we are developing, including the ability to routinely and sustainably meet relevant national safety, staffing and clinical standards.
- The WGH site operating as a clinically and financially sustainable 'Care Campus' model (refer to Figure 15 above showing those elements highlighted in purple) that brings together in one place the best of the Acute Trust with the best of primary care, community services, mental health, social services, the ambulance service, the local authority and the voluntary sector to support the creation of an integrated primary care led Community Hub working in close alignment with a new Acute Care Model.
- An Integrated Urgent Care Front Door service to effectively meet the urgent and emergency care needs of the local and visitor populations, acknowledging that more complex and life threatening conditions may be better treated elsewhere in the system.
- An Integrated Community and Acute Children's Paediatric service, that works closely with the new urgent care service model. Consider partnership options with other children's healthcare providers to improve service resilience and the potential to recruit scarce specialist staff.
- WGH operating as a recognised 'centre of excellence' for the effective treatment of frailty, including the development of new pathways - for example a specific integrated acute and community frailty pathway.
- Integrated working with primary and community care services to help proactively manage frail and older patients and help them stay healthy and out-of-hospital for as long as possible. Frail and older patients who do need to be admitted to an acute hospital bed are enabled to go home as soon as possible and that patients' experience of rehabilitation services both in and out of hospital is as seamless as possible.
- WGH operating as a recognised regional centre for NHS elective care, with a coordinated strategy to encourage more local people to choose it for their routine and non-complex elective care.
- Integrated services for patients by working jointly with local primary care and community colleagues, for example through joint LTC clinics in the community and/or the Community Hub, telemedicine / advice, and encouraging community services to routinely walk wards to "pull" patients through to discharge.
- The ability to use IT to appropriately share patient data and records, thereby improving coordination and efficiency of patient care.
- Integrated working with mental health services, including substance and alcohol misuse services, to ensure a joined-up service for vulnerable groups.
- Greater collaboration across Acute Trusts – working under the guidance of the Acute Care Collaboration workstream of the STP and further enabled by greater partnership working between UHB and WAHT and collaboration with NBT.

The CCG has identified below specific elements of WAHT's current acute service model that need further review. Any proposed changes to these elements need to be considered alongside a broader review of acute service provision that optimises the balance of local services across the three centres of acute provision in BNSSG.

### 10.3 Areas requiring detailed review

- A sustainable Acute Trust that is 'right sized', and doing the work that only it can do by moving services amenable to community care into a suitable community setting (e.g. elements of LTC management including diabetes care, COPD care, rehabilitation, cancer treatments, renal dialysis etc.).
- Fewer and fewer local mothers are choosing to have their babies in the Midwife led unit (MLU) at WGH, and this has long-term implications on the quality and safety of the service. Only around 170 births take place every year at the MLU (~10% of all births in North Somerset). The recommended number of births for a MLU is 500 to give a critical mass of activity to maintain appropriate clinical expertise. In order to reach 500 births, there would have to be a circa 200% increase in the number of people choosing to give birth at the MLU. With the population growing on average at about 1% per year in North Somerset as a whole and around 2% in Weston, relying on demographic growth to close the shortfall of around 300 births per year will not correct this issue. Therefore, it is the CCG's view that alternative options need to be explored as part of a wider review of maternity services across BNSSG.
- A CQC report recently precipitated the temporary closure of the A&E during the hours of 10pm and 8am due to concerns regarding safe and sustainable staffing levels throughout the night. The system has coped well and patients continue to receive safe care. The CCG will review the evidence of the impact that the unplanned closure has had on the wider system and will set this against the range of entrenched clinical and financial challenges that WGH's ED has faced for a number of years. Given these constraints, we need to identify what model of urgent and emergency care can best meet the needs of the population across the whole 24 hour period.
- With the move to focus more on prevention and planned care, this work will review whether emergency general surgery would be better provided at other larger acute hospitals in BNSSG. We think there are sound clinical and financial reasons for locating these services off-site<sup>11</sup>, which in turn would free up capacity at WGH to concentrate on becoming a recognised regional centre for non-complex elective care.
- In light of the other possible changes outlined above, the options for critical care (i.e. intensive care unit or 'ICU') should also be reviewed. Any possible changes would take place in the context of a strengthened 'Hospital at Night' Team.
- There are other factors that may affect further lines of service provision, for example concentration of acute stroke services and rationalisation of pathology services. Any such changes will need to be understood and factored into the final service delivery model.

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<sup>11</sup> <http://www.swsenate.org.uk/wp/wp-content/uploads/2013/12/Weston-Review-FINAL.pdf>

## **10.4 A continued focus on prevention & self-care**

Prevention is a key aspect of the NHS 5 year forward view and a key aspect of the new model of care. Efforts to prevent ill-health and promote positive health and well-being should consider all three levels of prevention i.e. primary prevention (preventing disease or injury before it occurs), secondary prevention (detecting and treating diseases early to halt or slow progression e.g. improving uptake of cancer screening and early identification of circulatory disease or hypertension) and tertiary prevention (reducing the impact of ill-health or injury on quality of life through initiatives such as patient education programmes, social support for people with long term conditions and ensuring services and communities are “dementia friendly”).

The temporary closure of the A&E department on patient safety grounds has understandably focussed public attention on overnight emergency care. While 24/7 urgent and emergency care will always be provided to the people of North Somerset, we want this work to be a catalyst for reframing the conversation with the public, focussing much more on prevention and self-care, the things that we know have a potentially very large impact on enabling people in the Weston area to live longer and more healthy lives.

## **10.5 How will these changes meet the identified priorities?**

In Appendices 4 and 5 there is a summary of the priority population and speciality groups that this work has identified and an outline description of how this new integrated model of care will be able to respond to the challenges that have been identified.

## **10.6 Recognising and responding to the public’s views**

At the beginning of this document we listed a set of key themes that local people and staff have identified as being important to them and would like to be addressed as part of reforming the local healthcare system. Appendix 6 summarises how we think the work described in this document can meet these requirements.



## 11 Key Enablers for our New Approach

There are a number of key enablers to support the development of this new model of care:

- **Workforce:** The key enabler to success cited by providers, and summarised in the supply side analysis (Section 3 and Appendix 3), is meeting the challenge of attracting and retaining the right workforce – including greater use of a range of healthcare practitioner roles including Physicians Assistants, Paramedics, and Clinical Pharmacists. We think that the integrated ‘Care Campus’ model being proposed will benefit:
  - Patients - by providing a more joined-up person centred experience of care.
  - Front-line staff - by offering a more diverse and exciting model of working, not bound by organisational boundaries and targeting those most in need of support to keep them well and out of secondary care.
  - Provider agencies - by reducing the problems caused by the poaching of in-demand and scarce skills/ staff.
  - The wider community - for example by using innovative community resource models such as Health Coaches (as per model at Yeovil Vanguard).

We will work closely with Health Education England and the SW Deanery to ensure that the reforms proposed under the Healthy Weston Programme is coordinated and in tune with regional training plans and requirements.

- **Diagnostics:** We need to ensure the diagnostic resource in Weston is shared across the whole system, with fewer unnecessary tests borne out of not knowing the patient and their history and more use of the previous resource to reactively spot and address health problems in their early stages.
- **Medicines Optimisation:** We already do medicines optimisation very well in North Somerset. However, we need to make sure that as this new model of service provision is developed, this important work continues to play a key part in improving efficiency and outcomes for patients.
- **IT:** There is no debate that IT could be better used in the local system. For this programme to be effective, there needs to be far greater integration and communication between local service providers. Although we have had some important gains recently (for example North Somerset Community Partnership and all primary care providers are now using a single clinical system called EMIS) there are further opportunities to improve the interoperability of systems across providers, for example by leveraging and emulating the work of the Digital Global Exemplar sites at both UHB and TSFT and also telemedicine opportunities.
- **Estate:** The estate plan that underlines this work will be a key enabler to its success. There are estates challenges in Central Weston for primary care whereas the WGH site affords opportunities to use a prime piece of estate more holistically and effectively. Work is already underway with local GP Practices in Weston and Worle as part of a successful bid for NHS England ETTF funding to conduct an options appraisal and develop a business case to address the local estate challenges in Central Weston and identify a suitable solution for the provision of primary care in Weston Villages. Further opportunities for use of the ‘One Public Estate’ approach are being actively explored with North Somerset Council when considering potential sites in the town centre of Weston.

## PART 3: DELIVERING THE CHANGE

This work is all about delivering a step change in service provision at a local level in Weston. As a system, we need to be ambitious and challenging in the timescales that we set ourselves to see real and material change in the way we commission and deliver services, supported by the knowledge that all of the things we have proposed in this document have been thought through, described and endorsed by the STP's work and/ or have been tested elsewhere nationally.

As mentioned previously, several attempts in the past have been made to address the sustainability of Weston Hospital. We are now at a time when the ingredients to enable real change are starting to come together, such as: a clear direction from the 5 Year Forward View and proven new models of care; local commissioners and providers working collaboratively to tackle the sustainability and transformation of the local health and care system; clinical leadership for the change; active patient and public dialogue.

In addition, with the bringing together of the three BNSSG CCG commissioning teams, the stronger commissioning organisation is looking at bold ways to support the local system in achieving the local vision.

Since starting the work, we have added a further underpinning principle that the approach we are taking in Weston will create a framework which can be rolled out across the other areas of BNSSG to support the implementation of the BNSSG wide objective of developing and strengthening community based integrated care. The methodology and supporting principles used in this work will be applied systematically across BNSSG, although the specific configuration of services may look different in other places due to local circumstances such as population need, the strength of existing provision and local workforce and estate challenges.

The following two sections focus on the critical building blocks for delivery, the proposed commercial model and key next steps.

### 12 Critical Building blocks for Delivery

As set out in the preceding sections of the Commissioning Context, the key building blocks for the delivery of our new care model include:-

#### **Enabling Primary Care to deliver at scale and providing system leadership**

We need to ensure that there is a resilient and robust primary care service to provide the platform and leadership to enable our community service model to thrive. As previously mentioned, BNSSG CCGs are already working with NHS England to ensure the GP Forward View (GPFV) funding is being used to support this model.

#### **Delivery of integrated community services & 'Care Campus' model at the WGH site**

The CCG's hypothesis is that we already have all the services we need. However, by providing more joined up care across settings, and reducing duplication, we can optimise resources and deliver better care for our patients. This includes being able to manage a higher level of acuity of care in the community which will relieve pressure on the acute sector. We want to encourage and enable providers to work together in a provider alliance, underpinned by a formal agreement (e.g. a memorandum of understanding or 'MoU'). This is initially about encouraging service delivery, but the CCG may progress to a shared contract mechanism with relevant risk and reward sharing (but probably not in Year 1).

### **Delivery of an Integrated Acute Care Model (Acute Care Collaboration)**

The work done by the North Somerset Sustainability Board over the past 12-18 months has led to the consensus that there is no “stand-alone” solution for WAHT and for WGH. The successful delivery of the vision and aspiration set out in this document is not only enabled by the greater integration of community services, as described above, but is also delivered by close and active collaboration across local Acute Trusts. For example NBT, as well as WAHT and UHB, will be closely involved in helping design the new service models so new ways of doing things will work for the whole system. The Partnership Agreement that was announced jointly by UHB and WAHT in February 2017 has the potential to be an important enabler to support the successful delivery of this work. We also expect T&SFT to be actively and fully involved in the Healthy Weston programme where appropriate.

### **Whole System collaboration**

All partners working together in a coordinated and systematic way will be key to ensuring this new model of care is successfully implemented. This of course applies to the providers who enter into an alliance arrangement, but it applies equally to other services in the system as these bold new ways of organising care for the people of Weston will only work if there is buy-in and cooperation from all parties.

## **13 Proposed Commercial Model**

The CCG’s ambition is to move to local integrated care models that wrap around natural ‘placed-based’ communities. These may range from a high level agreement between providers, all the way to the development of an Accountable Care System. However organised, we wish to incentivise the development of provider alliances which over time may move to capitated payment models. We think that this is the best way to allow providers to do things in a truly different way that puts the patient at the centre of the way services are designed, organised and delivered.

The CCG will carefully review the lessons learned from other places that have implemented this type of innovation. There will be a phased approach; we will test as we go and we will develop the model in partnership with providers. This will take place against the background of a shared understanding that we can only spend the resources we have and that we need to provide the best possible health and care for our whole population. The NHS England New Care Models Team has agreed to support the CCG in this work to benefit from their latest thinking and experience from other areas.

The phased approach will allow the staged introduction of the new model and there is also the potential for a risk share agreement in the early stages. Further, we may offer an extended contracting period to give stability, surety and the space to develop and evolve services. We would like to continue the conversation with partners over the next few months on the detail and possible options. We may also decide to have a mixed model in terms of acute provision, for example to retain the competitive incentives embodied by “Payment by Results” to pull in a bigger share of non-complex, high volume surgery (work done to date within the Weston Sustainability Programme to indicate a sizeable financial opportunity if more local people were to choose Weston Hospital as their place of elective care).

Section 4 (Finance) sets out the CCG’s initial thinking on how a capitated budget could be identified for the place of Weston. We know that today we spend more money than we have on providing health and care services across the system. Our collective challenge is to think laterally as well as

pragmatically about what needs to change in the way we deliver services to enable all parties to live within their means.

The CCG recognises that further work is required with local providers to agree the precise details of a final commercial model. However, there are a number of known service redesign requirements that can be progressed while these details are being finalised. The CCG will support providers to continue at pace with the redesign of services to improve delivery and patient outcomes wherever possible, rather than waiting for a final commissioning model to emerge.

In summary, the CCG's commissioning approach aims to deliver three key objectives:

1. Services that better meet the needs of the population, improve patient experience and keep people independent, well and healthy at home for as long as possible.
2. Enable health and care providers to be more resilient by sharing resources, eliminating duplication and breaking down organisational barriers.
3. Deliver affordable services and better respond to a rate of growth in funds that will not match the growing, and more importantly, changing demand unless we do something radically different.

## 14 Next Steps

This document is designed to test and consolidate the progress made so far in developing a broad consensus for both a vision of future services in Weston and the process by which we, as a system, will work towards implementing the necessary changes.

The section below outlines some of the key next steps that will be taken to design the new model of care and the underpinning services in more detail, and then start to implement them.

Further work is required over the coming months to ensure the right governance and programme structure is in place to enable delivery. Ongoing and robust staff engagement through-out the process will also be vital to the successful delivery of this work.

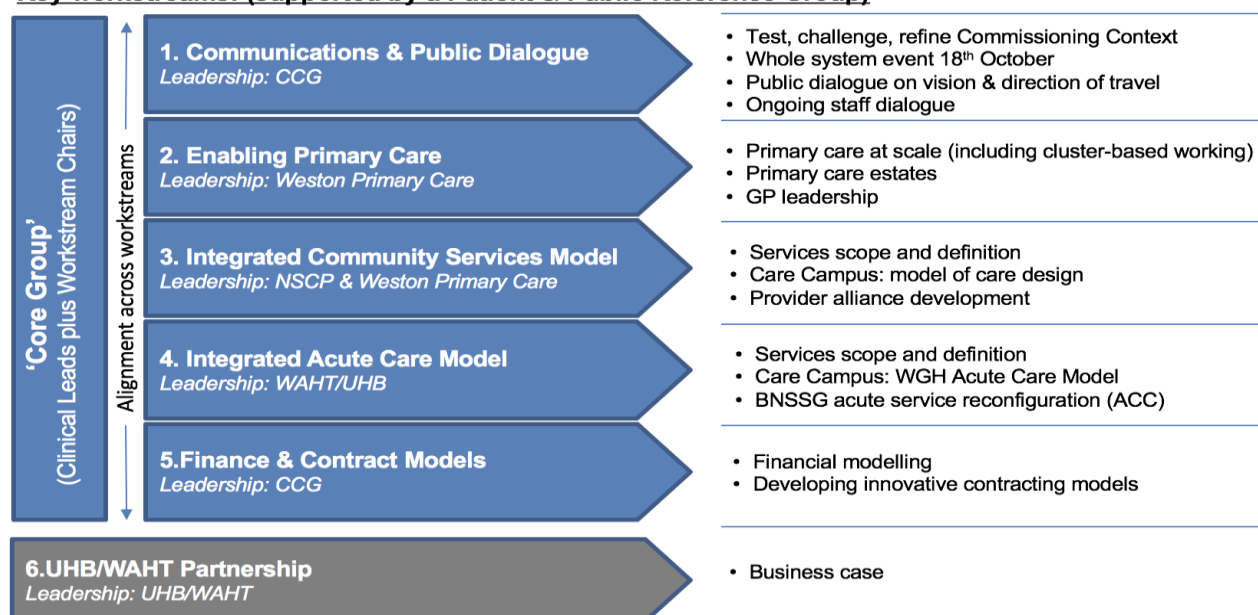
Some of the key next steps include:

### ***Whole System event***

A 'whole system' stakeholder event on the 18<sup>th</sup> October 2017 to describe the Commissioning Context to stakeholders. This will lay the ground for a process of public dialogue on the vision and proposed direction of travel. Attendees will include patient and public representatives, local provider clinicians and staff, representatives from other partner organisations, and key stakeholders.

### ***A re-structured and re-launched Weston Sustainability Programme***

The CCG is in the process of re-structuring the existing Weston Sustainability Programme (to be known externally as 'Healthy Weston') to ensure it is fit for purpose, in order to deliver the proposed vision and model of care. Figure 16 below provides an overview of the programme's key workstreams and what each one will be focused on delivering. Each workstream will have its own 'working group' consisting of a designated Chair, a Managerial Lead, admin support and will include representation from local providers, partners and stakeholders. Workstreams 1 to 3 and 5 will be chaired by the CCG, workstream 4 will be chaired by WAHT and workstream 6 will be jointly chaired by WAHT and UHB. In particular, workstream 4 will also include representatives from the whole system, with input from NBT and SWASFT being especially important.

**Key workstreams: (supported by a Patient & Public Reference Group)****Figure 16: Weston Sustainability Programme - workstreams**

Each workstream will develop a clear mandate setting out its key objectives, deliverables, dependencies and timelines. Each workstream will also report on a monthly basis to the North Somerset Sustainability Board, which in-turn will report to the STP Sponsoring Board.

This structure will be supported by two additional groups: a 'Core Group' including the Chairs from the various programme workstreams that will provide alignment and act as the 'custodians' of the overall design, and a Patient and Public Reference Group (PPRG) that will provide a sounding board for public and patient related activities. The PPRG group was set up as part of the engagement process held earlier this year. Its membership is being reviewed, but the currently invited organisations include:

- Healthwatch North Somerset
- Patient Participation Group – Graham Rd Practice
- Senior Community Link
- Older People Champions' Group
- 1 in 4 People
- North Somerset VANS
- Vision North Somerset
- LGBT Forum
- Supportive Parents
- Multicultural Friendship Association

The following provides a brief overview of each workstream and what each working group will be focused on delivering:

- *Workstream 1 Communications & Public Dialogue:* This workstream will oversee the development and delivery of a comprehensive Communications and Public Dialogue Plan. As part of the delivery of this plan, they will facilitate a period of public dialogue (see below) that will help to test, challenge and refine the Commissioning Context. They will also help to run a process of co-design whereby patients will be able to get involved in the design of key aspects of the new model of care. Finally, they will develop a standard set of communications materials.
- *Workstream 2 Enabling Primary Care:* This workstream, which will incorporate key elements of the current Weston Primary Care Transformation Programme, will be focused on the development of 'primary care at scale' through cluster/locality based collaborative working

arrangements supported by a new BNSSG locality leadership model and locality transformation scheme. As part of this, it will oversee the local implementation of improved access to primary care services (including urgent GP appointments), the delivery of the key objectives of the BNSSG GP Primary Care Strategy (which is based on the national GPFV) and the delivery of the Cluster Resilience Plans. It will also be tasked with addressing the various primary care estate issues across the local area (such as the town centre and provision for Weston villages).

- *Workstream 3 Integrated Community Services Model:* With strong GP leadership and support, this workstream will focus on the design of a new integrated community service model, including the design of the Care Campus at the WGH site and associated primary care led Community Hub. This will incorporate the work of the BNSSG STP's Integrated Primary and Community Care (IPCC) workstream and specifically the work of the multi-disciplinary cluster-based working programme which has already developed a high-level design and supporting infrastructure and is looking to develop a pilot in the Weston area. Working in close collaboration with primary and community providers, this workstream will also deliver new clinical models to better support the three target population groups including frail and older people and people in care homes, children, young people and pregnant women and vulnerable groups.
- *Workstream 4 Integrated Acute Care Model:* This workstream will focus on the development of an integrated Acute Care Model for Weston General Hospital as part of a wider BNSSG Acute Services Plan. A great deal of work has already been done by senior local clinicians in scoping out the options for reform of key acute services at WGH. A key task for this group will now be to finalise and describe the best and most realistic set of options for delivering sustainable services, both in the context of the new Weston 'Care Campus' model but also as part of the wider BNSSG acute provider landscape.
- *Workstream Finance and Contract Models:* As a system, BNSSG needs to move from a focus on what is spent to a focus on what is allocated to us and how this resource is best used to meet the needs of our population. This group will be charged with ensuring that the financial and activity modelling developed as part of this system redesign work is clear, recognised and owned by all parties. In addition, this group will explore the development of possible options for a new capitated funding / outcome-based contracting model, working closely with an alliance of providers to ensure buy-in and support. This model will focus on affordability and will be benchmarked against the existing PbR system for comparison. A key objective in designing a new contracting approach will be to enable money to follow the patient and reduce the perverse incentives that are a feature of multiple individual contracts. We will learn from best practice elsewhere and ensure that a robust work plan and governance structure is set up to support this process.
- *Workstream 6 UHB/WAHT partnership working:* The partnership between UHB and WAHT is an important enabler of the work described in this document. A joint Partnership Board was set up following the two Trusts' announcement regarding the partnership agreement in February 2017. Representatives from this Board will provide status/progress updates to the North Somerset Sustainability on a regular basis to ensure alignment across the other streams of work.

### ***Public and Staff Dialogue***

Subject to Governing Body approval and regulator assurance, the CCG is committed to a 12-week period of public dialogue on the content and objectives of the Commissioning Context, to share the latest thinking and to test our collective ideas.

Learning from the Healthwatch North Somerset report, we will use this period to engage more widely with the local population, building on the momentum created by the specific work on WGH that took place earlier this year. We want to focus on the positive messages around looking to secure the future of the WGH site by developing a 'Care Campus' model and our objectives of improving health outcomes for the population as a whole through a strong and proactive community provider system that is focused on preventive care.

Throughout this process, it is particularly important that each partner organisation ensures that its staff are kept fully informed and feel involved. The CCG will ensure that going forward, we build in regular and formal mechanisms to ensure that clinical commissioners have direct contact with staff, particularly WAHT staff, for the duration of this process.

As described above, Workstream 1 will develop a Communications and Public Dialogue Plan to support this work with input from the PPRG. This plan will focus on four key areas:

1. **Quantitative data collection:** through the period of public dialogue, we want to systematically gather the views and priorities of patients, carers and the public regarding our vision and proposed model of care.
2. **Public meetings and events:** through a combination of bespoke events and attending existing community and patient groups, we plan to ensure there is a wide ranging conversation with the local population.
3. **Service and pathway co-design:** The CCG is commissioning external expert advice to ensure that we can work with patients and 'experts by experience' to work on an equal basis with local clinicians to develop our new care models in a way that are clinically effective and built around the experience and needs of the patient and their family.
4. **Staff communication and input:** Throughout the lifetime of this programme of work, we will ensure that staff are both kept informed of developments and are fully represented and involved in the design of our new care model.

### ***Design phase (including patient co-design)***

Each workstream will undertake a period of design work to build out the core elements of the vision into a more detailed set of tangible design proposals. Specific elements of the design will require input from patients and a process of co-design has been put in place to support this. In addition, certain aspects of the work – such as operational improvements, or pre-requisite system changes will continue to be delivered in parallel during this phase. Note that the more complex elements of the design e.g the Care Campus and associated Acute Care Model may require additional time to complete, but this can only be determined once the workstreams are fully mobilised.

### ***Implementation planning***

In parallel with the design phase, an implementation plan will be developed that will set out the key timelines and deliverables across the various programme workstreams. This plan will develop over time and will become more granular as the design work progresses.

### ***Checkpoint***

A formal checkpoint will be held at the end of the design phase to assess the design proposals and agree next steps.

## **Delivery phase**

The details of the delivery phase are dependent upon the outcome of the design phase and the checkpoint described above. It is not possible at this stage to accurately predict the phasing, or how long any transitional period to the new model will take. However, when we arrive at this stage we will continue to involve our partners in this work and will keep the public fully informed. The timing of this phase will depend on any requirements for formal public consultation.

## **High-level timeline**

The table below provides indicative timeframes for each of the key next steps as described above.

#	Next step	Draft Time Frame
1	<b>Approval by Governing Body and regulator assurance</b>	Early October 2017
2	<b>Commissioning Context published</b>	11 <sup>th</sup> October 2017
3	<b>Whole System event</b>	18 <sup>th</sup> October 2017
4	<b>Mobilise Healthy Weston Programme</b>	October to December 2017
5	<b>Period of public dialogue</b> (14 weeks in total)	October to January (TBC)
6	<b>Staff dialogue</b>	Ongoing
7	<b>Design phase</b> ( <i>including patient co-design</i> )	Late October to March 2018
8	<b>Implementation planning</b>	November to March 2018
9	<b>Checkpoint</b>	End March 2018
10	<b>Delivery phase</b>	TBC

**Figure 17: Next steps high-level timeline**

To conclude; this piece of work is about delivering real change to improve the services for our local population; both now and into the future. While the design of the model of care being proposed in this document is still emerging, it is very much aligned to current policy and is similar in concept to other models of integrated care already being delivered elsewhere in the country.

Over the past few years, a lot of work has been done in analysing possible options for service change and more recently this has been supported by the work of the BNSSG STP. Therefore, we believe we have the basis for a sound, and evidence based approach, to deliver effective system reform.

Clearly, this document marks the start of a significant period of system transformation. Coordinated and supported by the North Somerset Sustainability Board, the programme workstream groups described above - along with strong patient, public and staff involvement - will be charged with identifying the best possible combination of services to meet the needs of Weston's population. We want to have an honest and positive conversation with the public about the options that we have at our disposal and how we might make the best overall choices on behalf of the population we serve.



# APPENDICES

## APPENDIX 1: Note on Population Figures

### Note on population and demographics from Public Health.

There are different sources of data to assess the population of North Somerset: the Office for National Statistics (ONS) based on the census (referred to as the 'resident' population) and the population registered with a local GP which includes people who are not resident in the area (referred to as the 'GP registered' population). The ONS figure is based on the census (last completed in 2011) with an annual adjustment made for the number of births and deaths and a figure estimated for net migration.

The latest figures from Public Health for the total population are 211,681 (ONS) and 216,364 (GP registered). A difference of 4,683. This is due to some people being registered, but not resident in North Somerset and an underestimate of population in the census. The total GP registered population based on figures from local GP Practices in July 2017 is ~219,000.

The ONS figure is available as a projection to estimate likely future population growth and is used as the source of planning (e.g. for housing numbers). ONS produce mid-year population estimates which are a recognised source of population figures. Smaller geography analysis based on the census allows for lower geographies such as middle and lower super output areas (LSOA and MSOA) but these may not correspond with the GP Practice groupings commonly used. For example, the area known as Weston-super-Mare may contain the area of Worle and corresponding GP Practices in some population information, whereas these areas may be considered separately in others.

Population projections at such lower geographies are not routinely available and are calculated as bespoke analyses. An example of such a service is offered by Hampshire Council's small area population forecast service. This service was commissioned to provide information on the projected Weston-super-Mare population change over a 10-year period (from 2014-2024) and the data is available using the following link: <http://www3.hants.gov.uk/factsandfigures/population-statistics/pop-estimates/small-area-pop-stats.htm>

It is therefore common to find a range of values for both population size and predicted growth, depending on the source data used, timeframe considered and (if projecting) the method used. If smaller geographies are applied, there is the additional variable of the boundary used.

## APPENDIX 2: Population and Needs Analysis

### Current population breakdown & future growth projections

In February 2016, North Somerset Public Health published an overview of the population health of North Somerset and North Sedgemoor.<sup>12</sup> Figure 18 below, which is taken from this overview, clearly shows that there are more people aged over 65 and over (23%) in North Somerset and North Sedgemoor than the England (17.5%) and South West averages (21%).

Age range	North Somerset & North Sedgemoor		North Somerset		England		South West	
	No.	%	No.	%	No.	%	No.	%
0-14	41,732	17.0	35,366	17.0	9,676,377	17.8	888,456	16.4
15-24	24,483	10.0	20,748	10.0	6,837,371	12.6	662,309	12.2
25-64	123,009	50.1	104,245	50.1	28,265,162	52.0	2,726,738	50.3
65-74	30,377	12.4	25,743	12.4	5,162,873	9.5	614,926	11.3
75-84	17,904	7.3	15,173	7.3	3,099,319	5.7	367,112	6.8
85+	8,117	3.3	6,879	3.3	1,275,516	2.3	163,762	3.0
<b>All ages</b>	<b>245,622</b>	<b>-</b>	<b>208,154</b>	<b>-</b>	<b>54,316,618</b>	<b>-</b>	<b>5,423,303</b>	<b>-</b>

**Figure 18: Age breakdown in North Somerset & North Sedgemoor, England and the South West, 2015**  
(Source ONS 2015)

Population change is effected by three factors: the number of babies being born, the number of deaths and the number of people moving into the area:

- **Babies being born** - There are ~2,500 babies born per year with the majority born at St Michael's Hospital and Southmead Hospital in Bristol with an average of only ~170 deliveries at the midwife led unit (MLU) at Weston General Hospital (WGH) and ~25 home deliveries. The recommended number of births for a MLU is 500 to give a critical mass of activity to maintain appropriate clinical expertise. In order to reach 500 births, there would have to be a ~200% increase in the number of people choosing to give birth at the MLU<sup>13</sup>.
- **Standard Mortality Ratio (SMR)** - The SMR for North Somerset is 94.2% (versus 100% for England) indicating a lower number of deaths than expected overall. However, the SMR ranges from 57% in Clevedon Yeo to 161% in central WsM which highlights the significant health inequalities that exist across our local population.
- **People moving into the area** – the majority of future growth is currently expected to be focused in Weston and Worle. The area is being redeveloped with key new build housing sites at Winterstoke Village and Parklands Village and Central Weston totalling approximately 6,500 new homes by 2026, many of which will be for younger families, with implications for local primary care, maternity and children's services. This equates to a total of ~15,000 people, although not all of these will be from outside the county. The emerging West of England Joint

<sup>12</sup> North Somerset Public Health team report: An overview of the population health of North Somerset (2016). Available from [www.n-somerset.gov.uk/my-council/statistics-data/jsna/overall-findings/](http://www.n-somerset.gov.uk/my-council/statistics-data/jsna/overall-findings/)

<sup>13</sup> North Somerset Joint Strategic Needs Assessment (JSNA): Population chapter. Available from [www.n-somerset.gov.uk/my-council/statistics-data/jsna/joint-strategic-needs-assessment/](http://www.n-somerset.gov.uk/my-council/statistics-data/jsna/joint-strategic-needs-assessment/)

Spatial Plan has also identified potential developments of up to 3,600 in Nailsea and Backwell and there is also a large population expansion planned between Long Ashton and Bristol. It should also be recognised that there is also a net importing of older people moving into North Somerset – both in terms of normal housing, but also sheltered flats and care homes.

Given the above, the longer-term projections based on ONS data suggest the population of North Somerset and North Sedgemoor will increase at an annual rate of 1% across all age groups, reaching an estimated combined population of 300,000 by 2030.

It should be noted that the ONS based estimate of a ~1% per year net population growth is assumed to take into account any new housing developments and are the same figures used by North Somerset Council's Planning Department. As many of the people occupying these new houses as they become available over the next decade will already be resident in North Somerset, expert advice from the Public Health team is to plan on the basis of the existing official ONS projections. This is to avoid double-counting, using guesswork and having multiple figures circulating.

Figure 19 below looks at the projected population increase over the next 10 years based on 2014 ONS projection. The largest increase is set to be in the 75-84 age group (50% vs. 36% in England) followed by the over 85s (~46% vs. 42%). In respect to the younger age groups, the population is projected to rise in the 0-14 age group by ~12% (vs. ~8% in England), which equates to an additional 4,000 children in total in the next 10 years. Both the 15-24 and the 25-34 age groups are also increasing faster than the England average.

Age	North Somerset & North Sedgemoor			North Somerset			% change 2015-25 North Somerset & North Sedgemoor	% change 2015-25 North Somerset	% change 2015-25 England
	2015	2020	2025	2015	2020	2025			
0-14	42,362	45,666	47,318	35,900	38,700	40,100	11.7%	11.7%	7.6%
15-24	24,308	23,482	24,662	20,600	19,900	20,900	1.5%	1.5%	-1.8%
25-64	123,782	127,794	130,508	104,900	108,300	110,600	5.4%	5.4%	4.0%
65-74	31,034	32,214	31,624	26,300	27,300	26,800	1.9%	1.9%	7.3%
75-84	18,172	21,830	27,258	15,400	18,500	23,100	50.0%	50.0%	35.9%
85+	8,496	10,148	12,390	7,200	8,600	10,500	45.8%	45.8%	42.1%
<b>All ages</b>	<b>248,154</b>	<b>261,134</b>	<b>273,760</b>	<b>210,300</b>	<b>221,300</b>	<b>232,000</b>	<b>10.3%</b>	<b>10.3%</b>	<b>7.0%</b>

**Figure 19: 2012-based sub-national population projections for North Somerset and North Sedgemoor combined and percentage change, England, 2015-2025** Source: ONS, 2014 (assume trends 2008-2012 continue)

### Specific population growth in Weston-super-Mare (WsM)

Estimates obtained from Hampshire Council's small area population forecast service which takes into account housing development suggests growth in WsM in the 10-year period from 2014-2024 will be 22%, compared to background growth across the whole of North Somerset of 13% (in the same time frame 2014-2024, current estimate 10% from 2015-2025). This area includes Worle, St. Georges, Kewstoke, Uphill, Locking and Hutton. Based on the 2014 population figure for that area (88,220) the 22% increase to 2024 will result in a population of 107,635 in WsM.

## Life expectancy & health inequalities

Life expectancy is the average number of years a person is expected to live based on a range of factors. Healthy life expectancy is an estimate of the years of life that will be spent in good health. Across North Somerset and North Sedgemoor, life expectancy at birth is ~80 years for males and ~84 for females. These figures are similar to the South West average and slightly higher than England overall. However, these figures mask significant health inequalities across our local population. Health inequalities are the differences between people or groups due to social, geographical, biological or other factors. These differences have a huge impact because they result in people who are worst off experiencing poorer health and shorter lives. The Joseph Rowntree Foundation estimates that poverty costs the NHS £29bn per year (equivalent to 25% of the entire NHS budget in England).

As commissioners, our approach to addressing health inequalities is to ensure health services are equitable and address the specific needs of our most deprived communities. Evidence shows that people in lower socio-economic groups are more likely to have a greater prevalence of severe and enduring mental and physical health problems. The impact is greatest on children living in poverty. The national rate of children living in poverty, after housing costs, in England is 25% with the average for North Somerset being 19%. However, in WsM Central Ward it is 36% and WsM South Ward is 38%. More than one in five children starting primary school in England are overweight or obese and obesity leads to serious increased risk of lifelong health problems including type 2 diabetes, heart disease and cancer. The figures in North Somerset are similar to the England average, but likely to be higher in Weston.

Life expectancy varies considerably across North Somerset. WsM Central Ward has the lowest life expectancy, where the respective figures are 67.5 years for males and 76 years for females. Conversely Clevedon Yeo has the highest life expectancy for both males and females, at ~86 years and 92.5 years respectively. This creates a gap in male life expectancy between these Wards of ~18.5 years for men and 16.5 years for women.

The main causes of the gap in life expectancy for men are circulatory diseases – such as coronary heart disease (CHD) and stroke (28.3%), cancers (17.6%) and external causes including injury, suicide and poisoning (17.8%). For women, the main causes were circulatory diseases (25.8%), respiratory – such as COPD (15.1%) and cancer (14.8%).

Although CHD has reduced significantly in recent years, it remains a leading contributor to the gap in life expectancy accounting for 15% of the gap in males and 12% of the gap in females. Other circulatory diseases are also important contributors to life expectancy inequalities. Stroke is an increasing contributor in female life expectancy and other circulatory diseases contributed relatively more to the gap in male life expectancy.

Other important contributors to the gap in life expectancy are cancer, pneumonia and COPD, with a notable increase in the contribution of COPD to the female life expectancy inequalities. Suicide and other external causes contribute more to the male life expectancy gap than the female gap whereas mental and behavioural disorders (including dementia) contribute relatively more to the female than male life expectancy inequalities.

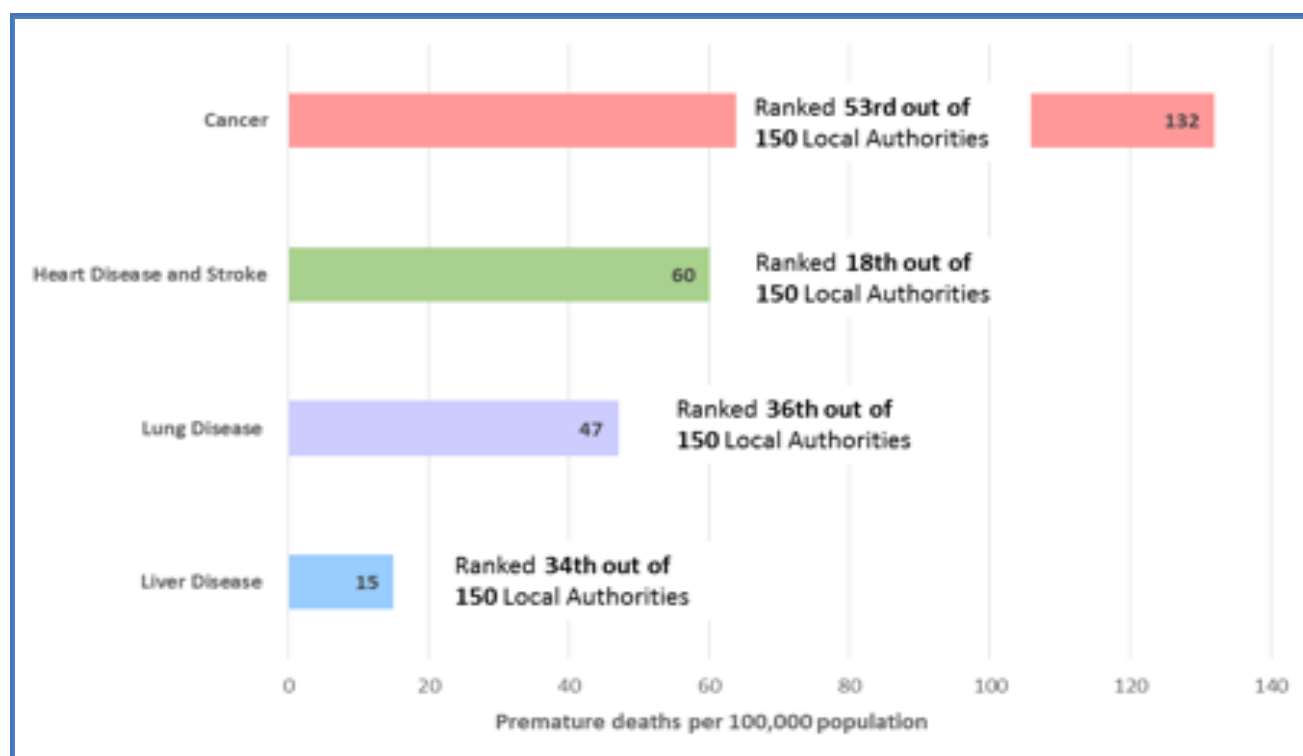
Using data from Public Health England it is estimated that 46% of male deaths and 36% of female deaths in the most deprived areas were considered 'excess'; i.e. these deaths would not have occurred if all areas in North Somerset had the same mortality profile as the least deprived areas<sup>14</sup>.

### Causes of death, premature death, and morbidity

The leading causes of death across all ages in North Somerset are CHD, Stroke, influenza and pneumonia, dementia and Alzheimer's, and cancer. There are differences by gender with a number of females dying from dementia and Alzheimer's disease and the higher proportion of males dying from CHD. North Sedgemoor is similar with the main causes of death being circulatory diseases, cancers and respiratory diseases.

Although numbers vary from year to year, the overall number of deaths is generally decreasing with the exception of deaths from pneumonia and influenza which are stable and deaths from dementia and Alzheimer's which are increasing. This is to be expected given the increases in life expectancy and ageing population.

Premature deaths are deaths that occur before a person reaches an expected age (set at age 75). Figure 20 below shows the leading causes of premature death in North Somerset.



**Figure 20: The leading causes of premature death in North Somerset and rankings compared to other local authorities in England, 2013-2015<sup>15</sup>**

North Somerset ranks 45th out of 150 local authorities with 305 premature deaths per 100,000 population (note: the leading local authority would rank 1<sup>st</sup>). This is statistically significantly lower than the premature death rate across England. However, when compared to 14 other comparable

<sup>14</sup> Public Health England: Longer Lives data tool: Available from <http://healthierlives.phe.org.uk/topic/mortality>

<sup>15</sup> Source: Public Health England - Longer Lives Mortality Rankings, 2013-2015

local authorities with similar levels of deprivation, North Somerset ranks 10th out of 15 and worse than average within the group. The rates for premature deaths from cancer and liver disease are higher than the group average.

WsM Central and South Wards have the highest premature death rates from all causes of death, cancer and circulatory diseases. Almost one in ten residents in these Wards describe their health as 'bad' or 'very bad' and between 25- 30% of residents report having a limiting long-term condition or disability.

Years of Life Lost (YLL) is a measure of the average number of years people would have lived had they not died prematurely. Overall YLL from causes considered amenable to healthcare in North Somerset have shown a decreasing trend since 2001-2003, however there is variation between disease groups. The potential years of life lost from amenable cancers (including breast, colorectal and skin cancer) in North Somerset have been increasing and are above national figures. Amenable cancers are now the primary cause of years of life lost from treatment amenable causes in North Somerset, representing more than a third of total years of life lost.

In the North Sedgemoor locality, the leading contributors to years of life lost before the age of 75 are cancer, circulatory diseases, respiratory diseases and diseases of the digestive system; the biggest cause in the latter category being chronic liver disease. Accidents, including land accidents are also a significant cause of years of life lost in North Sedgemoor.

DALYs take into account the number of years of a person's life are lost but also the amount of time spent with a disability, hence they capture the impacts of chronic conditions and those associated with pain and morbidity. In North Somerset the leading causes of DALYs lost are cancer (neoplasms), mental health and behavioural disorders, musculoskeletal conditions and cardiovascular disease; in particular low back and neck pain (6,249), ischaemic heart disease (4,887), chronic obstructive pulmonary disease (2,377) and cerebrovascular disease (2,233).<sup>16</sup>

## Prevention

Using the 3-4-50 model<sup>17</sup> can help to identify where initiatives on prevention can have the most impact. As stated above, the four leading causes of premature mortality locally are cancer, circulatory diseases, respiratory diseases and liver disease. Overall these account for over 50% of all premature deaths in North Somerset. Primary risk factors for these diseases include smoking, substance misuse, poor diet and low physical activity.

- Smoking prevalence in North Somerset is approximately 15%. However, this varies by Ward with 25% of residents in more deprived areas estimated to be smokers. North Sedgemoor locality is estimated to have a lower prevalence than the national rate (13% & 18% respectively).
- The pattern of alcohol consumption varies by deprivation within North Somerset. People living in more affluent areas tend to drink more frequently than those in less affluent areas. However, heavy or binge drinking is more common among residents of less affluent areas. In North Sedgemoor, alcohol-related admissions for the locality are lower than those seen nationally.

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<sup>16</sup> <http://www.n-somerset.gov.uk/my-council/statistics-data/jsna/overall-findings/>

<sup>17</sup> 3-4-50 Model - The 3-4-50 model was developed in Oxford but utilised in San Diego and published in 2010. It represents a useful framework for considering the major population health issues in a local area.

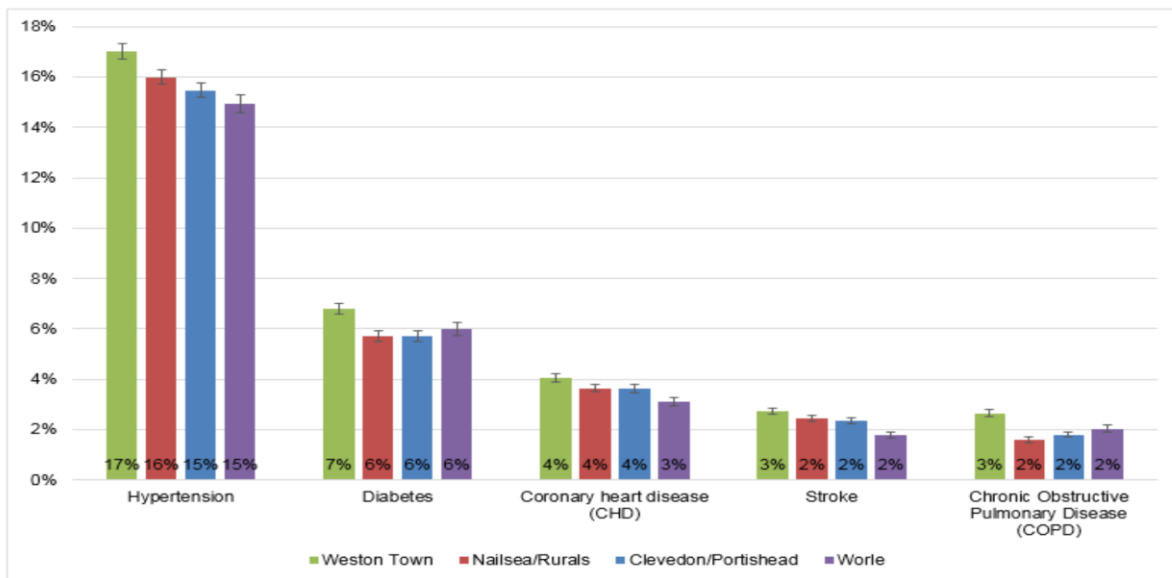
- National data suggests a fall in the number of people reporting taking illicit/ psychoactive drugs. However, in North Somerset there has been a 15% increase in the number of new presentations to structured treatment in 2015/16 compared with 2014/15.
- Physical activity levels in North Somerset are similar to regional and national averages (57%, 58% and 56% respectively), while the prevalence of childhood obesity in North Somerset and the North Sedgemoor locality is similar to that seen nationally with around a fifth of 4- 5year olds classed as obese or overweight.

The above risk factors in part contribute to the following average numbers of premature deaths (i.e. under 75 years of age) per year in North Somerset (total 617).<sup>18</sup>

- Cancer: 271
- Lung disease: 55
- Other causes: 139
- Circulatory disease: 122
- Liver Disease: 30

### Current & future disease prevalence summary (North Somerset only)

Figure 21 below provides details of the disease prevalence across the following areas: Weston Town, Worle, Nailsea/Rurals, Clevedon/Portishead (also referred to as ‘Gordano’).



**Figure 21: QOF disease prevalence 2015/16 for North Somerset**

The health status of people registered with practices living in and around Weston town is poor compared to North Somerset overall and the other locality areas. Nearly two thirds (64%) of those registered with Weston Town practices reported having a long term health condition, compared to 51% in Worle and 57% in the North Somerset area. More than one in five people in Weston town

<sup>18</sup> Based on 2013-2015 figures from the Public Health England outcomes framework. Available from [www.phoutcomes.info/](http://www.phoutcomes.info/)



(23%) and Worle (21%) reported a long-term health problem or disability that limits their day-to-day activities compared to 17% in both the Clevedon and Portishead and Nailsea and Rurals localities.

As would be expected from the above figures, disease prevalence figures are highest in the Weston town where 17% of people are recorded as having hypertension, 7% suffer from diabetes, 4% from coronary heart disease (CHD) and 3% from stroke.

The growing, ageing population of North Somerset is leading to a shift in the pattern of local health needs and an increase in demand on health and care services. More people are living with long term conditions, and many will live with more than one health condition, be it affecting physical or mental health. Managing these conditions in a holistic and proactive way is a significant challenge as local services and staff have historically focused on managing specific conditions rather than being integrated around the needs of the patient.

The pattern of risk factors within the local population will affect health needs and outcomes and preventative action, such as reducing tobacco and alcohol use, improving diets and increasing physical activity, will help to mitigate against some of the increases in demand for healthcare.

Modelling disease prevalence rates against predicted changes in the North Somerset population shows the number of people living with cardiovascular disease (including hypertension), respiratory disease (COPD), diabetes and dementia is likely to increase over the next 10-20 years. It is estimated that by 2030 there will be; over 1,700 more people living with CHD and around 750 more people having had a stroke compared to 2015; over 10,000 more individuals living with hypertension compared to 2015; and around 6,000 people living with COPD.

Estimates also indicate there will be around 20,500 people living with Diabetes by 2030, an increase of around 6,000 people. This is dependent on the prevalence of obesity within North Somerset and assumes the current increasing trend continues. Finally, the ageing population means the numbers of people living with dementia are predicted to increase to almost 6,000 people by 2030, an increase of almost 2,500.

In order to address current and future health needs effectively, and within the available resources, healthcare services not only need to develop new models of care to better manage illness and injuries out of hospital in the community and closer to home, but also be promoting healthier lifestyles and choices. Health professionals should encourage patients to engage in healthier lifestyles, both through “making every contact count” and signposting to community and voluntary services which support behaviour change, such as Health Trainers / Health Coaches.

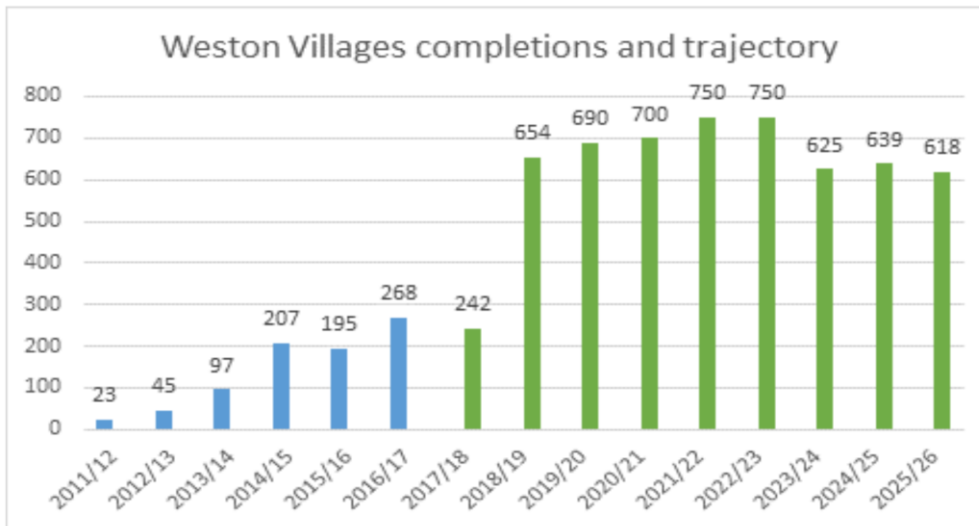
## **Weston Villages Profile**

The following information is based on a Public Health Report (July 2017) that specifically looked at the likely impact of significant new housing developments in the Weston Villages.

### **Weston Villages**

The Weston Villages are the main strategic growth area for North Somerset and are forecast to deliver up to 6,500 new homes and 10,000 new jobs. The population is likely to be generally younger than the North Somerset average and in better health with less disease prevalence.

The overall population figure is 14,880 based on the building of 6,500 homes with an average of approximately 2.3 persons per household. The current trajectory of housing development plan is shown below with blue representing completed dwellings and green planned developments. As at July 2017, approaching 1,000 of the homes are built and occupied.



**Figure 22: Weston Villages completions & trajectory**

(Total between 2011/12-16/17= 835, total between 2017/18-2025/26=5,668)

### Population profile

Previously the overall census profile for North Somerset was applied to this population number to give an illustrative example of what the population would be like if it mirrored the overall North Somerset profile. However, it is likely that new build housing will attract a different demographic profile and based on advice from North Somerset Council’s Research and Monitoring Officer, it was agreed the closest population match would be that of the Locking Castle area, which has seen similar new build development and has now established a resident population.

Therefore, the 2011 census data for four lower layer super output areas (LSOA) in Locking Castle was used to model the population age structure, ethnicity and long term health problems for the new population of Weston villages. The disease prevalence is based on data for the Stafford Medical Group, a practice with two branches; a small branch in Stafford Road in Central Weston and a larger branch in the Locking Castle area. It should be noted that the numbers used to create this profile are fairly small and therefore it should be interpreted with caution.

### Age profile & ethnicity

The age profile is likely to be much younger than North Somerset with a high proportion of 0-14 and 25-44 year olds. Estimates for the BME population suggest that the proportion in Weston Villages (3%) is fairly similar to North Somerset (2.7%).

### Life expectancy and fertility rates

Life expectancy for both males (82.6) and females (87.4) is higher than the North Somerset average (79.8 and 83.5 respectively). The fertility rate in Weston Villages (86 per 1,000 females aged 15-44) is likely to be the highest in North Somerset and is much higher than the average rate (66). In the Weston Villages area, the dependency ratio (i.e. the ratio of the number of dependents to working age people) is 52.5%, which is lower than the North Somerset average (60.7%).

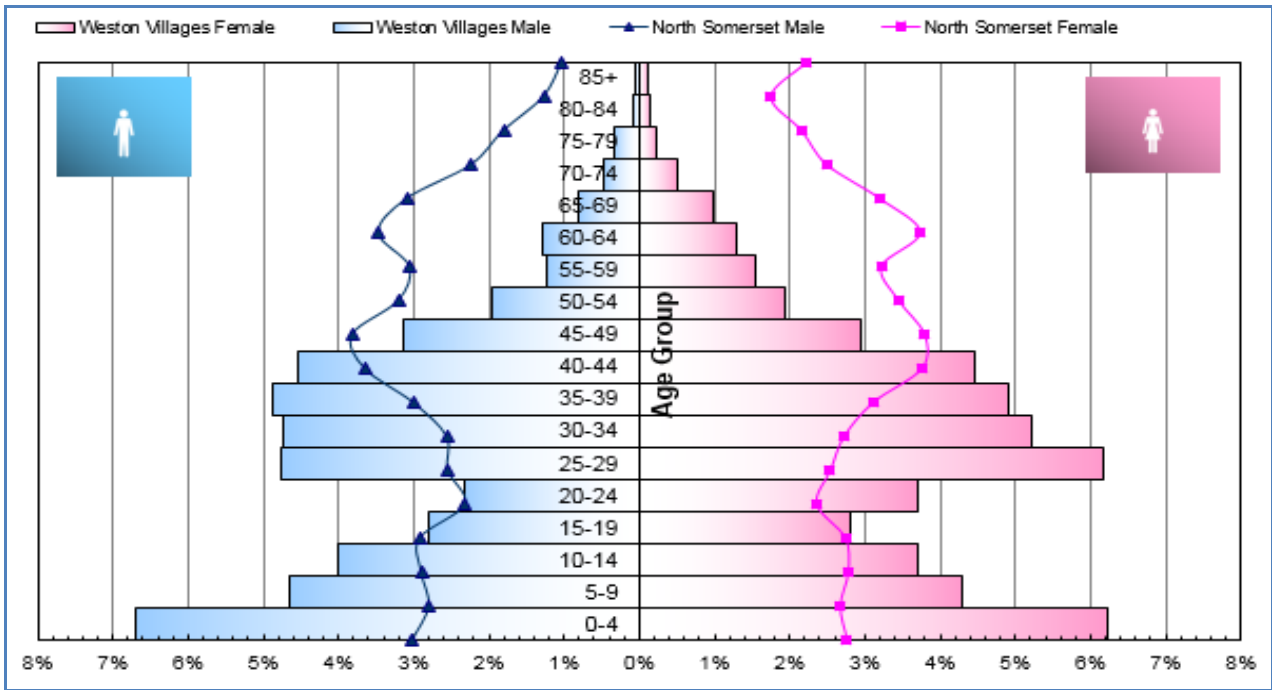


Figure 23: Population profile of Weston Villages

### Indicators of health

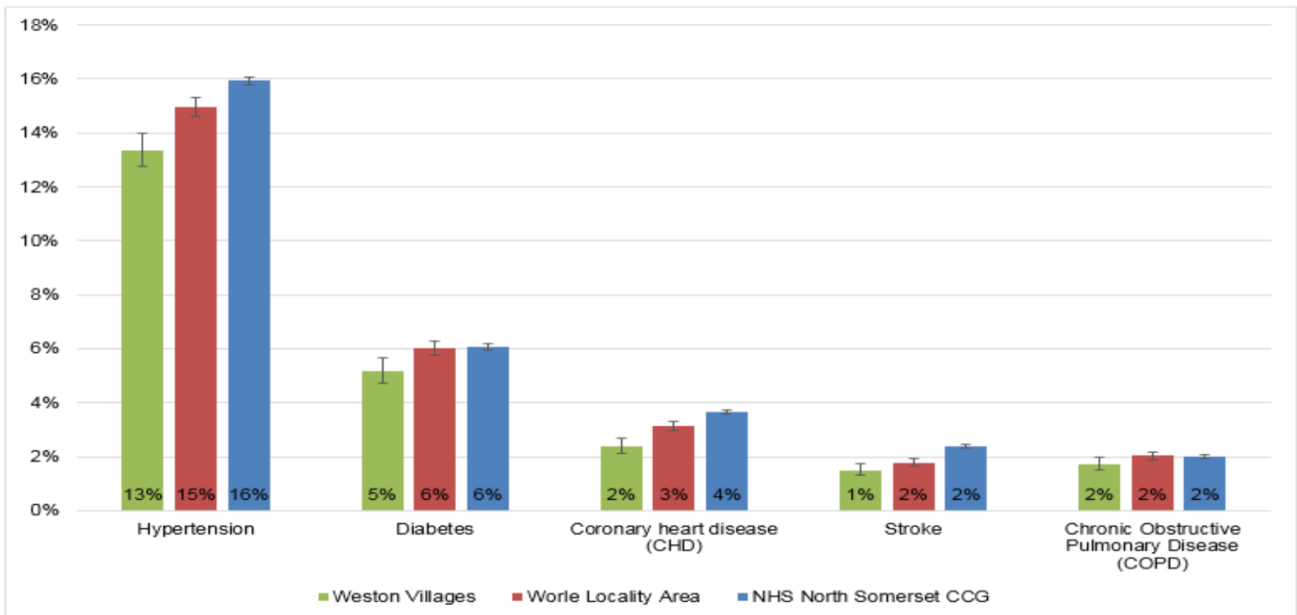


Figure 24: QOF disease prevalence for Weston Villages, 2015/16

Less than one in ten people in Weston Villages are likely to have a long term health problem or disability that limits their day-to-day activities compared to 19% in North Somerset. Levels of bad and very bad health (2.3%) were also lower than the North Somerset average (5.3%). There are fewer carers in Weston Villages (6.1%) than in North Somerset (11%).

As would be expected from the above figures, disease prevalence rates are lower in the Weston Villages area compared to both Worle and North Somerset as a whole. One in eight people are recorded as having hypertension (13%), 7% suffer from diabetes, 4% from CHD and 3% from stroke and COPD. This is shown in Figure QOF disease prevalence, 2015/16.

## APPENDIX 3: Supply Side Analysis

### Acute Hospital Services (WAHT, UHB, NBT)

#### Service provision

In North Somerset, 60% of secondary care acute services (excluding specialised services) are delivered by Weston Area Health Trust (WAHT), with the great majority of the remaining acute capacity provided by North Bristol Trust (NBT) and University Hospitals Bristol (UHB) in Bristol and Taunton & Somerset NHS Foundation Trust (TSFT) in Somerset. WAHT, which employs ~1,800 staff and has an annual turnover of circa £100m, delivers clinical services from three sites as described below.

The first site from which WAHT provides services is Weston General Hospital (WGH), which is one of the smallest district general hospitals (DGHs) in the country. It has ~265 beds and is located in the town of WsM providing acute emergency services for adults including a 24/7 emergency department (ED), critical care (a 5 bed intensive care unit or 'ICU'), medicine (including a medical assessment unit or 'MAU' and clinical decisions unit or 'CDU') and a surgical assessment unit or 'SAU', together with supporting diagnostic services. There is also a midwife led unit (MLU) for maternity services and a range of planned or 'elective' treatments including general surgery, urology, orthopaedics, and other services such as endoscopy, haematology and some cancer care.

WAHT also provides children's and young people's community health services, including child and adolescent mental health services (CAMHS), from two children's centres located at Drove Road in WsM and The Barn in Clevedon. It also provides some community services including physiotherapy, speech and language therapy (SALT) and occupational therapies (OT).

WAHT not only provides acute health services to the population of North Somerset, but also provides acute services to the population of the North Sedgemoor area of Somerset. Around 20% of the Trust's activity is made up of patients resident in North Sedgemoor accounting for around 2% of Somerset CCG's total population. The total catchment population of WAHT is estimated to be between 160,000 and 180,000 people. This is comparable to other small coastal hospitals such as North Devon Trust, which is similarly struggling with service sustainability issues.

Such small coastal hospitals consequently find it difficult attract sufficient market share to generate sufficient economies of scale and WGH is no different. In WGH's case, to the west is the sea, and to the east is an arc of three much larger, higher profile acute service providers as described above. This is particularly the case with urgent and emergency care as little – if anything at all – by way of urgent care activity is likely to pass the larger hospitals in preference for treatment at WAHT.

Within BNSSG, there are also two large tertiary acute providers: UHB and NBT. These hospitals, which are 24 and 26 miles away from WsM respectively, are used far more extensively by residents who live in the northern half of North Somerset while in the southern part, 25 miles from WsM, patients also attend Musgrove Park Hospital (part of TSFT) where Somerset CCG acts as that provider's coordinating commissioner.

WAHT has established joint working and network arrangements with its neighbouring acute providers (sometimes referred to as 'acute care collaboration'). This allows WAHT to deliver a range of additional services at WGH and support local consultants in maintaining their clinical skills. In February 2017 UHB and WAHT announced a partnership agreement, undertaking to:

- Draw-up a formal partnership agreement, describing how the partnership will help address long-standing issues of clinical and financial sustainability at WGH.
- Develop a joint service strategy, setting out proposed areas for co-operation, which could include a greater range of shared clinical and management services.
- Establish a joint management board to oversee delivery of this work.

The precise detail of how the partnership agreement will work is still being developed between the two providers. The final model of closer working and support between the two hospitals is recognised by the system as being an important component of ensuring a stable and well-functioning local health economy and is welcomed.

### Overview of current quality and performance against targets

**WAHT:** The latest CQC report (June 2017) rated the Trust as ‘Requires Improvement’ overall. The Caring domain was rated as ‘Good’ while the domains of Safety; Effective and Well-led rated as ‘Requires Improvement’. The Responsive domain was rated as ‘Inadequate’ which means that at the time of the inspection, there was an insufficient sense of urgency to respond to patients in the emergency department (ED) to promote discharge that would initiate flow through ED to the rest of the hospital. This responsiveness is an important element in reducing overcrowding in the ED.

**UHB:** The latest CQC report rated the Trust as ‘Outstanding’ overall. The Effective and Well-led domains were individually rated as ‘Outstanding’, with Safety and Caring as ‘Good’ and Responsive as ‘Requires Improvement’.

**NBT:** The latest CQC report rated the Trust as ‘Requires Improvement’ overall. The Well-led domain was rated as ‘Good’ while the domains of Safety, Caring and Responsive were rated as ‘Requires Improvement’.

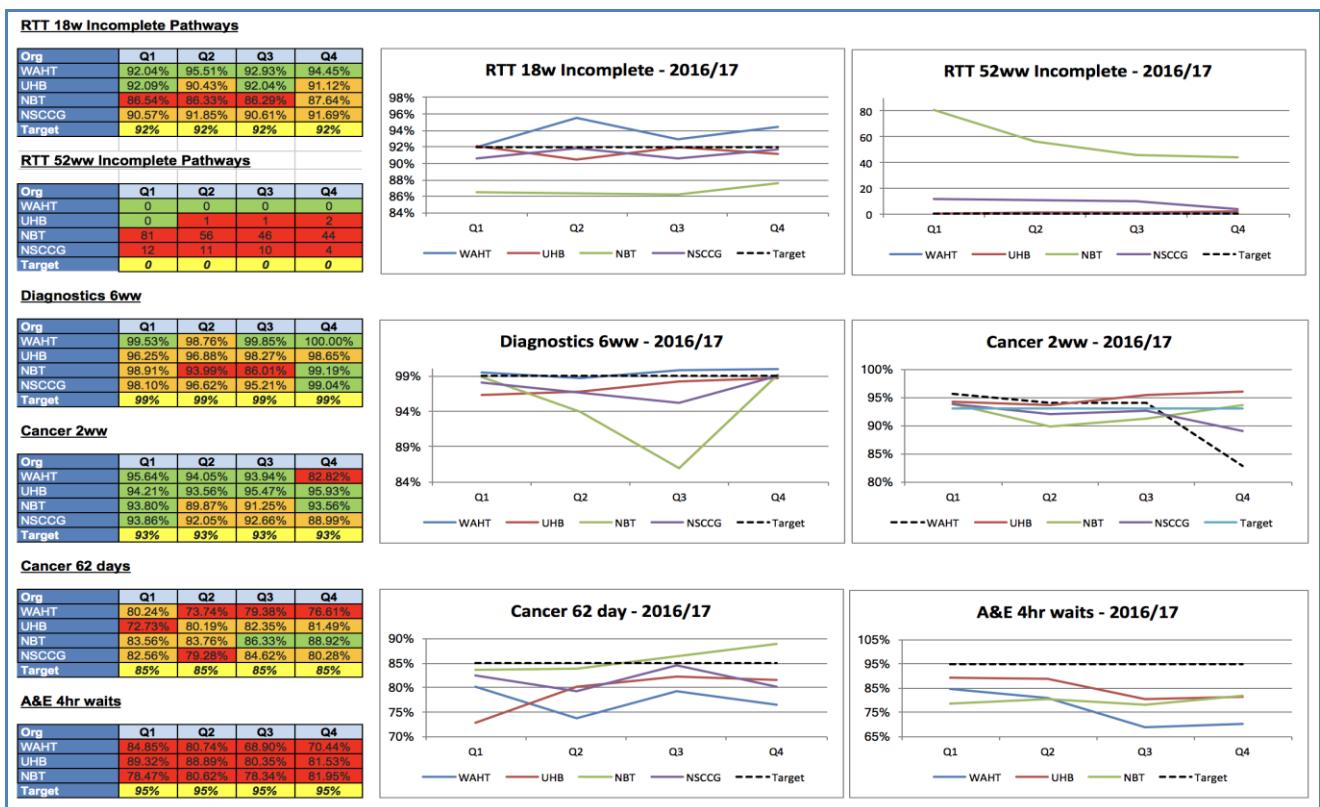


Figure 25: Acute provider performance Q1-Q4, 2016/17

Figure 25 above summarises the performance data for the four quarters of 2016/17 for key acute performance targets. Please note that these numbers are in relation to all Trust activity, not just North Somerset residents. The average for North Somerset CCG is shown as 'NSCCG' and most of the targets are rated as 'amber' with challenges around the 2 week wait and 62 day treatment targets for cancer.

### **Service delivery challenges (including workforce & capacity constraints)**

**WAHT:** A pressing constraint for WAHT is an inability to attract and retain sufficient numbers of emergency department (ED) specialist doctors – both consultants and middle grades. Although the ED is busy, 50-55,000 attendances per annum, these numbers may not be sufficient to generate the critical mass required for a financially self-sustaining service under standard NHS contracting rules. Coupled with this, the long-standing uncertainty about the future of services at the hospital and the more varied options on offer at other local providers has made it doubly difficult to recruit ED specialists – a group for which there is already a national shortage. This results in the CCG needing to pay premiums for a number of services, in particular A&E and critical care services) to keep the services running which impacts the funding available to invest in other services.

This situation was compounded by the withdrawal in 2015 of FY2 trainee doctors from overnight ED shifts due to a lack of appropriate supervision. This meant the Trust has relied very heavily on agency and locum doctors to fill shifts, which ultimately has culminated in the temporary closure of the ED overnight on the grounds of patient safety.

The Trust also has recruitment challenges in other areas such as acute medicine, gynaecology, CAMHS and community paediatrics and requirements to change service models/staffing on the back of a number of Royal College reports.

Training of junior doctors at WAHT overall has been under enhanced monitoring since 2015 as a result of coming bottom nationally in the Junior Doctor GMC survey. FY2 overnight doctors were removed from the ED overnight at the same time. The Trust improved to 7<sup>th</sup> lowest nationally in the 2016 survey of all Trusts in England, but returned to last place in England in the 2017 survey. A follow-up inspection has been scheduled for November 2017.

**UHB:** The key issues for UHB are clinical recruitment and retention in some specific areas and meeting a number of constitutional standards as shown in Figure 25.

**NBT:** NBT has recently come out of financial special measures, although the provider continues to run a very significant deficit. The key issues for NBT are as follows: significant imbalance in demand and capacity for planned/elective surgery leading to a heavy reliance on outsourcing to the Independent Sector and meeting a number of constitutional standards as shown in Figure 25.

### **Summary Hospital-level Mortality Indicator (SHMI)**

The SHMI reports on mortality at trust level across the NHS in England using a standard and transparent methodology. It is produced and published quarterly as a National Statistic by NHS

Digital. The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there<sup>19</sup>. A ratio of 100 equates to 'as expected'.

For the main acute providers serving North Somerset, the SHMI for Jan 2016 – Dec 2016 is set out below. Please note that this information relates to all patients at each Trust, rather than specifically residents of North Somerset:

- Weston Area Health Trust: 111.06
- University Hospitals Bristol: 99.30
- North Bristol Trust: 96.67

## Out of Area Acute Hospital Services (TSFT)

TSFT is commissioned by Somerset CCG and was rated 'Good' overall in its last CQC inspection. The organisation has one main location at Musgrove Park Hospital; a large acute hospital providing a wide range of acute services. Musgrove Park does take patients from parts of North Somerset. For example, in the recent modelling prior to the temporary overnight closure of the ED at WGH, it was assumed that Musgrove Park would take around 12% of the displaced activity. At the four week stage after closure, Musgrove Park has seen more walk-ins, more ambulance arrivals and more emergency admissions than the modelling would suggest. Although the proportional differences have been high, the numbers are around 2 more walk-ins per day and 2 more ambulance arrivals per day. Any future provider alliance will need to ensure strong operational and planning links with TSFT.

## Non-NHS Acute Provision

Somerset Surgical Services – an independent healthcare provider – also use WGH's theatres. The organisation provides a range of services, many of which are not currently provided by WAHT. Procedures available under this arrangement include Cataract Surgery, Lumbar Spinal Surgery, Non-Cosmetic Plastic Surgery, Specialist Foot and Ankle and Hand and Wrist, Orthopaedic Hip and Knee and Oral-Maxillofacial Services.

Through patient choice, North Somerset residents also access planned care treatment through a range of local providers, including Care UK's facility at Emerson's Green and the Nuffield's facilities in Bristol and Taunton. In 2015/16 BNSSG spent £40m on planned care in non NHS facilities, the largest proportion being on trauma and orthopaedics.

## South Western Ambulance Service

### **Service provision**

South Western Ambulance Service Foundation Trust (SWASFT) covers 20% of the landmass of England and has significant travel distances to address in order to achieve response times for clinical delivery. The Trust's primary role is to respond to emergency 999 calls, 24 hours a day, 365 days a year. 999 calls are received in one of two emergency operation centres, where clinical

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<sup>19</sup> <http://content.digital.nhs.uk/SHMI>

advice is provided and emergency vehicles are dispatched if required. In addition, air ambulance services are provided by charity support and staffed by SWASFT.

Although the traditional view of the ambulance service is one of a transport service responding to calls and conveying patients to the nearest A&E department, this view is outdated and not the position in SWASFT.

Currently, only 46% of patients are conveyed to an A&E department, which is the lowest appropriate patient conveyance rate in the country.

SWASFT's ambition is to safely manage more patients on scene, or in their own homes, using alternate referral pathways and supporting community based services, and only where this is not appropriate, convey them to the most clinically suitable facility (not necessarily the nearest e.g. all major trauma patients have been conveyed to NBT (Southmead) since 2012).

### **Overview of current quality and performance against targets**

The latest CQC report for SWASFT rated the organisation overall as 'Requires Improvement' along with the domains of Safe, Effective and Well-led. The Trust was ranked 'Good' for Responsiveness and 'Outstanding' for Caring.

SWASFT has been participating in a national pilot called the Ambulance Response Programme which measures performance differently from current national standards.

- Response times for Category 1 calls (life threatening injuries or illnesses) for North Somerset was at 71.76% for June 2017 (against a target of 75%), better than the Trust's overall performance. However, some unpredictable spikes in demand remain an issue that SWASFT are working with commissioners to review; these can affect monthly performance.
- Time to call answer – ambulance services are expected to answer 95% of all 999 calls within 5 seconds. SWASFT are currently at 55 seconds. Recent underperformance has been driven by a combination of staff vacancy, sickness and unexpected spikes in demand.
- Hospital handover delays continue to impact on available resource. In June 2017, there were 252 handovers involving North Somerset patients which took longer than 15 minutes, equating to roughly 35 hours of lost time. For WGH specifically, 206 handovers took longer than 15 minutes, equating to over 21 hours lost.
- Number of incidents per head of population for North Somerset is 38.59 per 1000 population, which is average against the other SWASFT areas.

### **Service delivery challenges (including workforce & capacity constraints)**

Workforce is a particular challenge for SWASFT, specifically the recruitment and retention of specialist paramedics, paramedics and clinical hub call takers and clinicians. The training time for paramedics is three years and as a staff group they are in high demand. There are also non-personnel constraints to SWASFT; for example, the lead in time for ordering and taking delivery of new vehicles, if capacity requirements increase, can be 4-6 months.



## Primary Care (General Practice)

### Service provision

There are currently 18 GP contracts in North Somerset – 14 PMS<sup>20</sup>, 3 GMS and 1 APMS. Services are offered to a current GP registered list size of ~219,000 people (as of July 2017) from across 29 sites. Ten of these contracts are for GP services in the Weston & Worle localities with services delivered from 14 sites serving ~100,000 patients.

The number of contracts has declined from 25 since the CCG was formed in 2013. This has predominantly been through mergers. An APMS GP led walk-in and registered GP list service at WDH and the Boulevard Weston were initially changed to a ‘front-door’ nurse led service at the hospital and a GP practice at the Boulevard and then both services were closed in September 2013 following an unsuccessful tendering process. Two practices have recently applied to NHSE to close branch surgeries – Wrington village (Mendip Vale Medical Group) and Stafford Place (Stafford Medical Group). These are going through due process and the CCG has been consulted.

Most practices operate hard and soft list boundaries. These are more porous in Weston/Worle where many practices have patients living in or around the town, but outside of the practice boundary. There are no closed lists and no applications for such in progress.

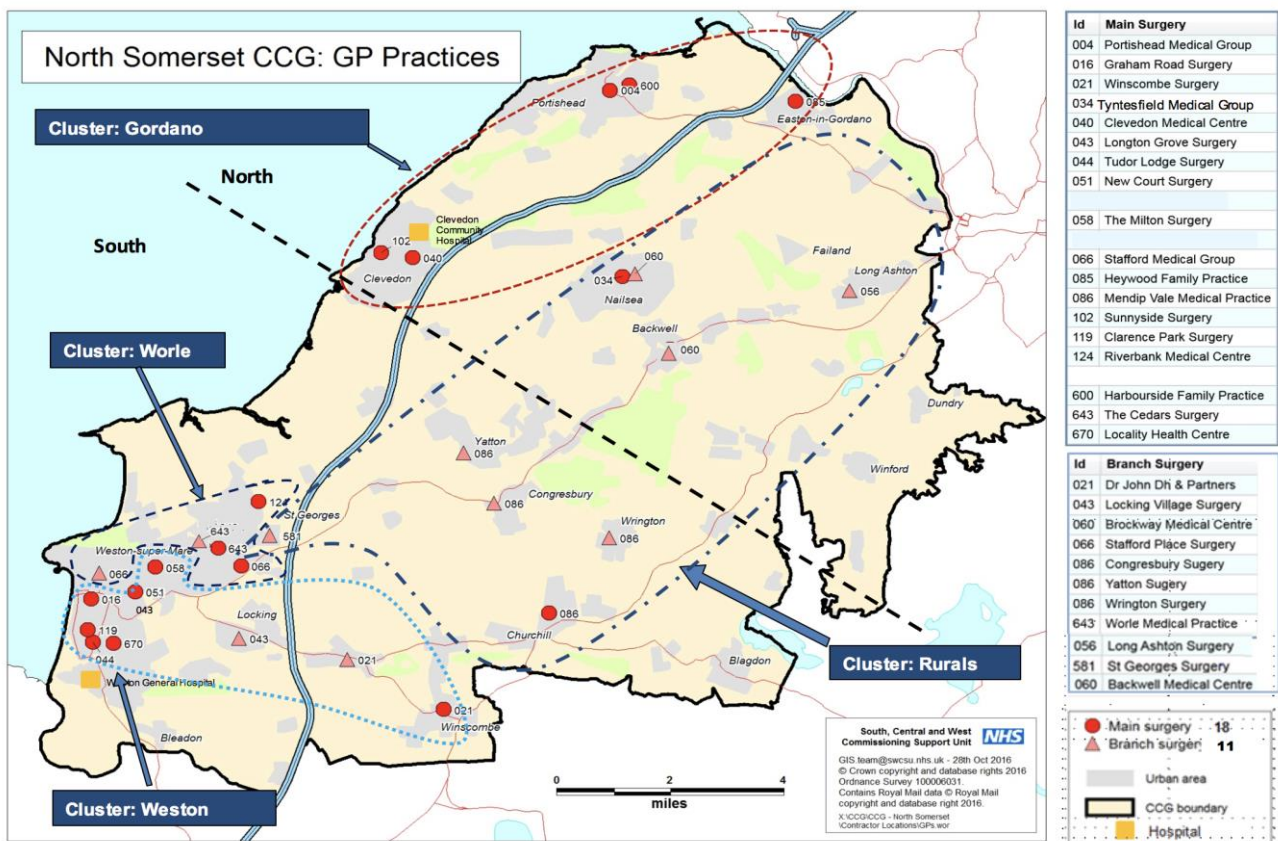


Figure 26: North Somerset CCG GP Practice map (as of July 2017)

<sup>20</sup> PMS contracts –are currently in the second year of a five year process of alignment, to ensure all practices are being bought to the same level of funding to be in line with funding for GMS contract.

Figure 26 above marks out both the main and branch surgery locations for GP Practices across North Somerset. GP Practices are currently split into four groups called ‘clusters’<sup>21</sup>: Weston, Worle, Gordano and the Rurals. These clusters are geographically based and closely match the North Somerset Community Partnership’s (NSCP) community ward teams. Although formal cluster-based working (also referred to within the CCG as primary care working ‘at scale’) is still developing, the CCG is working closely with local GP Practices to develop greater resilience to demand pressures by working across clusters of practices to create additional capacity and share services to reduce costs.

The table below provides further detail on which GP Practice is aligned to which cluster as well as current cluster list size as of July 2017. It should be noted that future GP Practice mergers are more than likely which may result in further movement of GP Practices between the various cluster groupings.

<b>Weston</b>		<b>Worle</b>	
List size as at 1 <sup>st</sup> July 2017: <b>66,480</b>		List size as at 1 <sup>st</sup> July 2017: <b>36,521</b>	
<ul style="list-style-type: none"> <li>• Clarence Park Surgery</li> <li>• Locality Health Centre</li> <li>• Graham Road Surgery</li> <li>• Longton Grove Surgery</li> <li>• The Milton Surgery</li> <li>• New Court Surgery</li> <li>• Tudor Lodge Surgery</li> <li>• Winscombe &amp; Banwell Family Practice</li> </ul>		<ul style="list-style-type: none"> <li>• Stafford Medical Group</li> <li>• Riverbank Medical Centre</li> <li>• The Cedars Surgery</li> </ul>	
<b>Gordano</b>		<b>Rurals</b>	
List size as at 1 <sup>st</sup> July 2017: <b>58,349</b>		List size as at 1 <sup>st</sup> July 2017: <b>57,659</b>	
<ul style="list-style-type: none"> <li>• Clevedon Medical Practice</li> <li>• Harbourside Family Practice</li> <li>• Heywood Family Practice</li> <li>• Portishead Medical Group</li> <li>• Sunnyside Surgery</li> </ul>		<ul style="list-style-type: none"> <li>• Mendip Vale Medical Practice</li> <li>• Tyntesfield Medical Group</li> </ul>	

**Figure 27: GP Practices by cluster (as of July 2017)**

Five practices across eight sites have formed a company (which may become a Community Interest Company) partly in response to the increasing population in the Weston Villages. The original members have agreed to keep their lists open to new Weston Village residents. Discussions are underway with other local practices and more may join in due course.

The Locality Health Centre practice has recently taken over the management of Clarence Park and Graham Road surgeries. A formal merger is not possible at present because Locality is an APMS contract (expiry 31.10.18) but it is expected that the two PMS practices will merge pending a decision on any 2018 procurement for the Locality contract.

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<sup>21</sup> Defined here as the registered population of a specific group of General Practices based on a geographical location where different services work in an integrated way for the population. These clusters are likely to be for a population of 30,000 to 50,000, but could be higher. In contrast, Primary care ‘Localities’ will be between 100-150,000 population.

Interest in working more collaboratively is more evident and advanced in Weston, Worle and Winscombe, driven in part by the Weston Primary Care Transformation Programme. It is least evident in the Rurals.

### **Overview of current quality and performance against targets**

All but one of the current practices in North Somerset have been inspected and rated by the CQC. The only one that hasn't is Mendip Vale Medical Group, although some of the constituent practices were inspected prior to merger.

All practices were assessed as good except:

- Locality Health Centre Outstanding
- The Cedars Requires improvement
- St Georges Requires improvement (now part of Mendip Vale Medical Group)
- Worle Requires improvement (now part of The Cedars)

When asked about their overall rating of GP services in North Somerset, patients responded as follows:

- 87% of patients surveyed said their experience is 'very good' or 'fairly good'. This is similar to the satisfaction ratings reported in South Gloucestershire and Bristol. This ranges between 69-98% depending on the GP Practice that the patient is registered with.
- A total of 8 practices in North Somerset are below the CCG average for overall satisfaction.
- Amongst patients aged 65 or over, 94% rate their experience as 'very good' or 'fairly good'.
- Currently 77% of patients are very/fairly satisfied with opening hours. This ranges by GP Practice between 58% and 93%.

### **Service delivery challenges (including workforce & capacity constraints)**

As with all health and social care agencies in North Somerset, GP services are challenged by the higher proportion of frail older patients in the local population, including those living in the high local concentration of residential and nursing homes. The position is compounded in the Weston area by the large socio-economic inequalities with the usual attendant challenges to individual health and wellbeing – both physical and mental. Recruitment presents a similar challenge for BrisDoc, with North Somerset being the most challenging area within BNSSG for recruitment of GPs to work out-of-hours.

Recruitment is a material issue for a number of practices in North Somerset, particularly in the south of the patch. This is complicated by the fact that four practices in the centre of Weston do not meet national standards for premises providing GP services. Practices across the CCG report difficulty in recruiting GPs, particularly at partner level. Training practices generally appear to have less of an issue than non-training practices.

In terms of an ageing workforce, more than 17.5% of BNSSG GPs are over 55 and 4.3% are over 60 years old. In North Somerset, the percentages of GP and nursing staff over the age of 55 are shown in Figure 28 below.

Cluster	GPs over 55 (%)	Nurses over 55 (%)
Weston	37	45
Worle	40	57
Gordano	16	29
Rurals	17	32
<b>North Somerset average</b>	<b>27.5</b>	<b>41</b>

**Figure 28: % of GPs and Practice Nurses aged over 55 by cluster**

Access to primary care services can be more difficult in rural areas especially for patients relying on public transport. Lack of access in the centre of Weston (Central Ward, Weston Hillside and Weston Uphill) is also a cause for concern particularly since the closure of the Boulevard and the relocation of two practices – Longton Grove and New Court – into a co-located site elsewhere in the town. Recent public engagement has shown that the public, media and elected councillors are concerned over the sustainability and accessibility of local primary care services.

The annual total rental cost for these premises is estimated to be circa £2.2 million, excluding rates, services charges and running costs. The rent charges across practices ranges widely. 71.5% of GP premises were constructed pre-2000, which highlights the need to implement changes in the estate to make it fit for future provision. There are some immediate challenges to a number of surgeries in the Weston area.

## Primary Care (Out of Hours)

### Service provision

Out of Hours GP services are provided by BrisDoc Healthcare Services which is a co-operative social enterprise working out of two bases in North Somerset: New Court Surgery on Locking Road in WsM and the Community Hospital in Clevedon. In a typical weekend BrisDoc will have more patient contacts than the emergency departments of WAHT, NBT and UHB combined.

Location	Opening hours
Newcourt Surgery, Locking Road, Weston	19.30–8am Monday to Friday 24 hours Sat, Sunday, Bank Holidays
North Somerset Community Hospital (Clevedon)	19.00–23.00 Monday to Friday 09.00–21.00 Sat, Sunday, Bank Holidays

**Figure 29: BrisDoc services and opening hours**

In 2016/17:

- 4,694 North Somerset patients were referred via BrisDoc’s professional line, which provides senior clinical support to SWASFT, acute EDs, nursing homes and other community providers.
- BrisDoc work closely with NHS111 and are the primary recipient of onward referrals.
- 80% of calls from paramedics on the scene are closed by the out-of-hours service, or referred to the patient’s own GP.
- Referral to 999 or emergency admission is <8%.
- BrisDoc has a workforce including a varied and effective skill mix – 36% of the clinical rota is filled by Advanced Nurse Practitioner (ANP) prescribers, Telephone Advice Nurses, Emergency Care Practitioners (ECP) and Pharmacists.

## **Overview of current quality and performance against targets**

In 2016/17:

- 110,737 patients were cared for by the service across BNSSG – 26,082 from North Somerset.
- 10,297 North Somerset patients received a clinical advice call (12,000 + calls in total including those who were subsequently converted to a Home visit or face to face appointment).
- 11,575 North Somerset patients had a face to face appointment.
- 4,209 North Somerset patients received a home visit.
- 96.6% of urgent patients have an appointment booked and are in a base within two hours of referral by 111.

## **Service delivery challenges (including workforce & capacity constraints)**

The clinical workforce model for the out-of-hours GP service relies on sessional (i.e. self-employed) GPs for approximately 60% of the rota fill. GP availability is a constraint nationally and locally, with engagement from GPs willing to work sessions out-of-hours being limited and GP willingness to work Weston shifts is challenging in the summer months due to the traffic congestion en-route.

GPs working out-of-hours sessions face increased indemnity costs approximately double that of those seen in daytime care – this can disincentivise GPs to work shifts, and fixed indemnity cover may limit the number of shifts a GP can work per annum. Fluctuations in daytime GP availability have a large impact on Out of Hours demand, and although capacity is flexible, it cannot be flexed indefinitely. A 1% fall in daytime capacity leads to a potential 40% increase in out-of-hours demand.

It is important to optimise the location of a base in North Somerset – Clevedon is often underutilised by North Somerset patients and patients are sent from south and central Bristol. Traffic routes and public access are important, as well as footfall and patient demand.

## **NHS 111 (Urgent Care by phone)**

NHS 111 is a free-to-call single non-emergency medical helpline and has replaced the telephone triage and advice services provided by NHS Direct, NHS24 and local GP out-of-hours. The service is available 24 hours a day, every day of the year and is intended for urgent but not life-threatening health issues.

### **Service provision**

Care UK provides NHS 111 services for the BNSSG CCGs. For 2017/18, the total contractual value (excluding any financial adjustments for performance) is £2.8m and the financial split across the three commissioners is Bristol 49%, North Somerset 26% and South Gloucestershire 25%.

## **Overview of current quality and performance against targets**

In 2016/17, the 111 service received 326,143 calls for BNSSG patients, against contractual levels of 295,455 – 10.4% more activity. Activity above contract has been common across the lifespan of the contract.

Figure 30 below includes latest performance against some of the key national metrics:

Metric	Performance – May 2017	Standard	Commentary
Calls answered in 60 seconds	93.0%	≥95%	Strong performance in past 6 months
Call abandonment	0.9%	≤5%	Consistently achieves target
Combined clinical contact (warm transfers plus call backs in 10)	79.2%	≥70%	Generally strong performer
Referrals to Emergency Departments	7.9%	≤5%	Target has never been achieved. Causal factors include staffing pressures
Referrals to the ambulance service	9.9%	≤10%	Mixed performance traditionally, but generally performs in line with the national average

**Figure 30: 111 Performance against target for May 2017**

### **Service delivery challenges (including workforce & capacity constraints)**

Care UK has challenges with recruitment and retention for both clinical and non-clinical staffing; this is an issue common to 111 across the country. At the present time, there is a clinical vacancy rate of circa 25% and a Health Advisor vacancy rate of about 13%. The provider is able to flex its existing, predominantly part-time, workforce to manage demand as well as accessing the network as described above, although it is clear that more resilient staffing would be likely to result in improved service delivery - (e.g. a reduction in referrals to ambulance services and hospital emergency departments).

## **Community Services**

### **Service provision**

North Somerset Community Partnership (NSCP) is a Community Interest Company (CIC) that provides healthcare services on behalf of the CCG to the people of North Somerset. The organisation is staff owned and was founded in 2011, employing over 750 staff. The contract value is in excess of £28.5m per year.

The majority of services that NSCP provide are adult community focused and are usually delivered in the patient's usual place of residence, with a number of clinics based across the area. These services include district nursing, rapid response, therapies and a range of specialist services. NSCP run the minor injuries unit (MIU) at North Somerset Community Hospital in Clevedon, and also provide a number of children's services including school nursing and health visitors.

### **Overview of current quality and performance against targets**

The latest CQC inspection for NSCP rated the organisation as 'Good' overall, and 'Good' in all individual domains for all services, except for Safety for community health services for adults and community health services for children, young people and families, which were both rated as 'Requiring Improvement'.

### **Service delivery challenges (including workforce & capacity constraints)**

NSCP are managing an ever-increasing number of frail and complex patients in the community. The high number of care home beds in North Somerset, and the imperative of admission avoidance for this cohort of patients, adds to the service pressures. The availability of home care and other packages of care also puts further demand on the service.

There are workforce recruitment and retention challenges particularly with regard to community nursing roles in specific localities and some specialist clinical roles such as community matrons.

Historically, there have been a high level of Delayed Transfers of Care (DTOC) at WGH (although more recent figures show a significant improvement) and challenges of maintaining patient flow across the three BNSSG Acute Trusts. Also, multiple assessment procedures across organisations mean the processes to enable discharge from local acute hospitals are different and therefore complicate efforts to ensure patients can always be discharged as soon as it is appropriate to do so. A new integrated discharge service has recently started at WGH to address some of these issues.

The current model of rehabilitation in North Somerset includes a 24-bedded unit operating out of WGH, plus Discharge to Assess capacity. The community in-patient ward at North Somerset Community Hospital in Clevedon (which NSCP manage) has been closed for an extended period due to building works but is due to reopen this winter.

## Mental Health Services

### Service provision

Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) is a significant provider of mental health services commissioned by a number of CCGs in a catchment area covering Bath and North-East Somerset (B&NES), Bristol, North Somerset, South Gloucestershire (BNSSG), Swindon and Wiltshire. The North Somerset contract with AWP is in excess of £16m per year.

AWP provides a range of mental health services for the adult population of North Somerset. Figure 31 below summarises the range of services provided and their key locations:

Inpatient services	
Juniper Ward, Long Fox Unit, (Weston General Hospital)	Adult Mental Health Inpatient Beds x 18
Cove and Dune Wards, Long Fox Unit, (Weston General Hospital)	Later Life Mental Health Inpatient Beds x 25 (Cove =15 & Dune =10)
Elmham Way, Worle	Community-based in-patient rehab beds x 7
Community services	
The Coast Resource Centre	Recovery Team Early Intervention in Psychosis IAPT / Positive Step Psychological Therapies Service Assessment Team (incorporating ex- PCLS functions)
Long Fox Unit, Weston General Hospital.	Intensive Team NSC AMHP Service A&E Hospital Liaison
Windmill House	Complex Interventions Team DEST Memory Team Later Life Therapies
Weston Super Mare Town Hall	Mental Health Triage Service (incorporating ex- PCLS functions)
Other LDU Services	
Portishead Police HQ	MH Control Room and Street Triage Service
Carlton Centre, Weston.	Vocational Services

**Figure 31: AWP services in North Somerset**

## **Overview of current quality and performance against targets**

AWP awaits the publication of their CQC Report following the recent inspection. The Trust was rated as 'Good' for the Effective, Caring and Responsive domains and 'Requires Improvement' for the domains of Safety and Well-led.

## **Service delivery challenges (including workforce & capacity constraints)**

There are significant staffing challenges in some parts of AWP – particularly in the east of the footprint. Recruitment has been challenging particularly with regards to staffing on acute mental health in-patient wards.

## **Local Authority Services**

North Somerset Council (NSC) commission and provide a wide range of services that are extremely relevant to the issues that this document seeks to address. Services managed by NSC include:

- Dementia
- Learning disabilities
- Mental health conditions
- Personal care
- Physical disabilities
- Sensory impairments
- Substance misuse problems
- Caring for adults <65 years
- Caring for adults >65 years
- Children's services
- Safeguarding adults & children

## **Home care capacity & service delivery challenges:**

The CCG commissions home care provision via NSC. Between 2015 and 2017, the CCG has supported the NSC with its recommissioning of home care into single locality providers. The completed process sees the three main providers Alliance, Brunel Care, and Notaro taking the lead provider roles across the county. These three providers are expected to meet the need for the majority of home care provision in North Somerset. The challenges these providers face are largely in recruiting sufficient care staff to meet demand. Recruitment challenges are seen most acutely across the rural areas of North Somerset, and also the more affluent urban/commuter areas such as Portishead, Clevedon, Nailsea and Backwell, where better paid employment is available either locally, or by commuting to Bristol.

## **Care home capacity & service delivery challenges:**

North Somerset is currently served by 110 care homes (69 residential and 41 nursing). The 2013 Market Position Statement (MPS) identified that the 83% of care homes in North Somerset are small (1-20 places) and medium (20-40 places) in size, with the remaining 17% being larger (over 40 places) in size. At the time of the MPS publication 61% of homes were in WsM and Uphill; 13% were in Clevedon; 5% in Nailsea and Backwell; 4% in Worle and Kewstoke; 4% in Portishead; 4% in Congresbury and Yatton; and the others are dotted around in smaller communities. These figures highlight part of the challenge to commissioners in attempting to support patient and family choice with a care home placement near to home, particularly where those choices are for care in the northern parts of North Somerset and the rural areas.



There were 3,202 care home beds in 2011, which has reduced to 3,051 as of August 2017, with that figure likely to fall by an estimated 100 beds by the end of the financial year due to further home closures. The CCG requires an estimated 220-300 beds at any one time in order to meet the needs of individuals that are health funded via Continuing Healthcare or Section 117 aftercare. Further reductions in the available capacity is likely to affect the CCG and local authority's ability to control the fees paid for care home beds, which has historically been more effective than Bristol and South Gloucestershire. Based on a total population of approximately 50,000 aged over 65, this equates to a ratio in North Somerset of 1 bed for every 16 people over 65. The ratio in Bristol is 1:21 and in South Gloucestershire it is 1:26.

## **Voluntary Sector**

There is a plurality of service provision commissioned from the voluntary and community sector in North Somerset. The two largest contracts are with the British Red Cross and 1 in 4 (a local mental health charity). Voluntary Action North Somerset (VANS) represents, develops and empowers the voluntary, community and social enterprise sector in North Somerset to be at the forefront of positive social change and development. It will be very important in the provider service model that is developed from this work that we maximise the use and contribution of local community and voluntary sector resources.

## APPENDIX 4: Additional Finance Information

The table below shows the original forecast deficit figures submitted to NHS England as part of the BNSSG STP October submission. The table shows that every provider and every CCG across the BNSSG STP footprint is forecast to be in significant deficit by 2020/21, assuming no action is taken to address the situation. The table clearly demonstrates that there are no easy solutions to the problems we face. To achieve an affordable and sustainable service model for the North Somerset population, it will necessitate a radical transformation of the way in which health and care services are provided for local people.

Surplus / (Deficit)	"Do Something" Solutions					Total BNSSG STP
	"Do Nothing" 2020/21 Positon	STF Funding	Identified Savings	Unidentified Savings	Weston Sustainability	
	£'m	£'m	£'m	£'m	£'m	£'m
<b>Providers</b>						
University Hospitals Bristol NHS FT (UHB)	(47.6)	13.3	36.1	4.4		6.2
North Bristol NHS Trust (NBT)	(80.6)	14.0	65.0	1.6		(0.0)
Weston Area Healthcare NHS Trust (WAHT)	(20.6)	3.1	10.1	0.0	7.4	(0.0)
Avon & Wiltshire Mental Health Partnership (AWP)	(17.3)	0.7	4.6	12.0		(0.0)
South Western Ambulance Service (SWAST)	(3.2)	1.5	1.6	0.1		0.0
Community Interest Companies (CiCs)	(15.0)			15.0		0.0
<b>Sub-total Providers</b>	<b>(184.3)</b>	<b>32.6</b>	<b>117.4</b>	<b>33.1</b>	<b>7.4</b>	<b>6.2</b>
<b>Commissioners</b>						
Bristol CCG	(60.9)		8.0	52.9		0.0
North Somerset CCG	(30.3)		3.7	26.6		0.0
South Gloucestershire CCG	(30.0)		9.8	20.3		0.0
<b>Sub-total Commissioners</b>	<b>(121.2)</b>	<b>0.0</b>	<b>21.5</b>	<b>99.8</b>	<b>0.0</b>	<b>0.0</b>
System Wide		28.4		(28.4)		0.0
<b>Total Organisational Financial Plans</b>	<b>(305.5)</b>	<b>61.0</b>	<b>138.9</b>	<b>104.4</b>	<b>7.4</b>	<b>6.2</b>

Figure 32: BNSSG STP financial position (October 2016 submission)

### CCG Benchmarking Data

Figure 33 below compares CCG programme spend with programme spend at national level taken from the "NHS 5 Year Forward View Review: Recap briefing for the Health Select Committee on technical modelling and scenarios" (May 2016). In 2014/15 North Somerset is spending some £11-£12m more on acute services than the national average would indicate

	Programme Expenditure 2014/15					
	National		North Somerset		North Somerset based on National Profile	North Somerset v National Profile
	£bn	%	£m	%	£m	£m
Acute	35.5	52.9%	151.3	57.3%	139.67	11.6
Mental Health	6.7	10%	23.4	9%	26.36	(3.0)
Primary Care	9.3	14%	35.8	14%	36.59	(0.8)
Community Provision	7.8	12%	24.0	9%	30.69	(6.7)
Continuing Healthcare	4	6%	14.8	6%	15.74	(0.9)
Other Programmes	2.1	3%	9.5	4%	8.26	1.2
CCG Reserves/Contingency	0.4	1%	-	0%	1.57	(1.6)
Running Costs	1.3	2%	5.2	2%	5.11	0.1
<b>Total</b>	<b>67.1</b>	<b>100%</b>	<b>264</b>	<b>100%</b>	<b>264.00</b>	<b>0.0</b>

Figure 33: CCG programme spend vs national level 2014/15

Figure 34 below compares North Somerset programme spend per weighted capital with peers. Absolute peer comparisons across programmes are difficult because of differences in reporting and classification of spend but a high level review of 2016/17 spend across main programme heads indicates higher spend on acute services in North Somerset in the order of £9.7-£13.4m.

	Spend per Wtd Capita £ 2016/17			Potential (Saving)/Cost(£m)	
	North Somerset	C4V Peer Avge (10)	C4V Peer Avge (5)	@ 10 Peer Avge	@ 5 Peer Avge
Acute	716	673	657	(9.7)	(13.4)
Non Acute	318	291	286	(6.0)	(7.1)
Continuing Care	70	88	94	3.9	5.3
Prescribing	154	163	168	2.0	3.3
1% Reserve	12	13	13	0.2	0.2
<b>Total</b>	<b>1,271</b>	<b>1,228</b>	<b>1,219</b>	<b>(9.7)</b>	<b>(11.8)</b>

**Figure 34: Comparison of spend with Commissioning for value peers (C4V)**

The national RightCare Programme focuses on the value for money of hospital admissions. The comparison with peer CCGs is limited to admissions covered by the national Payment by Results tariff, but it indicates higher levels of acute spend in North Somerset as summarised by disease group in Figure 35 below. The potential reduction in acute spend if North Somerset matched peer performance is £9.9m.

Disease Area	Planned	Urgent	Total
	£m	£m	£m
Cancers and Tumours	1.3		1.3
Circulation (CVD)	0.3	1.1	1.3
Endocrine, Metabolism & Nutrition	0.1	0.1	0.3
Gastrointestinal	0.5	0.7	1.2
Genitourinary	0.3	0.5	0.8
MSK	2.3	0.3	2.6
Neurological	0.1	0.8	0.9
Respiratory	0.2	0.3	0.5
Trauma and Injuries	0.2	0.8	1.0
<b>Total</b>	<b>5.2</b>	<b>4.7</b>	<b>9.9</b>

**Figure 35: RightCare Potential Savings**

MSK is the biggest single opportunity identified from RightCare and there is a BNSSG wide programme of work in progress to realise these potential savings.

## APPENDIX 5: Key Priority Population Groups

### Frail and Older People

Frail older people are the most significant patient group in terms of complexity, growing demand and potential for improved care pathways. The JSNA uses the definition of frail older people to be “people over 75 with a significant level of physical or mental impairment which may interfere with the ability to undertake daily living and requires support from either formal or in-formal care services.” However, it’s not just the over 75s who can be described as ‘frail’. People living in the most deprived areas of WsM can also be described as frail even if they are only in their 40s due to mental health issues or alcohol and substance abuse.

Given the current pressures on the urgent care system, frail older people are more at risk of having a poor experience of care, worse clinical and social outcomes, and more rapid deterioration than would be expected in our particular population. Because care is fragmented, thresholds for admission are often lower than medical necessity criteria would indicate and lengths-of-stay (LOS) exceed the need for the delivery of true acute inpatient care, resulting in poorer outcomes for patients.

The Five Year Forward View (5YFV), NHS England’s ‘Frail Older People, Safe Compassionate Care’ and the British Geriatric Society’s ‘Fit for Frailty’ all identify a strong evidence base to support a holistic approach to meeting the needs of people living with frailty: “Care needs to be just as important as treatment. Older people should be properly valued and listened to, and treated with compassion, dignity and respect at all times. They need to be cared for by skilled staff who are engaged, understand the particular needs of older people and have time to care.”

‘Hard Truths, the Journey to Putting Patients First’, is the government’s response to the Francis Report, and was published in November 2013. It states: “There are two building blocks. Firstly, what we already know works for older people in crisis, but needs to be deployed more universally. Secondly, a newly-emerging preventative approach that offers the real possibility of living better with frailty and of a reduction in the unscheduled primary and secondary care contacts that characterise our current response. If frail older people are supported in living independently and understanding their long-term conditions, and educated to manage them effectively, they are less likely to reach crisis, require urgent care support and experience harm.”

### Key statistics:

- The rate of hospital admission increases significantly with age so that in North Somerset, 1 in 3 people aged over 85 were admitted to hospital as an emergency in 2016/17 compared with 1 in 13 aged 65-74.
- Across BNSSG, the over 85s account for 13.5% of all emergency hospital admissions with an average acute LOS of 12 days. The over 65s account for 42.6% with an average acute LOS of 9.2 days. The average cost of an emergency admission for a frail older person is £4,856.
- In North Somerset, 22,000 residents are aged over 75 of which 6,500 are aged over 85. The over 75 population currently accounts for 30% of all admissions, 60% of beds and 40% of admitted patient costs. The number of over 75s is predicted to rise to 37,000 in 2030; a 68% increase.
- The impact of projected growth in the older population for North Somerset is illustrated in Section 4: The Financial Challenge (Figure 10). Overall this represents an additional 20 hospital beds based on current lengths of stay with an estimated £2m increase in cost related to

emergency admissions alone. If this is projected into the future an additional 65 beds would be required over the next 10 years.

- NHS RightCare (2016) analysis has identified relatively high spend on emergency care for complex co-morbidities due to falls/fractures, UTI/urology, pneumonia /respiratory conditions which typically relate to frail older people.
- 83% of the beds in WGH for non-elective admissions are occupied by people who are 65 or over.
- In North Somerset, 63% of the total admissions of people over 85 are admitted to WGH (59% for over 75s).
- 1 in 3 over 85s were admitted more than once in a year for an unplanned admission and 1 in 6 of over 75s.
- 75% of the total bed capacity in North Somerset is in Care Homes. There are 110 care homes (69 residential & 41 nursing), and 3000 beds in North Somerset, of which 38% are in Weston town. The care home population will increase by 88% by 2030.

We need to do more in supporting our older population in keeping healthy and out of hospital. When people in this group do need to go into hospital, services need to work together more effectively to support them to return to their place of residence much more quickly.

### **Children & Young People (including complex needs and young people mental health)**

In summary, the provider landscape for children and young people services is fragmented with services provided across a number of different providers including WAHT, NSCP and CCHP (Community Children's Health Partnership) which is part of the North Bristol Trust. There are also capacity problems in WAHT community paediatric services (which includes OT, Physio & SALT services) meaning that in some cases, patients are waiting a long time to be seen.

#### Key statistics:

- The child population (those aged under 14) is projected to rise by ~12% (an extra 4,000 children) in the next 10 years.
- In some areas, demand for children's community services is rising and complexity is increasing:
  - Paediatric referrals were 659 in 2015/16 and had risen to 784 in 2016/17, a 16% increase
  - Physiotherapy referrals were 355 in 2015/16 and had risen to 326 in 2016/17, a 9% decrease
  - Speech and Language referrals were 581 in 2015/16 and had fallen to 564 in 2016/17, a 3% decrease
  - Occupational Therapy referrals were 222 in 2015/16 and had risen to 308 in 2016/17, a 39% increase
  - Number of Children requiring Continuing Health Care (CHC) has risen dramatically since 2012/13 (from 3 to 11 as of Sept 2017) and is expected to rise even further.
- The increase in referrals has increased pressure on access and waiting times. There are also challenges due to the impact of seasonal spikes on demand and the ability of the community provider (WAHT) to cope.
- Services have been historically underfunded, e.g. mental health average is £40 per child in North Somerset compared to £46 in Somerset

- 1 in 10 children aged 5 to 16 will have a diagnosable mental health need, with 50% of all mental health conditions emerging before the age of 14. 75% of all mental health conditions emerge before the age of 25.
- North Somerset has a higher than average (England & regional averages) number of:
  - Children and young people admitted to hospital due to self-harm
  - Children and young people with a conduct disorder (estimated through proxy measures)
  - Children and young people in care who are in the 'borderline' or 'cause for concern' mental health categories (as measured by the Strengths and Difficulties Questionnaire)
- Specialist CAMHS referrals are up 10% in the last year. Of these referrals, an average of only 54% are accepted which may indicate a lack of awareness of thresholds, a lack of early help services, or particular issues relating to holding cases in the community.
- The WAHT specialist CAMHS team is small, not resilient and has experienced problems with recruitment.
- For specialist CAMHS, 35% of children and young people have to wait more than 18 weeks to be seen. Waiting times for the autistic spectrum pathway are approximately 56 weeks.
- Specialist CAMHS in-patient beds – children and young people often have to travel to a different part of the country to access a bed. Recently for example a young person in crisis was placed in Bury, Lancashire.
- The national rate of children living in poverty, after housing costs, in England is 25% with the average for North Somerset being 19%. However, in WsM Central Ward it is 36% and WsM South Ward it is 38%.

#### **Pregnant Women:**

- The local Midwife led maternity service at Weston is not chosen by enough women to make it clinically or financially viable in its current form.
- The number of deliveries at the midwife led unit (MLU) at Weston General Hospital is currently at around 170 per year; the minimum level for a clinically appropriate unit of this type is considered to be ~ 500.

#### **Vulnerable Groups for example people with mental health needs, learning difficulties and those who struggle with drug and alcohol addiction.**

There are areas in North Somerset, particularly in Weston, with concentrated numbers of people living with mental health issues, learning disabilities and those struggling with drug and alcohol addiction. People with these issues tend to have much poorer physical health and a lower life expectancy.

#### Key statistics:

- In North Somerset, mental health is one of the top four causes of Disability Adjusted Life Years (DALY) lost.
- North Somerset has a higher prevalence of depression than the England average, but rates of serious mental health problems recorded in GP Practices are similar to the England average and are higher in more deprived areas.
- Suicide rates are a third higher than the national average, but have improved more recently. The rate of self-harm hospital stays is 222 per 100,000, worse than the England average

- Nationally the number of adults with learning difficulties (LD) is increasing and is predicted to increase by 1% each year for the next 15 years. GP Practice prevalence of LD (0.48%) is higher than the average for England (0.45%) and has increased over the last few years. LD prevalence is higher in more deprived areas.
- By 2020, 75% of all people with LD over the age of 14 should receive an annual health check and receive a health action plan. In North Somerset, the current rate is just 53%; however there is significant variation between practices.
- The rate of alcohol related hospital admissions per 100,000 population has increased year on year and is higher than the national rate. Annually there are around 2,700 hospital admission of problem drinkers in the North Somerset population.
- Alcohol harm related hospital admissions in North Somerset are estimated to cost the NHS more than £3m in healthcare costs each year.
- 63% of males and 48% of females engaged with the local drug treatment service also have a current diagnosed mental health issue.
- Weston has a high number of alcohol and drug rehabilitation beds and people living in the locality are four times more likely to be admitted to hospital for alcohol specific conditions.
- Years of life lost to potentially amenable conditions such as HIV, Hepatitis C and TB are increasing in North Somerset, whereas the national trajectory is decreasing

The local system has also identified a number of key specialities that have been highlighted as priorities. The following section provides a number of the key statistics as to why these have been chosen.

## APPENDIX 6: Key Priority Speciality Groups

### Urgent & Emergency Care (including Emergency Surgery)

#### Key statistics:

- The Weston General Hospital (WGH) A&E – referred to by clinicians as the ‘emergency department’ (ED) is currently closed temporarily overnight for safety reasons (CQC 2017).
- There have been unsuccessful efforts to recruit sufficient numbers of key clinical posts to reliably and safely staff the ED. The removal in 2015 of FY2 trainees in department overnight has caused further pressure in this area. This situation has contributed to a comparatively large amount of spend on agency staff to help fill gaps in this service, amongst a range of others across the Trust. In 2016-17 WAHT spent £11.7m on agency staff, more than double its cap set by NHS Improvement of £4.68m.
- WGH sees 50,000 to 55,000 A&E attendances per annum (~141 per day): 80% are minors, 29% arrive by ambulance, 58% walk-in, and the remainder are mainly GP referrals.

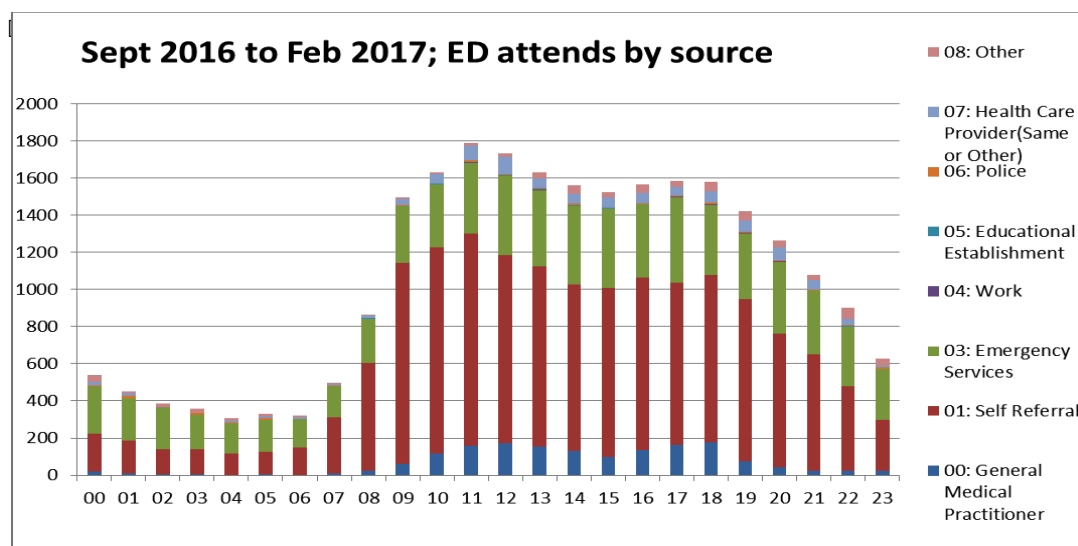


Figure 36: Weston ED demand across 24hr period

- The ED has a 23% conversion rate of attendances to admissions and 80% of activity occurs between 8am and 10pm.
- The number of attendances at the ED are generally flat, and the conversion rate of attendance to admission (around 23%) is comparable to WAHT's peers.
- During quarter 4 of 2016-2017, WAHT reported the highest bed occupancy rate of any acute provider in England (reported level of 100% general & acute beds occupied). This contributes to the challenges of achieving effective patient flow within the hospital.



Arrival			Disposal Method	
Arrival Source	% of Arrivals	No of Arrivals	Admitted	Discharged
00: General Medical Practitioner	6.47%	9.1	47.72%	52.28%
01: Self-Referral	57.72%	81.4	7.69%	92.31%
03: Emergency Services	29.07%	41.0	50.00%	50.00%
04: Work	0.17%	0.2	2.38%	97.62%
05: Educational Establishment	0.14%	0.2	22.22%	77.78%
06: Police	0.44%	0.6	15.18%	84.82%
07: Health Care Provider (Same or Other)	3.54%	5.0	24.53%	75.47%
08: Other	2.42%	3.4	12.54%	87.46%
TOTAL	100%	141.0	23.34%	76.66%

**Figure 37: Pattern of demand during a 24 hr period, by referral source**

### Critical Care

- 350 patients were treated in the critical care unit in the year 2016 – 2017. (That is the report run from ICNARC which only calculates the statistics on patients within the 4 walls of the ITU).
- In addition to the above, the unit managed another 50 patients for a total of 1050hrs in the recovery area in escalation.
- Bed occupancy (within the critical care unit, not including recovery) is 84.3%.
- A total of 164 patients were admitted under general medicine, with the remaining 186 being a mixture of general surgery, orthopaedics, urology, breast surgery, colorectal surgery.
- 47% (144 patients) of the unit's admissions for the year, were at Level 3 status, meaning they required advanced respiratory support (level 3 status).
- Of the 164 general medical patients requiring admission to ITU, 92 required invasive ventilation.
- 55 patients required haemofiltration.

### Planned Care

- WAHT has an overall market share of 31% for elective inpatients and day cases in North Somerset. This share rises as high as 55% in some GP practices closest to the hospital, but is significantly lower in others.
- WGH has 4 theatres of which three are laminar flow. Elective sessions include: x8 Colorectal, x2 UGI, x4 Breast, x2 General surgery, x3 CEPOD (which is done in main theatres). Elective and CEPOD lists are done in the day time.
- The day surgery unit has two theatres. There are 8 male and 8 female beds on the unit. Increased use of OP surgery rather than day-case for hysteroscopies. (Source: Fিন্নamores report 2016)
- During 2016/17, WAHT completed: 1,442 elective in-patient procedures, 14,267 day case procedures and 105,036 out-patient attendances. (Source: WAHT annual report 16-17)

### Mental Health

- Refer to Appendix 5: Vulnerable Groups.

## Cancer

- Cancer is the second most common cause of death in North Somerset after cardiovascular disease.
- Based on Public Health England Cancer Dashboard for North Somerset, the all type incidence rate (in 2014 per 100,000 population) for cancer was 679.98 vs. an England average of 608.3 (higher incidence seen for breast, colorectal and prostate cancers).
- Overall, the most common cancer diagnosis is non-melanoma skin cancer. If non-melanoma skin cancer is excluded, the most common cancer in females is breast (195 deaths per year on average) and in men prostate (175 deaths per year on average). In North Somerset the second most common cancer diagnosis for both men and women is colorectal (bowel).
- Deaths from cancer are the leading cause of premature death in North Somerset. Between 2013 and 2015 the average number of deaths per year in people under 75 from cancer was 271, accounting for 44% of all early deaths.
- A large proportion of early deaths are from cancers with modifiable risk factors such as smoking, alcohol consumption, poor diet and physical inactivity and around 10 lives could be saved each year in people under 75 from cancers such as colorectal and lung.
- There are also a number of years of life lost from cancers that are considered treatment amenable cancers (including breast, colorectal and skin cancer). These account for a third of total years of life lost in North Somerset and are where early detection and treatment increase survival.
- Based on RightCare data (Jan 2017) there are opportunities to reduce emergency presentations for lung, breast and colorectal cancer – implying the need for earlier detection and diagnosis. There are also opportunities to increase the number of women attending breast and cervical screening and increase the % of 60-69 year olds screened for bowel cancer. The % of patients with cancer who have had a review 6 months after diagnosis is 61% which is significantly lower than the England average of 80%. This equates to 621 patients.
- There are currently on-going challenges in meeting 2 week wait (particularly for WAHT) and delivering the 62 day treatment target across BNSSG (refer to Figure 25 for performance data).
- BNSSG in line with The Cancer Alliance are prioritising improvements in early diagnosis of cancer through improved access to diagnostics and reducing emergency presentations.

## Circulatory Disease

- An estimated 71% of all over 75s have high blood pressure, which given the associated diseases of having hypertension, indicates this as an area of concern.
- According to disease prevalence models, cardiovascular disease is set to increase at a rate of 1.05% annually for people aged 16 and over.
- By 2030, a predicted 25,897 people will have circulatory disease.
- The over 75 age group will have the fastest growth rate at 4.4% annually, reaching 14,525 over 75s with the disease by 2030. This is nearly 40% of all people in North Somerset over the age of 75 years.
- Outcomes are slightly above average for North Somerset, but circulatory disease is the biggest single cause of life expectancy inequalities for both men (28.3%) and women (25.8%).

## **Stroke**

- There are 30+ more deaths from stroke than the national average (RightCare 2016), with variation in practice, referrals & outcomes for patients at high risk of stroke or following stroke across BNSSG.
- Only 28% of high risk patients are being seen within 24 hours. Alternative models are achieving 90%, which equates to 23 strokes prevented each year.
- Sentinel Stroke National Audit Programme reports overall acute scores of C/D (on a scale of A-E).
- Stroke services cost BNSSG CCGs £24m per annum.

## **Respiratory (COPD)**

- Respiratory disease is the third leading cause of premature death (i.e. aged under 75) in North Somerset. It claims around 90 deaths per year in total across North Somerset.
- The prevalence of COPD has a clear gradient of increasing prevalence with increasing deprivation. In North Somerset there are twice as many people with COPD in the most deprived areas than the most affluent.
- In 2015, approximately 4,352 people were diagnosed with COPD and almost 1,000 were estimated to be undiagnosed.
- There is a limited community based respiratory service and a very limited specialist service in Weston General Hospital. North Somerset does not meet NICE guidance or GOLD standards regarding admission avoidance or early supported discharge.
- Length of stay may be unnecessarily extended due to early supported discharge support not being available. This can lead to patients becoming deconditioned, in greater need for social care on discharge.
- There is a large non-elective opportunity to reduce respiratory admissions due to pneumonia HRG (DZ11A, B and C) against peer group average. Spells are particularly high compared to peers for Pneumonia with major complications (HRG DZ11A). There were 860 excess bed days for DZ11A in 8 months for North Somerset CCG. This may be partly due to the age profile of the patients admitted for pneumonia as the case mix variances are in age groups 75 to 84 years and 85+ years.
- Weston are £296,016 over reference costs (mostly for 'non-admitted face-to-face attendance follow up' (£179,668) & 'non-admitted face-to-face attendance 1st appointment (£32,046)).
- There is a key in-balance in skills and resources in North Somerset as compared with Bristol and South Gloucestershire in relation to community and secondary care specialist respiratory staff.

## **Liver Disease**

- Liver disease is amongst the top four causes of premature mortality in North Somerset.
- Early deaths from liver disease are twice as high for men as for women; causes being alcohol, obesity and Hepatitis C.

- Estimates suggest 1,300 injecting drug users in North Somerset of which 40% have the Hepatitis C virus. Although proportionally this is not high for this population<sup>22</sup>, it does indicate a potentially significant demand on treatment services.
- For further alcohol related statistics, refer to Appendix 5: Vulnerable Groups.

### **Frailty as a specialty**

- Refer to Appendix 5: Frail and Older People.

### **Musculo-skeletal conditions (MSK)**

- The term “musculoskeletal conditions” encompasses well over 200 disorders affecting bones, muscles and soft tissue and also includes musculoskeletal injuries due to sports and in the workplace, and trauma related to external causes such as falls and road traffic accidents.
- In North Somerset, MSK conditions are one of the top 4 causes of Disability Adjusted Life Years (DALYs) lost. For example, low back and neck pain account for 6,249 DALYs per year in North Somerset.
- Based on RightCare analysis, non-elective spend in North Somerset is above average for total MSK spend. This is also the case for its spend on emergency admissions for back, neck and musculoskeletal pain. Locally there is a higher than average non-elective spend for osteoporosis and rheumatoid arthritis which is likely due to a higher prevalence due to an older demographic footprint. North Somerset also has a slightly higher spend on hip fractures in people aged 65-79.
- MSK and trauma and orthopaedic programmes appear in the top ten areas of spend for North Somerset and it has two outcomes defined as a 'worse outlier' (Hip fracture: collaborative orthogeriatric care and Hip fracture: multifactorial risk assessment).

### **Diabetes**

- Prevalence is predicted to increase by 42% from 14,437 in 2015 to 20,483 in 2030 – a rise of ~6,000 people (APHO, 2011) coupled with an ageing population.<sup>23</sup>
- North Somerset patients have poorer blood glucose control than the England average (National Diabetes Audit 15/16).
- There are significant difficulties within North Somerset recruiting to podiatry posts and the diabetic foot clinic does not have 'Hot Foot' status in North Somerset; patients with emergency 'hot foot' problems go to NBT.
- Outcomes are lower than the England average. The National Diabetes Audit (2015-16) shows that 14.2% of people with type 1 diabetes met all 3 treatment targets (versus an England average 18.3%) while 35% of people with type 2 diabetes met all 3 treatment targets (versus an England average of 40.4%). There are also 4 more major amputations every year compared with the average rate in England.

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<sup>22</sup>[http://www.emcdda.europa.eu/system/files/publications/2953/TDXD16002ENN\\_final\\_web.pdf](http://www.emcdda.europa.eu/system/files/publications/2953/TDXD16002ENN_final_web.pdf)

<sup>23</sup> <http://webarchive.nationalarchives.gov.uk/20170106081135/http://www.apho.org.uk/DISEASEPREVALENCEMODELS>

- The growing elderly population, and increasing diabetes prevalence due to rising obesity levels/poor diet will place a greater strain on specialist nurses.
- Numbers of patients attending structured diabetes education have been reported as being very low. All patients diagnosed with type 2 diabetes should be offered structured education to enable them to help themselves delay disease progression.
- Tackling obesity, promoting exercise, and helping patients with non-diabetic hyperglycaemia delays the onset of diabetes.

## **Dementia**

- Dementia and Alzheimer's is one of the three biggest causes of death in North Somerset.
- In North Somerset, it is estimated that 1.79% of people are living with dementia.
- In 2015, 3,634 people were diagnosed with dementia, and it is estimated that by 2035 this will increase to 7,012 people.
- Whilst most causes show a declining death rate the rate from dementia and Alzheimer's appears to be increasing.
- RightCare data identifies North Somerset as having upwards of 15% more short stay emergency admissions for people aged 65+ with dementia than our 10 comparator sites. The best comparator site achieved 111 fewer admissions and 72 fewer short stay admissions.

## **End of Life**

- An estimated 2,400 people die per year in North Somerset.
- North Somerset performs well against national benchmarks in terms of managing end of life (EOL) deaths within the community. 2015 data shows 54% of deaths took place in a person's usual place of residence, compared with a national figure of 46%.
- North Somerset has a higher rate of deaths within care homes: 34.4% in North Somerset versus 22.6% nationally and 27.2% across the south west. It also has a higher rate of deaths in hospice: 6.3% in North Somerset versus 5.6% nationally and 4.9% across the south west.
- Limited EOL community nurse capacity has resulted in an increased reliance on hospice nurses.
- There is scope to improve the way residential homes manage EOL patients. There are pockets of good practice in North Somerset currently, but plenty of potential to further reduce the number of people who die in hospital. This is likely to require increased training for residential homes to achieve this.

## **Maternity**

- Refer to Appendix 5: Pregnant Women.

## APPENDIX 7: How Will These Changes Meet the Identified Priorities?

The table below sets out the CCG's view as to how the proposed model of care will better meet the needs of the population and the identified priority groups and specialities.

Priority	Way forward
<p><b>Frail and Older adults</b></p> <p><i>(Including Care Homes)</i></p>	<p>The opportunity to develop a more effective, joined up and efficient service for our Frail Older and Care Home population is clear. We want this work to result in a more resilient and integrated primary and community care system, with wrap around support from other key community partners, and the Acute Trust, to deliver a more holistic and patient centred service to better meet the needs of the Frail Older and Care Home population. This service will include a 7-day Frailty Centre based in a primary care led Community Hub co-located on the Weston 'Care Campus' that will provide an integrated suite of both proactive and reactive services to a clearly defined cohort of patients to keep them well and at home and if they are appropriately admitted to a hospital bed and provide excellent rehabilitation and support services to help them get home as soon as possible. This service could include a Specialist Mental Health Care Home liaison service.</p>
<p><b>Children, Young People &amp; Pregnant Women</b></p> <p><i>(including complex needs and young people's mental health)</i></p>	<p>The option to pool staffing resource and expertise across community and acute paediatric services and co-locate them in the Weston 'Care Campus' presents an opportunity to provide a more joined up model of care for an important and growing section of our population. This opportunity includes the possibility of strengthening the urgent care offer if a seven day service model can be developed.</p> <p>In terms of maternity, we need to find the right location and configuration of birthing services to ensure numbers are sufficient to maintain clinical expertise, exploring a range of clearly defined options that best meets the needs of the local population. A solution needs to be found for maternity services across the whole of BNSSG.</p>
<p><b>Vulnerable Groups</b></p> <p><i>For example people with mental health needs, learning difficulties and those who struggle with drug and alcohol addiction.</i></p>	<p>Conditions such as poor mental health and substance misuse can in themselves create a type of frailty that requires a joined up and comprehensive response. GPs with a special interest may be able to serve a much larger population than their own practice list for some specific conditions, supported by specialist community services. By coalescing these services in a primary care led Community Hub co-located on the Weston 'Care Campus', integrated care pathways can be developed that bridge the traditional divide of 'in versus out of hospital' to better manage these patients in a more holistic, proactive way. The voluntary sector, mental health and public health will all play a critical role in helping to develop these pathways and provide services in the Hub.</p>
<p><b>Urgent &amp; Emergency Care</b></p> <p><i>(including Emergency Surgery)</i></p>	<p>Developing the right "front door" model for urgent and emergency care at Weston General Hospital (WGH) is a crucial part of this work, and the design will need to be considered in the context of its proposed role as an integrated 'Care Campus'. The unplanned temporary overnight closure of WGH's emergency department provides an opportunity to learn from a real life situation as to how we can best provide services for our local population out-of-hours. We also need to take this opportunity to see how the flow through the whole hospital can be improved through better joined up working. An integrated rehabilitation offer should help to reduce length of stay for example, and should help flow, which we know from the recent CQC report, has been a major issue at WGH.</p>

<b>Critical Care</b>	There is a clear consensus that although the service as presently configured was rated as 'Good' recently by the CQC, the current model of critical care offered on the Weston Hospital site (5 Level 3 beds) is sub-optimal due to size and scale. The model of critical care is dependent upon the model of care of other services in the hospital. However, the Critical Care Clinical Expert Group has said that there are two broad options of either expanding the unit or contracting it. Regardless of the service model that is finally agreed, there needs to be a 24/7 on site resuscitation team if the site is to continue to have acute inpatient wards. There is also a recognised need to ensure that the 'Hospital at Night' Team is sufficiently robust, although this is a business as usual requirement rather than something that is linked to a transformational change agenda.
<b>Planned Care</b>	Moving certain services (e.g. emergency surgery) off site would afford the potential to develop the provision of high volume non-complex elective surgery on the Weston site. This would take advantage of WGH's refurbished theatres and ability to attract and retain (for example) a strong orthopaedic team.
<b>Mental Health</b>	Refer to Vulnerable Groups section above.
<b>Cancer</b>	Cancer is a major priority for our system. A significant number of deaths from "treatment amenable" conditions are from cancers such as skin and breast. We want this new model to deliver better early diagnosis, supported by a coordinated screening and diagnostic programme. We would like to explore the possibility of using the Weston 'Care Campus' and the primary care led Community Hub for community based treatments for cancer wherever possible so local residents don't need to travel to Bristol for treatment.
<b>Circulatory Disease</b>	In North Somerset the over 75's have the fastest growing rate of circulatory disease and this must present a major risk for unplanned admission if not managed in a proactive way. The Weston 'Care Campus' provide opportunities for improved long term conditions (LTC) management through the availability of rapid access to diagnostics, multi-speciality LTC clinics, integrated multi-disciplinary teams and expert support and advice from acute clinicians.
<b>Stroke</b>	<p>We know that as the number of older adults grows, the higher the number of strokes that are likely to occur. Across BNSSG we need to review the best place to treat patients who have suffered a stroke, using evidence based models such as Hyper Acute and Acute Stroke Units. The Weston 'Care Campus' could also potentially play a vital role in this process by focussing on stroke rehabilitation and reablement.</p> <p>However, the best outcome of course is to prevent the stroke in the first place. As the risk of stroke increases with age, the local primary care and integrated Community Hub services have an opportunity - by monitoring and treating high blood pressure for example - to help offer a more comprehensive preventive service.</p>

<b>Respiratory (COPD)</b>	The Weston 'Care Campus' / Community Hub model will provide improved integrated primary and community care working to prevent admission through the provision of: closer pathway integration with secondary care, integrated community /acute respiratory teams, including early supported discharge, improved mentoring across primary, community and secondary care, specialist respiratory support to Practice Nurses and GPs, improved access to diagnostics, hot clinics and a single point of access (SPA) for referrals, enhanced LTC management and multi-speciality clinics (to include, for example, heart failure).
<b>Liver Disease</b>	Liver disease contributes disproportionately to poor outcomes in North Somerset. We want to reduce unnecessary Liver Function Tests and unnecessary referrals to secondary care in order to free up capacity to focus on effective treatment of those in need. The Weston Campus model will allow for better shared care of patients who often (if their liver disease is for example related to substance misuse, alcohol or obesity) may have multifaceted needs
<b>Frailty as a specialty</b>	Refer to Frail and Older adults above.
<b>Musculo-skeletal conditions (MSK)</b>	Our new service model is designed to support older patients at risk of non-elective admissions, particularly for falls and fractured neck of femur. Also a more resilient, federated primary care service would have the opportunity to support people living with MSK problems and ensure they have timely access to community physiotherapy and improved support to self-manage their condition.  For those patients who do need surgery for MSK, WGH represents an excellent choice for many of the most common conditions and there should be an assumption throughout the system that choosing Weston is a good option for many common MSK conditions.
<b>Diabetes</b>	The Weston 'Care Campus' and Community Hub service provides an opportunity to improve the management of patients with LTCs such as Diabetes by moving the provision of general diabetes care into the community. This will involve providing rapid access to diagnostics, improved access to rapid access clinics and hot foot clinics, improved access to Diabetes Specialist Nursing teams, and swift access to secondary support.
<b>Dementia</b>	Dementia that is not diagnosed and/or supported is a major risk for unnecessary acute admissions of frail older patients who then may suffer the deconditioning associated with an in-patient environment.  We want Weston to be known as a centre of excellence for frailty and as such services will need to become highly effective in identifying and managing dementia working collaboratively within well-defined and rehearsed pathways and operating models. This could also involve improved access to Mental Health Liaison services and to the Dementia Support Team to avoid admissions and help maintain individuals with dementia in their own homes and in residential / nursing homes.
<b>End of Life</b>	The best place for patients to die is often at home. This doesn't always happen for a variety of reasons. The integration of services that are commonly involved in the care of a person on an end of life pathway affords us the opportunity to improve the choices and overall care of these patients meaning more people will be able to live out their days in their place of residence.
<b>Maternity</b>	Refer to Children, Young People & Pregnant Women above.



## APPENDIX 8: Recognising and Responding to Public & Staff Views

Theme	Response
<i>Core services should be provided as locally as possible (care closer to home) and provided in a more integrated and joined-up way</i>	The work to improve the resilience and coverage of local primary care services, through a federated 'at scale' approach, is a core element of this work. Another core element is the development of more integrated community services wrapped around GP practices and a more effective interface with local acute services.
<i>The need to focus more resources on improving access to General Practice, and at Primary and Community Services more broadly to reflect the increased demand from an ageing and growing population.</i>	<p>We have set out clearly in this document as to the projected growth in the population over the course of the next decade, which will average about 1% per year. Within this estimate the new housing stock has been factored in although clearly the rate of growth in particular parts of North Somerset, and particularly around Weston, will vary. The challenge is not so much about volume, but age as we will see proportionally large increases at both ends of the lifespan. This is why two of our three priority population groups are frail/older adults and children/young people</p> <p>Although there is rising pressure on GP services – in common with the system as a whole – the centralisation of specific services for key population groups is intended to enable a more resilient and responsive set of services, making best use of the system's human and building resources.</p>
<i>The need for a clear and sustainable future for Weston General Hospital and to Ensure other larger acute hospitals support WAHT to deliver sustainable services</i>	The proposals to turn the Weston General Hospital site into a 'Care Campus' model with a primary care led, integrated Community Hub is a great step forward in ensuring the sustainability of the site. Of course, acute services will also continue to operate from WGH, in close cooperation with primary and community services – supported by the UHB Partnership Agreement.
<i>Ensure other larger acute hospitals support WAHT to deliver sustainable services</i>	We agree that the ultimate outcome of the Partnership Agreement between UHB and WAHT is a key part of the solution for the local health economy. Stronger collaboration between UHB, WAHT and NBT are also very important and are being coordinated through the BNSSG STP.
<i>Provision of 24/7 urgent and emergency services, including sufficient resources for South Western Ambulance Service.</i>	<p>We know that a clear and sustainable future model for emergency services must be an output of this collective work. We need to be clear about how the whole system can work together (given for example how many of the serious and life threatening cases already bypass Weston and go to larger, specialist hospitals). If sustaining a specific model of care is likely to take up a disproportionate amount of time, energy and funds we need to have an honest conversation as to what that means in terms of other services that cannot be provided if we choose to spend our resources in this way.</p> <p>Any long term changes to the urgent care model in Weston would need to include a detailed analysis of the any additional capacity requirements for the ambulance service. SWASFT are closely involved with this work and therefore we are confident that any final set of proposals will ensure the right level of ambulance support will be factored in.</p>

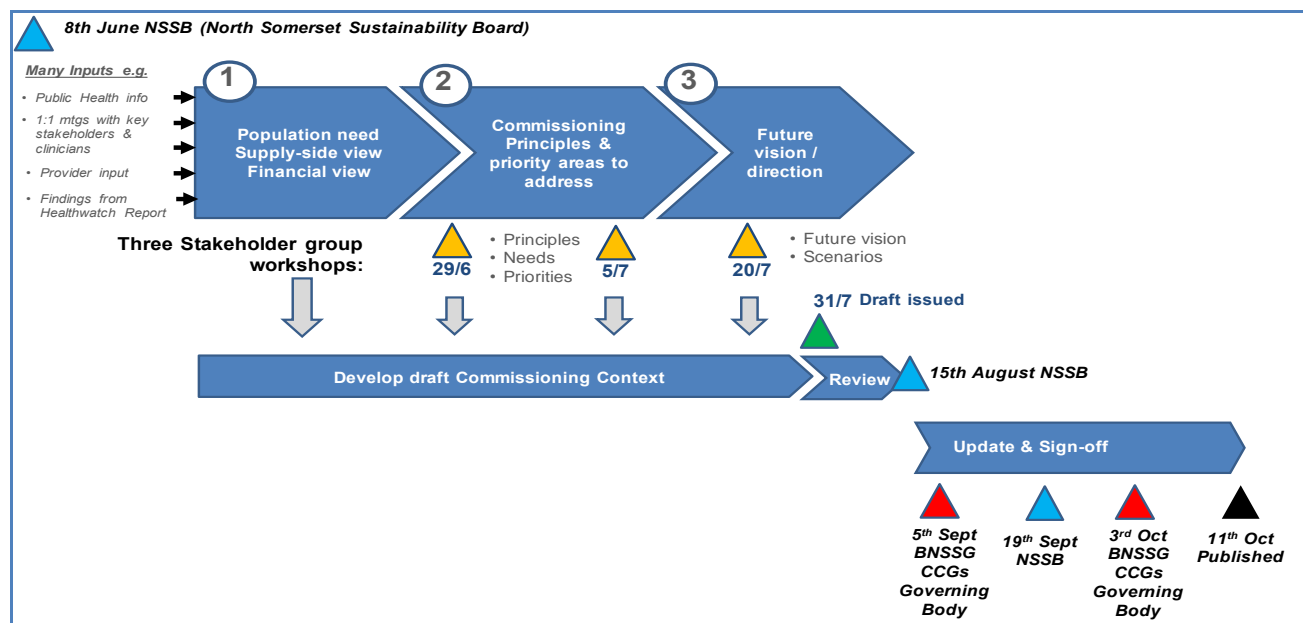
<p><i>People being treated in hospital for conditions that could be managed in a community setting. If a person is admitted, they should be better supported to come home as soon as possible.</i></p>	<p>For frail older patients we know that the evidence is undeniable that if they stay in hospital longer than is medically necessary then this is likely to do long term harm to their health as it can affect – for example - mobility, confidence and muscle mass. The whole idea of the integrated out of hospital model and the aspiration to turn Weston in to a centre of excellence for frailty revolves around the desire to help people keep well and out of hospital, but equally enabling them to return to their normal place of residence as soon as possible through strong rehabilitation and coordinated care.</p>
<p><i>Collaborating more effectively to optimise support and services provided by our voluntary, community and social enterprise sector.</i></p>	<p>A key feature of the new model of care is an increased role for our local voluntary, community and social enterprise sector.</p>
<p><i>The need to create interesting and satisfying jobs and roles to address the gaps in the workforce and create interesting and exciting opportunities for provider staff to work across organisational boundaries.</i></p>	<p>The ability to work with the patient holistically, rather than seeing them for one isolated part of their care is something that we hope will appeal to staff across all organisations. The idea of redefining WGH as a centre of excellence for certain specific areas of care is also intended to ensure that Weston becomes a more attractive and exciting place to work.</p>
<p><i>Travel times are an important consideration for patients, particularly for those from deprived and/ or rural populations</i></p>	<p>We need to ensure that core services are available locally wherever possible to meet this concern, with more complex and specialised services potentially being provided elsewhere to enable this and where clinically appropriate to do so. Travelling long distances is particularly challenging for frail older people – hence the need to provide services more locally and in the community where possible.</p>
<p><i>The need to reduce variation in service pathways by adopting best practice from across BNSSG</i></p>	<p>By bringing together best practice from BNSSG (and beyond) we intend to ensure that unnecessary clinical variation and inefficient service pathways can be identified and clinicians and services supported to improve the effectiveness and efficiency of the care offered to patients.</p>
<p><i>Professionals and organisations should be better at sharing information (supported by integrated IT systems and shared medical records).</i></p>	<p>We want this work to break down organisational boundaries and enable providers to think of themselves as part of a system rather than individual contractors doing specific task paid for by commissioners.</p>
<p><i>Address patient need holistically rather than a set of individual conditions to avoid repeating the same information to multiple professionals (i.e. say something once) and having needs re-assessed multiple times.</i></p>	<p>Patients regularly tell us that having to tell their story over and over again can be a major source of frustration and in some cases leads to delays in progressing smoothly and quickly through the system. Integrating services both physically, and through the better use of IT, affords us great potential to reduce unnecessary duplication of effort.</p>

<p><i>Help to understand and navigate the 'system' and be kept informed about what's happening</i></p>	<p>Every patient should be kept fully informed and involved in their care. Sometimes the reasons they are not is actually to do with poor communication channels between the different agencies involved in their care. By enabling providers to come together we expect that patients will experience a more joined up and seamless service.</p>
<p><i>Before any significant decisions are made, local people must be fully involved</i></p>	<p>The Communications and Public Dialogue Plan sets out how we will involve local people in this work to get their views and support our co-design model of service development. Local staff will also be involved.</p>

## APPENDIX 9: Developing the Commissioning Context

The following section describes the approach taken in developing this Commissioning Context and provides details of the organisations, clinicians and people who provided their time and expertise.

### Approach



**Figure 38: Approach to developing the Commissioning Context**

The work to develop the Commissioning Context was initiated at the North Somerset Sustainability Board (NSSB) on the 8<sup>th</sup> June 2017 and the approach taken is summarised in the figure above. The NSSB is Chaired by Mike Jackson, Chief Executive of North Somerset Council, and includes senior representation from across the local health economy (refer to the following section for further details on membership). The approach consisted of three key phases as outlined below:

#### Phase 1: Population Need, Supply-side and Financial View

- The first phase involved gathering a significant amount of information from a wide variety of sources to build a comprehensive view of population need including local demographics, population trends and future projections and local health and care need information sourced from various joint strategic needs assessment (JSNA) reports and data from public health, as well as more detailed information from local commissioners. This information was supplemented by a series of 1-2-1 meetings with key stakeholders and clinicians.
- To develop the supply-side view of the provider landscape, information was provided by local providers and partners, including current service provision and key service delivery challenges.
- The financial section, and supporting narrative, was developed by the CCG and then subsequently shared with local providers for feedback and comment. The information in this section aligns with the CCG's Financial Recovery Plan for 2017/18, the CCG's two year Operating Plan for 2017/18 and 18/19, and the provider financial figures provided in the BNSSG STP.
- Finally, the recommendations highlighted in the recent Healthwatch North Somerset report were also taken into account.

## Phase 2: Commissioning Principles & Priority Areas

Through a series of workshops with a core group of key local clinicians and stakeholders, the CCG defined the following:

- A set of Commissioning Principles (refer to Section 5) to set out a clear set of commissioning parameters or 'guard rails' against which the Commissioning Context and the future vision for local services could be developed.
- An agreed set of Priority Areas of Focus (refer to Section 6) based on a comprehensive review of the local population need that looked at the data both through a population 'lens', and a clinical speciality 'lens', to identify those areas most in need of system transformation.

## Phase 3: Future Vision & Direction

The future vision for local services was shared, discussed and developed in a half-day workshop on the 20<sup>th</sup> July. Using a series of common real-life patient scenarios to bring the session to life, key local stakeholders compared and discussed how patient need is managed currently in comparison with how it could be managed in a more integrated way. Various 'Care Campus' examples were explored along a spectrum of possible options that brought together acute, community and social care services into a single integrated model of care co-located at the Weston General Hospital site.

An initial draft of the Commissioning Context was issued for review at the end of July 2017 and the future direction of travel to deliver the vision and model of care was then discussed and agreed at the North Somerset Sustainability Board on the 15<sup>th</sup> August 2017, along with specific points of feedback on the draft report. The report was subsequently updated based on the feedback submitted along with further clarification discussions on specific topics to ensure alignment and agreement. The document was then submitted for BNSSG CCG Governing Body review on the 5<sup>th</sup> September 2017 and review by the North Somerset Sustainability Board on the 19<sup>th</sup> September 2017. A final version was then submitted for BNSSG CCG Governing Body approval on the 3<sup>rd</sup> October and the final version published on the 11<sup>th</sup> October 2017.

## **Organisations and People**

The CCG developed this Commissioning Context in close collaboration with key local partners and with the involvement of a significant number of senior stakeholders from across the local health and care economy.

The organisations involved included:



The people involved from these organisations included:

**Workshop 1 (26/6):**

- Mary Backhouse (GP)
- Colin Bradbury (CCG)
- Judith Brown (NSCP)
- Debbie Campbell (CCG)
- Peter Collins (WAHT)
- Eva Dietrich (AWP)
- Deborah Greenfield (LA)
- John Heather (GP)
- Andy Hollowood (UHB)
- Mike Jenkins (GP)
- Alison Moon (CCG)
- Julia Ross (CCG)
- Kathy Ryan (Brisdoc)

**Workshop 2 (5/7):**

- Colin Bradbury (CCG)
- Judith Brown (NSCP)
- Debbie Campbell (CCG)
- Peter Collins (WAHT)
- Eva Dietrich (AWP)
- John Dyer (SWAST)
- Deborah Greenfield (LA)
- Mike Jenkins (GP)
- Alison Moon (CCG)
- Anne Morris (CCG)
- Julia Ross (CCG)
- Kathy Ryan (Brisdoc)

**Workshop 3 (20/7):**

- Miriam Ainsworth (GP)
- Mary Backhouse (GP)
- Georgie Bigg (Healthwatch)
- Colin Bradbury (CCG)
- Judith Brown (NSCP)
- Debbie Campbell (CCG)
- Paula Clarke (UHB)
- Peter Collins (WAHT)
- Eva Dietrich (AWP)
- John Dyer (SWAST)
- Mark Graham (Weston Primary Care)
- Deborah Greenfield (LA)
- John Heather (GP/OneCare)
- Andy Hollowood (UHB)
- Mike Jenkins (GP)
- Mary Lewis (NSCP)
- Ray Montague (Brisdoc)
- Anne Morris (CCG)
- Laura Nicholas (STP)
- James Rimmer (WAHT)
- Julia Ross (CCG)
- Mike Vaughton (CCG)
- Eve Wilson (Protect our NHS)
- Andrea Young (NBT)

The table below provides the full list of people who were either involved in the workshops to develop the Commissioning Context, or who provided feedback on the document:

Name	Position	Sustainability Board?
<b>Miriam Ainsworth</b>	Clinical Lead for Community Services & LTCs, North Somerset CCG	N
<b>Mary Backhouse</b>	Clinical Chair, North Somerset CCG	Y
<b>Georgie Bigg</b>	Chair, Healthwatch North Somerset	Y
<b>Colin Bradbury</b>	Area Director for North Somerset, BNSSG CCGs	Y
<b>Judith Brown</b>	Chief Executive, NSCP	Y
<b>Debbie Campbell</b>	Programme Director, Weston Primary Care Transformation Programme, North Somerset CCG	Y
<b>Paula Clarke</b>	Executive Director of Strategy & Transformation, UHB	N
<b>Peter Collins</b>	Medical Director, WAHT	Y
<b>Eva Dietrich</b>	Clinical Director, AWP	N
<b>John Dyer</b>	Head of Operations, SWAST	Y
<b>Paul Goodwin</b>	Deputy Chief Officer & Director of Commissioning & Governance - Somerset CCG	Y
<b>Mark Graham</b>	CEO, For All Healthy Living Centre - Weston Primary Care	N
<b>Deborah Greenfield</b>	Acting Service Leader Adults' Support & Safeguarding, North Somerset County Council	N
<b>John Heather</b>	GP at New Court Surgery, Chair of OneCare	Y
<b>Maria Heard</b>	Transformation Programme Director, NHS England	Y
<b>Andy Hollowood</b>	Clinical Strategy Lead, UHB	N
<b>Suzanne Howell</b>	Managing Director, AWP	Y
<b>Mike Jackson</b>	Chief Executive, North Somerset County Council	<b>Chair</b>
<b>Mike Jenkins</b>	GP at Riverbank Medical Centre & Mental Health Clinical Lead for North Somerset CCG	N
<b>Victoria Keilthy</b>	Head of Delivery and Development	Y
<b>Mary Lewis</b>	Director of Nursing, NSCP	N
<b>Doreen Smith</b>	CEO, Voluntary Action North Somerset	Y
<b>Ray Montague</b>	Chairman, BrisDoc	N
<b>Alison Moon</b>	Director of Transition, BNSSG CCGs	N
<b>Anne Morris</b>	Director of Nursing and Quality, BNSSG CCGs	N
<b>Laura Nicholas</b>	BNSSG STP Programme Director	Y
<b>James Rimmer</b>	Chief Executive, WAHT	Y
<b>Julia Ross</b>	Chief Executive, BNSSG CCGs	Y
<b>Derek Sprague</b>	Local Director - South West, Health Education England	N
<b>Mike Vaughton</b>	CFO, North Somerset CCG	N
<b>Eve Wilson</b>	Local Protect our NHS Representative	N
<b>Andrea Young</b>	Chief Executive, NBT	Y

## APPENDIX 10: 'You said... and your views have influenced the CCG to...'

This section links public and staff feedback gathered as part of the earlier engagement process for the Weston Sustainability Programme with the content of this Commissioning Context document. It shows where feedback has influenced the CCG's vision and the direction of travel for a new model for health and care in the 'place' of Weston.

The feedback presented below came from a mixture of public and staff contributors and from a range of different sources: e.g. on-line survey, community and public meetings, staff engagement, correspondence and social media. The direct quotes (italicised) are illustrative of many of the 6600 items of feedback data received. Other 'You said ...' entries are summaries of commonly occurring themes.

Healthwatch North Somerset collated all of the feedback received through the engagement into an independent report: Healthwatch North Somerset - Weston General Hospital at the Heart of the Community - Public and Staff Engagement - 30 June 2017.<sup>24</sup>

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### You said...

### Your views have influenced the CCG to ...

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#### Q1. Do our reasons for change make sense to you?

Responses: = 391

Yes: 63% No: 37%

**Your reasons for needing services to change made sense to most of us:**

*"To make better use of resources in the current climate and opportunity to improve efficiency"*

*"Opportunity to redesign for improved efficiency".*

**Additional service areas are just as important as the services expressed as the four main ideas for the engagement. Including Primary Care, Mental Health, Children and Young People's Services, and especially Child & Adolescent Mental Health Services (CAMHS).**

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

Build on this foundation. The Commissioning Context document provides much more detail about why "doing nothing" is not an option for the future.

Widen the scope of the Weston Sustainability Programme to look at a whole system approach to improving services for the population of the 'place of Weston'. This includes Primary Care, Community Care, Mental Health Services as well as Acute Hospital Services. It also includes services across all life stages.

Plan to better meet the needs of older people and people with frailty. They are one of three

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<sup>24</sup> [https://www.northsomersetccg.nhs.uk/media/medialibrary/2017/07/Engagement\\_Report\\_Weston\\_General\\_Hospital\\_at\\_the\\_Heart\\_of\\_the\\_Community.pdf](https://www.northsomersetccg.nhs.uk/media/medialibrary/2017/07/Engagement_Report_Weston_General_Hospital_at_the_Heart_of_the_Community.pdf)

## You said...

## Your views have influenced the CCG to ...

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

priority groups identified for service re-design.

The Care Campus model includes an Acute Frailty service.

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

Develop a new model for health and care offering holistic care that will make the most of scarce resources and place the right service in the right place, to meet the needs of patients, services users and staff.

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

Set out and explain the financial challenge in detail. Being transparent about affordability is a main principle underpinning our public dialogue and co-design process.

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

Responses = 391

Yes: 208 (83%) No: 44 (17%) (139 no response)

**83% of respondents said ... ‘we need to change’.**

Offer a 12 week public dialogue phase and a process of co-design that will enable people to explore together how we can make the most of our scarce emergency care workforce and change current services to provide an affordable, good, safe and appropriate 24/7 urgent and emergency care service.

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

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

Set out some key ambitions for the developing new model for health and care, in that it will be both affordable and sustainable. The focus is on providing solutions to current challenges into a long term future.

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

Set out in detail the challenges around a growing and ageing population and the impact of tourism. The impetus for change starts from how we will best address the health needs of the population. We also look at how the workforce will need to develop to meet those needs. The new model of health and care focuses on better facilities to meet the specific ‘place of Weston’ population need within the finances available.

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

No your ideas don't make sense – what

Widen the scope of the Weston Sustainability



## You said...

## Your views have influenced the CCG to ...

about:

- [the]Increasing population
- Hospital needs to be bigger and better funded
- Impact of journey times to other hospital
- Insufficient information to make comment
- A&E is needed 24/7
- Transport
- Risks to patients in being transferred
- Ambulance provision
- Ability of other hospitals to cope with extra patients

Programme to include these additional factors and provide sufficient information to ensure people can continue to contribute to developing the proposed new model of health and care.

Ensure that a key principle of the new model of health and care is to provide services as close to where people live as possible and as appropriate for the best patient outcomes.

Consider the impact of patients travelling to other hospitals for certain treatments and procedures.

Factor in the interdependencies between services and organisations by working at a health system level.

### Q. 3 Have we represented our ideas clearly? If not what further information would be helpful?

Responses = 221

Yes: 154 (70%) No: 67 (30%)

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

Offer an opportunity through public dialogue and co-design to work on the detail of how services will operate within the proposed new health and care model including services offering 7 day working. Implementation will be informed by staff views and the views of public contributors. Co-design groups will work together to see how best specific service changes can be implemented.

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

Provide much more detail about how primary care; community care; social care; mental health care and acute hospital care can work within a more joined up way supported by services from the Voluntary, Community and Social Enterprise

Sector within the proposed new model for health and care for the ‘place of Weston’.

***“Ideas are presented clearly but sound too***

Provide assurance within the Commissioning

## You said...

## Your views have influenced the CCG to ...

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

Context document that the ‘deal is not done’ and that public and staff contributions are vital to develop the new model of health and care proposed. The public dialogue and co-design process will aim to draw as many contributors into the planning and shaping of the new model as wish to participate.

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

Provide assurance that the ‘ultimate goal’ is to have affordable, appropriate and sustainable acute hospital, community, and mental health and primary care services to meet the health needs of the population. In particular, the Care Campus model is proposed to be created within the Weston General Hospital estate.

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

Provide assurance that no decisions about long term service configuration and re-design have been made. The public dialogue and co-design process offers opportunities for staff and public contributors to participate by working alongside clinicians and health planners to develop the new model of health and care.

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

Clarify further, to explain that patients with very serious illness or major trauma have better outcomes when they are treated by specialist teams with access to all of the right equipment to manage their condition. Not every hospital provides the full range of teams and equipment needed to treat every possible serious illness or major trauma. For example, in our area North Bristol Trust treats major trauma and University Hospitals Bristol treats serious heart conditions. We do acknowledge the difficulties arising for visitors who need to travel further to visit loved ones but the priority is for patient safety and ensuring the best patient outcomes.

**You said that you would have liked further**

Provide much more detail on most of these

## You said...

## Your views have influenced the CCG to ...

### information on:

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

factors within the Commissioning Context Document. Further work will be undertaken as the Weston Sustainability Programme of work progresses. Any significant service re-design proposal/s will require impact assessments for equality and quality.

***“More information about why these proposals have been made would be helpful”.***

Provide more detailed information in the Commissioning Context Document about the various challenges to the system and why ‘doing nothing’ is not an option.

***“Very jargony in your articles in the Mercury. Nobody knows what you're trying to say. Be Clear”.***

Provide a detailed Commissioning Context Document to meet the need for openness and transparency acknowledging that the document is not written specifically for a public audience and uses by necessity some professional and technical language. To support greater accessibility to key information, and to promote a shared understanding of the challenges and potential solutions, a range of more accessible materials are being prepared. These will include presentations, Easy Read versions of key topic areas and will be supported by community meetings where the information can be discussed and clarified. We aim to keep jargon to a minimum and to respond to any enquiries clearly and promptly.

***“I think your ideas are very vague and misleading, the titles don't reflect exactly what you're trying to say, for example increasing the number of ITU beds then saying you are going to take the intensive care part of it away and send the patients to larger hospitals leaving Weston to only deal with HDU patients. I think your explanations needed to be more in depth”.***

Provide much more detail in the Commissioning Context Document. This will be strengthened through the period of public dialogue and co-design.

**Q4. What issues do these ideas (any or all of them) raise for you, that you would want us to**

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## You said...

## Your views have influenced the CCG to ...

explore before any decisions are made?

Responses: 391, 261 comments received

***“You should consolidate public’s views and publish the frequently occurring and best suggestions. The public can then be asked to comment further”.***

Publish the independent Healthwatch North Somerset report which details all of the feedback received through the public engagement period from February to April 2017. For the Public Dialogue and Co-design period we plan to publish the outputs of place based meetings and co-design groups as we progress through the process. We will also publicise ways to become involved.

***“I recognise the value of utilising planned surgery - particularly in view of a new theatre and a lot of surgeons sat around kicking their heels when electives are cancelled. However, my concern would be having a significant drive towards more planned surgeries whilst the situation in ED is not solved. My worry is that there will be a significant promotion of WGH’s ability to do more non-complex elective surgeries but that the hospital will still cancel these when in Opel 4 thereby reducing public confidence in the hospital to meet the needs of the community”.***

Provide a public dialogue and co-design process that will include staff currently delivering services, and who understand some of the challenges on the ‘frontline’.

Provide a whole system approach to problem solving through the new model of health and care set out in the Commissioning Context document that considers in detail the interdependencies between services and pre-empts unintended consequences associated with any service change.

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

Responses: 391, 232 comments received

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

Provide a proposal for a new model of health and care that will ensure that people who enter the health system will be seen by the right health professional, in the right place at the right time. This will help to ensure that the health professional treating the patient will be able to manage their condition appropriately and effectively. Self-care and prevention of illness is seen as a core part of the model, with health education being incorporated within the services offered by the Care Campus. Overall this approach should increase patient satisfaction with their experience and so help to reduce claims and complaints.

***“We need to make better use of IT and this***

Consider within the new model of health and

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## You said...

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

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## Your views have influenced the CCG to ...

care and the Care Campus model in particular, how IT can improve the patient and workforce experience. With appropriate consent, sharing electronic patient records across organisational boundaries is an example of this.

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

Responses: 391 187 comments received, 70 stated 'do not close' A&E

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

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

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

Provide a further opportunity to review long term solutions for emergency and urgent care services at Weston General Hospital. These services are set out within the Commissioning Context Document for public dialogue and co-design.

Since the earlier engagement; due to the Care Quality Commission report and for issues of safety, the Emergency Department at Weston General Hospital is now closed between 22:00hrs and 08:00hrs.

The Weston Sustainability Programme Team is gathering data to accurately measure the impact of this situation on patient flow and patient care.

Findings from this analysis will be fed into discussions about future services.

### Idea 2 Bring day to day Non-Complex Planned Operations Back to Weston General Hospital

## You said...

## Your views have influenced the CCG to ...

Responses: 391 (HWNS report states 'smaller response to this idea')

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

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

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

Provide more detail in the Commissioning Context document about how planned surgery could be provided at Weston General Hospital by developing the concept for a stronger, focused Acute Trust and Acute Care Model.

The Acute Care Model includes consideration of the need for further discussion concerning critical care beds; both as Intensive Care beds and/or High Dependency beds.

### Idea 3: Transfer Some Emergency Surgery to Other Hospitals

Responses:391 'HWNS report states 'very few direct answers to idea 3'.

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

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

Provide a proposal for a new model of health and care set out in the Commissioning Context document that considers recruitment and retention issues.

By developing the new model of health and care and the especially the Care Campus model it is hoped that this will offer a new and exciting opportunities for clinical and non-clinical staff as well as new roles for voluntary sector providers and for volunteers.

### Idea 4: Increase the Number of Beds in the Critical Care Unit on the Weston General Hospital

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## You said...

## Your views have influenced the CCG to ...

### Site.

Responses: 391

114 comments – HWNS state ‘that the staff and public focus was on possible closure of ITU’

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

***“Increasing the size of the ITU. Too expensive”.***

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

Providing clearer information within the Commissioning Context document will help to explain the interdependencies between services and how we need to ensure that patients are treated in the right place to achieve the best and safest patient outcomes.

One of the key principles embedded within the new model for health and care for Weston is that it has to be both affordable and sustainable into the future.

By starting from a perspective of meeting the health needs of the population we can design services together to meet these particular needs rather than keep a narrow focus on changes to one element or service within the whole system.

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

Responses: 391 187 comments received 37 stated ‘no’ or ‘N/A’

**Shutting A&E because of the distances to travel to other hospitals and risks to patient safety.**

Provide a further opportunity to review long term solutions for emergency and urgent care services at Weston General Hospital. These services are set out within the Commissioning Context Document for public dialogue and co-design. Since the earlier engagement; due to the Care Quality Commission report and for issues of safety, the Emergency Department at Weston General Hospital is now closed between 22:00hrs and 08:00hrs. The Weston Sustainability Programme Team is gathering data to accurately measure the impact of this situation on patient flow and patient care. Findings from this analysis will be fed into discussions about future services.

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## You said...

## Your views have influenced the CCG to ...

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

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

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

***“No, pretty well covered all aspects that I’m aware of”.***

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

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

The Commissioning Context document proposes a Care Campus concept that is based on clear integration between primary and community care and mental health and acute care services.

Will make decision making committees and processes and committees clearly identified within our Public Dialogue and Communication processes. The North Somerset Sustainability Board and the Bristol, North Somerset and South Gloucestershire CCGs Governing Body (meeting in common) are decision making groups for the Weston Sustainability Programme.

Children and Young people’s services and mental health services will be included in the new model of health and care set out within the Commissioning Context document.

Noted!

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

Responses: 391 152 comments

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

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

Continue to work closely with Somerset CCG to see how we can redesign services that work for the population.

Reorganise our commissioning organisation to optimise and strengthen our leverage (power to make things happen). North Somerset CCG is in a process of transition with an intention towards merger with Bristol and South Gloucestershire (BNSSG) CCGs. Working from a stronger basis and as part of the

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**You said...**

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**Your views have influenced the CCG to ...**

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

BNSSG Sustainability and Transformation Partnership will help us to ensure we have both the means and ability to deliver this programme of work.

Ensure better publicity for the population in Somerset of our Public Dialogue process and opportunities to become involved in co-design work as the programme of work progresses.

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## APPENDIX 11: Glossary

<b>AWP</b>	Avon and Wiltshire Mental Health Partnership NHS Trust
<b>BME</b>	Black and Minority Ethnic
<b>BNSSG</b>	Bristol, North Somerset and South Gloucestershire
<b>BP</b>	Blood Pressure
<b>CAMHS</b>	Child and Adolescent Mental Health Services
<b>CCG</b>	Clinical Commissioning Group
<b>CHC</b>	Continuing Health Care
<b>CHD</b>	Coronary Heart Disease
<b>COPD</b>	Chronic Obstructive Pulmonary Disease
<b>CQC</b>	Care Quality Commission
<b>CT</b>	Computerised Tomography
<b>DALY</b>	Disability Adjusted Life Years
<b>DNAR</b>	Do Not Attempt Resuscitation
<b>DVT</b>	Deep Vein Thrombosis
<b>ED</b>	Emergency Department
<b>EOL</b>	End of Life
<b>ETTF</b>	Estates, Technology and Transformation Funding
<b>GMC</b>	General Medical Council
<b>GP</b>	General Practice
<b>GPFV</b>	GP Forward View
<b>IAPT</b>	Improving Access to Psychological Therapies
<b>ICNARC</b>	Intensive Care National Audit and Research Centre
<b>ICU</b>	Intensive Care Unit
<b>IM&amp;T</b>	Information Management and Telephony
<b>IPCC</b>	Integrated Primary and Community Care
<b>ISTC</b>	Independent Sector Treatment Centres
<b>IV</b>	Intravenous Fluid
<b>JSNA</b>	Joint Strategic Needs Assessment
<b>LGBT</b>	Lesbian, Gay, Bisexual, and Transgender
<b>LOS</b>	Length of Stay
<b>LSOA</b>	Lower Super Output Areas
<b>LTC</b>	Long-Term Conditions
<b>MH</b>	Mental Health
<b>MIU</b>	Minor Injuries Unit
<b>MLU</b>	Midwife Led Unit
<b>MPS</b>	Market Position Statement
<b>MSK</b>	Musculo-skeletal Conditions
<b>MSOA</b>	Middle Super Output Areas
<b>NBT</b>	North Bristol Trust
<b>NEWS</b>	National Early Warning Score
<b>NHS</b>	National Health Service
<b>NHSE</b>	NHS England
<b>NICE</b>	National Institute for Health and Care Excellence
<b>NSCP</b>	North Somerset Community Partnership

<b>NSSB</b>	North Somerset Sustainability Board
<b>ONS</b>	Office for National Statistics
<b>OT</b>	Occupational Therapies
<b>PCLS</b>	Precision-cut Lung Slices
<b>PICC</b>	Peripherally Inserted Central Catheters
<b>PPRG</b>	Patient and Public Reference Group
<b>QOF</b>	Quality and Outcomes Framework
<b>SALT</b>	Speech and Language Therapy
<b>SHMI</b>	Summary Hospital-level Mortality Indicator
<b>SMR</b>	Standard Mortality Ratio
<b>SPA</b>	Single Point of Access
<b>STP</b>	Sustainability and Transformation Partnerships
<b>SWASFT</b>	South Western Ambulance Service NHS Foundation Trust
<b>TEP</b>	Treatment Escalation Plan
<b>TSFT</b>	Taunton and Somerset NHS Foundation Trust
<b>UHB</b>	University Hospitals Bristol
<b>UTI</b>	Urinary Tract Infections
<b>VANS</b>	Voluntary Action North Somerset
<b>WAHT</b>	Weston Area Health NHS Trust
<b>WGH</b>	Weston General Hospital
<b>YLL</b>	Years of Life Lost

**END**