Bristol, North Somerset and South Gloucestershire
Integrated Care Board

# Meeting of BNSSG ICB Board

**Date: Thursday 6th April 2023**
**Time: 12:00 – 15:15**
**Location: The Ball Room, Winter Garden, The Royal Parade, Weston super Mare, BS23 1AJ**

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| **Agenda Number:** | 6.2 | |
| **Title:** | **Healthy Weston 2 Phase 1 Full Business Case – Safe, high-quality and sustainable emergency care at Weston General Hospital, that is in line with national and local standards** | |
| **Confidential Papers** | **Commercially Sensitive** | No |
| | **Legally Sensitive** | No |
| | **Contains Patient Identifiable data** | No |
| | **Financially Sensitive** | No |
| | **Time Sensitive – not for public release at this time** | No |
| | **Other (Please state)** | No |

**Purpose: Decision**

**Key Points for Discussion:**

The Healthy Weston 2 Phase 1 Full Business Case (FBC) brings forward a new approach to urgent care for Weston General Hospital and is the foundation on which the full Healthy Weston 2 clinical model, approved by the BNSSG System in June 2022, is dependent.

Phase 1 leads the development of safe, high-quality and sustainable emergency care at Weston General Hospital, that comes into line with national and local standards, and ensures that local people have equity of access to the best urgent care. The plans will deliver the following:

- Enhances the **24hr observation unit** for adults providing rapid assessment, treatment, and quick discharge
- Extends **Same Day Emergency Care provision** across 7 days, providing the right care, in the right place at the right time
- Significantly increases the number of frail patients supported by the already award winning **Geriatric Emergency Medicine Service**, by extending service provision across 7 days, better meeting the needs of the ageing population and integrating with a GEMs@Home "virtual ward" pathway
- Creates a new 14 bedded **Older People's Assessment Unit** providing specialist rapid assessment and treatment for older frail patients
- Preserves the current 14/7 A&E service at Weston

The key benefits secured from the investment are detailed in section 2.2.7. Key indicators include reductions in non-elective bed capacity (27 beds); increased ambulatory care access (minimum KPI of 20% of A&E attendances through SDEC by 2024); reduced reliance on agency staff (equivalent to £3.3m) also improving resilience and continuity of care; up to 10% increase in 'time to be seen, treated and discharged' performance; at least a 10% reduction in Length of Stay.

Plans set out within this FBC are the culmination of close partnership working between a wide range of organisations from across BNSSG and Somerset integrated care systems. While the focus is on the "front-

door" services at the Hospital, these services are essential to interface with primary and community pathways and secure a shift in the emphasis of care for people at home where possible (Home First) or, if they are admitted to hospital, to get them back home again as soon as possible. The place of Weston equally offers unique opportunities for BNSSG ICS to be a national exemplar in integrated and innovative care models for frail older people and opportunities are being explored through implementation of this case, including joint roles, blended career options, increased integration of frailty services such as with the Pier Health care home hub, virtual wards and shared frailty assessment processes plus potential integrated frailty research.

Approval is being sought for this Full Business Case.

The investment requirement set out in this Full Business Case is detailed below:

- £2.5m revenue investment in 2023/24 (including non-recurring costs of £0.6m).
- Recurring revenue cost of £2.6m by 2025/26. The recurring revenue cost is net of savings secured by 2025/26 from reduced premium/agency costs of £3.3m and reduced non-elective bed capacity benefit from phase 1 of £1.2m. Additional offset benefit from further bed reductions and increased system income from surgical elective will be assessed within the phase 2 and 3 business cases.
- £154,000 capital expenditure

Decisions on investment will be subject to agreement through system operational planning and in line with the 2023 / 2024 Operational Plan.

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| **Recommendations:** | It is recommended that the ICB Board:<br>○ Approve the Full Business Case (FBC)<br><br>Decisions on investment will be subject to agreement through system operational planning and in line with the 2023 / 2024 Operational Plan. |
| **Previously Considered By and feedback:** | The Healthy Weston 2 Outline Business Case (OBC) was agreed by the system in June 2022. The following sets out the key decision points where the OBC was presented, assured, and agreed:<br>• BNSSG Quality Committee, 10 March 2022 – Review and support given towards the HW2 Quality Impact Assessment<br>• Clinical Executive Meeting, 10 March 2022 – Draft OBC was reviewed and supported, with feedback given to strengthen the clinical elements.<br>• Healthier Together Partnership Board, 15 March 2022 - Healthier Together Partnership Board provided review and support towards the draft OBC.<br>• South West Clinical Senate, 31 March 2022 - Assurance given towards model of care Option 2<br>• North Somerset HOSP, 20 April 2022 - The model of care and evaluation criteria were reviewed, with HOSP confirming that the model of care set out in Option 2 did not constitute substantial variation or change requiring public consultation.<br>• Clinical Cabinet, 11 May 2022 - Support and assurance given towards the OBC Clinical Model<br>• Healthier Together Clinical Execs, 12 May 2022 - Support and agreement given to proceed with taking the HW2 OBC to HW Steering Group and Governing Body |

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| | • UHBW SLT, May 2022 - Support and agreement given to proceed with taking the HW2 OBC to HW Steering Group and Governing Body<br>• Healthy Weston Steering Group, 31 May 2022 - Agreement given to take OBC to Governing Body for final decision making.<br>• Open Governing Body, 07 June 2022 - Approval given to proceed with Outline Business Case delivery.<br><br>System wide support for the clinical model agreed through the OBC has led to the development of the Healthy Weston 2 Phase 1 Full Business Case (FBC). The case has been discussed at the following:<br>• Healthy Weston Programme Group, 8 February 2023 - full support was given to the Phase 1 FBC<br>• Health & Care Professional Exec, 9 February 2023 – Clinical model was fully supported subject to confirmation that it aligns with NHS Delivery plan for recovering urgent and emergency care [post meeting confirmation given]<br>• System DoFs, 10 February 2023 – action required for a) review of workforce plan by CPO/DHRDs, b) clarification of impact on future flow, c) consideration of sources of funding and review of implementation in line with Phase 2 business case<br>• UHBW Executive Committee, 14 February 2023 - full support was given to the Phase 1 FBC<br>• System Executive Group, 16 February 2023 – FBC noted and issues raised for further discussion at HW Steering group 20th Feb<br>• Healthy Weston Steering Group, 20th February 2023 – support for clinical model and approach, request to consider recruitment phasing in 24/25 and opportunities for greater integration and innovation<br>• ICB Finance, Estates and Digital Committee, 23 February 2023 – support was given to the Phase 1 business case, with a requirement to test and review the phase 2 and 3 benefits through a gateway process<br>• ICB Board [closed] – 2 March – qualified support given with a requirement to undertake further work on benefits realisation, ahead of ICB Board in April |
| **Management of Declared Interest:** | None identified. |
| **Risk and Assurance:** | A full risk register is held by the Healthy Weston Steering Group (FBC Appendix 1), which is reviewed regularly.<br><br>The key risks for implementing Phase 1 include:<br>• There is risk that national workforce shortages mean that it is difficult to recruit to posts<br>• There is a risk that the revenue investment required in the Phase 1 Full Business Case is not sourced, resulting in the implementation of the Healthy Weston 2 model stalling, leading to ongoing exposure to risk of unsustainable clinical services needing to be suspended at short notice |

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| | • There is a risk that other system initiatives, including D2A, don't deliver the bed savings required to deliver the full HW2 programme |
| **Financial / Resource Implications:** | The full detail of the financial position is laid out in the FBC.<br>The investment required for the implementation of the new model of care is:<br>○ £2.5m revenue investment in 2023/24 (including non-recurring costs of £0.6m).<br>○ Recurring revenue cost of £2.6m by 2025/26. The recurring revenue cost is net of savings secured by 2025/26 from reduced premium/agency costs of £3.3m and reduced non-elective bed capacity benefit from phase 1 of £1.2m. Additional offset benefit will be assessed within the phase 2 and 3 business cases.<br>○ The total capital works and equipment is estimated at £154k. |
| **Legal, Policy and Regulatory Requirements:** | The programme is being supported by BNSSG ICB and is subject to the associated assurance processes. |
| **How does this reduce Health Inequalities:** | The programme will reduce health inequalities by delivering improved urgent care locally and through more equitable access to local services. |
| **How does this impact on Equality & diversity** | An Equalities Impact Assessment (EIA) has been developed and is included as part of the Full Business Case appendices. The EIA is iterative and will continue to inform engagement and communications activities. |
| **Patient and Public Involvement:** | A full patient, staff and public engagement process is in place. This has been running since January 2022, including a public engagement period June-August 2022. |
| **Communications and Engagement:** | The programme has worked extensively with staff, system partners, patients and carers, stakeholders, community representatives over the past four years. This will be further developed in the delivery phase. |
| **Author(s):** | Helen Edelstyn, Head of Healthy Weston Programme |
| **Sponsoring Director / Board Member:** | Paula Clarke, Executive Managing Director (WGH), UHBW & SRO Healthy Weston programme |

# Agenda item: 6.2

# Report title: Healthy Weston 2 Phase 1 Full Business Case – A new approach to urgent care where patients get better support, at the right time in the optimal setting

## 1. Background

Healthy Weston 2 seeks to lead the country as an exemplar in high quality, safe and integrated health services that meet local people's needs, now and in the future. A fundamental building block is establishing an equitable and sustainable urgent care "front-door" model at Weston General Hospital, that delivers minimum national and local standards. This will provide the foundation for innovative, integrated UEC pathways that capitalise on the exciting ICS HomeFirst models of care currently in implementation.

**Our vision** is for Weston General Hospital to be a strong and dynamic hospital, at the heart of the community, that is fit for the future, with a range of services providing the very best care, experience, safety, and outcomes to local people.

The Healthy Weston 2 Outline Business Case (OBC), agreed in June 2022, describes a series of ambitious reforms centred around delivering sustainable all age services at Weston General Hospital that better meet local healthcare need. The Healthy Weston 2 Phase 1 Full Business Case (FBC) is the first part in the operationalisation of the Healthy Weston 2 OBC, ensuring the people of Weston have equity of access to the very best urgent care and outcomes as other people in BNSSG.

A phased approach to the development of three interlinked full business cases has been agreed to cover the improvement plans described in the Healthy Weston 2 OBC. These phases are:

- Phase 1 – Safe, high quality and sustainable urgent care
- Phase 2 – Inpatient medical care and specialist centre for care of the elderly
- Phase 3 – Surgical Centre of Excellence @ Weston

Adopting a phased approach to delivery enables an initial focus to be on those projects that are standalone and can be delivered quickly. Other elements of the programme that are more complex or sequentially dependent on one another, and in some cases require capital investment to be effectively planned, will follow.

This Full Business Case sets out the stand alone plans for delivering the Phase 1 service improvements, with approval being sought for the maximum mitigated revenue funding of £2.6m by 2025/26. In year 1 (23/24) this is £1.9m of recurrent funding and £0.6m of non-recurrent funding to support programme implementation, recruitment supplements and fees for international recruitment. The key monetary benefits released through this investment include initial reductions in non-elective bed capacity (27 beds); increased ambulatory care access (minimum KPI of 20% of A&E attendances through SDEC by 2024); and reduced reliance on agency staff (equivalent to £3.3m) which also improves resilience and continuity of care. Additional offset benefit from further bed reductions and increased system income from surgical elective delivery will be assessed within the phase 2 and 3 business cases.

Phase 1 leads the development of safe, high-quality and sustainable emergency care at Weston General Hospital, that comes into line with national and local standards, and ensures that local people have equity of access to the best urgent care. It delivers a series of system benefits including continuing to mitigate the risk of lack of resilience in acute medical services thereby safeguarding UEC flow across BNSSG and into Taunton, improving Emergency Department performance, system flow, reducing diverts, improving patient outcomes, reducing length of stay and a more sustainable workforce.

Senior leaders, clinicians, patients, and the public from across Bristol, North Somerset, South Gloucestershire, and Somerset have led the progression of the Phase 1 Full Business Case in line with the OBC Clinical Model, ensuring that the case continues to deliver the Healthy Weston vision and system priorities.

Through the successful implementation of the service enhancements set out in this Full Business Case, a future for Weston General Hospital can begin to be built that is sustainable, dynamic, and provides the best urgent care to support improved health outcomes for local people. It equally builds on the positive indicators for improvement in the workforce at WGH, which are in part due to increased confidence in the vision for the future models of care and on the early impact from winter plans that demonstrates increased SDEC flow and reduced diverts.

The ICS strategic intent is to enable care and treatment out of hospital through HomeFirst models of care. A modern urgent care service, focused on getting people home again as soon as possible, is an essential part of the Weston HomeFirst model of care. In addition, work is underway to explore further opportunities to develop a truly integrated urgent care approach including joint/blended roles building on roles, such as the GEMS@Home role, that already exist.

The consensus is that doing nothing carries the greatest risk for the wider system, as it brings with it the possibility of continuing unplanned changes that have the potential to destabilise the system and affect patient care. A Review Panel from the South West Clinical Senate agreed that 'do nothing' is not an option, stating that there is significant and robust clinical evidence that it is neither sustainable nor safe to continue services as they are.

## 2. Strategic case for change (Business Case Section 2.1)

At the heart of Healthy Weston 2 Phase 1 is a need to bring forward and accelerate a new approach to urgent care in which patients in Weston get better support, and properly joined-up urgent care at the right time in the optimal care setting.

The new model of urgent care will deliver national and local commitments, effectively bringing WGH to the required level of front door hospital services:

The NHS Long Term Plan states:

- *'… every acute hospital with a type 1 A&E department should move to a comprehensive model of Same Day Emergency Care'*

The NHS delivery plan for recovering urgent and emergency care services (Jan 2023) states:

- *'Urgent and emergency services have been through the most testing time in NHS history with a perfect storm of pressures impacting the whole health and care system but causing the most visible problems at the front door. Variation in care must be reduced when patients arrive at A&E, ensuring greater consistency in direct referrals to specialist care, and access to same day emergency care (SDEC) so patients avoid unnecessary overnight stays'.*

  And

- *"Same day emergency care (SDEC) means shorter stays for patients and fewer unnecessary delays to leaving hospital. Current pressures often mean hospitals need to use their same day emergency care staff and space for other emergency care. NHS England will work with systems to spread best practice to ensure greater resilience ahead of next winter so that all hospitals with Type 1 emergency departments provide appropriate SDEC seven days a week with a minimum opening of 12 hours per day".*

## 3. Population case for change (Business Case Section 2.2)

The Weston population is growing, getting older and there are significant inequalities amongst local communities. Within North Somerset, 20% of the population are expected to be over the age of 70 by 2025.

Significant pockets of deprivation also exist, particularly in Weston-super-Mare, where the average life expectancy of a man in Weston Central Ward is 10 years lower than the English average, and the rate of children living in poverty is 36% compared to the national rate of 25%. The BNSSG population management work has also demonstrated through segmentation of our population into a pyramid of five segments (defined by the Cambridge Multimorbidity Index score) that three of the top six Segment 5 areas in BNSSG are in Weston (where segment 5 includes 3% of the population with multiple health conditions,

greater risk of mortality and a higher acute healthcare need.) It is essential that we deliver a new model of emergency care that is better able to meet these changing health and care needs.

## 4. Patient, public and staff engagement (Business Case Section 6)

Patients and public have helped shape the Healthy Weston 2 Phase 1 Full Business Case. An 8-week public engagement exercise took place over the summer 2022 – where we heard the views of nearly 900 people. Of these, 73% thought that the plans would improve Weston General Hospital.

There has also been significant staff engagement across UHBW and staff were as positive about the plans as the public. Healthy Weston 2 gives both the Hospital and staff a future which is helping to drive change and improvement. It is already making a difference. There has been an increase in applicants for substantive posts, including a Care of the Elderly consultant with expertise in movement disorders – a hard to recruit to post - and a high number of Advanced Clinical Practitioner applicants for frailty roles.

Healthy Weston 2 Phase 1 builds on the extensive engagement that has taken place over the last four years. More than 5,000 local people have influenced plans to date. The programme is committed to delivering a proactive and accessible communications and engagement approach and continuing to enable a broad range of groups to be involved and have their voices heard as the Phase 1 plans are implemented.

## 5. The clinical model (Business Case Section 4)

The Phase 1 clinical model leads the development of safe, high-quality, and sustainable emergency care at WGH, that ensures that local people have equity of access to the best urgent care. If agreed, it will secure a firm foundation for the ongoing transformation of WGH, provide a fundamental basis for creating an exemplar integrated model of delivery within the place of Weston, as well as enable Phase 2 & 3 of Healthy Weston 2 and associated additional benefit release.

HW2 Phase 1 delivers the following:

- Enhances the **24hr observation unit** for adults providing rapid assessment, treatment, and quick discharge
- Extends **Same Day Emergency Care provision** across 7 days, providing the right care, in the right place at the right time
- Significantly increases the number of frail patients supported by the already award winning **Geriatric Emergency Medicine Service**, by extending service provision across 7 days, better meeting the needs of the ageing population and integrating with a GEMs@Home “virtual ward” pathway
- Creates a new 14 bedded **Older People’s Assessment Unit** providing specialist rapid assessment and treatment for older frail patients
- Preserves the current 14/7 A&E service at Weston

The case delivers significant system benefits:

| Benefit | Impact | KPI |
|---|---|---|
| Reduction in length of stay (LOS) in hospital | More people maintain their independence<br>Fewer delays are experienced for treatment<br>More people access services where national standards are met, and specialised care is available<br>Reduced risk to frail older patients of conditions related to longer LOS e.g. delirium, pressure sores and deconditioning | 10% reduction in LOS *<br>Net reduction of 27 escalation beds [Equivalent to £290k per quarter profiled from Q4 23/24 in Table 2] |

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| Improved outcomes for patients receiving urgent and emergency care | Improvements in the quality and responsiveness of care<br>Reduced risk of mortality because of overcrowding<br>Reduced risk to frail older patients of conditions related to longer LOS e.g. delirium, pressure sores and deconditioning | 60 fewer deaths because of improvements in time to be seen **<br>% reduction of safety Datix raised related to overcrowding [at minimum sustain current level of 1 per month] |
| Improved ED performance | Increase in 'time to be seen, treated and discharged'<br>Improved patient flow<br>Improved patient experience<br>Reduced risk to frail older patients of conditions related to longer LOS e.g. delirium, pressure sores and deconditioning | 10% increase in 'time to be seen, treated and discharged' targets increasing performance to 74% and close to the national target of 76% ***<br>20% of ED attendances through SDEC by 2024<br>% reduction in ambulance diverts [at minimum sustain current level achieved in Q4 22/23 [1 per month]]<br>14 additional people seen, treated and discharged each day |
| Hospital care maintained locally | People living locally to Weston General Hospital can still receive the majority of their care locally<br>Improved access for local visitors and family<br>Decreased travel for the system | |
| Improved workforce outcomes | More resilient and sustainable workforce<br>Reduced reliance on agency staff<br>Enhanced access to training and development<br>New workforce models that create opportunities for progression<br>Improved network working with other hospitals<br>Staff experience | % reduction in agency staff [at minimum less than 10% medics] [Equivalent to £3.3m savings @ 94%]<br>% decrease in vacancy rate [at minimum sustain 5%]<br>Staff survey results |
| Improved system flow | Improvements in the efficiency of services<br>Decrease in length of stay for patients<br>Improvements in the quality and responsiveness of care | % reduction in ambulance diverts [at minimum sustain current level achieved in Q4 22/23]<br>10% decrease in length of stay for patients * |
| Improved patient experience | Improvements in the quality and responsiveness of care<br>Improvements to the reputation of the hospital<br>Clinical outcomes and patient safety enhanced | Friends and family test results<br>Number of patient complaints received<br>Number of serious incidents reported |
| Increased care at home | Hospital services are utilised only by those that need acute care, reducing demand on staff in-hospital<br>Decreased length of stay for patients<br>Increased hospital bed availability in acute care<br>People are supported to be independent | 10% reduction in LOS * |

** 10% reduction in LOS is the percentage LOS reduction because of the collective impact from Phase 1 enhancements*

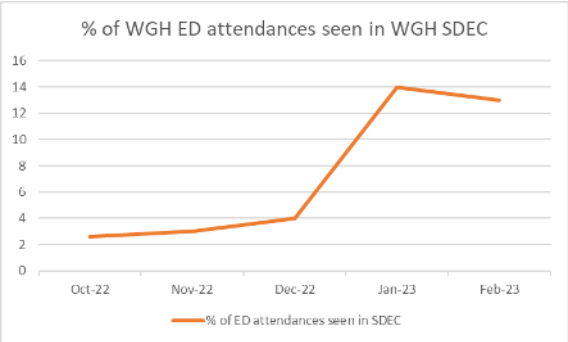
*** For every 82 patients who wait beyond 6-8 hours for a bed there is one excess death within 30 days. Using same logic as above current excess death rate + 1 every 1.8 days [204 a year]. This would reduce to 1 every 2.52 days (145 a year) because of 'time to be seen' improvements. [BMJ, Volume 39, Issue 3]*
**** 10% increase in time to be seen, assumes all patients admitted to SDEC / short stay bed do not breach time to be seen targets.*

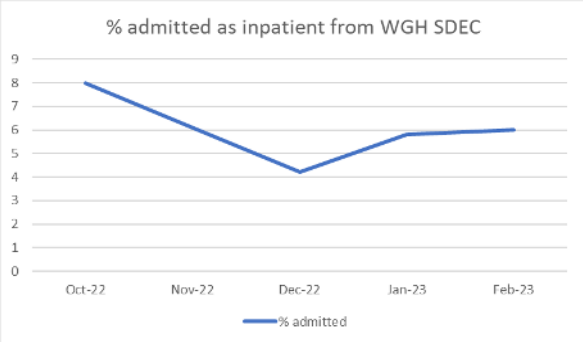
As a result of these benefits, and in particular reduced admission rates and improvements to length of stay, there is a reduction of 27 non elective bed need. A full benefit realisation plan can be found in Appendix 6 and section 4.1.11 in the case sets out the specific bed and activity impacts. A benefits addendum to the Full Business Case with further detail on benefits realisation can be found in Appendix A.

## 6. Winter plan improvements (Business Case Section 4.1.10)

In preparation for Phase 1 implementation and to help reduce winter pressures, the first step in the Phase 1 enhancements have been introduced and funded on a short-term basis (to March 2023) through winter funding. This includes SDEC pathways and rapid patient reviews, enhancement to the Ambulatory Emergency Care (AEC) Unit and the introduction of ED Observation beds. These early Phase 1 improvements offer the opportunity to further test the model and to collect data on benefits realisation.

Early analysis, following the introduction of Same Day Emergency Care pathways, funded via winter pressure investment, is already showing a positive difference. The figures below show an upward trend of the % of ED patients being seen and treated in SDEC, and a downward trend in the number of patients being admitted. This work is being done with partners in social care and Sirona to ensure a joined-up approach to expediting discharges.




## 7. Workforce model and recruitment plan (Business Case Section 7)

Investment in key services and staff groups will bring care forward to the front door of the hospital, ensuring patients are provided with front-loaded input from a multi-disciplinary team to prevent admission. The opportunity to build increasingly seamless integrated and innovative pathways will be supported by this enhanced and substantive workforce.

The medical, nursing, and allied health professional workforce will be enhanced across the new model of care, enabling the safe and efficient delivery of care in line with standards and service requirements, including the staffing of resilient and sustainable workforce rotas. This in turn enhances the employment offer at WGH and supports opportunities for blended roles across UHBW and the APC as well as with Sirona and primary care.

Rapid access to diagnostics is a critical component of the Phase 1 service improvements. Radiology capacity and service levels will be increased across the imaging modalities, securing faster access to diagnostics, faster diagnosis, and treatment times. This increase in capacity will ensure that patients are not admitted to an inpatient bed while they wait for a diagnostic assessment but can instead be more appropriately diagnosed and treated on the same day before returning home. This capacity is currently at a very low base at WGH.

Pharmaceutical support will be enhanced providing quick access to medicines expertise, supporting the efficient diagnosis and treatment of patients. This dedicated team will have a significant impact on admission, flow, and patient safety.

Consultant teams are also under-pressure, as set out within the OBC case for change. Shortages in some staff groups mean that doctors at WGH work more weekends, are on call more and carry more risk than their counterparts in neighbouring hospitals. This isn't resilient nor does it attract a sustainable workforce fit for the future. Higher staffing ratios across the professional groups will increase job satisfaction, reduce clinical risk, and increase staff retention and recruitment rates to deliver the future model.

**Recruitment plan:**
The phase 1 recruitment plan has been developed with HR and clinical and professional representatives and tested by Executive leads. The phased approach sees most of the recruitment to posts over the initial 12 months of the project (23/24). The focus will be on recruiting substantively to the new posts, whilst maintaining the existing temporary workforce to expand the services.

In the following year (24/25) the recruitment efforts will be on addressing the underlying vacancy position currently covered by bank and agency staff, and the vacancies created because of the internal promotions in year 1. The conversion of the temporary arrangements into substantive posts will result in a cost saving.

The intent is to progress implementation of the Phase 1 recruitment plan as part of the system workforce plan, ensuring the opportunities for joint/blended posts are maximised and recognising the likely need for agreed prioritisation of where workforce is directed to secure maximum benefit for the overall system/population. Healthy Weston offers a unique opportunity for innovative integrated workforce possibilities, e.g., Geriatric consultants could undertake a joint role with Sirona and Pier health care home hub PAs, strengthening the individual's career progression, whilst maximising integration and collaboration with local services.

## 8. Home First – Integrated care (Business Case Section 2.1.5)

Healthy Weston is part of wider system change to enable a 'Home First' approach. The aim of this approach is to shift the emphasis of health and care to care for people at home where possible, or if they are admitted to hospital, to get them back home again as soon as possible.

The Healthy Weston programme are working closely with Primary Care, Social Care, Ageing Well programme, Virtual Wards, Locality teams and other system initiatives to make sure that the plans are integrated and create seamless pathways for patients. This offers real opportunity for BNSSG and the locality of Weston to become a national exemplar and maximise the potential for research drawing on the BNSSG national status as a Clinical Research Centre and the multidisciplinary Health Integration Team approach under Bristol Health Partners.

## 9. Financial resource implications (Business Case Section 8)

The recurring net revenue cost of this case is £2.6m by 2025/26. This is net of savings from reduced premium/agency costs of £3.3m and further offset by benefits from phase 1 impact on reduced NEL bed capacity also achieved by 25/26 of £1.2m.

The additional revenue cost is £2.5m in 2023/24 (including non-recurring costs of £0.6m). The capital consequences of Phase 1 are £0.15m.

Further work in the Phase 2 and 3 business cases will test the additional costs and benefits to be secured from further reductions in NEL bed capacity required at Weston Hospital and associated increased in surgical activity.

There is variation between the finance assessment in the Outline Business Case and this Phase 1 Full Business Case for a number of key reasons, including:

- The assumptions applied in the OBC didn't disaggregate phases 1 and 2 (HomeFirst and CoE/IP Medical Care) at the level of detail now completed for the FBC stages
- The existing workforce baseline is lower than anticipated, and comparatively lower than other hospitals "front-door" levels, especially in some workforce groups including radiology, therapy, and pharmacy
- The number of staff needed to run safe and efficient rotas across the extended service operating hours is higher than anticipated.
- System NEL pressures and sustained reliance on escalation beds require the initial impact of service change to be on reducing escalation usage rather than closing core IP medical beds. Escalation capacity may have a lower running cost.

A full phased recruitment plan is set out in section 7.8 of the Full Business Case. The expectation is that there will be some slippage in some posts in the 23/24 recruitment plan with the associated in year cost/funding managed within the Operating Plan processes.

**Capital cost:**

The capital investment for the phase one front door enhancements are minimal. The total capital works and equipment is estimated at £154k. There is an estimated:

- £12k for minor changes required to create office space in the existing AEC area to create the SDEC
- £112k is estimated for 10 reporting workstations, desks and chairs for radiology
- £30k for additional therapeutic equipment including seating for older patients, re-turns and standing hoists.

## 10. Governance

This Full Business Case has been discussed and supported at a number of governance meetings including Healthy Weston Programme Group, 8 February 2023 – where full support was given, Health & Care Professional Exec, 9 February 2023 – where the clinical model was fully supported,

System Directors of Finance, 10 February 2023, System Executive Group, 16 February 2023, Healthy Weston Steering Group, 20 February 2023 – support for clinical model and approach, ICB Finance, Estates and Digital Committee, 23 February 2023 – support was given to the Phase 1 business case, with a requirement to test and review the phase 2 and 3 benefits through a gateway process and ICB Board [closed] 2 March 2023 – qualified supported was given, with a requirement to undertake further work on benefits realisation. The below table sets out the main queries and actions raised, and action taken in response.

**Response to questions raised through Governance**

| Date | Governance | Query / action | Action / response |
|---|---|---|---|
| 02/03/23 | ICB Board [closed] | a) Undertake further assessment on benefits realisation | a)benefits realisation addendum developed and attached [Appendix A] |
| 23/02/23 | ICB Finance, Estates and Digital Committee | a) Undertake further assessment on benefits realisation and recruitment phasing | a)benefits realisation addendum developed and attached [Appendix A] |
| 20/02/23 | Healthy Weston Steering Group | a) Review of costs to see if there is scope to contain at a lower level in 23/24<br>b) Highlighting the metrics to better demonstrate benefit against investment.<br>c) Strengthen the case about the unique opportunity for the locality to implement the plan in an integrated way.<br>d) Assurance that the clinical model doesn't increase impact on LA or Sirona by faster through put. | a) Review of costs and recruitment phasing undertaken [verbal update to be provided at ICB Board]<br>b) Full benefits realisation plan set out in Appendix 6 of the Full Business Case. Summary of benefits and metrics included within the Board cover report.<br>c) Additional emphasis added to both the ICB cover report and Full Business Case about the unique opportunity for the locality to implement the plan in an integrated way<br>d) Improvements to the quality and responsiveness of care because of enhancements to Frailty SDEC, GEMS and OPAU will significantly reduce the risk to frail older patients of conditions related to longer length of stay e.g., delirium, pressure sores and de-conditioning. As a result, the clinical expectation is that more frail older patients will receive their care and treatment quickly and return home when it is safe to do so, avoiding complex conditions associated with longer lengths of stay. This in turn should increase the number of patients discharged on P0 pathways [patients return to usual place of residence fully dependent] and therefore the impact on community will improve or be minimal.<br>The impact on community provision will be monitored and reviewed as Phase 1 is implemented; any negative impact on community provision will be highlighted, understood, and mitigated. This position has been considered and confirmed with Sirona. Discussion with North Somerset colleagues has also included the opportunity for increasing use of currently underutilised pathways. |

| | | | |
|---|---|---|---|
| 10/02/23 | System Directors of Finance | a) Review of workforce plan by CPO/DHRDs<br>b) Clarification of impact on future flow<br>c) Consideration of sources of funding and review of implementation in line with Phase 2 business cases | a) Workforce plan to be reviewed by CPO/DHRDs 3rd March alongside the realism of the totality of the system workforce plans<br>b) Full Business Case Table 13 (workforce investment and benefits) shared by programme SRO with explanation of planned deep dive to review impact of implementation, particularly around enhancing the radiology offer. It was also reinforced that the phased approach to opening hours is factored into recruitment plan (13/02/23) |
| 09/02/23 | Health Care Professional Executive | Assurance that the clinical model supports delivery of the NHS delivery plan for recovering urgent and emergency care. | Confirmation given that HW2 Phase 1 clinical model support the commitments set out with the plan. Below are some examples of how the HW2 Phase 1 model delivers on the five focused areas set out within this Delivery plan.<br><br>**Increasing capacity**<br>The HW2 Phase 1 clinical model delivers against the commitment in the Delivery plan for Same Day Emergency care as set out below:<br><br>*'Same day emergency care (SDEC) means shorter stays for patients and fewer unnecessary delays to leaving hospital. Current pressures often mean hospitals need to use their same day emergency care staff and space for other emergency care. NHS England will work with systems to spread best practice to ensure greater resilience ahead of next winter so that all hospitals with Type 1 emergency departments provide appropriate SDEC seven days a week with a minimum opening of 12 hours per day.' NHS Delivery plan for recovering urgent and emergency care services.*<br><br>**Growing the workforce size and flexibility**<br>HW2 Phase 1 develops the workforce mix, including physiotherapists, occupational therapists, speech and language therapists and dieticians, as per the commitment within the Delivery plan. These workforce areas are starting from a zero to low workforce base in Weston General Hospital and are enhanced throughout the model of care to provide expertise, treatment, and faster discharge times.<br><br>**Improving discharge**<br>The HW2 Phase 1 model will reduce longer stays in hospital, that can lead to poorer health outcomes, through enhancements to Same day Emergency Care, Acute Monitoring Unit and the introduction of a new Older Persons Assessment Unit. These units will help to avoid unnecessary admission, reduce length of stay and |

| | | | |
|---|---|---|---|
| | | | unlock additional bed capacity for further improvements in HW2 Phase 2 & 3. |
| 08/02/23 | Healthy Weston Programme Group | Ambition of the workforce [esp. radiology] | 23/24 cost is the maximum and any slippage in recruitment will mitigate the in-year cost pressure but does not affect the recurrent recruitment requirement. Rapid access to diagnostics is a critical component of the Phase 1 clinical model and to reducing admissions. Radiology capacity is increased, securing faster access to diagnostics and treatment times. Recruitment plan and phasing has been developed and considered alongside other system initiatives such as the Community Diagnostic Centres and will be further tested through implementation. |

## 11. Legal implications

Bristol, North Somerset and South Gloucestershire ICB has taken legal advice during the development of the Business Case, to ensure that the ICB's legal duties are met by the Phase 1 FBC and public engagement.

The table below outlines the legal duties that are applicable to the Healthy Weston Programme and how the Programme has complied with them.

It should be noted that the main pieces of law that are applicable in these circumstances are the NHS Act 2006, as amended by the Health and Social Care Act 2012, and the Equalities Act 2010. FED members should be assured that the ICB has shown due regard to its duties.

| **Legal Duty** | **Compliance** |
|---|---|
| *NHS Constitution*<br><br>Section 14P of the NHS Act imposes a duty upon ICBs both to exercise their functions with a view to ensuring that health services are provided in a way that promotes the NHS Constitution and to promote awareness of the Constitution among staff, patients and the public. | The Healthy Weston 2 OBC and Phase 1 FBC sets out the objectives of the programme and how these support the delivery of systems priorities and the ambitions set out in the NHS Long Term Plan and NHS Delivery plan for recovering urgent and emergency care |
| *Duty to exercise functions effectively, efficiently and economically*<br><br>Section 14Q of the NHS Act each ICB must exercise its functions effectively, efficiently and economically. | A detailed financial assessment is set out in the Phase 1 FBC |
| *Duty to secure improvement of service* | The Healthy Weston 2 Phase 1 FBC recommends improvements to the delivery of healthcare in Weston General Hospital that will establish a sustainable |

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| Section 14R of the NHS Act places ICBs under a duty to exercise their functions with a view to securing continuous improvements in the quality of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness. Quality of services comprises in particular outcomes which show effectiveness, safety and patient experience. | position on which further ongoing and continuous improvements can be made.<br><br>A Quality Impact Assessment has been completed as part of the programme. This is included as Appendix 4 of the Full Business Case. |
| *Duty to reduce inequalities*<br><br>Section 14T of the NHS Act provides that ICBs must, in the exercise of their functions, have regard to the need to:<br><br>(i) reduce inequalities between patients with respect to their ability to access health services; and<br><br>(ii) reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services. | The Healthy Weston 2 improvement proposals will improve outcomes for local people in Weston Worle and surrounding villages and reduce inequalities through access to improved local health care. |
| *Duty as to patient choice*<br><br>Section 14V of the NHS Act imposes a duty on ICBs, in the exercise of their functions, to act with a view to enabling patients to make choices about aspects of the health services provided to them. | The Healthy Weston Programme seeks to address issues with the quality-of-service provision. Patient choice is maintained across the improvement proposals. |
| *Duty to promote integration*<br><br>Section 14Z1 of the NHS Act states that ICBs must exercise its functions with a view to securing that services are provided in an integrated way where this would improve the quality of the services, reduce inequalities of access or reduce inequalities in outcomes. | The Healthy Weston Programme has as a guiding principle of the promotion and creation of integrated services across community, primary and acute services. Healthy Weston is part of wider system change to enable a 'Home First' approach, and the programme is working closely with Primary Care, Social Care, Ageing Well programme, Virtual Wards, Locality teams and other system initiatives to make sure that the plans are integrated and create seamless pathways for patients |

| | |
|---|---|
| *Duty to involve the public*<br><br>Under section 14Z2 of the NHS Act the ICB must make arrangements to secure that individuals to whom health services are being, or may be, provided are involved in the planning of those services; the development of proposals for change and decision making in respect of those services. | The Healthy Weston programme has been developed with key stakeholders, staff and patient representative groups as described in Chapter 6.<br><br>The outcomes from the public engagement period delivered between June – August 2022 can be found in Appendix 8. |
| *Duty to reduce inequalities*<br><br>Under section 149 of the Equality Act a public authority must, in the exercise of its functions, have due regard to three main aims:<br>(i) to eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Equality Act;<br>(ii) to advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it; and<br>(iii) to foster good relations between persons who share a relevant protected characteristic and persons who do not share it. | The ICB has considered the equalities implications of the recommendations in detail through its Equality Impact Assessment process.<br><br>This work has informed Appendix 7: Equality Impact Assessment of the Healthy Weston 2 Phase 1 Full Business Case |
| *Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013*<br><br>Section 244 of the NHS Act outlines the duty for NHS bodies to consult relevant Local Authority Health Scrutiny Committees in respect of the planning and delivery of service changes where those changes are deemed to be a substantial development or option in services locally. | The ICB has engaged and consulted with the relevant Local Authority Health Scrutiny Committees through the development of the Outline Business Case, including the North Somerset Health Overview and Scrutiny Panel held on 20 April 2022. At this meeting North Somerset Health Overview and Scrutiny Panel confirmed that the clinical model proposed does not meet the threshold to be considered a substantial variation rather continuous improvement. Therefore, consultation with the local authority was not required. |

## 12. Risk implications (Business Case Section 2.2.8)

The key risks for implementing Phase 1 include:

- There is risk workforce shortages mean that it is difficult to recruit to posts

- There is a risk that the revenue investment required in the Phase 1 Full Business Case is not sourced, resulting in the implementation of the model stalling, leading to ongoing exposure to risk of unsustainable clinical services needing to be suspended at short notice
- There is a risk that other system initiatives, including D2A, don't deliver the bed savings required to deliver the full HW2 programme

## 13. How does this reduce health inequalities

There are significant inequalities amongst local communities in the Weston population, with considerable pockets of deprivation existing particularly in Weston-super-Mare. In Weston Central Ward the average life expectancy of a man is 10 years lower than the English average, and the rate of children living in poverty is 36% compared to the national rate of 25%.

The BNSSG population management work has also demonstrated through segmentation of our population into a pyramid of five segments (defined by the Cambridge Multimorbidity Index score) that three of the top six Segment 5 areas in BNSSG are in Weston (where segment 5 includes 3% of the population with multiple health conditions, greater risk of mortality and a higher acute healthcare need.) People in Segments 4 and 5 of the population use most of BNSSG's non-elective bed days, yet ambulatory care sensitive conditions are high amongst these population groups [43% of ambulatory care is in segment 5]. This matters because it suggests that a significant number of admissions from our most complex people are for low complexity reasons such as a fall or UTI. It is essential that we invest in high-quality ambulatory care, that is integrated with the community, that is better able to meet the health and care needs of this population group.

It is essential that we deliver a new model of emergency care that is better able to meet these changing health and care needs. The Healthy Weston Programme is designed to address inequalities through ensuring equity of access to the very best care and outcomes to the Weston population, matching that of other people in BNSSG.

## 14. How does this impact on Equality and Diversity?

An Equality Impact Assessment is included in Appendix 7 of the Full Business Case.

## 15. Consultation and communications, including Public Involvement (Business Case Section 6)

Healthy Weston 2 Phase 1 builds on the extensive engagement that has taken place over the last four years. More than 5,000 local people have influenced plans to date, with a recent period of public engagement delivered between June and August 2022 providing feedback from 890 individuals. During this public engagement period, 73% of respondents indicated that they thought the plans would improve the Hospital. The full engagement themes report can be found in Appendix 8 of the Full Business Case.

There has also been significant staff engagement across UHBW, who have shown support towards the plans. The programme will continue to engagement with the public, staff, patients, and wider stakeholders, including local politicians, as the programme develops.

## Glossary of terms and abbreviations

Please explain all initials, technical terms and abbreviations.

| | |
|---|---|
| **OBC** | **Outline Business Case -** The Healthy Weston 2 Outline Business Case (OBC), agreed in June 2022, describes a series of ambitious reforms centred around delivering sustainable all age services at Weston General Hospital that better meet local healthcare need. |
| **FBC** | **Full Business Case -** The Healthy Weston 2 Phase 1 Full Business Case is the first part in the operationalisation of the Healthy Weston 2 OBC, ensuring the people of Weston have equity of access to the very best urgent care and outcomes as other people in BNSSG. |
| **WGH** | Weston General Hospital |

# HW2 Phase 1 – benefits addendum

Healthy Weston 2 seeks to lead the country as an exemplar in high quality, safe and integrated health services that meet local people's needs, now and in the future. A fundamental building block is establishing an equitable and sustainable urgent care "front-door" model at Weston General Hospital, that delivers minimum national and local standards. This will provide the foundation for further innovative transformation in HW2 Phase 2 [inpatient care] and Phase 3 [surgical care].

**The benefits ambition for the future Phase 1**

The core benefits to be secured from developing an enhanced ambulatory and front-loaded urgent and emergency care service at WGH derive from improved flow and associated positive improvements in safety, quality and performance; reduced admissions to hospital; reduced length of stay in hospital where an admission is appropriate. The early success of the Phase 1 enhancements, funded until March 23 and staffed by a temporary 'ad-hoc' workforce, gives the Weston General Hospital operational team confidence of delivering and building on the original benefits as set out in the HW2 bed and activity model, especially when a substantive and more resilient workforce model is in place towards the end of 2024. Table 1 below sets out the specific benefits ambition for the HW2 Phase 1 enhancements.

*Table 1 – Benefits realisation plan*

| Benefit | Impact | KPI |
|---|---|---|
| Reduction in length of stay (LOS) in hospital | More people maintain their independence<br>Fewer delays are experienced for treatment<br>More people access services where national standards are met, and specialised care is available<br>Reduced risk to frail older patients of conditions related to longer LOS e.g. delirium, pressure sores and deconditioning | 10% reduction in LOS *<br>Net reduction of 27 escalation beds [Equivalent to £290k per quarter profiled from Q4 23/24 in Table 2] |
| Improved outcomes for patients receiving urgent and emergency care | Improvements in the quality and responsiveness of care<br>Reduced risk of mortality because of overcrowding<br>Reduced risk to frail older patients of conditions related to longer LOS e.g. delirium, pressure sores and deconditioning | 60 fewer deaths because of improvements in time to be seen **<br>% reduction of safety Datix raised related to overcrowding [at minimum sustain current level of 1 per month] |
| Improved ED performance | Increase in 'time to be seen, treated and discharged'<br>Improved patient flow<br>Improved patient experience<br>Reduced risk to frail older patients of conditions related to longer LOS e.g. delirium, pressure sores and deconditioning | 10% increase in 'time to be seen, treated and discharged' targets increasing performance to 74% and close to the national target of 76% ***<br>20% of ED attendances through SDEC by 2024<br>% reduction in ambulance diverts [at minimum sustain current level achieved in Q4 22/23 [1 per month]] |

| | | |
|---|---|---|
| | | 14 additional people seen, treated and discharged each day |
| Hospital care maintained locally | People living locally to Weston General Hospital can still receive the majority of their care locally<br>Improved access for local visitors and family<br>Decreased travel for the system | |
| Improved workforce outcomes | More resilient and sustainable workforce<br>Reduced reliance on agency staff<br>Enhanced access to training and development<br>New workforce models that create opportunities for progression<br>Improved network working with other hospitals<br>Staff experience | % reduction in agency staff [at minimum less than 10% medics] [Equivalent to £3.3m savings @ 94%]<br>% decrease in vacancy rate [at minimum sustain 5%]<br>Staff survey results |
| Improved system flow | Improvements in the efficiency of services<br>Decrease in length of stay for patients<br>Improvements in the quality and responsiveness of care | % reduction in ambulance diverts [at minimum sustain current level achieved in Q4 22/23]<br>10% decrease in length of stay for patients * |
| Improved patient experience | Improvements in the quality and responsiveness of care<br>Improvements to the reputation of the hospital<br>Clinical outcomes and patient safety enhanced | Friends and family test results<br>Number of patient complaints received<br>Number of serious incidents reported |
| Increased care at home | Hospital services are utilised only by those that need acute care, reducing demand on staff in-hospital<br>Decreased length of stay for patients<br>Increased hospital bed availability in acute care<br>People are supported to be independent | 10% reduction in LOS * |

*10% reduction in LOS is the percentage LOS reduction because of the collective impact from Phase 1 enhancements

** For every 82 patients who wait beyond 6-8 hours for a bed there is one excess death within 30 days. Using same logic as above current excess death rate + 1 every 1.8 days [204 a year]. This would reduce to 1 every 2.52 days (145 a year) because of 'time to be seen' improvements. [BMJ, Volume 39, Issue 3]

*** 10% increase in time to be seen, assumes all patients admitted to SDEC / short stay bed do not breach time to be seen targets.

The success of the winter plans enhancements gives the operational team confidence of bed saving potential. Table 2 below sets out the total number of beds that the team are aiming to save across 23/24 Q4 to 24/25 Q4. The number of beds represent total number of beds saved at that point and are not accumulative i.e. at the end of 23/24 Q4 there will be 5 beds saved in total, and at the end of 24/25 Q1 there will be 9 beds saved in total etc. Section 8.2.5 of the Full Business Case sets out the approach to target initial bed savings on reducing sustained use of escalation bed capacity.

The bed savings are profiled across 23/24 and 24/25; recognising that a significant proportion of the posts for recruitment in 23/24 are training posts, and therefore the benefits realisation is not immediate .

*Table 2 – Bed saving profile*

| | 23/24 Q4 | 24/25 Q1 | 24/25 Q2 | 24/25 Q3 |
|---|---|---|---|---|
| Bed saving [escalation beds] | 5[total bed saving] | 9 [total bed saving] | 9 [total bed saving] | 15 [total bed saving] |

This profiling will mitigate the recurrent costs set out in section 8.2.3 of the Full Business Case.

There may be additional benefits gains, based on patients currently admitted to an inpatient bed for radiology investigations not available after 5pm and weekends at WGH. A recent audit at the BRI demonstrated this was the case there, and a similar audit is now being undertaken to establish the impact at Weston that would then be released once the radiology availability was improved.

Recruitment phasing

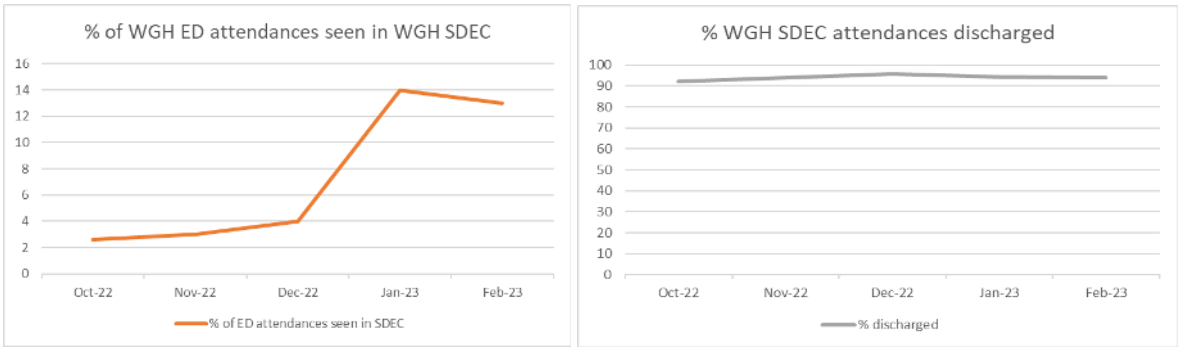
A full phased recruitment plan is set out in section 7.8 of the Full Business Case. The expectation is that there will be some slippage in some posts in the 23/24 recruitment plan with the associated in year cost/funding managed within the Operating Plan processes.

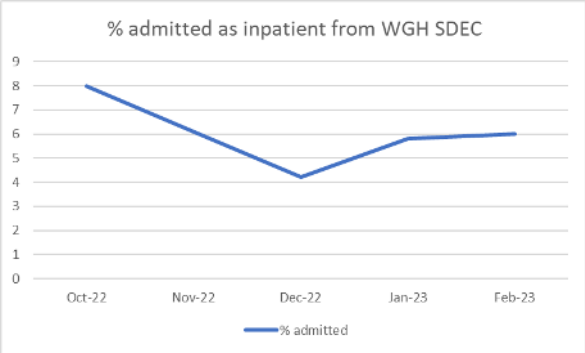
**Benefits potential – building on the success of the winter plans**

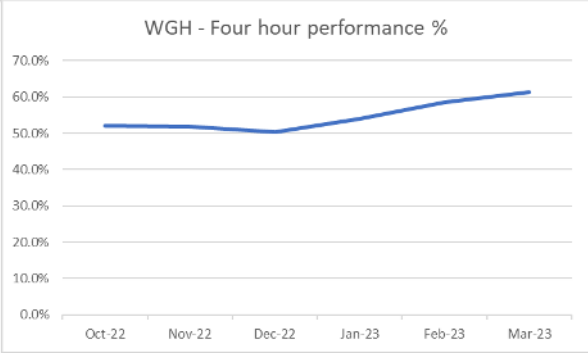
In preparation for Phase 1 implementation and to help reduce winter pressures, the first step in the Phase 1 enhancements were introduced in December 22 and funded on a short-term basis (to March 2023) through winter funding. This includes SDEC pathways and rapid patient reviews via enhancement to the Ambulatory Emergency Care (AEC) Unit and the introduction of ED Observation beds. These early Phase 1 improvements offer the opportunity to further test the model and to collect data on benefits realisation.

Early analysis, following the introduction of Same Day Emergency Care pathways, is already showing a positive difference. Figure 1 below shows an upward trend of the % of ED patients being seen and treated in SDEC, and an upward trend in the number of patients being discharged 'home'. Currently 13% of ED attendances, around 500 per month [16 a day], are being seen, assessed, and treated through SDEC and around 94% of these are discharged. ….. check what this is benchmarked against … e.g. what attendance number I have used.

*Figure 1 – Winter funded SDEC performance*






Early analysis also shows a significant [-57%] decrease in 12-hour trolley breaches, as can be seen in Table 3 below.

*Table 3 – 12-hour trolley waits*

| | Oct- 22 | Nov-22 | Dec-22 | Jan-23 | Feb-23 |
|---|---|---|---|---|---|
| 12 Hour Trolley Waits | 445 | 412 | 553 | 506 | 192 |

The number of 'patient diverts' has also significantly improved. So far in 2023 [January – March], there has been 2 ambulance diverts, compared to 15 between November and December 2022. Similarly, there were 11 patient safety risks relating to overcrowding between Oct – Dec 22, compared to 2 in year to date [January to March].

**Benefits context – the HW2 Bed and Activity model**

To plan the service improvements needed for the HW2 clinical model a bed and activity flow model was commissioned in 2021 to better understand the scale of the challenge, impact on flow of service reform and non-elective bed need at Weston General Hospital. This was developed by clinicians from across Somerset and BNSSG and agreed by the Clinical Design and Delivery Group, and the Healthy Weston Steering Group for the full Healthy Weston 2 clinical model set out in the Outline Business case.

The change proposals set out within this Phase 1 Case are grounded in the outputs from this bed and activity flow model; ensuring the hospital and wider system have a good understanding of the impact of change. To support the development of this business case the model was updated with 21/22 activity data. Table 4 below sets out the Phase 1 bed and activity outputs of the HW2 bed and activity model.

*Table 4 - Expected Phase 1 bed and activity outputs*

| | 21/22 bed and activity model outputs per year [with no D2A] | | |
|---|---|---|---|
| **Summary Output Table** | **21/22 Baseline** | **Phase 1 [extrapolated from the full model]** | **Full Model** |
| All Weston ED attendances (inc. stabilise & transfer) | 45,853 | 45,853 | 45,547 *[some ambulances diverted at source]* |
| Acute medical patients stabilised & transferred to neighbouring sites | - | - | 3,030 *[includes ambulances diverted at source]* |

| | | | |
|---|---|---|---|
| All admission [long stay. Short, SDEC] | 13,243 | 12,889 *[500 less admitted – as discharge rates amended in modelling]* | 11,247 |
| All long stay admissions *[this is a subset of all admissions]* | 8,674 | 5,046 | 3,692 |
| Number of patients repatriated | - | - | 298 |
| Long stay beds *[excluding repatriations]* | 210 | 163 | 133 |
| Repatriation beds | - | - | 14 |
| Older People Assessment Unit beds [frail - short stay] | 3 | 14 | 12 |
| Acute Monitoring Unit / ED Observation [Non-frail short stay] | 6 | 15 | 13 |
| Total Weston NEL Bed Need | 215 | 188 | 171 |

*Explanatory note:*

- *Table above sets out key HW2 bed and activity model outputs including 21/ 22 baseline, HW2 Phase 1 enhancements and full HW2 model attendance rates.*
- *All admissions - shows total number of patients admitted. This figure includes patients admitted to SDEC, short stay and long stay beds – as a result the conversion rate between the baseline and phase 1 enhancements only sees a small drop.*
- *Long stay admissions – shows total number of patients admitted to a long stay bed. There is a significant reduction in patients admitted to a long stay bed in the Phase 1 model outputs – reflecting the benefit of the Phase 1 SDEC and short stay enhancements. This is also reflected in the number of long stay beds required in the Phase 1 model outputs.*

*Key point – whilst the number of people admitted [conversion rate] in the Phase 1 model remains more or less the same, there is a significant decrease in LOS. This reflects improvements to length of stay because of the Phase 1 short stay interventions.*

Table 5 below sets out the number of additional patients who will avoid admission, because of the Phase 1 enhancements. These patients would have otherwise been admitted to a long stay bed in the 21/22 baseline.

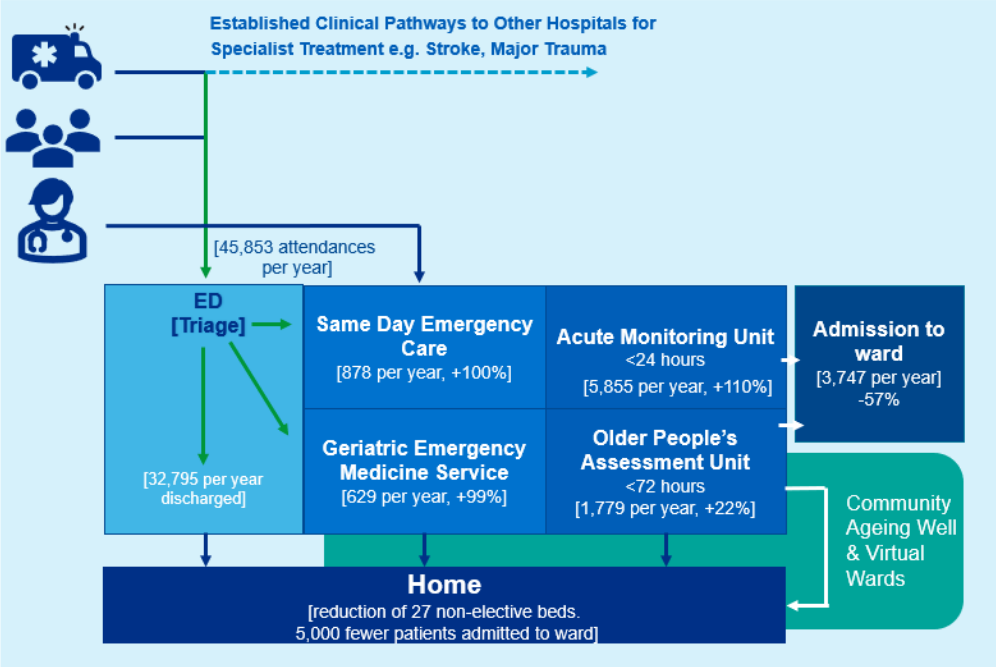
*Table 5 - Forecasted impact of Phase 1 on patients, admissions and beds*

| Phase 1 Change | Forecast Impact – patients, admissions, beds | Per day | Per week | Per year |
|---|---|---|---|---|
| SDEC GEMS AMU | Additional non-frail patients who appropriately avoid an admission via SDEC pathways | 2.4 | 16.9 | 878 |
| | Additional frail patients who appropriately avoid an admission via frailty SDEC pathways [GEMS] | 1.7 | 12.1 | 629 |

| | | | | |
|---|---|---|---|---|
| OPAU | Additional patients [frail and non-frail] discharged through short stay units (LOS <1&<3days) rather than admitted with longer LOS into wards | 9.3 | 65.0 | 3381 |
| | An additional 14 people per day, avoid admission because of Phase 1 enhancements, when compared to the 21/22 baseline. | | | |
| | Net reduction of 27 escalation beds *[This is a combination of both reduced LOS and admissions avoided]* | | | |

Figure 2 below shows the number of additional patients discharged through short stay units because of Phase 1 enhancements and the impact this has on number of patients admitted to a long stay bed, when compared to the 21/22 baseline.

*Figure 2 – Forecasted impact on long stay admissions*




*Explanatory note:*

- *All percentages are compared to the 21/22 baseline. There is no SDEC in the 21/22 baseline but some frail and non frail short stay.*
- *There are 8673 long stay admissions in the 8673 baseline which reduced to 3747 because of the Phase 1 enhancements. This is a reduction of 57%.*

*The Healthy Weston 2 bed and activity model assumes a 92% occupancy rate – in line with the national target. However, delivery of this occupancy rate is subject to UHBW approach and the successful delivery of other Trust and system initiatives such as Discharge to Assess, which are out of scope of Healthy Weston 2.*

As a result of these combined benefits, and in particular improvements to length of stay and reduced admission rates, the HW2 bed and activity model predicts a reduction of 27 non elective bed need, and 5,000 fewer patients admitted to a long stay ward, alongside other patient outcome improvements including better patient experience and reduced risk of de-conditioning.

University Hospitals Bristol and Weston NHS Foundation Trust

# Healthy Weston 2
# Phase 1 delivery

# Full Business Case

## Version 1.0

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# 1 Introduction

*State the purpose of the business case and the spend for which approval is being sought, specifically, "to procure X and/or to do X at the cost of £Y". Provide an overview of sections 1-5 of your proposal in no more than half a page.*

Healthy Weston 2 seeks to lead the country in having a high quality, safe and integrated health service that meets local people's needs, now and in the future. A key part of this is Weston General Hospital.

**Our vision** is for Weston General Hospital to be a strong and dynamic hospital, at the heart of the community, that is fit for the future, with a range of services providing the very best care, experience, safety, and outcomes to local people.

A structured, clinically led process has been used throughout the Healthy Weston Programme, with Healthy Weston 1, agreed in 2019, laying the foundations for further improvement at the hospital and in the community. Healthy Weston 2 builds on this, and the transformational change opportunities resulting from the Weston Area Health Trust (WAHT) and University Hospitals Bristol NHS Foundation Trust (UHB) merger. Together this seeks to secure a dynamic future for health services in Weston, from community frailty to outstanding hospital care.

The consensus from the Healthy Weston programme is that **doing nothing carries the greatest risk** for both Weston General Hospital and the wider system, as it brings with it the possibility of continuing unplanned changes that have the potential to destabilise the system and affect patient care. A Review Panel from the South West Clinical Senate agreed that 'to do nothing' is not an option, stating that there is significant and robust clinical evidence that it is neither sustainable nor safe to continue services as they are.

The Healthy Weston 2 Outline Business Case (OBC), agreed by the system in June 2022, describes a series of ambitious reforms centred around delivering sustainable all age services at Weston General Hospital that are in line with national standards, and better meet local healthcare need through specialist pathways, such as geriatric emergency medicine and increased elective surgical access.

The health outcomes and life expectancy of people in some areas of Weston is poorer in comparison to other parts of BNSSG and there are significant pockets of deprivation. The population served by Weston General Hospital is older than the England average with 20% of people expected to be over the age of 70 by 2025[1]. Healthcare reforms at Weston General Hospital must respond directly to these challenges and ensure that the people of Weston have equity of access to high quality local health care. This relies on creating confidence in the future model of care at the hospital thereby attracting and retaining a permanent workforce and reducing reliance on agency and locum staff.

A phased approach to the development of three interlinked full business cases has been agreed to cover the improvement plans described in the Healthy Weston 2 OBC. These phases are:

- Phase 1 – Safe, high quality and sustainable urgent care
- Phase 2 – Inpatient medical care and specialist centre for care of the elderly

[1] North Somerset JSNA – Disease Prevalence Models Accessed: https://www.n-somerset.gov.uk/sites/default/files/2020-02/disease%20prevalence%20models.pdf

- Phase 3 – Surgical Centre of Excellence @ Weston

Adopting a phased approach to delivery enables an initial focus to be on those projects that are standalone and can be delivered quickly. Other elements of the programme that are more complex or sequentially dependent on one another, and in some cases require capital investment to be effectively planned, will follow.

This Full Business Case sets out the plans for delivering the Phase 1 service improvements, with approval being sought for revenue funding of £3,802m by 25/26. In year 1 (23/24) this is £1.9m of recurrent funding and £0.6m of non-recurrent funding to support programme implementation, recruitment supplements and fees for international recruitment.

Phase 1 leads the development of safe, high-quality and sustainable emergency care at Weston General Hospital, that is in line with national and local standards, and ensures that local people have equity of access to the best urgent care. It delivers a series of system benefits including improvements to Emergency Department performance, system flow, patient outcomes, reductions in length of stay and a more sustainable workforce.

Senior leaders, clinicians, patients and the public from across Bristol, North Somerset, South Gloucestershire, and Somerset have led the progression of the Phase 1 Full Business Case in line with the OBC Clinical Model, ensuring that the case continues to deliver the Healthy Weston vision and system priorities.

The Bristol, North Somerset and South Gloucestershire (BNSSG) Integrated Care System (ICS) strategic intent is to enable care and treatment out of hospital through HomeFirst models of care. A modern urgent care service, focused on getting people home again as soon as possible, is an essential part of the Weston HomeFirst model of care. In addition, work is underway to explore further opportunities to develop a truly integrated urgent care approach including joint/blended roles building on roles, such as the GEMS@Home role, that already exist.

Through the successful implementation of the service enhancements set out in this Full Business Case, a future for Weston General Hospital can begin to be built that is sustainable, dynamic, and provides the best urgent care to support improved health outcomes for local people.

The health outcomes and life expectancy of people in some areas of Weston is poorer in comparison to other parts of BNSSG and there are significant pockets of deprivation. The population served by Weston General Hospital is older than the England average with 20% of people expected to be over the age of 70 by 2025[1].

Healthcare reforms at Weston General Hospital must respond directly to the challenge of increasing health inequality, as well as the needs of a growing and ageing population to ensure that the people of Weston have equity of access to high quality local healthcare.

# 2 Strategic Case

## 2.1 Strategic Context

*Provide a high-level overview of the nature and work of the Organisation in which this procurement or project is taking place. Describe how the proposed investment supports*

*Organisational objectives, and any links to other programmes or projects. You may need to consider:*

1) *National Context*
2) *Local Context (System and Regional)*
   - *How the case delivers the strategic objectives of the Integrated Care System (ICS) and broader regional/network objectives as relevant*
3) *Trust Strategic Context*
   - *How the case delivers the objectives within our current strategy*

### 2.1.1 National Context

The NHS published the Long-Term Plan (LTP) in 2019 to celebrate the national commitment to our Health Service and to address the potential threats to its long-term sustainability from pressures on funding, staffing, increasing inequalities and the needs of a growing and ageing population. It set out how, as a national service, we must accelerate the redesign of patient care to future-proof the NHS.

The 23/24 priorities and operational planning guidance reconfirms the ongoing need to recover our core services and improve productivity, making progress in delivering the key NHS Long Term Plan ambitions and continuing to transform the NHS for the future.

At the heart of Healthy Weston 2 Phase 1 is a need to bring forward and accelerate a new approach to urgent care in which patients in Weston get better support, and properly joined-up urgent care at the right time in the optimal care setting. Underpinning this is a focus on prevention, health inequalities and delivering better outcomes ensuring the population of Weston has equity of access to high quality urgent care. However, none of this can be delivered without a commitment to understand and tackle current workforce pressures and provide support to staff.

The impact of the COVID-19 pandemic on the implementation of the LTP, the continuing need to respond to future patterns of disease, and the challenge of restoring services and reducing the care backlogs that are a direct consequence of the pandemic have shaped the Healthy Weston 2 plans. Investment in same day emergency care, as set out within this business case, will reduce the pressure on inpatient bed stays, helping to create system flow and capacity.

The need to continue to invest in resilience at Weston General Hospital to deliver safe, high-quality services that meet the full range of people's health and care needs draws on the LTP and will require that the NHS:

- accelerate plans to grow the substantive workforce and develop ways of working
- use the learning from the pandemic to rapidly and consistently adopt new models of care that exploit the full potential of digital technologies
- work in partnership as systems to make the most effective use of the resources available to us across acute, community, primary and social care settings.

Each of these principles have shaped the design of service improvements set out within the Healthy Weston 2 Outline Business Case and this Phase 1 Full Business Case.

### 2.1.2 Local Context

The health and social care organisations of Bristol, North Somerset and South Gloucestershire [BNSSG] have come together as an Integrated Care System (ICS) to improve the health and care of local people. The BNSSG ICS focusses on tackling the issues that matter most and finding ways to continue providing safe, high-quality care for local people and generations to come.

Healthy Weston 2 is a key part of turning the emerging system vision of a more integrated health and care system that enables people to live healthy lives ensuring that personalised care is delivered closer to home into a reality. At the heart of the Healthy Weston 2 programme are the emerging Integrated Care System objectives, which are to:

- Improve outcomes in population health and health care
- Tackle inequalities in outcomes, experience, and access
- Enhance productivity and value for money
- Help the NHS support broader social and economic development

### 2.1.3 University Hospital Bristol and Weston Foundation Trust Strategic Context

University Hospitals Bristol and Weston NHS Foundation Trust (UHBW) agreed a five-year strategy in 2019, setting out the vision for the future.

The strategy describes how the Trust plans to:

- Grow its specialist hospital services and its position as a leading provider in South West England and beyond
- Work more closely with health and care partners to provide more joined up local healthcare services and support the improvement of the health and wellbeing of our communities
- Become a beacon for outstanding education and research and our culture of innovation.

Supporting the delivery of the Trust's Strategy, the vision of the Healthy Weston 2 programme is to have joined up and collaborative care, focusing on those services most people in Weston, Worle and the surrounding area need most of the time.

### 2.1.4 Integration between University Hospital Bristol and Weston Area Health Trust

In April 2020, Weston Area Health Trust (WAHT) and University Hospitals Bristol NHS Foundation Trust (UHB) merged to form University Hospitals Bristol and Weston NHS Foundation Trust (UHBW). Since this merger, clinical and corporate teams across the newly formed Trust have worked together, collaborating across the Bristol and Weston sites during the pandemic response. Teams have also been working hard to realise the benefits of integrated services for patients, staff, and local people, driving improvement across a range of services, systems, and clinical specialities. These changes have allowed a new model of improved care to be developed at Weston General Hospital that best serves the population, that the Healthy Weston 2 builds upon.

**Benefits of integration**

- Creates more resilient services through cross cover for example ICU services
- Enables the sharing of best practice

- Removes the barriers to delivering a wider range of clinical services to the patients of Weston. An example of this is in the Audiology service at Weston, which have been able to modernise the hearing test equipment and improve the standard hearing aid of choice to the more modern rechargeable Bluetooth hearing aid, previously only available to Bristol patients
- The estates and building infrastructure are steadily improving at Weston General Hospital (WGH), with the first £2.5m investment into essential works, as part of a wider £10m improvement programme over 5 years
- A 5-year Digital systems convergence programme is replacing outdated legacy IT systems at WGH and moving to modern cross-site solutions that enable better and more flexible management of patient care by clinicians

**Recruitment**

A key enabler of improvement at Weston General Hospital is the recruitment of more permanent staff across the clinical professions. The five-year plan to achieve this is being supported by dedicated recruitment and retention resources. Despite the challenging national and operational workforce conditions, registered nursing numbers in post remains on track, supported by both local, regional, and international nursing recruitment initiatives.

In the medical workforce, the Trust has been successful in recruiting clinical fellow doctors to the Weston Division as well as recruiting to some of the most challenging areas such as ED, however consultant recruitment remains challenging, despite extensive recruitment and retention initiatives.

Whilst the Trust is developing comprehensive and targeted recruitment campaigns and a range of incentives, the situation is only expected to improve slowly over time as the long-term clinical models of care at Weston are agreed and rolled out as part of the Healthy Weston programme. The incremental, phased approach to the overall implementation of Health Weston 2 is predicated on building the confidence of the public and of current and prospective staff, that implementation will happen.

Healthy Weston 2 is already having a positive effect on the Hospitals workforce position, with more recent successful recruitment to roles (e.g., a specialist Care of the Elderly consultant) and the Hospital recently receiving a record number of applicants for ACP roles in Care of the Elderly services, illustrating the increasing desirability of Weston General Hospital as a site for specialisms, learning and development.

*Figure 1 - UHBW road map of integration*


### 2.1.5 Home First system initiatives

Healthy Weston is part of wider system change to enable a 'Home First' approach. The aim of this approach is to shift the emphasis of health and care to care for people at home where possible, or if they are admitted to hospital, to get them back home again as soon as possible.

It forms part of a local and national drive to improve patient flow within the health and care system and to ensuring an efficient system where patients are discharged as soon as they are well enough, improving their outcomes and reducing risk of infection.

Alongside a series of Home First programmes including One Weston Ageing Well, One Weston Community Mental Health, One Weston General Practice transformation, Discharge to Assess (D2A), BNSSG Urgent and Emergency Care transformation and Virtual Wards, Healthy Weston is supporting a new service model in which patients get better support, and properly joined up care at the right time in the optimal care setting.

For example, investment in Virtual Wards and a GEM@Home consultant at Weston will help accelerate plans to allow frail patients to get the specialist care they need at home safely and conveniently, rather than being in Weston General Hospital. This investment will also help create additional capacity for specialist advice and guidance, supporting primary care to care for frail patients within the community.

## 2.2 Case for change

### 2.2.1 Investment objectives

*Specify the key objectives for undertaking the investment proposal, expressed in terms of what you are seeking to achieve by way of targeted outcomes. Make your objectives SMART (specific, measurable, achievable, realistic, and time-bound).*

*Be guided by the generic drivers for intervention and spend:*

- *to improve the quality of public services by delivering better social outcomes, e.g., to meet new policies and operational targets (effectiveness).*
- *to improve the delivery of public services through better use of inputs and outputs (efficiency).*
- *to reduce the costs of public services (economy).*
- *to meet legal, regulatory, or organisational requirements and accepted best-practice (compliance and conformance).*
- *to re-procure services or equipment to avert service failure and provide business continuity (replacement).*

*The Better Business Cases guidance recommends holding a workshop (See Appendix 1 for details) for "Making the Case for Change" consisting of stakeholders, end users, the Sponsor/SRO, and other key participants.*

This section puts forward the compelling case for why a new clinical model for emergency care is needed. It builds on the work of Healthy Weston Phase 1 and considers the changes that have occurred over the last two years. There are four key reasons why emergency care services in Weston General Hospital must be reformed.

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

- **The current model of care is unsustainable**: Some health services at Weston General Hospital are not able to consistently meet national and local clinical quality standards because of low activity volumes and shortages of specialist staff. However, Weston General Hospital can provide enhanced services in specific areas relevant to its population, learning from the success of areas such as orthopaedics, which can thrive with the right clinical model.

- **Whole system changes are required to ensure timely access to equitable, integrated care**: The introduction of Integrated Care Systems and the creation of University Hospitals Bristol and Weston Foundation Trust gives opportunities to improve patient care across the system, increasing access and continuity of care. Organisations can collaborate to ensure that patients receive care in a setting appropriate to their needs, joining up pathways across primary care, community care and hospital care. Weston General Hospital plays an important role in the system's clinical strategy delivering key priorities such as reducing local health inequalities and accelerating elective care.

- **There is an opportunity to better use our resources**: Healthcare resources are limited across our system, with Bristol, North Somerset and South Gloucestershire Integrated Care System in recurrent deficit by £76m in 2022/23. The COVID-19 pandemic has put further pressure on these limited resources. Workforce, finance, and estates must be best used to provide care for our local population in the right place, first time.

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

The case for change was developed with input from stakeholders, including clinicians and patient representatives, from across BNSSG and Somerset. A draft version was reviewed by

the South West Clinical Senate to examine the clinical appropriateness and feasibility of the case put forward. The sections below take account of their feedback.

Table 1 below sets out the Healthy Weston 2 Phase 1 objectives to address the case for change.

*Table 1 - Healthy Weston 2 Phase 1 objectives to address the case for change*

| Objective number | Benefit | Enablers | Outcomes | Measure | Target date |
|---|---|---|---|---|---|
| **Objective 1** | **Reduce length of stay (LOS) in hospital** | • Enhanced short stay provision at Weston General Hospital (WGH)<br>• Enhanced care of the elderly services implemented | • More people maintain their independence<br>• Fewer delays are experienced for treatment<br>• More people accessing services where national standards are met, and specialised care delivered<br>• Reduced risk to frail older patients of conditions related to longer LOS e.g. delirium, pressure sores and deconditioning | • LOS for emergency care at WGH and neighbouring sites<br>• Number of bed days utilised<br>• 90-day readmission rates | From April 2023 [subject to approval to implement] |
| **Objective 2** | **Workforce is more sustainable** | Successful implementation of new workforce models | • Fewer vacant posts<br>• Improved retention and recruitment rates<br>• Reduced cost of contracting with agency staff<br>• Increased % of substantive staff employed<br>• Improved staff experience<br>• Improved network working with other hospitals<br>• More opportunities and progression available to staff<br>• Enhanced access to training and development for staff | • % Agency use<br>• % Bank use<br>• % Staff with joint working job plans / contracts<br>• Vacancy rate<br>• Sickness rate<br>• Workforce turnover rate<br>• Staff survey results | From April 2023 [subject to approval to implement] |
| **Objective 3** | **Improve ED performance** | Enhanced Urgent and Emergency care offer at WGH | • Improvement in time to be assessed, treated, and discharged<br>• Improved patient flow<br>• Improved patient experience<br>• Reduced risk to frail older patients of | • ED total time in department (% under 4 hours)<br>• ED time to initial assessment (% under 15 mins)<br>• ED time to start of treatment (% | From April 2023 [subject to approval to implement] |

| | | | | | |
|---|---|---|---|---|---|
| | | | conditions related to longer LOS e.g. delirium, pressure sores and deconditioning | under 60 minutes)<br>• Number of ED 12-hour trolley waits<br>• Ambulance handover times / time lost to handover delays | |
| **Objective 4** | **Improve outcomes for patients receiving Urgent and Emergency Care** | Implementation of Healthy Weston 2 changes to Urgent and Emergency Care, short stay models, same day emergency care | • Improvements in the quality and responsiveness of care<br>• Decreased length of stay for emergency care at Weston<br>• Increased bed availability<br>• Reduced risk to frail older patients of conditions related to longer LOS e.g. delirium, pressure sores and deconditioning | • Outcomes measures / PROMS<br>• Emergency re-admission rates<br>• Hospital mortality indicators<br>• Friends and Family test results (ED) | From April 2023 [subject to approval to implement] |
| **Objective 5** | **Improve system flow** | Increased interventions at the front door at Weston General Hospital | • Improvements in the efficiency of services<br>• Decreased length of stay for patients<br>• Increased bed availability at WGH<br>• Improvements in the quality and responsiveness of care | • % of general and acute beds occupied<br>• % of beds occupied by no criteria to reside patients<br>• % unplanned diverts from WGH ED | From April 2023 [subject to approval to implement] |
| **Objective 6** | **Maintain hospital care locally** | Urgent and Emergency Care, Care of the Elderly, care for children and young people and a range of planned care services are provided on the Weston General Hospital site | • People living locally to Weston General Hospital can receive the majority of their care locally<br>• Improved access for local visitors / family<br>• Reduced travel for the system | • ED attendance rates at WGH and neighbouring sites for patients from WGH catchment area postcodes | From April 2023 [subject to approval to implement] |
| **Objective 7** | **Improved patient experience** | Enhancements to Urgent and Emergency Care, Front door services and Care of the Elderly | • Improvements in the quality and responsiveness of care<br>• Improvements to the reputation of the hospital<br>• Clinical outcomes and patient safety enhanced | • Friends and family test results<br>• Number of patient complaints received<br>• Number of falls reported<br>• Number of serious incidents reported | From April 2023 [subject to approval to implement] |

| | | | | | |
|---|---|---|---|---|---|
| **Objective 8** | **Increase care at home** | • Development of community services for older people<br>• Implementation of frailty model<br>• Application of short stay models to ensure that long hospital stays are avoided unless absolutely necessary | • Hospital services are utilised only by those that need acute care, reducing demand on staff in-hospital<br>• Decreased length of stay for patients<br>• Increased hospital bed availability in acute care<br>• People are supported to be independent | • LOS for emergency care at Weston care home hub measures | From April 2023 [subject to approval to implement] |

### 2.2.2 The health needs of the local population

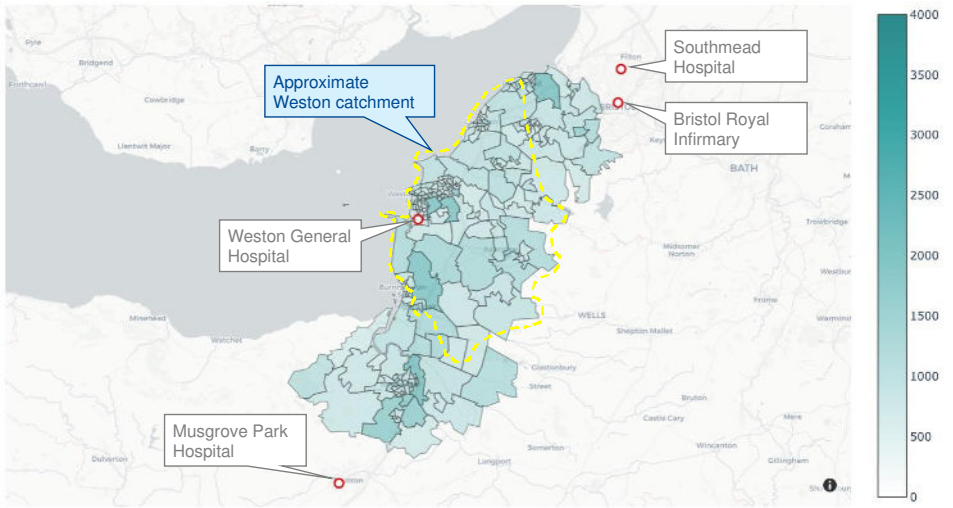
The population of the Weston, Worle and Villages is in the region of 94,000, but the Healthy Weston programme includes the wider population served by Weston General Hospital, including the surrounding villages and population in Somerset who are referred to and use Weston General Hospital services.

Based on 2019/20 activity, the population served by Weston General Hospital is just over 120,000, as determined by the inpatient activity from the surrounding post-codes. This is shown in Figure 2 below.

*Figure 2 - Catchment geography of Weston General Hospital*

**Weston General Hospital has a coastal catchment in the South West of England, surrounded by three larger acute sites**

**Weston General Hospital catchment and surrounding acute sites**
Colouring reflects LSOA populations




Source: Office for National Statistics population data

The population is on average older than the England national average, with 25% of people predicted to be over 65 years of age by 2025. In North Somerset, 25,000 residents are aged over 75 (about 10%), of which around 7,500 are aged over 85.

Significant new build housing is planned in Weston, many of which will be for younger families. This has implications for the type and number of local services needed including primary care and children's services. Additional new build developments are also expected near Nailsea, Yatton, Portishead and between Long Ashton and Bristol. Although residents in those areas typically receive acute care from hospitals in Bristol; if Weston were to extend its reach this would support the wider health system in BNSSG.

**Age**

Age is one of the most critical factors in planning the healthcare for Weston, Worle and the surrounding areas. The population served by Weston General Hospital is older than the England average and within the North Somerset area, 20% of people are expected to be over the age of 70 by 2025[2]. In addition, over half of the total population increase between 2018 and 2025 will be in the 70+ group.

The 65+ population of North Somerset (as outlined below) is proportionally greater than other areas in the region and therefore increased consideration must be given to ensure appropriate mitigations to address this demand on services such as frailty and care of the elderly.

*Table 2 - Population of Bristol, North Somerset and South Gloucestershire*

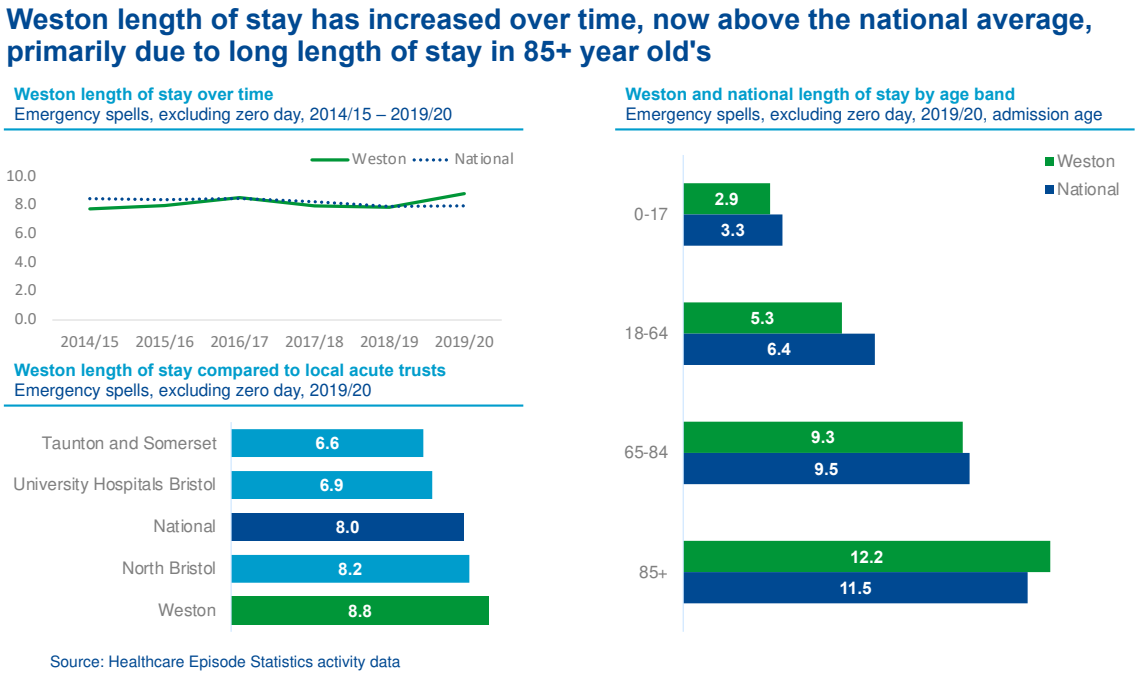
| Group description | Bristol population (2021 Census) | North Somerset population (2021 Census) | South Glos population (2021 Census) |
|---|---|---|---|
| Aged 0-15 | 17.53% | 17.6% | 18.28% |
| Aged 16-64 | 69.64% | 58.45% | 63.04% |
| Aged 65+ (85+) | 12.87% | 23.95% | 18.65% |

With a significant increase in the projected frail and elderly populations in the future, WGH must change the way services are delivered to better meet their health and care needs and build learning for the BNSSG system on effective models of integrated care.

As with in other parts of the country, over 85-year-olds in Weston, Worle and surrounding areas are more likely to attend A&E and be admitted to hospital than other age groups. Those aged over 65 years makeup 23% of the Weston General Hospital catchment population but accounted for 34% of all A&E attendances at Weston General Hospital in 2019/20. The over 65 population currently accounts for 61% of all acute admissions and 83% of hospital emergency beds, with an associated proportion of older people having a longer length of stay at Weston General Hospital than local peers and the national average. This has increased since the overnight closure of A&E in 2017. Figure 3 below shows the Weston General Hospital elective and emergency care bed days.

[2] North Somerset JSNA – Disease Prevalence Models Accessed: https://www.n-somerset.gov.uk/sites/default/files/2020-02/disease%20prevalence%20models.pdf

*Figure 3 - Hospital spells and bed days for Weston elective and emergency care*




Unplanned and emergency admissions can be detrimental for older people. Frail older people experience 5% muscle wastage for every day spent in a hospital bed, meaning they can find it difficult to return to their previous level of independence. Thresholds for admission are often lower than medically necessary and lengths of stay are longer than they need to be, resulting in poorer outcomes.

This business case ensures local health care services are more focused on both the elderly frail population, which is increasing and health inequality affecting all ages, securing continued access to high quality urgent care, avoiding unplanned acute where possible and ensuring patients do not stay in hospital longer than required.

### Health inequality

The health status of people in Weston Town is poor compared to other parts of North Somerset and other BNSSG locality areas, as shown in the table below. While life expectancy in North Somerset is broadly in line with the England average, it varies by area, with Weston-super-Mare Central Ward having the lowest life expectancy (69.3 years for males and 76.6 years for females). The difference in the average life expectancy for those living in the most deprived areas of North Somerset (IMD1) and least deprived (IMD5) is 9.5 years in males and 7.9 years in females[3].

*Table 3 - Healthy life expectancy at birth (ONS)*

| | Male | Female |
|---|---|---|
| **England** | 79 | 82.9 |
| **South West region** | 80.3 | 84.1 |
| **North Somerset** | 80.5 | 84.6 |
| **Weston Central Ward** | 69.3 | 76.6 |

[3] Our Future Health Report (September 2022), Bristol, North Somerset and South Gloucestershire Integrated Care Board. Accessed: OurFutureHealth-Sept-2022-1.pdf (icb.nhs.uk)

| | | |
|---|---|---|
| **Clevedon Yeo** | 83.8 | 93.1 |

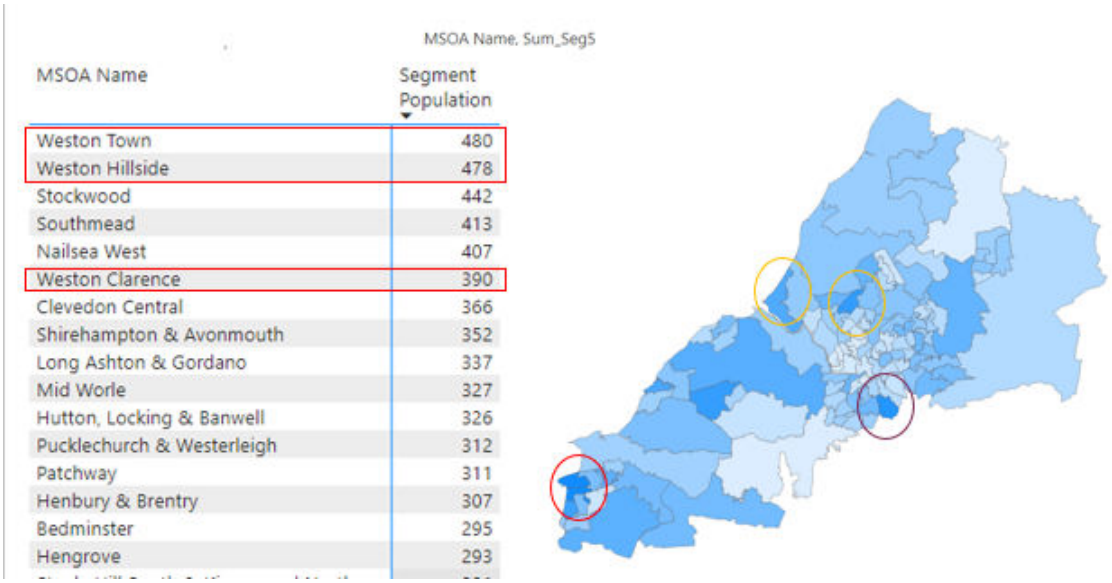
*Source: Office for National Statistics Life expectancy estimates 2018-2020*

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

**Weston's health care need**

BNSSG has segmented its population into a pyramid of five segments, defined by the Cambridge Multimorbidity Index (CMMI[4]) score. Segment 1 includes the 'healthiest' 50% of the population and segment 5 includes 3% of the population with multiple health conditions, greater risk of mortality and a higher acute healthcare need. Three of the top six Segment 5 areas in BNSSG are in Weston.

*Figure 4 - BNSSG Segment 5 population*




People in Segments 4 and 5 of the population use most of BNSSG's non-elective bed days, yet ambulatory care sensitive conditions are high amongst these population groups [43% of ambulatory care is in segment 5]. This matters because it suggests that a significant number

Population growth, an ageing population, and a greater healthcare need are all critical factors for planning healthcare in Weston and addressing the health inequality that exists. Healthy Weston 2 Phase 1 will help create equity of access to high quality urgent care, but ongoing system support will be required as the population continues to age and grow.

[4] The Cambridge Multimorbidity Index (CMMI) is a method for measuring multiple long-term health conditions amongst patients, intended to help healthcare planners respond to patients with the greatest healthcare needs.

of admissions from our most complex people are for low complexity reasons such as a fall or UTI. It is essential that we invest in both high-quality ambulatory care, that is integrated with the community, that is better able to meet the health and care needs of this population group.

### 2.2.3 Existing arrangements

*Describe any arrangements currently in place (business as usual): how services are presently organised and provided to patients and service users; including associated throughput, costs, current asset availability, utilisation, and condition.*

Figure 5 below shows the current mix of clinical specialities operating in Weston General Hospital, with Figure 6 presenting the service improvements as part of the full Healthy Weston 2 Programme.

*Figure 5 - Weston General Hospital current service portfolio*

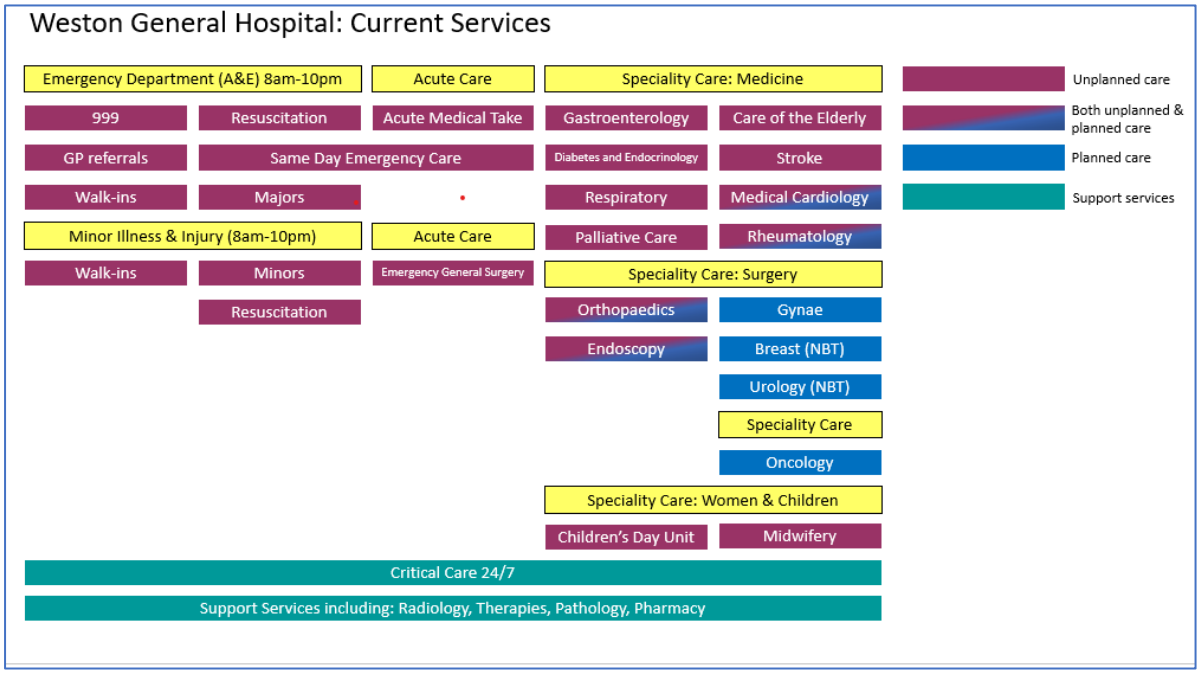
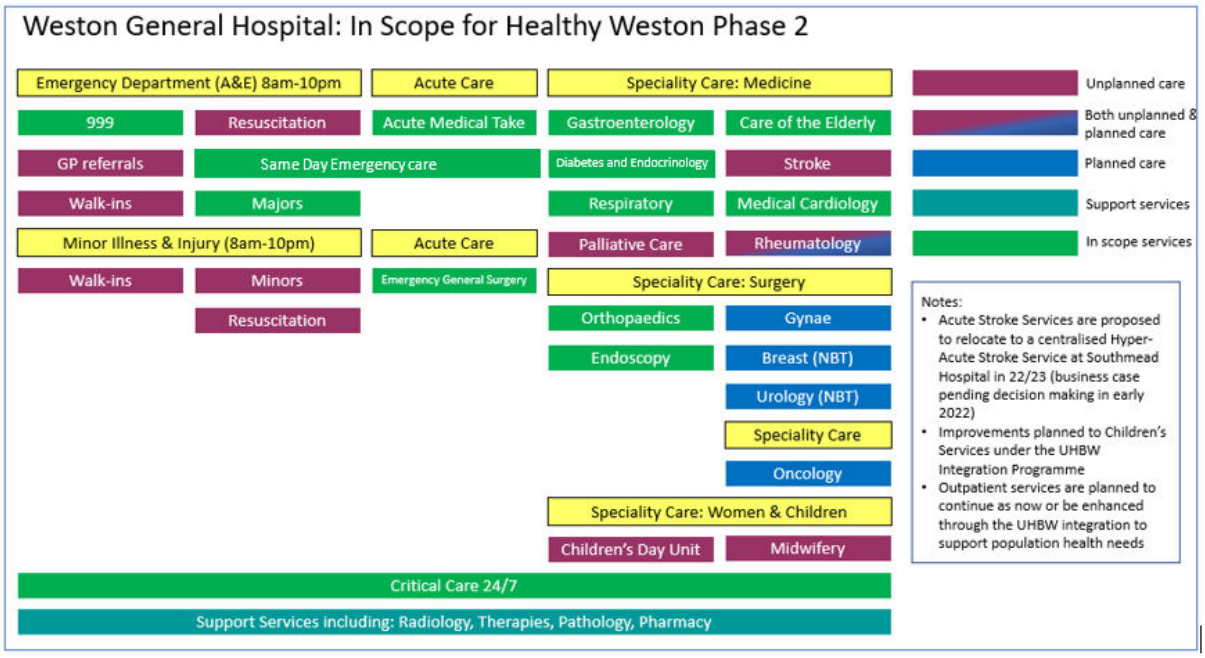


*Figure 6 - Weston General Hospital services: Healthy Weston 2 Service Improvements*




This business case is focussed HW2 Phase 1 and introducing and enhancing the following urgent care services:

- Same Day Emergency Care (SDEC)
- Expansion of Geriatric Emergency Medicine Service (GEMS)
- Acute Monitoring Unit (AMU)
- Older People's Assessment Unit (OPAU)

## Weston General Hospital – Emergency Department performance measures

The following section provides a high-level performance overview of the current condition of urgent care services at WGH and why reform is important.

**Weston General Hospital Emergency Department (ED)**
The national standard for the number of patients discharged, admitted, or transferred within four hours of arrival in an Emergency Department is 95%. Weston General Hospital ED did not achieve the 95% standard in any month of 2021/22 and achieved 67.3% for the year.

More recent performance analysis at WGH ED between October 2022 and January 2023 highlighted a similar pattern, with the average 4-hour breach performance score being 50%, meaning around half of all patients attending Weston ED are waiting over 4 hours to be discharged, admitted, or transferred.

*Figure 7 - Weston ED 4-hour breach performance*

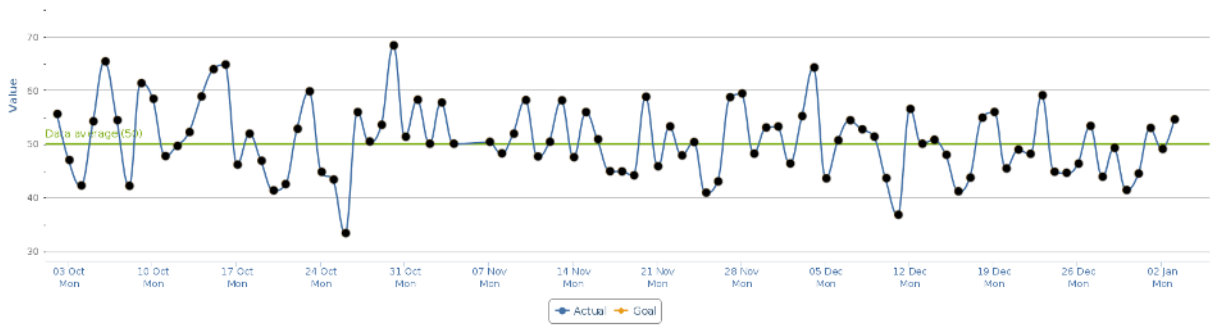
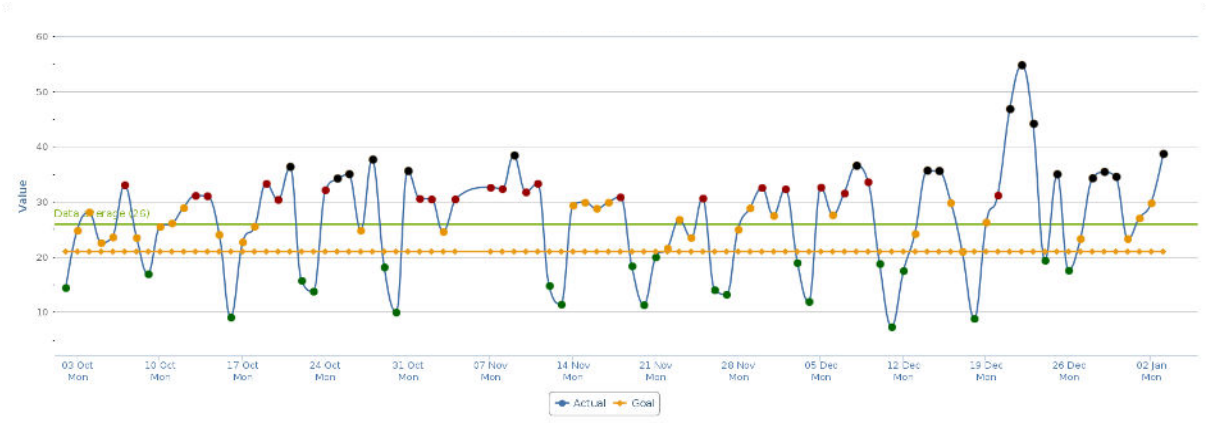



Figure 8 illustrates the average ED conversion rate (% admitted) is 5% higher in WGH ED than the target level, with an average of 26% of all attendees to Weston ED being admitted.

Research has shown that admitting frail older people can lead to a decline in their physical ability through deconditioning and increases risk of the development of conditions such as delirium. Avoiding admittance where appropriate with options to refer to services such as community aging well and virtual wards can help improve outcomes and experience for patients, as well as providing a financial benefit to the hospital.

*Figure 8 - Weston ED conversion rate*




In 2021/22 there were 2608 12 Hour Trolley Wait Breaches at WGH. It is well established that long waiting times in EDs are associated with poor clinical outcomes, patient experience and are illustrative of wider pressures faced by the NHS and social care system.

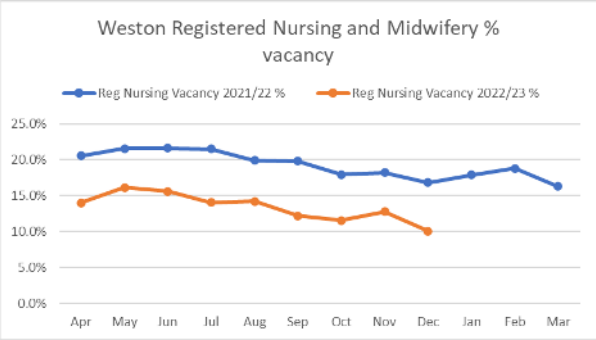
**Staff measures**

Over several years Weston General Hospital has historically had a lack of substantive staff. The position has improved significantly particularly recently in relation to Registered and Unregistered Nursing vacancies. Figure 9 below illustrates the reduction in Registered Nursing vacancies from over 20% in July 2021 to 10% in December 2022. Weston now performs better than the wider UHBW Trust overall in both nursing vacancy rates and turnover, and the pipeline of nursing recruits means this is forecast to reduce to around 1% vacancies by April 2023.

However there remain problems in the wider workforce, particularly Medical and Dental. The actual picture is worse than the headline Medical and Dental vacancy rate of 5.6%, as much of the workforce is made up of long-term locums. For example, in the Emergency Department approximately half of the consultant workforce are locum medics, a quarter agency, and a remaining quarter are substantive.

The success with the nursing workforce demonstrates that with the right vision, focussed support and international recruitment that this business case proposes, it is possible to turn the wider workforce situation around.

*Figure 9 - Weston site and UHBW workforce metrics December 2022*




| | | Trust wide | Weston |
|---|---|---|---|
| Vacancy Rates | Vacancy – All Staff Groups | 7.20% | 6.40% |
| | Vacancy – Medical and Dental | 0.00% | 5.60% |
| | Vacancy – Nursing and Midwifery Registered | 10.70% | 10.00% |
| | Vacancy – Nursing and Midwifery Unregistered | 5.30% | 2.60% |
| Turnover | Turnover – All Staff Groups | 15.00% | 14.50% |
| | Turnover – Allied Health Professionals | 17.70% | 42.90% |
| | Turnover – Medical and Dental | 7.10% | 27.30% |
| | Turnover – Nursing and Midwifery Registered | 14.70% | 12.90% |
| | Turnover – Nursing and Midwifery Unregistered | 16.90% | 17.60% |
| Agency Usage | Agency Usage – All Staff Groups | 1.90% | 4.30% |
| Bank Usage | Bank Usage – All Staff Groups | 6.10% | 12.70% |

### 2.2.4 Business needs

*Describe the problems and difficulties with the existing arrangements and what needs to be done to fill the service gap, i.e., the difference between where we are now and where we want to be in terms of our spending objectives.*

*Describe the primary and supporting risks the business case is addressing, with a link to Datix risk and describe the extent to which the proposed change will mitigate the risk.*

There is clear rational why health and care services in Weston General Hospital need to continue to change. The current urgent care model at the Hospital does not deliver the NHS Long Term Plan objectives, performance expectations, or a service level that is equal to other BNSSG emergency care provision.

The NHS Long Term Plan states:

*'That the **emergency care system is under real pressure**. The number of A&E patients successfully treated within four hours is significantly higher than five years ago …… urgent care must be expanded and reformed. The goal is to ensure patients get the care they need fast, relieve pressure on A&E departments and better offset winter pressure spikes'.*

It goes on to say that:

*'… every acute hospital with a type 1 A&E department should move to a comprehensive model of Same Day Emergency Care. This will increase the proportion of acute admissions discharged on the same day from a fifth to a third'*

*'All type 1 A&E's should provide an acute frailty service at least 70 hours a week, with the aim to complete a clinical frailty assessment within 30 minutes of arrival in the ED unit'.*

The NHS delivery plan for recovering urgent and emergency care services (Jan 23) states:

*'Urgent and emergency services have been through the most testing time in NHS history with a perfect storm of pressures impacting the whole health and care system but causing the most visible problems at the front door. Variation in care must be reduced when patients*

*arrive at A&E, ensuring greater consistency in direct referrals to specialist care, and access to same day emergency care (SDEC) so patients avoid unnecessary overnight stays'.*

The Healthy Weston 2 Phase 1 model of care delivers reforms to emergency care provision, reducing pressure in the Emergency Department and cutting delays in patients being able to go home the same day, in line with the Long Term Plan.

Despite continued efforts to recruit and retain high-quality staff for several years, Weston General Hospital has had a lack of substantive staff across workforce groups, although there have been some recent improvements. The effects of the high levels of vacancies and temporary staff usage are seen in the Hospitals adverse financial position. The level of workforce challenge at Weston General Hospital was also highlighted in May 2021 when Health Education England withdrew ten trainee doctors from the site after the General Medical Council said 'junior medical staff were frequently left without adequate senior supervision and support on understaffed wards'.

Health and care teams work hard to provide good quality services, but the Healthy Weston programme identified some challenges in ensuring that care at Weston General Hospital is delivered in line with national and local guidance and standards if changes are not made. As one of the smallest acute hospitals in the country, the Hospital has found it difficult to preserve the full range of services that a district general hospital of its type might have provided in the past. This has largely been because of its inability to recruit and retain specialist staff, resulting in a small substantive workforce. A small workforce can make it difficult to sustain 24/7 services, which in turn can increase the risk to the patient.

Together, these challenges mean that action is needed to ensure that urgent care at the Hospital is reformed, and a new model of care is put in place in line with national and local standards and performance expectations, now and into the future. **Weston General Hospital must become a desirable place to work to recruit and retain staff across all workforce groups. Changes to urgent care must be made to address delays and to improve the sustainability of care provision at Weston General Hospital.**

The consensus from the Healthy Weston programme is that doing nothing carries the greatest risk for both Weston General Hospital, the Trust, and the wider system, as it brings with it the possibility of continuing unplanned changes that have the potential to destabilise the system and affect patient care. A Review Panel from **the South West Clinical Senate agreed that 'do nothing' is not an option**, stating that there is significant and robust clinical evidence that it is neither sustainable nor safe to continue services as they are.

### 2.2.5 Scope and Services

*Describe the potential scope for service improvement on a continuum of need as follows:*

- *"core" coverage - the "essential" requirements without which the procurement or project will not be judged a success.*
- *"desirable" coverage - the "additional" requirements which the procurement or project may justify extra spend on a value for money basis; and*
- *optional" coverage - the "possible" requirements which the procurement may justify on a marginal low cost and affordability basis.*

The improvement plans for Healthy Weston 2 have been agreed for delivery over three phases, with three interlinked full business cases. The scope of this Full Business Case is the Phase 1 urgent care improvements, with approval being sought for transitional investment to support the development of the following service enhancements:

- Enhanced 24hr observation unit for adults providing rapid assessment and treatment [**Acute Monitoring Unit**]
- Improved **Same Day Emergency Care** [SDEC], providing the right care, in the right place at the right time
- Increased number of frail patients supported by already award-winning **Geriatric Emergency Medicine Service** [GEMS] meeting local need
- Creating **Older People's Assessment Unit** [OPAU] providing specialist rapid assessment and treatment
- Improve and increase surgical efficiency

The Rapid Assessment Clinic for Older People (RACOP) as described in the Healthy Weston 2 OBC has been redefined as a Frailty SDEC and is included within the expansion of GEMS plans.

Phase 1 also includes the increased efficiency and improvement of existing surgical activity, which will feed into the later delivery of the Surgical Centre of Excellence as part of Phase 3 implementation. There are no costs associated with this element of the business case. The phase 1 plans will support the ability to avoid elective beds being used for escalation or outlying capacity hence maximising the opportunities from increased surgical efficiency.

Table 4 below sets out the transitional investment required against service development and benefits achieved.

*Table 4 - Transitional investment required against service development and benefits achieved*

| Service reform | Service enhancement | Total additional workforce requirement | Investment requirement | Main benefits |
|---|---|---|---|---|
| Acute Monitoring Unit and ED Observation Unit | Adult short stay is enhanced to a 15 bedded short stay unit including an Acute Monitoring Unit and an Emergency Department Observation Unit | 76.02 WTE [Medical - 19.34, Nursing – 16.49, Radiology, Therapy and Pharmacy 40.19] | Recurring revenue requirement £2.6m (25/26)<br><br>£0.15m capital requirement | More people access services where national standards are met, improvements in the quality and responsiveness of care, fewer delays are experienced for treatment, improvements in 'time to be seen, treated and discharged', improved hospital flow, improved equity of access. |
| Same Day Emergency Care | Same Day Emergency Care is enhanced treating up to 20% of ED attendances | | | |
| Geriatric Emergency Service | The existing Geriatric Emergency Medicine Service is enhanced to assess and treat most frail attendances | | | More people access services where national standards are met, improvements in the quality and responsiveness of care, fewer delays are |

| | | | | |
|---|---|---|---|---|
| Older People's Assessment Unit | A 14 bedded Older Person's Assessment Unit is introduced assessing and treating frail patients with lengths of stay less than 72 hours | | | experienced for treatment, improvements in 'time to be seen, treated and discharged', improved hospital flow, more people maintain their independence, reduced risk to frail older patients of conditions related to longer LOS. Creates foundations for delivering phases 2 and 3 of the full Health Weston vision. |

### 2.2.6 Phasing and approach to business case development

Whilst this Full Business Case focusses on Healthy Weston 2 Phase 1, the delivery of Phase 2 and Phase 3 are sequentially dependent on the successful implementation of the Phase 1 service improvements. The scope of the 3 interlinked Full Business Cases is set out in the table below.

*Table 5 - Healthy Weston 2 business case, scope and phasing*

| Workstream | Scope | Delivery phase |
|---|---|---|
| **Home First** | Same Day Emergency Care (SDEC) | Phase 1 |
| | Geriatric Emergency Medicine Service (GEMS) including Frailty SDEC | Phase 1 |
| | Acute Monitoring Unit (AMU) | Phase 1 |
| **Care of the Elderly** | Older Persons Assessment Unit (OPAU) | Phase 1 |
| | Care of the Elderly Wards (CoE Wards) | Phase 2 |
| **Inpatient Medical Care** | Transfer of inpatient beds | Phase 2 |
| **Surgical Centre of Excellence** | Increase efficiency and to improve productivity | Phase 1 |
| | New development modular theatres | Phase 3 |
| | Refurbishment and growth | Phase 3 |

The Fracture Liaison Service [FLS] is a core part of Care of the Elderly, providing specialist care and reducing the risk of fractures by systematically identifying, treating, and referring high risk groups who are vulnerable to fragility fracture. The benefits of an FLS are well documented and include the prevention of fractures, admissions avoidance, and better patient outcomes. The FLS will form part of the Phase 2 full business case.

Figure 10 below sets out the critical path and interdependencies between the different phases, benefits and interdependencies of the Healthy Weston 2 programme.

*Figure 10 - Critical path and interdependencies between the different phases, benefits and interdependencies of the Healthy Weston 2 programme*

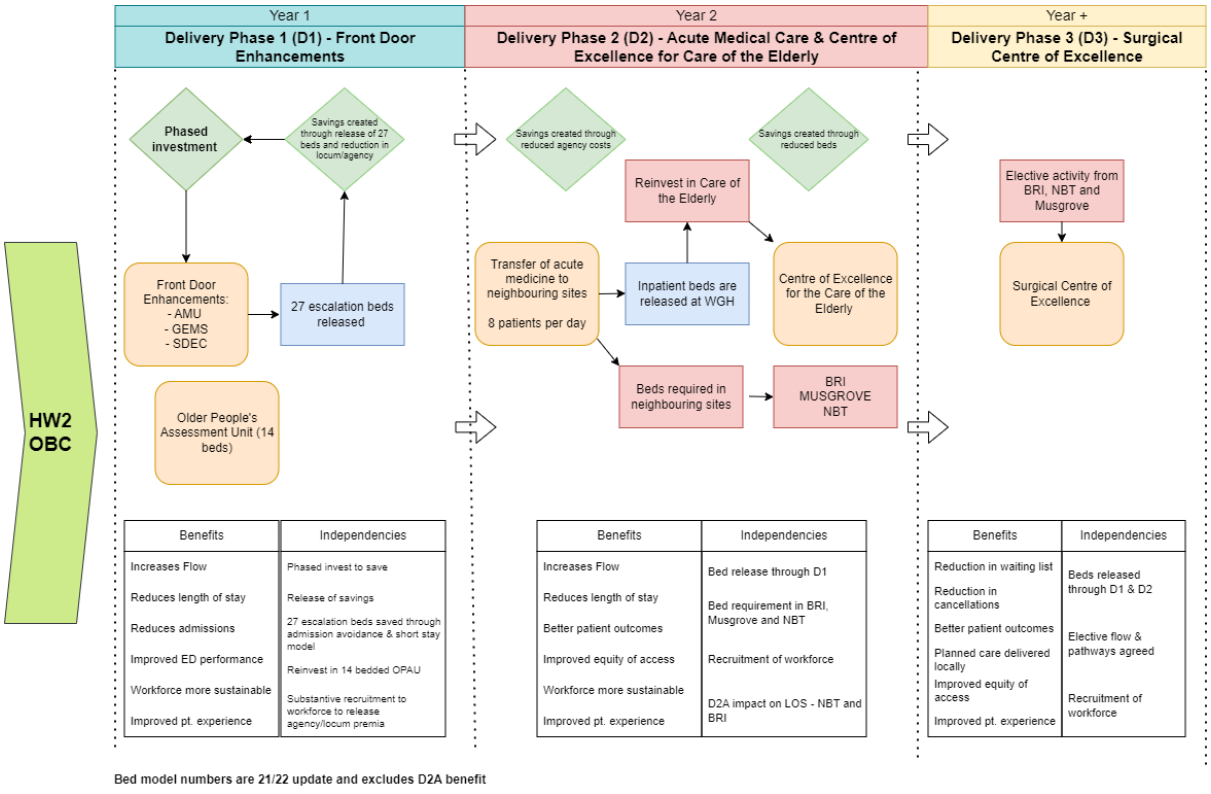



*Figure 10 - explanatory notes:*
*Delivery Phase 1*

- *£2.6m by 25/26 for recurrent revenue investment in phase 1 [this investment will be phased according to the recruitment plan]*
- *The investment will enhance the front door bringing Weston ED in line with national and local standards [AMU, GEMS, SDEC]*
- *14 bedded Older Person's Assessment Unit [OPAU] will be created further reducing length of stay*
- *These enhancements will reduce admissions and length of stay, which will reduce NEL bed need by 27 beds*

*Delivery Phase 2*

- *Inpatient medical care transfers to neighbouring hospitals, which means 8 patients per day will be stabilised and transferred. This reduces non-elective bed need at Weston General Hospital, however there is an impact at neighbouring hospitals linked to creating capacity from lower LOS and reliant on Home First / D2A impact or additional beds (Taunton)*
- *Specialist Care of the Elderly Wards are created; this is sequentially dependent on non-elective bed capacity created through delivery phase 1 and 2.*

*Delivery Phase 3*

- *Surgical Centre of Excellence is created as a result of non-elective beds released in Phase 1 and 2*

- *Savings are created throughout the programme as the proportion of substantive appointments increases and the number of agency appointments reduces*

In parallel with implementing Phase 1, the improved data on case mix and impact of the changes will provide scope to review the modelling and assumption for Phases 2 and 3 and build these into both business cases. This will require an agreed system position on Home First and D2A impacts across BNSSG.

### 2.2.7 Main benefits

*Describe the main benefits. These should be split into 2 categories:*

- *Benefits to the Organisation (direct public sector benefits)*
- *Benefits to other System(s) (direct / indirect benefits to System partners)*
- *Benefits to other public sector organisations (indirect public sector organisations)*
- *Wider benefits to society (households, individuals, and businesses)*

Healthy Weston 2 Phase 1 will bring about a range of system benefits, as depicted in Table 6 below:

*Table 6 - Benefits of proposed clinical model*

| Benefit | Impact | Driver |
|---|---|---|
| Reduced length of stay (LOS) in hospital | - More people maintain their independence<br>- Fewer delays are experienced for treatment<br>- More people access services where national standards are met, and specialised care is available<br>- Reduced risk to frail older patients of conditions related to longer LOS e.g. delirium, pressure sores and deconditioning | Short stay provision at Weston General Hospital enhanced for all adult care<br>Enhanced care of the elderly services implemented |
| Improved outcomes for patients receiving urgent and emergency care | - Improvements in the quality and responsiveness of care<br>- Decreased length of stay for emergency care at Weston<br>- Increased bed availability<br>- Reduced risk to frail older patients of conditions related to longer LOS e.g. delirium, pressure sores and deconditioning | Changes to Urgent and Emergency Care, short stay models and same day emergency care implemented |
| Improved ED performance | - Improvements in 'time to be seen, treated and discharged' targets<br>- Improved patient flow<br>- Improved patient experience<br>- Reduced risk to frail older patients of conditions related to longer LOS e.g. delirium, pressure sores and deconditioning | Enhanced Urgent and Emergency care offer at Weston General Hospital |
| Hospital care maintained locally | - People living locally to Weston General Hospital can still receive the majority of their care locally<br>- Improved access for local visitors and family<br>- Decreased travel for the system | Urgent and Emergency Care, Care of the Elderly, care for children and young people and a range of planned care services are provided on the Weston General Hospital site |

| | | |
|---|---|---|
| Improved workforce outcomes | - Enhanced access to training and development<br>- New workforce models that create opportunities for progression<br>- Improved network working with other hospitals<br>- Staff experience<br>- Reduced cost of contracting with agency staff | New workforce models successfully implemented |
| Improved system flow | - Improvements in the efficiency of services<br>- Decreased length of stay for patients<br>- Increased bed availability at Weston General Hospital<br>- Improvements in the quality and responsiveness of care | Increased interventions at the front door at Weston General Hospital |
| Improved patient experience | - Improvements in the quality and responsiveness of care<br>- Improvements to the reputation of the hospital<br>- Clinical outcomes and patient safety enhanced | Enhancements to Urgent and Emergency Care, Front door services and Care of the Elderly |
| Increased care at home | - Hospital services are utilised only by those that need acute care, reducing demand on staff in-hospital<br>- Decreased length of stay for patients<br>- Increased hospital bed availability in acute care<br>- People are supported to be independent | Development of community services for older people<br>Implementation of frailty model<br>Application of short stay models to ensure that long hospital stays are avoided unless necessary |

A full benefits assessment approach has been put in place to ensure the outcomes and benefits of the programme are continually understood and tested, realised, and reviewed. This includes a programme of work that will begin in March 2023 to test the benefits assumptions set out in the Healthy Weston bed and activity model including the non-elective bed release assumptions.

Further details on programme benefits can be found in section 5.

### 2.2.8 Main risks

*This section identifies the main risks to the delivery of your scheme / project (i.e., not the organisational risks that the case is addressing). The 'Risk register' template in Appendix 1 should be referenced here.*

*You should list the main risks to delivery of the business case in the table below (we would recommend a maximum of 5 risks listed here to avoid duplicating the risk register).*

The governance and assurance arrangements of the Healthy Weston 2 programme were set up to ensure rigorous oversight of the development of plans for improvement. Programme risk is managed by the Healthy Weston 2 Head of Programme, alongside the Senior Responsible Officer (SRO). It is the responsibility of the Healthy Weston Head of Programme and SRO to share regular risk updates with the Healthy Weston Programme Group and Healthy Weston Steering Group, and to escalate any new risks or change in risk status for review. Overall responsibility for risk sits with the Healthy Weston Steering Group.

*Table 7 - Main risks*

| Risk nº | Category | Risk description | Mitigation of risk | Risk LIKELIHOOD after mitigation | Risk IMPACT after mitigation |
|---|---|---|---|---|---|
| 3 | Workforce | There is a risk that potential solutions do not give sufficient consideration to **workforce deliverability** which may result in an un-viable clinical model, meaning that the model cannot be implemented. See section 6.8.4 for further details on recruitment delivery risk | 1) Consideration of Workforce included in implementation work<br>2) Ongoing work between Workforce and Finance sub-groups to refine and test the activity and workforce modelling<br>3) Workforce group developed considered workforce recruitment and retention plans and trajectories alongside other system initiatives | 3 - possible | 3 - moderate |
| 12 | Finance - revenue investment **[do nothing scenario]** | There is a risk that the **non-recurrent revenue investment** required in the Phase 1 Full Business Case is not sourced, resulting in the implementation of the model stalling, leading to | 1) Work ongoing with BNSSG system to identify opportunities for non-recurring revenue investment in HW2 Phase 1 Full Business Case<br>2) Develop a benefits realisation plan that will help identify when invest to save benefits will be realised | 3 - possible | 3 - moderate |

| Risk nº | Category | Risk description | Mitigation of risk | Risk LIKELIHOOD after mitigation | Risk IMPACT after mitigation |
|---|---|---|---|---|---|
| | | ongoing exposure to risk of unsustainable clinical services needing to be suspended at short notice | | | |
| 1 | Strategic - Threat | There is a risk that **system pressures** impact on the ability to secure the right clinical/system input to develop HW2 implementation plans resulting in delay to delivery, a lack of engagement, and impact on timeline | 1) Clinically led programme teams and good engagement with Clinical System Leaders<br>2) Commitment of clinical leaders established through HWSG<br>3) ICB working closely with wider clinical colleagues.<br>4) PMO considers and adapts according to system guidance in programme plan / governance schedule<br>5) Regular engagement meetings with UHBW and other partners regarding capacity and programme involvement<br>6) Healthy Weston Steering Group members have made clear their commitment to ensure their teams prioritise the development of the model within the timelines required<br>7) Programme resource request including clinical time | 2 - unlikely | 3 – moderate |
| 6 | Finance - Reliance on Discharge to Assess (D2A) | There is a risk that the programme is reliant on the **system approved Discharge to Assessment Business Case being implemented** and delivered by all partners in accordance with the Business Case, to release the bed capacity to accommodate the non-elective bed transfer to the | 1) Discharge to Assess operational delivery must be tracked and understood in the System via the D2A Project Board and reported into the HW Finance & BI Group.<br>2) Discharge to Assess operational delivery programme pending. | 3 - possible | 3 – moderate |

| Risk nº | Category | Risk description | Mitigation of risk | Risk LIKELIHOOD after mitigation | Risk IMPACT after mitigation |
|---|---|---|---|---|---|
| | | BRI and Southmead Hospitals. | | | |

The full Healthy Weston 2 risk register can be found in Appendix 1.

### 2.2.9 Potential risk apportionment

*Outline the potential risk apportionment between the organisation and the supply side. Seek to allocate the risk to the best party able to manage and optimise a particular service risk. This is generally where responsibility / control for the risk is held. Demonstrate how we have understood the impact of the risks on the service provider / supplier's incentives and financial costs and if the risk transfer is value for money (VFM).*

*Complete the risk allocation matrix below, noting that the risk categories are examples only and will need to be tailored to your scheme.*

Table 8 below describes the potential risk apportionment between BNSSG Integrated Care Board (ICB) and University Hospitals Bristol and Weston NHS Foundation Trust (UHBW). Risk has been allocated to the most appropriate organisation to best manage and optimise a particular service risk, based on where responsibility and control for the risk is held. Further details on the programmes approach to risk management can be found in section 9.3.

*Table 8 - Potential risk apportionment*

| Risk category | Potential allocation | | |
|---|---|---|---|
| | Trust (UHBW) | BNSSG ICB | Shared |
| 1. Design | | | Yes |
| 2. Estates changes | 100% | | |
| 3. Transition and implementation | 80% | 20% | |
| 4. Availability and performance | 80% | 20% | |
| 5. Operating | 100% | | |
| 6. Revenue | | | Yes |
| 7. Financing | | | Yes |
| 8. Legislative | 100% | | |

### 2.2.10 Constraints

*Specify any constraints that have been placed on the investment proposal, including any external conditions, and agreed parameters within which it must be delivered e.g., cost, timescale, location.*

The constraints placed on the transitional investment required in this Full Business Case is linked to the delivery of benefits across the full Healthy Weston 2 programme. The phased nature of the Healthy Weston 2 programme means that benefits realisation will take place across the phases and over time, this includes the release of financial savings linked to reductions in non-elective bed need and reliance on agency staff. These financial savings are central to delivering the financial position set out in the Outline Business Case.

A full benefits realisation approach has been adopted by the programme, with further details on benefits realisation found in section 5.

### 2.2.11 Dependencies

*Specify any dependencies outside the scope of the investment proposal upon which successful delivery is dependent e.g., dependent upon securing external funding; dependent upon completion of another scheme / project.*

Table 9 below sets out a series of dependencies outside the scope of the investment plans upon which successful delivery of this Full Business Case is dependent.

*Table 9 - Phase 1 dependencies*

| Category | Description | Mitigations |
|---|---|---|
| Workforce deliverability | The programme is dependent on recruitment of the required workforce to successfully deliver Phase 1 benefits. If unable to deliver this, the result may be an un-viable clinical model, partial model with limited benefits, meaning that the model cannot be implemented or is delayed. | 1) Consideration of Workforce to be included in implementation work [Recruitment Plan] as detailed in Section 7<br>2) Workforce group developing considered workforce recruitment and retention plans - that fit with other system initiatives |
| Revenue investment | Delivery of the full Healthy Weston programme is dependent on transitional revenue investment in Phase 1 Full Business Case | 1) Work ongoing with BNSSG system to identify opportunities for transitional investment in HW2 Phase 1 Full Business Case<br>2) Develop a benefits realisation plan that will help identify when invest to save benefits will be realised |
| Reliance on Discharge to Assess (D2A) | There is a risk that the programme is dependent on the system approved Discharge to Assessment Business Case being implemented and delivered by all partners in accordance with the Business Case, to create capacity to accommodate service improvements and the non-elective bed transfer to the BRI and Southmead Hospitals. | Discharge to Assess operational delivery must be tracked and understood in the System via the D2A Project Board and reported into the HW Finance & BI Group to track and understand impact on the HW programme |

# 3 Development of Options

## 3.1 Critical Success Factors

*Specify the critical success factors for the investment proposal, i.e., the attributes essential for successful delivery, against which the options will be appraised, together with the agreed spending objectives.*

*Consider the following and tailor as required for your investment proposal:*

- *Strategic fit*
- *Business needs*
- *Optimisation of cost and benefits*
- *Supply side capacity and capability*
- *Affordability*
- *Achievability/deliverability*

Figure 11 below sets out the critical success factors for the investment plans against which the Healthy Weston 2 clinical model was appraised. Further sub-criteria provided additional focus to the appraisal, ensuring a full and objective approach. The criteria were tailored to meet the need of the clinical model and covered strategic fit, business needs, optimisation of cost benefit, capacity and capability, affordability and deliverability.

*Figure 11 - Evaluation criteria*

| Evaluation criteria | Defined as |
|---|---|
| 1 **Quality of Care** | 1.1 Clinical effectiveness<br>1.2 Patient and carer experience<br>1.3 Safety |
| 2 **Access to care** | 2.1 Impact on patient choice<br>2.2 Distance, cost and time to access services<br>2.3 Service operating hours |
| 3 **Workforce** | 3.1 Scale of impact<br>3.2 Impact on recruitment, retention, skills |
| 4 **Value for money** | 4.1 Forecast income and expenditure at system and organisation level<br>4.2 Capital cost to the system<br>4.3 Transition costs required |
| 5 **Deliverability** | 5.1 Expected time to deliver<br>5.2 Sustainability<br>5.3 Co-dependencies with other strategies/strategic fit |

The evaluation criteria were considered and supported by clinicians, North Somerset Health Overview and Scrutiny Panel and the Healthy Weston Steering Group prior to full and independent evaluation. Outputs from the evaluation of the clinical model are set out in Appendix 2.

## 3.2 Main options

*Identify and complete the financial appraisal for each option in Annex A and attached as an Appendix to the Business Case.*

*Your options must include:*

- *The "do nothing" business as usual (the baseline from which improvement will be measured)*
- *The "do minimum" (a realistic option that meets core requirements)*
- *Any additional options considered*

*Complete Table 1 below for each option, referencing the benefits and risks in relation to Sections 2.2.5 (main benefits) and (2.2.6 main risks) and the estimated costs as shown in the financial appraisal in Annex A.*

*The Better Business Cases guidance recommends holding a workshop (See Appendix for details) for "Identifying and Assessing the Options" consisting of stakeholders, end users, the Sponsor/SRO, and other key participants; and use of the Options Framework (Appendix 3).*

The Healthy Weston 2 OBC describes the decision-making process to determine the clinical model for Healthy Weston 2. A summary of the clinical design process can be found below, with further details around the options evaluation workshop held in April 2022 found in Appendix 2.

### 3.2.1 Previous design work the starting point

The Healthy Weston 2 clinical design process started with the "Stage Three" model that was recommended by the Clinical Senate in February 2019:

*"The CRP (Clinical Review Panel) recommends an initial move to Stage One with a very carefully planned transition to Stage Three as soon as is deemed possible through further work up of the plans"*[5].

The Stage Three model (also known as the 27b model) was the final destination proposed as a result of the clinical design process carried out in 2019. At that time, it was agreed that more work needed to be done on the detail of the model. Therefore, although it was trialled in the 2019 public consultation exercise, it was not formally put forward as the plan. Instead, it was made clear that this second phase of Healthy Weston would be required to finalise the transformation of Weston General Hospital into a dynamic hospital in the heart of the community.

### 3.2.2 The proposed options

Four options were developed, based on the Healthy Weston 2 activity and bed model, by the Healthy Weston Clinical Design and Delivery Group, chaired by the Weston General Hospital Medical Director. A summary of these options is provided in the table below.

Option 1 was discounted as a 'do nothing' scenario does not meet the case for change. Option 3 was removed as it placed complex decision making around differentiating unwell frail patients from unwell non-frail patients with the ambulance paramedic.

*Table 10 - Recommendation to eliminate urgent care options*

| Option | Recommendation |
|---|---|
| 1 – No change | **Do not progress** – see case for change |
| 2 – Ambulances diverted; frailty by referral only | Progress to further appraisal and within OBC development process |

[5] BNSSG-Healthy-Weston-Stage-2-Clinical-Review-Report-February-2019-FINAL-CONFIDENTIAL.pdf (swsenate.nhs.uk) – page 6 of 22.

| | |
|---|---|
| 3 – Frailty ambulances only | **Do not progress** – clinical risk of receiving undifferentiated ambulances carrying frail patients outweighs benefits:<br><br>*The differentiated ambulance model will affect less than 10% of the ED attendances so will make minimal difference to flow. It does however place a complex decision around differentiating with the ambulance paramedic: simple differentiation tools such as the major trauma triage tool or age-based triage will not be effective, and it is likely that there will be high levels of inaccurate triage as the frailty score will be calculated on patients during an acute illness or injury which makes calculation of baseline frailty difficult. As a result, there is a high risk that non-frail patients presenting as frail because of an acute illness are conveyed inappropriately to Weston General Hospital, where the future state service provision may not sufficiently meet their needs.* |
| 4 – All ambulances received | Progress to further appraisal and within OBC development process |

The two options that were taken forward for detailed clinical and financial consideration as part of the OBC can be seen in the table below.

*Table 11 - Clinical options*

| Option | Description | Impact |
|---|---|---|
| **Option 1** [Option 2 in the table above] – Take people who are likely to need specialist medical care straight to neighbouring hospitals where appropriate sub-specialty care is available | Divert ambulances at source unless referral for specialist older peoples' services is accepted at Weston General Hospital | Around 17 people per day would be taken to other hospitals by the responding ambulance crew; around 16 people would still be taken to Weston General Hospital and 5 would need secondary transfer after arrival at Weston General Hospital |
| **Option 2** [Option 4 in the table above] – Take people to Weston General Hospital for assessment/initial treatment before transferring those that need sub-specialty care to neighbouring hospitals | Bring all ambulances to Weston General Hospital, as now, with onward transfer to other hospitals for those that need it | Around 34 people would come by ambulance to Weston General Hospital (as now) and 8 of these people would be transferred to another hospital after arrival |

### 3.2.3 Assessing clinical options

The evaluation process was undertaken in stages from quarter 4 2021/22 and included internal review and assessment through the Clinical Design Group and culminating in an independently chaired evaluation workshop in April 2022 against the co-developed and approved evaluation criteria. The workshop was attended by clinical, operational, strategic leads from across secondary, community and primary care and all partner organisations as well as patient representatives and was chaired by an independent representative.

External review and challenge from the South West Clinical Senate through a desktop review of the outline plans reported took place in January 2022. A further Clinical Senate Review Panel meeting on 31 March 2022 facilitated detailed scrutiny of the plans put forward against a set of Key Lines of Enquiry.

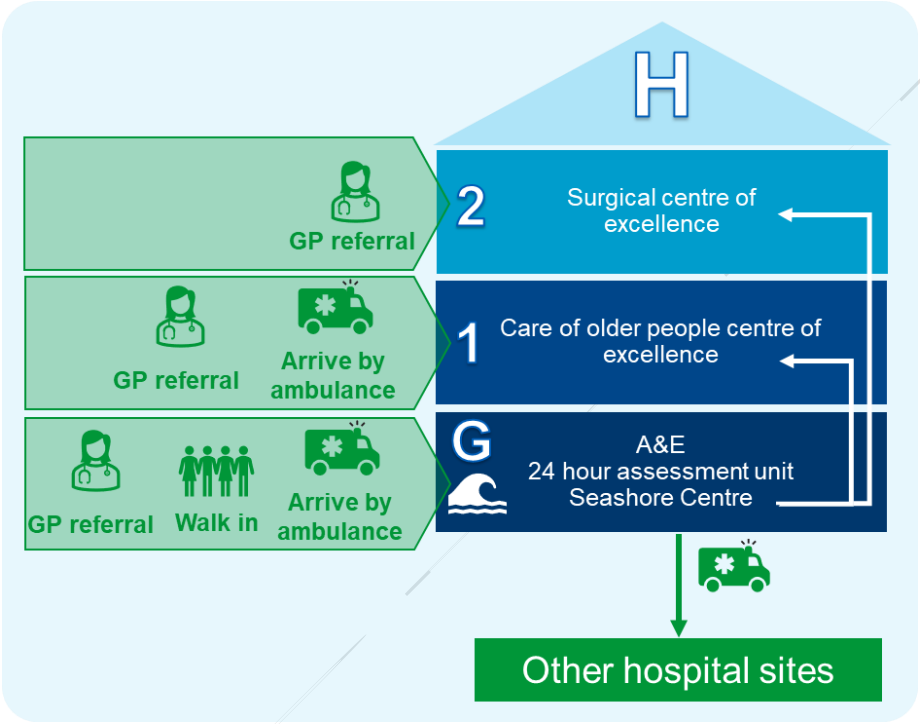
The two shortlisted options were objectively considered based on expected delivery of the service model in 2023/24, drawing on evidence from national guidance and best practice as well as data laid out in the Case for Change and the Outline Business Case. The consensus reached was in favour of option 2, which was then agreed by the Healthy Weston Steering Group. Appendix 2 provides the full report from the Evaluation Workshop.

This Full Business Case sets out the detail for operationalising the urgent care elements of the agreed Healthy Weston 2 clinical model.

# 4 HW2 Phase 1 Clinical Model

The main components of the HW2 model of care, can be seen in Figure 12 below:

*Figure 12 - Model of care components*




As described above, this Full Business Case focuses on the Phase 1 elements of this clinical model and reforming the way emergency care is provided in Weston General Hospital, in line with the Long-Term Plan and other local Emergency Departments. Figure 13 below sets out the Phase 1 components of the Healthy Weston 2 clinical model.

*Figure 13 - Phase 1 model of care components*

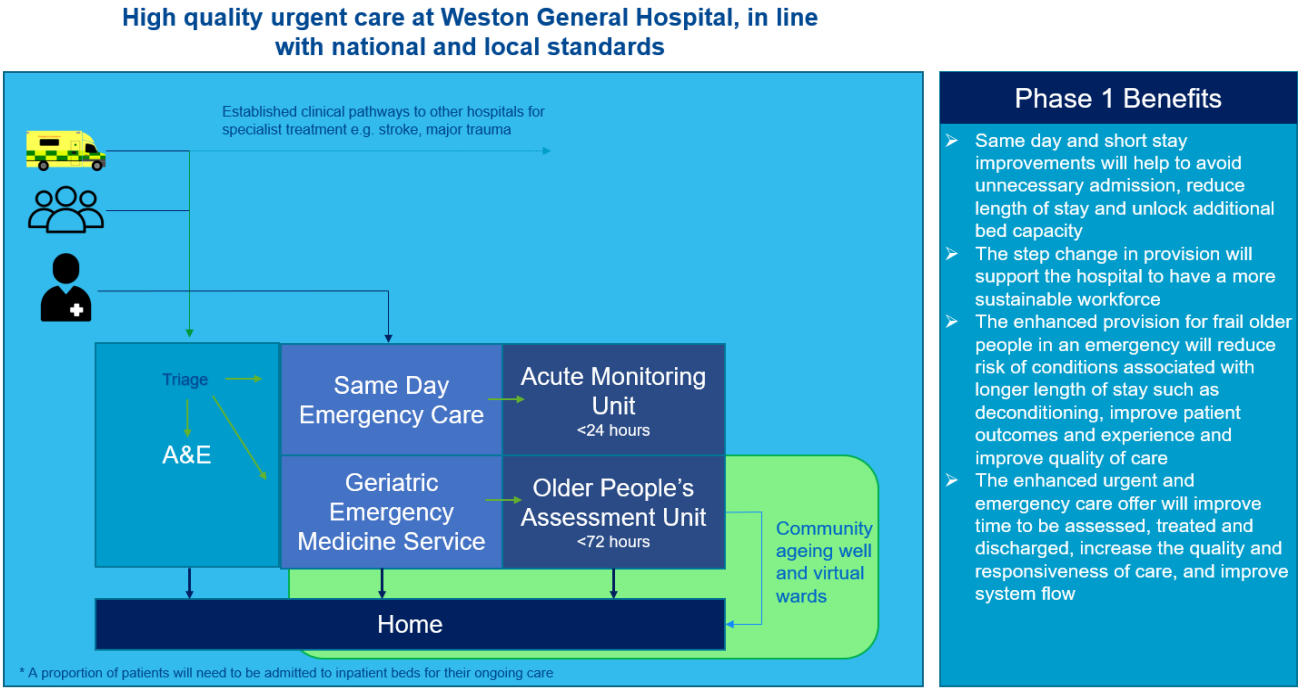



Table 12 below provides a high-level description of the Phase 1 service components.

*Table 12 - Phase 1 model of care service improvement plans*

| Service area | Improvement plans |
|---|---|
| **Same day emergency care (SDEC)** | Introduction of same day emergency care; enabling patients to be rapidly assessed, diagnosed, and treated without being admitted to a ward or trolleyed area, 7 days a week, 8am – 10pm. |
| **Acute Monitoring Unit (AMU) and Emergency Department Observation Unit** | Increase short stay provision and activity for non-frail patients to provide rapid assessment, investigation and treatment for patients requiring a short stay [24 hours] in hospital [15 bedded ward – 9 beds AMU / 6 beds EDOU] |
| **Geriatric Emergency Medicine (GEMS)** | Enhance the already a strong (and award-winning) clinical speciality that provides a person-centred clinical service for frail older people in an emergency to treat most frail attendances |
| **Older People's Assessment Unit (OPAU)** | Introduce an Older People's short stay ward [72 hours] providing rapid assessment, diagnosis, and treatment [14 bedded ward] |
| **Improve and increase surgical efficiencies** | Improve and increase existing surgical productivity in WGH theatres |

This new model of emergency care will be more accessible and better support the local population by:

- Continuing to provide all-age general hospital services to the local community, including an Emergency Department (open from 8am-10pm).
- Reducing the time that people spend in hospital through the introduction of new same day care and short stay pathways.
- Improving the quality of care and patient outcomes

The sections below provide further detail on each clinical component of the HW2 Phase 1 Clinical Model.

## 4.1 HW2 Phase 1 service improvements

### 4.1.1 Emergency Department Observation Unit

Weston General Hospital will continue to operate a consultant led, all age, Emergency Department, 8am to 10pm, 7 days a week with full resuscitation case and facilities. Staffing within the Weston General Hospital Emergency Department has been stable since the overnight closure was confirmed. The workforce has continued developing and is comprised of consultants, GPs, middle grades, senior house officers, emergency nurse practitioners, nursing, and administrative staff.

To enable the Emergency Department clinical team to manage as many people locally as possible, an **Emergency Department Observation Unit** (EDOU) will be established. This will be adjacent to the Emergency Department and provide 24-hour clinical assessment, investigation, and interventions to patients with initially the following example presentations:

- Head Injury
- Toxicology
- MH
- Social
- Non-frail trauma requiring mobilisation
- Pre or post procedural sedation
- Suspected renal calculi
- Seizure
- Safeguarding (adult)

Care within the EDOU would be provided by the Emergency Department team, supplemented by acute medical expertise and primary care support. A core part of this service is the rapid access to diagnostics to ensure quick diagnosis and turn around.

To provide this new service staffing cover to the Emergency Department will be enhanced with a middle grade doctor trained in emergency medicine based in the hospital overnight to oversee the unit and to continue to appropriately assess, manage and where appropriate discharge patients fit to go home after the Department has closed who would previously have been admitted overnight, and supported by a consultant on call for emergency medicine.

### 4.1.2 Enhanced 24hr observation unit for adults

The model set out within the Healthy Weston 2 Outline Business Case is to enhance the existing Monitoring Unit into a 15-bed short stay [24 hours] Acute Monitoring Unit [AMU] for non-frail patients, initially encompassing a 9 bedded unit overseen by the acute medical

consultant team, and a 6 Emergency Department Observation Unit [EDOU] linked to the Emergency Department and overseen by the Emergency Department team. As these units will be co-located there is some flexibility in terms of bed numbers such that maximal flow can be achieved.

The AMU acts as a gateway between primary care, the Emergency Department, and the wards of the hospital. Its primary role will be to provide rapid assessment, investigation and treatment for patients requiring a short stay [24 hours] in hospital. The AMU helps the Emergency Department produce a healthy turnaround for patients, helping with waiting times and avoiding admission, where appropriate.

A patient admitted to the AMU will receive care that will include the necessary investigations and management required until the patient is discharged, stabilised, or transferred to a higher level of care. This model of care is in line with the Royal College of Physicians 2007 report 'Acute Medical Care: the right person, in the right setting – first time'.

AMU will operate 24 hours a day, 7 days a week and will be led by the acute medical consultant team. The inclusion criteria for the Acute Medical Unit are:

- Gastrointestinal bleeding
- Acute asthma, chest infection and other respiratory conditions
- Acute illness
- Toxicology
- Renal colic
- Infection requiring anti-biotics
- Vulnerable adults who cannot be discharged over night
- Low risk chest pain

Patients will be reviewed and assessed by the Emergency Department or Same Day Emergency Care senior decision maker prior to referral to AMU or EDOU. The AMU is admissions only. Patients cannot be referred directly into this unit but will come via assessment in ED or SDEC to ensure all alternatives to short stay admission have been considered.

Once admitted to the AMU or EDOU patients will undergo further observation, tests, and treatment before being discharged home or to an appropriate speciality team.

The AMU care model will be delivered by a multidisciplinary team, including medical, nursing alongside in reach from pharmaceutical, therapeutic and diagnostic teams. This integrated workforce approach will support the delivery of coordinated, safe and high-quality care for patients.

Based on the Healthy Weston 2 activity and bed model [21/22] it is anticipated Weston AMU and EDOU will treat at least16 patients per day.

### 4.1.3 Improved Same Day Emergency Care [SDEC]

The NHS Long Term Plan states:

'… every acute hospital with a type 1 A&E department should move to a comprehensive model of Same Day Emergency Care'

Same Day Emergency Care will be enhanced, providing the right care, in the right place, at the right time for patients. It will benefit both patients and the healthcare system by reducing waiting times and hospital admissions, where appropriate.

SDEC is the provision of same day urgent care without an overnight inpatient admission. Under this care model, patients presenting at WGH with relevant conditions will be rapidly assessed, diagnosed, and treated without being admitted to a ward, and if clinically safe to do so, will go home the same day their care is provided.

The Weston SDEC model builds on previous improvement work in ambulatory emergency care (AEC) at the hospital, with the aim of providing a consistent approach to SDEC across UHBW Trust.

SDEC will operate 7 days a week, from 8am to 10pm aligned with the Emergency Department opening hours. The inclusion criteria for Same Day Emergency Care is:

- Acute headache
- Asthma
- Abscesses
- Community acquired pneumonia
- Urinary disorders
- Gastroenteritis
- Cellulitis
- Deep Vain Thrombosis [DVT]

Although in practice WGH will be a non-pathway based SDEC creating flexibility across the inclusion criteria and optimising the number of patients that are cared for by SDEC.

Suitable patients will be referred through different routes [as set out below] based on an expectation of same day discharge, with assessment and treatment pathways that do not include an overnight stay.

Relevant SDEC patients will be referred through different routes, including:

- Streamed by a senior decision maker in the Emergency Departments (ED)
- Direct referral from Primary Care
- Direct referral from paramedics
- Referral from wards to support discharge [discharge review clinic]

SDEC will be led by a mix of ED consultants, acute medics, and medical consultant on call [CPOD]. The SDEC will be supported by a multidisciplinary team, including medical, nursing and in reach from pharmaceutical, therapeutic, and diagnostic teams. A core part of this service is the rapid access to diagnostics, therapeutic and pharmaceutical support to ensure quick diagnosis and treatment turnaround times. This integrated workforce approach will support the delivery of coordinated, safe and high-quality care for patients. WGH is starting from a nil or very low base for some of these teams such as therapies hence the need for frontloading investment int Phase 1 implementation that will support efficiencies when the full model is delivered.

The Geriatric Emergency Service will also provide frailty SDEC assessment, care, and treatment.

There are significant benefits associated with treating people through SDEC including:

- the ability for patients to be assessed, diagnosed, and start treatment on the same day, improving patient experience and reducing hospital admissions
- improve patient flow within the hospital
- avoiding unplanned and longer than necessary stays in hospital, resulting in lower risk of infections and de-conditioning for patients
- financial benefits and cost savings for the hospital

It is expected that up to 20% of attendances will be treated through WGH SDEC by 2024.

### 4.1.4 Enhanced Geriatric Emergency Medicine Service

Geriatric Emergency Medicine Service is already a strong (and award-winning) clinical speciality that provides a person-centred clinical service for frail older people in an emergency at Weston General Hospital. It was developed to improve the care and outcomes of frail older adults in an acute emergency.

Moving away from the traditional Emergency Department model of care that focuses on the diagnosis and treatment of an acute presentation [an approach that fails to identify many subtler threats to an older person's health], the GEMS provides holistic, patient-centred care for acutely ill older people, with frailty and complex care needs. This means that high quality care is focused on meeting a patient's individual needs, that takes into consideration the overall health of the patient, including their physical and psychological wellbeing and their care needs.

The Comprehensive Geriatric Assessment [CGA] process, [defined as a multidisciplinary diagnostic and treatment process that identifies medical, psychosocial, and functional limitations of a frail older person to develop a coordinated plan to maximise overall health with ageing] is a key component of care at the Geriatric Emergency Service. The CGA is the gold standard of care for patient with frailty recommended by NHS England. It is an evidence-based process that can reduce length of stay, reduce dependency, and reduce mortality.

What the NHS Long Term Plan says:

*'All type 1 A&E's should provide an acute frailty service at least 70 hours a week, with the aim to complete a clinical frailty assessment within 30 minutes of arrival in the ED unit'*

This business case seeks to expand the existing GEMS team to enable early review of most frail patients arriving at Weston Emergency Department and a CGA within 30 minutes. The GEMS will also provide advice and guidance to support the care of frail trauma patients who will be treated by the Emergency Department team.

The enhanced GEMS will operate 8am – 8pm, 7 days a week. Extended to better align to Emergency Department opening hours and moving from 5 days a week. Mon – Fri GEMS will be GEMS consultant led; weekend cover will be provided by an autonomous frailty practitioner overseen by Emergency Department consultant. The inclusion criteria for GEMS are all acutely ill older people, with frailty and complex care needs [frail major patients are excluded].

Appropriate patients will be directed from the Emergency Department to GEMS. Direct referrals to GEMS will be accepted from GPs, the Weston Frailty Coordination Hub and other Ageing Well services.

Following thorough CGA, diagnosis and discussion with the patient, and the administration of any initial treatment needed, GEMS can then agree on the next steps in a patients' pathway of care. This may involve discharge to community where no further care is required, referral to community teams to support the patient at home during ongoing recovery, admission to the Older People's Assessment Unit or Care of the Elderly wards. Figure 14 below shows next steps in GEMS care pathway.

*Figure 14 - Next steps in GEMS care pathway*


The GEMS team will also provide a frailty Same Day Emergency Care for appropriate patients on specific care pathways and to treat as many people as possible without hospital admission. This might include frail patients with:

- Abscesses
- Community acquired pneumonia
- Urinary disorders
- Gastroenteritis

The GEMS care model will be delivered by a multidisciplinary team, including medical, nursing and in reach from pharmaceutical, therapeutic, and diagnostic teams. This integrated workforce approach will support the delivery of coordinated, safe and high-quality care for patients.

Alongside the enhancement of the in-hospital Geriatric Emergency Medicine Service NHS@Home investment is funding a GEMS@Home consultant post. This consultant will be part of the WGH in-hospital GEMS team and help support the rapid assessment and MDT management for frail people who can be safely managed at home using a blend of remote monitoring and in-person care and treatment. This approach allows patients to get the care they need at home safely and conveniently, rather than being in hospital.

### 4.1.5 Older People's Assessment Unit

There is a 'Golden Window' of opportunity during a frail patients' first three days in hospital [72 hours] to influence care plans, provide assessment and treatment and to prevent longer lengths of stay. The OPAU will target this 'golden window' of opportunity and facilitate rapid clinical assessment, investigation, and interventions to support early discharge, reducing patients' time spent in hospital.

> '*One study highlighted that 65% of older people were deconditioned after just 48 hours of being of in hospital and of those 67% failed to improve before discharge and 10% deteriorated further' Brian Dolan, Nov 22 Twitter*

The OPAU will provide the highest quality care for the frail older patients admitted on the medical take at Weston General Hospital. The guiding principle will be the use of 'Comprehensive Geriatric Assessment' – a multidisciplinary diagnostic process to determine a frail older person's medical conditions, mental health, functional ability, and social circumstances. The purpose is to develop and carry out a coordinated and integrated plan for treatment, rehabilitation, support and long term follow up. The CGA process will underpin the care that will is offered on the OPAU.

Patients on the OPAU will be cared for by a multidisciplinary team including in reach from physiotherapy and occupational therapy, and in reach from social services. This should speed up their discharge from hospital and put strategies into place to try and avoid unnecessary admissions in the future.

The OPAU will be a part of the frailty medical team that works across the Care of the Elderly wards, where doctors as part of an MDT workforce will manage new patients that enter the service. MDT working with the Care of the Elderly ward is fundamental to the transformation required to older peoples' services within Weston General Hospital.

If the patient's stay is likely to be longer than 72 hours, for medical or other reasons, then their care is transferred to one of the Care of the Elderly wards as quickly as possible to maintain patient flow on OPAU.

Further detail on each clinical component is set out in Appendix 3. This includes the service inclusion criteria, operating hours, workforce, and phasing.

### 4.1.6 Creating a sustainable workforce model that delivers the change

Phase 1 HW2 will secure a firm foundation for the transformation of Weston Hospital to deliver a new model of care meeting the needs of the local population. Investment in key services and staff groups will bring care forward to the front door of the hospital and improve interface with community admissions avoidance services seeking to ensure that patients are provided with front loaded input from a multi-disciplinary team on first contact to prevent admission either for people who will be best cared for at home or where an admission has previously been required to wait for access to services.

The medical, nursing, and allied health professional workforce will be enhanced across the new model of care increasing capacity in the Emergency Department and the new short stay units. This will enable the safe and efficient delivery of care in line with standards and

service requirements, including the staffing of resilient and sustainable workforce rotas and setting the foundation stones for future development.

Rapid access to diagnostics is a critical component of the Phase 1 service improvements. Radiology capacity and service levels will be increased across the imaging modalities, securing rapid access to diagnostics, faster diagnosis, and treatment times. This increase in capacity will ensure that patients aren't admitted to an inpatient bed while they wait for a diagnostic assessment but are instead diagnosed and treated on the same day before returning home.

Some professional groups, such as therapies, and pharmaceutical, are starting from a low workforce base. These teams have been focused almost exclusively on inpatient care with limited capacity to engage with the front door. The introduction of these workforce groups in the Emergency Department will support the delivery of the new model of care, giving patients more options, better support, and properly joined-up care at the right time in the optimal care setting.

Therapeutic in reach support will be enhanced to deliver optimum, safe, and effective services. These teams will be situated within the hospital and provide in reach support across all Emergency Department and short stay units. Therapeutic staff will undertake activities including expert assessment, requesting, and interpreting investigations, managing soft tissue injuries, and providing advice on treatment, freeing doctors to manage more complex conditions and increasing flow across the Department.

Pharmaceutical support will be enhanced providing quick access to medicines expertise, supporting the efficient diagnosis and treatment of patients. This dedicated team will have a significant impact on admission, flow, and patient safety. The 2019 WGH CQC report stated, 'ensure pharmacy staffing levels meet demand and Carter model hospital indicators, and therefore, protect patient safety'. The increase in pharmaceutical capacity will ensure WGH better meets demand and Carter model hospital indicators.

Consultant teams are also under-pressure, as set out within the case for change. Shortages in some staff groups mean that doctors at WGH work more weekends, are on call more and carry more risk than their counterparts in neighbouring hospitals. This isn't resilient nor does it attract a sustainable workforce fit for the future. Higher staffing ratios across the professional groups will increase job satisfaction, reduce clinical risk, and increase staff retention and recruitment rates to deliver the future model.

This care model isn't about increasing activity rather front-loading diagnostics and treatment, staffing enhanced services that are open longer, to prevent admission, reduce length of stay and improve patient outcomes.

Table 13 below sets out further detail on the new workforce model and the benefits it will deliver.

*Table 13 - Workforce investment and benefits*

| Additional workforce proposed | Increased service level delivered | Benefit |
|---|---|---|

| | | |
|---|---|---|
| Increase in Emergency Department consultants [2xWTE] | Increased cover to run a more sustainable workforce rota<br><br>Composed of the following:<br><br>• 2 consultants on an early [Mon- Fri]<br>• 2 consultants on a late [Mon to Fri]<br>• 1 consultant covering SDEC [Mon to Fri pm]<br>• 1 consultant on an early [Sat – sun]<br>• I consultant on a late [Sat – Sun]<br>• 0800-00 on call rota of 1:12<br>• Weekend rota of 1:6<br><br>Consultant cover will be 16 hours 7days a week. | • Provides a sustainable and resilient workforce rota.<br>• Supports recruitment through reducing on call/weekend rota to 1:6 which is more attractive in a highly competitive market<br>• Reduces reliance on agency consultant staffing<br>• Provides more senior decision-making clinical time across ED and SDEC to support effective streaming to pathways, reducing time to be seen by a clinician, enabling earlier treatment and discharge from ED and focussing on admission prevention and achieving 20% of patients receiving Same Day Emergency Care. |
| Increase in acute medical consultants [2xWTE] | Increased cover to staff a 7 day a week consultant rota covering the Acute Monitoring Unit and SDEC.<br><br>6 x AMU acute medical consultants will provide the following leadership and cover:<br><br>1 x AMU consultant Mon to Fri – 9am to 5pm<br>1 x SDEC consultant Mon to Fri – 11am – 7pm<br>1 x consultant Sat to Sun 9am – 5pm | • Increase medic to bed ratio bringing care standards closer to neighbouring hospitals<br>• Increase of 2 acute medics across SDEC and AMU to a total staff cohort of 6 to ensure sustainable provision of 7 day a week service<br>• Consistent service will prevent admission and variable processes supporting more efficient management of resources to prevent backlogs occurring in pathway creating 'crunch' points eg Monday morning<br>• Reduces risk of high turnover in staff expected increase in retention and resilience of service |
| Increase in middle grade doctors. [2.43 WTE] | Increase in middle grade doctors to safely staff the Acute Monitoring Unit overnight. | • 15 middle grade doctors are required to safely open an Acute Monitoring Unit overnight with resilient and sustainable rota (5-line rota). Increasing this level supports recruitment and retention by enabling expansion of the CESR programme for international doctors; international recruitment is a key foundation for the recruitment strategy for HW2 |

| | | |
|---|---|---|
| Increase in Physician Associates [3xWTE] | | • Introducing new roles to Weston Hospital is key to developing resilient and sustainable services building a more modern and diverse workforce that is resilience, dynamic and fit for the future<br>• Supports development of stable team structure reducing reliance on staff such as junior doctors who rotate frequently<br>• PAs will free up senior clinical decision-making time to focus on complex procedures resulting in faster care and treatment for patients by providing procedural support, including diagnosis and assessment, across the Emergency Department services including Geriatric Emergency Medicine Service [GEMS] and Same Day Emergency Care. This will help free-up consultant time, enabling them to focus on more complex procedures. |
| Increase in geriatric emergency medicine consultants [2xWTE] | Increased capacity to cover 7 days a week Geriatric Emergency Medicine Service [GEMS consultant cover Mon – Fri] | • GEMS provision to increase from 5 days a week [8.30am to 17.30] to 7 days a week [8am to 8pm] service.<br>• Significant increase in the number of frail older patients who can be assessed and treated by the GEMS service.<br>• Joint working across community and acute services will be exemplified by GEMS with outreach and advice and guidance supported to primary and community services<br>• Diversification of workforce to include ACP/ANP- led weekend GEM service supports resilience<br><br>• GEMS team will operate 8am – 8pm, 7 days a week.<br>• Mon – Fri GEMS will be GEMS consultant / senior Dr led<br>• GEMS will be ACP/ANP led at weekend with escalation to ED Consultant if needed |
| Increase in geriatric consultants [2.75xWTE] | Increased capacity to run a 5 day a week rota covering the new Older People's Assessment Unit. | • Older Persons Assessment Unit is a new service, reducing length of stay for frail older people to <72hours preventing admission and risks of deconditioning during prolonged hospital stays<br>• 2.75 WTE increase in Geriatric consultants will ensure a 5 day service can be operated at the front door working in partnership with GEMS, Care of the Elderly wards and community services<br>• Weekend consultant cover to OPAU will be provided by Care of the Elderly ward consultants<br>• 7-day focus on admissions of <72hours will reduce admissions to long term bed base, |

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| | | support Home First culture and aid flow through the hospital |
| Increase in radiologists [2.24xWTE] | Increase in capacity to ensure rapid access to diagnostics unlocking faster diagnosis and treatment times. This is a key component of Phase 1 service improvements and the ability to turn patients around quickly at the front door. | • Enables same day investigations and faster turnaround times for reporting increasing the number of patients diagnosed treated and discharged on the same day<br>• Expands capacity to 7 day service preventing needless admissions overnight/weekend to wait for Monday morning tests<br><br>Increase in cover:<br>• An extension in hours Mon – Fri from 9am – 6pm to 8am to 8pm [an additional 2.30hrs per weekday]<br>• An extension in hours on Sat from 1pm to 4pm to 8am – 2pm [an additional 3 hrs cover on Sat mornings]<br>• Introduction of Sunday working 8am – 2pm<br>• The increase is based on a consultant radiologist being onsite 8am – 8pm Mon to Fri and 8am – 2pm Sat to Sun. |
| Increase in nurses [8.14 x WTE GEMS, 6.2x WTE SDEC] | Increase in nursing capacity to support the enhanced Geriatric Emergency Service and Same Day Emergency Care. | • Will provide cover to the enhanced Geriatric Emergency Medicine Service, which will move from a 5 day a week service to a 7 day a week service<br>• Will provide enhanced cover to Same day Emergency Care, which will be extended to cover longer opening hours aligned with Emergency Department, as set out below.<br><br>GEMS will be enhanced to provide the below service level:<br>• GEMS team will operate 8am – 8pm, 7 days a week.<br>• Mon – Fri GEMS will be GEMS consultant / senior Dr led.<br>• GEMS will be ACP/ANP led at weekend with escalation to ED Consultant if needed<br><br>SDEC will be enhanced to provide the below service level:<br>• 8am – 10pm 7 days a week<br>• [Current SDEC hours of operation are relatively ad-hoc, based on the availability of an un-resilient workforce].<br><br>• The increase in capacity will be across a range of roles and includes additional education capacity with a band 6 practice educator role. |

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| Increase in Therapists including Occupational Therapy and Physiotherapy<br><br>[12.52 x WTE]<br><br>Increase in pharmaceutical staff [3xWTE] | Increase in therapeutic in reach support to enable multi-disciplinary working and optimum, safe, and effective services. | • These teams are starting from a historically low workforce base, focused almost exclusively on inpatient care.<br>• Increase will support the delivery of the new model of care, giving patients more options, better support, and properly joined-up care at the right time in the optimal care setting.<br>• The proposed therapist workforce is the minimum number required to provide 10 hours a day - 7 days a week service at Weston ED.<br>• New roles are senior therapists based on the risk appetite and the need for safe decision making for admission avoidance.<br>• Dedicated pharmaceutical support will provide quick access to medicines expertise, supporting the efficient diagnosis and treatment of patients.<br>• These dedicated teams will have a significant impact on admission, flow, and patient safety.<br><br>Moving forward these roles will increase admissions avoidance releasing inpatient capacity [and may create a bridge of staffing between the phase 1 and phase 2 full business cases]. |
| Increase in radiographers [18.91 x] WTE | Radiology staff are enhanced and reorganised to focus on radiography at the start of the patient journey within the new enhanced 'front door' model of care. This will ensure rapid access to the radiology input required to support the delivery of SDEC, GEMS and acute monitoring.<br><br>This is a key component of Phase 1 service improvements and the ability to turn patients around quickly at the front door- 7 days a week between the hours of 8am and midnight for all front door services and after Midnight to 8am for ED. | This increase will enhance the service level provided as set out in the bullet points below:<br><br>• MRI: an extension in hours Mon – Fri from 9am – 5pm to include 8am – 9am [an additional 1hr per weekday on site presence}<br>• MRI: an extension in hours Mon – Fri from 9am – 5pm to include a new on call services 5pm to 9pm on call [an additional 4hrs per weekday on call],<br>• MRI: a new on-call service from 8am – 9pm on Sat and Sun and BH's [an additional 13hrs per weekend or BH day on call]<br>• CT: an additional shift to current Mon – Sun from 8am to 8pm to include an additional shift of 4pm to midnight [an additional 8hrs per day on site presence]<br>• CT: on call service 8pm to 8am – no service level change<br>• Plain Imaging: an extension in hours to current Mon- Fri 9-5pm to include 8am – 9am and 5pm to midnight [an additional 8hrs per weekday]<br>• Plain Imaging: an extension in hours to current Mon- Fri 9-5pm to include 8am to Midnight on Sat and Sun and BH's [an additional 12hrs per weekend or BH day]<br>• Ultrasound - no service level change [Mon - Fri 9am – 5pm] |

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| | | • Radiology support staff – additional support required to support the additional modality opening hours described above for MRI/CT and Plain imaging<br><br>• Access to MRI radiographer on call Mon – Fri 5pm to 9pm and Sat, Sun and BH 8am to 9pm will support urgent/emergency imaging for query Cauda Equina Syndrome (CES) patients. Removing the requirement to transport them to Bristol for imaging, ensuring a prompt diagnosis and more rapid onward referral to NBT should this be required or discharge home with appropriate care plan. This will bring the service at Weston in line with that provided Front door at the BRI. |

### 4.1.7 Improve and increase surgical efficiencies

The full Healthy Weston 2 OBC releases non-elective bed capacity in WGH for a new Surgical Centre of Excellence dedicated to the delivery of surgical procedures. This new Centre will build on Weston General Hospital's current strengths in general and orthopaedic surgery and seek to expand day case provision in specialist breast, gynaecology, ophthalmology, and urology surgery, although the detail is still to be worked through as part of the Phase 3 business case and wider system elective planning.

In advance of the Phase 3 business case, work is being undertaken to improve and increase existing surgical productivity in WGH. This will ensure that existing theatre capacity is able to perform high quality surgeries with minimal waste, expense, and effort, ultimately leading to full optimisation of operating time, and increased activity. This improvement and increased theatre productivity will set the platform from which the Surgical Centre of Excellence at Weston will build. The investment into the Phase 1 model will provide reduced pressure on flow and ensures the required bed base is 'protected' to maximise theatre capacity.

### 4.1.8 Digital initiatives

There are several Digital Initiatives supporting integrated care in WGH Emergency Department, this includes:

**UHBW Single electronic patient record**
The integration of Weston General Hospital with UHBW has provided a single electronic patient record across all the UHBW hospital sites and this will include NBT in coming years, following the decision of that organisation to migrate its electronic patient record to System C.

These, and other digital solutions, that enable clinicians to have "sight" of patients that are in other locations will enhance the safety of the Weston General Hospital Site, ensure that people are not moved between hospitals unless necessary and support integration with primary and community services.

**Improving Local Services: Virtual Ward / GEMS@Home**

Remote monitoring solutions are being stood up to support the safe management of higher acuity patient care in the community including the GEMS@Home programme. This programme will support people to be looked after in their homes with the support of an integrated clinical team monitoring their clinical condition remotely.

### 4.1.9 Quality Impact Assessment [QIA]

A full quality impact assessment has been carried out that considers the positive impact expected on healthcare quality of the Phase 1 improvements and ensures that any known or expected negative impact on quality has been robustly assessed and understood and that any potential unintended negative consequences have been identified and mitigated. The full QIA is set out in Appendix 4.

A clinical standards document found in Appendix 5 also describes how the Heathy Weston 2 clinical model will improve compliance of the clinical services affected with national clinical quality standards at Weston General Hospital.

### 4.1.10 2022/23 winter plans

In preparation for Phase 1 implementation and to help reduce winter pressures the first step in the Phase 1 enhancements have been introduced and funded on a short-term basis (to March 2023) through winter funding. This includes SDEC pathways and rapid patient reviews, enhancement to the Ambulatory Emergency Care (AEC) Unit and the introduction of ED Observation beds. These early Phase 1 improvements offer the opportunity to further test the model and to collect data on benefits realisation.

### 4.1.11 Identifying the improvements needed through bed and activity modelling

To plan the service improvements needed in a more effective way a bed and activity flow model was commissioned to better understand the scale of the challenge, impact on flow of service reform and non-elective bed need at Weston General Hospital. This was developed by clinicians from across Somerset and BNSSG and agreed by the Clinical Design and Delivery Group, and the Healthy Weston Steering Group for the full Healthy Weston 2 model.

The change proposals set out within this Phase 1 Case are grounded in the outputs from this bed and activity flow model; ensuring the hospital and wider system have a good understanding of the impact of change. To support the development of this business case the model was updated with 21/22 activity data. Table 14 below sets out the expected Phase 1 bed and activity outputs following operationalisation of the HW2 Phase 1 model of care.

*Table 14 - Expected Phase 1 bed and activity outputs*

| | 21/22 bed and activity model outputs per year | | |
|---|---|---|---|
| **Summary Output Table** | **21/22 Baseline** | **Phase 1 (Option 2)** | **Full Model** |
| Weston ED Attendances (inc. Stabilise & Transfer) | 45,853 | 45,853 | 45,547 |
| Stabilise & Transfer Non-Weston ED Presentations | - | - | 3,030 |
| Weston NEL Admissions | 13,243 | 12,889 | 11,247 |

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|---|---|---|---|
| COE Ward NEL Admissions | 8,674 | 5,046 | 3,692 |
| Long-Stay Early Discharge | - | - | 297 |
| COE Beds Excluding Repatriations | 210 | 163 | 133 |
| Repatriation Beds | - | - | 14 |
| Short-Stay Beds – OPAU | 3 | 14 | 12 |
| Short-Stay Beds – Non-Frail Short Stay | 6 | 15 | 13 |
| Total Weston NEL Bed Need | 215 | 188 | 171 |

Table 15 below sets out the forecasted impact on patients, admissions, and beds of the 21/22 bed and activity model.

*Table 15 - Forecasted impact of Phase 1 on patients, admissions and beds*

| Phase 1 Change | Forecast Impact – patients, admissions, beds | Per day | Per week | Per year |
|---|---|---|---|---|
| SDEC GEMS AMU OPAU | Increase of non-frail patients seen & discharged through SDEC pathways | 2.4 | 16.9 | 878 |
| | Increase of frail patient seen & discharged through GEMS | 1.7 | 12.1 | 629 |
| | Increase of patients admitted & treated through Short Stay Units (LOS <1&<3days) | 9.3 | 65.0 | 3381 |
| | Net reduction of 27 escalation beds [This is a combination of both reduced LOS and admissions avoided] | | | |

It is anticipated that there will be at least a 10% reduction in Length of Stay because of Phase 1 improvements.

In addition to the improvements to admissions rates and lengths of stay, there will also be improvements to national ED targets. It is anticipated that there will be circa 10% improvement in 'time to be seen, treated and discharged' targets.

Moving forward, the assumptions and outputs from this bed and activity flow model will be tested, tracked, and reviewed as the care model is put into place. This will also ensure updated assumptions and outputs inform the development of the Phase 2 Full Business Case. Further detail of the net reduction of escalation beds is provided in Section 8.2.5.

# 5 Benefits realisation

## 5.1 Benefits realisation arrangements

*This section should confirm arrangements for identification of potential benefits, their planning, modelling, and tracking. It should also describe the framework / governance arrangements for assigning responsibilities for actual realisation of benefits post approval of the business case.*

*This section should confirm that responsibility for benefits realisation lies with the Senior Responsible Officer (SRO).*

The Healthy Weston 2 Phase 1 benefits realisation plan can be seen in Appendix 6. This has been developed alongside key stakeholders including programme clinicians, BNSSG ICB Business Intelligence and UHBW Finance, to ensure a rigorous and robust approach to benefits realisation. The benefits are based on both outputs from the Healthy Weston activity and bed model and national and local expectations.

A full benefits management approach will be put in place to ensure the outcomes and benefits of the programme are quantified, tested, realised, and reviewed. This includes an initial programme to audit and test the benefits, and assumptions behind the Healthy Weston activity and bed model, following early implementation of the Phase 1 model as part of 22/23 winter interventions.

The governance and assurance arrangements of the Healthy Weston 2 programme will ensure thorough oversight and delivery of the agreed programme benefits. Regular benefits updates will be prepared and presented to the Healthy Weston Programme Group and Healthy Weston Steering Group, who will help unblock any issues and escalate issues to the Healthy Weston Steering Group when needed.

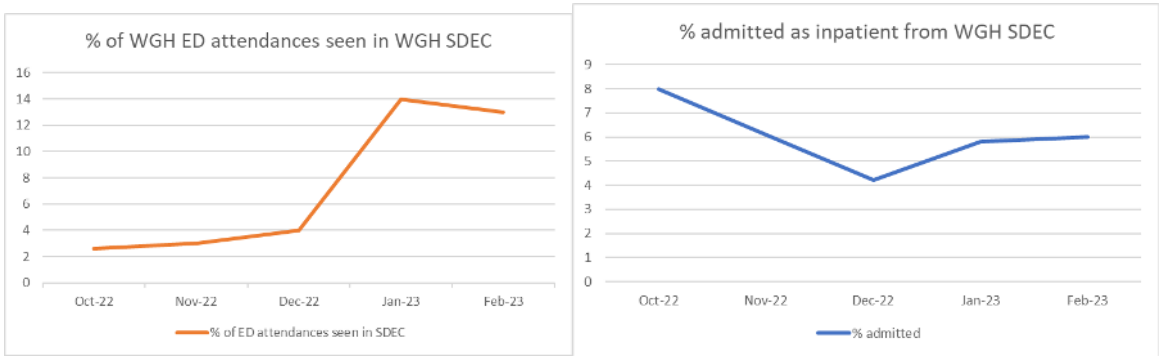
## 5.2 Benefits realisation plan

*This section should refer to the benefits register in the appendices. It should confirm how the anticipated benefits will be captured (e.g., dedicated workshops, regular review at Project Board) and indicate how they will be realised (e.g., Mobilisation / implementation project team responsibilities and Operational team responsibilities). It should confirm the process by which the benefits will be continually reviewed and updated throughout the programme / project.*

The Healthy Weston 2 Phase 1 benefits realisation plan [Appendix 6] provides the framework for which the programme will manage, monitor and assess benefits realisation throughout the operationalisation of Phase 1 improvements. Benefits are based on both outputs from the Healthy Weston activity and bed model and national and local expectations for service delivery.

Early analysis, following the introduction of Same Day Emergency Care pathways, funded via winter pressure investment, is already showing a positive difference.

*Figure 15 - % of ED attendances seen in SDEC and % admitted as inpatient from SDEC*



The figures above show a definite upward trend of the % of ED patients being seen and treated in SDEC, and a downward trend in the number of patients being admitted.

Following the planned phased implementation of Phase 1 from April 2023, key programme milestones will define the points at which specific elements of the benefits realisation plan are assessed. A process will be established to facilitate the regular sharing of key metrics over time which will enable the programme to monitor progress towards the achievement of the outlined benefits. The ongoing tracking of measures over time will also enable the programme to continually review the impact of the changes and allow plans to be reviewed and updated as required.

The Senior Responsible Officer (SRO) holds overall accountability for benefits realisation, with the day-to-day management of benefits overseen by the Weston General Hospital Director. Where any changes to the plan are required, or if action is needed to address specific elements or issues in relation to benefits realisation, this will be passed through the programme governance structures as appropriate for approval.

The process of reviewing and monitoring benefits will continue throughout the implementation phase of Healthy Weston 2 Phase 1.

# 6 Engagement

Healthy Weston 2 Phase 1 builds on the extensive engagement that has taken place over the last four years. More than 5,000 local people have influenced plans to date, with a recent period of public engagement delivered between June and August 2022 providing feedback from 890 individuals.

The programme is committed to delivering a proactive and accessible communications and engagement approach, enabling a broad range of groups the opportunity to be informed and have their voices heard in the shaping of future services at Weston General Hospital. This includes targeted activity with health inequality groups, seldom heard communities and those most likely to be impacted by the plans. The Equalities Impact Assessment found in Appendix 7 details further the approach to engagement with seldom heard communities and health inequalities groups, describing the adaptions made to ensure any activity is accessible, culturally appropriate and meeting the broad range of needs to the population of BNSSG and Somerset.

## 6.1 Engaging with clinicians

Integrated working led by and with clinicians is at the heart of the Healthy Weston 2 programme and the development and operationalisation of the clinical model for Weston General Hospital. Clinicians play a core role in the leadership, governance, and oversight of Healthy Weston 2 Phase 1 Full Business Case. Clinical leaders from BNSSG ICB and UHBW chair design and decision-making meetings and subgroups, contribute to the design and evaluation of new pathways and plans, and work in partnership with clinicians from across BNSSG and beyond, including for example with South West Ambulance Services NHS Foundation Trust and Somerset NHS Foundation Trust.

There has been a regular flow of information, briefings, and updates for all staff in UHBW and other partner organisations, including primary and community care colleagues, throughout the Healthy Weston programme, which will continue as the programme progresses.

This engagement with clinicians has ensured clinical expertise is at the heart of Healthy Weston 2 Phase 1 service improvement plans.

## 6.2 Patient, public and staff involvement

The Healthy Weston 2 Outline Business Case describes the engagement carried out to refine the Healthy Weston 2 vision, evaluation criteria and options. This included a public survey delivered in March 2022, where nearly 900 shared their views. The survey highlighted that the vast majority of people agreed that services at the Hospital need to change.

In April 2022, the North Somerset HOSP deemed that Healthy Weston 2 is a programme of continuous improvement, not a substantial variation to services. This meant that there was no legal requirement for formal public consultation prior to considering implementation. However, the Healthy Weston programme led an eight-week period of public engagement between 20 June and 14 August 2022, to gather the views of local people and organisations to help refine plans and to inform how we let people know about the changes.

## 6.3 Results from the public engagement period

Between 20th June and 14th August 2022, the Healthy Weston Programme asked members of the public, staff, people who might be particularly affected and those who had not been involved before to help plan practical next steps for Healthy Weston 2.

A total of 890 people shared their views. A summary of who we heard from can be found below.

*Figure 16 - Geographic area of respondents and respondent age profile*

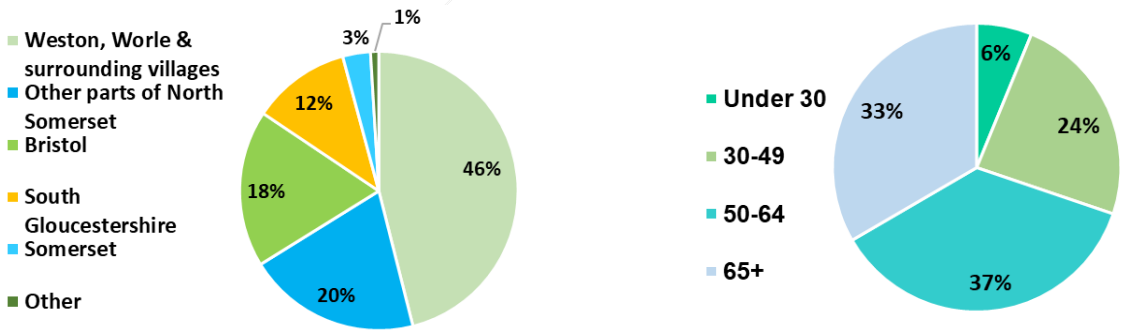



*Table 16 - Demographic characteristic of people providing feedback, where known*

| Characteristics | Percentage of respondents |
|---|---|
| NHS employee | 25% |
| Ethnic Minority Groups | 10% |
| Parent of a child under 18 years | 14% |
| Disabled person or person with a long-term condition | 27% |

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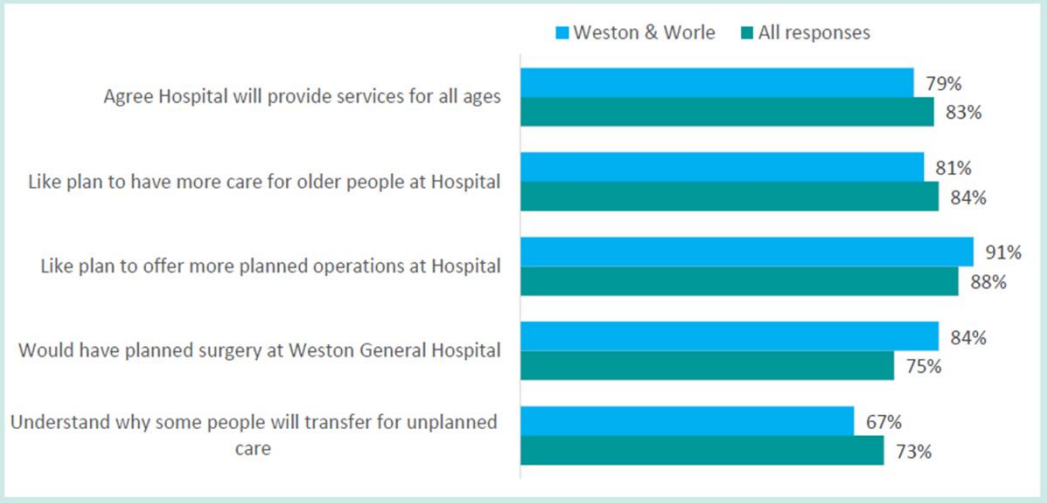
| Member of the LGBTQ+ community | 4% |

The key findings included:

- Of 376 responding to a survey question, three quarters thought the plans would improve Weston General Hospital (73%)
- Two thirds of people living in Weston, Worle and surrounding villages thought the plans would improve the hospital (68%). Even more people from other parts of North Somerset (87%), Bristol (83%) and South Gloucestershire (90%) thought this.
- People were equally positive no matter what their age, gender or ethnicity; whether or not they had a long-term health condition or disability and whether they were NHS staff or members of the public.

*Figure 17 - Overall feedback on the Healthy Weston 2 programme plans from public engagement period*




While there was positive feedback about the plans, people also shared their views on the extra travel that could affect up-to eight patients per day. They commented on the physical, emotional, and financial challenges that further journeys could bring, not just on the patients but for loved ones and carers too. People said that technology, such as video call equipment, could help to overcome this, but also shared thoughts on improving transport links.

People also said that more could be done around communicating the plans, with one in four people not clear on what was being proposed and many saying that more needs to be done to enhance the reputation and trust in Weston General Hospital.

The full summary of what we heard during the engagement period can be found in the engagement themes report in Appendix 8. The outcomes of the engagement period are being used to inform plans for implementation of Healthy Weston 2 Phase 1, alongside informing how we communicate the changes to staff and public.

## 6.4 Strengthening engagement and involvement through programme structures

To support the engagement process and to strengthen levels of involvement, Healthy Weston programme governance includes:

- A Staff Reference Group (SRG) established since February 2022.
- A Patient and Public Reference Group (PPRG) established between February and September 2022
- Two patient representatives who are part of the Healthy Weston Programme Group
- Healthwatch representative on the Healthy Weston Steering Group

Further details on the SRG and PPRG can be found in the Healthy Weston 2 Outline Business Case.

## 6.5 Wider communications and engagement

An 'early socialisation' approach to communications is being implemented providing staff, stakeholders (including MPs and councillors) and the public with a consistent core narrative about Healthy Weston 2. Existing channels and opportunities are being utilised to share information widely, for example through intranets and websites, newsletters and bulletins, social media channels and conventional media, as well as through existing meetings, forums, networks, and interest groups.

Feedback mechanisms have been and will continue to be put in place through Phase 1 implementation, including staff meetings, discussion, correspondence and meetings with Health Overview and Scrutiny members and other elected members such as MPs, and outreach work; to ensure we are capturing a wide range of views from a wide range of people.

Staff at UHBW, particularly those working at Weston General Hospital and specifically those across the trust most likely to be impacted by any proposed changes, have had a regular opportunity to be involved and engaged in discussion. There has also been a regular flow of information delivered by the trust as the programme has progressed.

Engagement has also been extended to GPs and primary, community care and mental health teams in Weston and the surrounding area to ensure their views have been fully considered, and that they continue to be informed as Phase 1 changes are implemented.

## 6.6 The feedback that has been heard and how it has influenced plans

Table 17 below describes how the feedback gathered during the public engagement period is being considered and incorporated by the Healthy Weston programme.

*Table 17 - How feedback has influenced plans*

| What we heard | How the feedback is being addressed |
|---|---|
| **Implementation Planning** | |
| Some responses queried **the deliverability of the plans**, particularly given the reliance on integrated work with other services to enable the plans to be delivered. Worries were shard around integrated ways of working not yet being fully in place, and | When planning for future services, the Healthy Weston Programme has delivered an integrated approach, bringing together the expertise of local clinicians and providers, alongside listening to staff and public feedback. This has helped to embed |

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| that they would take time and resource to embed. People wanted to see more prevention, population health and follow-on care elements built into the longer-term plan to help increase the sustainability of services at Weston General Hospital. This included suggestions around increasing rehabilitation and outpatient care at Weston, strengthening access to primary care, and making sure that there was good follow-on care at home after discharge | integrated ways of working from the outset, and ensured the necessary planning and resource is applied.<br><br>Healthy Weston is part of wider system change to enable a 'Home First' approach. The aim of this approach is to shift the emphasis of health and care to care for people at home where possible, or if they are admitted to hospital, to get them back home again as soon as possible.<br><br>It forms part of a local and national drive to improve patient flow within the health and care system, and to ensuring an efficient system where patients are discharged as soon as they are well enough, improving their outcomes and reducing risk of infection.<br><br>Alongside a series of Home First programmes including One Weston Ageing Well, One Weston Community Mental Health, One Weston General Practice transformation, Discharge to Assess (D2A), BNSSG Urgent and Emergency Care transformation and Virtual Wards, Healthy Weston is supporting a new service model in which patients get better support, and properly joined up care at the right time in the optimal care setting.<br><br>This integrated approach will continue to be adopted by the programme throughout the delivery of the plans, working closely with local and national initiatives to provide the best outcomes for patients and to provide sustainable services at Weston General Hospital. |
| People shared their views on the **extra travel that could affect up-to eight patients per day as part of Phase 2**. They commented on the physical, emotional and financial challenges that further journeys could bring, not just on the patients but for loved ones and carers too.<br><br>Practical suggestions to mitigate this included:<br>• Liaising with transport providers to campaign for direct pubic transport links between hospital<br>• Providing a free or subsidised shuttle between sites for patients and visitors | Overall, the Healthy Weston 2 plans mean most people will travel less. Weston General Hospital will provide thousands more planned operations each year, so fewer people will need to travel to other hospitals for surgery, or for outpatient appointments before and afterwards, or to visit people having surgery in another hospital.<br><br>The health service does not have control over public transport and cannot pay for visitor travel. However, there are some things that are being done to reduce the impact of travel: |

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| • Providing free and readily available parking<br>• Using technology, such as video call equipment, to connect people with loved ones | • Reducing the number of people who need to be admitted to hospital by strengthening community services and same day emergency care<br>• Providing a patient transport service to neighbouring hospitals for those who need to transfer<br>• Signposting visitors to help with travel and transport to hospital if they are eligible.<br>• Considering ways to help people stay in touch if people cannot visit. For example, providing laptops or tablets to help people in hospital speak with loved ones on video<br>• Meeting with transport providers and local authorities to discuss bus routes and timetables<br>• Making sure that people who are transferred to other hospitals can come back to Weston General Hospital after their specialist care, so they can finish their inpatient stay closer to home if possible<br><br>The impact of travel on staff has been covered extensively as part of a formal staff consultation with a number of financial and flexible working options in place to accommodate the need to travel and cost of taxis. There is also a Trust wide bus being put in place to provide transport between hospital sites. |
| The engagement period included a question asking **what practical things could health care services do to help if people and visitors are at a hospital away from home**. In addition to the feedback noted previously on travel and communications, common practical suggestions included:<br><br>• Providing access to laundry services, newspapers and toiletries if people have no visitors to bring things. This may include having volunteers visiting wards to provide books, papers and conversation<br>• Having longer visiting hours<br>• Providing support for loved ones such as signposting to subsidised or inexpensive accommodation for loved | The Healthy Weston 2 Phase 1 model will have minimal impact on the number of patients accessing care away from home. It is recognised that Phase 2 and Phase 3 will have significantly more impact, and further detailed work will be undertaken to understand and plan how the programme can best mitigate any impact this may have. This includes considering the feedback shared during the public engagement period into the planning process.<br><br>Digital enhancements across hospital sites in Bristol, North Somerset, South Gloucestershire and Somerset also means that patients and loved ones can connect more readily via remote channels, with additional improvements in Wi-Fi provision and tech support being delivered. The Healthy Weston Programme will continue to work collaboratively with local hospital sites |

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| ones, proving family/meeting rooms outside the wards and catering facilities | to address the challenges of accessing care away from home, supporting an integrated approach to supporting patients and loved ones. |
| **Communications** | |
| Part of the engagement exercise involved local people sharing their views on **how we should communicate with them about the service improvements.**<br><br>The most frequently mentioned suggestions were:<br>• Using local media (tv, radio and newspapers), social media campaigns and placing leaflets and posters in local venues.<br>• Direct communication methods including posting leaflets into every letterbox and emailing and/or texting everyone that we hold contact details for.<br>• Other suggestions included working with others, such as using partner newsletters and communicating with health and care staff so they can share messages with patients.<br>• **Staff also fed back the importance of keeping them informed** | The outcomes from the public engagement period have been used to inform the communications plan for Phase 1 implementation and will continue to be built upon for the subsequent Phases. This includes exploring and utilising the channels suggested such as local media and direct communications, as well as applying targeted communications approaches with seldom heard communities and health inequalities groups. The public engagement period enabled the Healthy Weston Programme to develop relationships with local communities across BNSSG and Somerset, which will continue to be built upon as the programme continues.<br><br>A dedicated plan to inform and involve staff through Healthy Weston 2 implementation will be designed by UHBW communications leads. This builds on the dedicated programme of staff activity to date, including staff drop-in sessions, programme updates at team meetings, communications through the staff intranet and newsletter, and printed materials distributed around the Hospital site. The staff communications and engagement plans will be closely linked to the implementation plan, correlated with key milestones and delivery dates to ensure staff are aware of any changes in advance and have the opportunity to share any feedback. |
| Another aspect of the engagement period included analysing the description of the plans. While most people said we described the plans clearly, they also told us:<br><br>• **More clarity is needed on which services will be available** at Weston General Hospital, including who these are for e.g. maternity services and children's services<br>• **To be clearer on the specifics within the plan**, such as defining what we consider as 'older' or 'frail', what a centre of excellence is, and more | Healthy Weston 2 will be delivered over three phases, with each phase bringing about a range of enhancements to specific service areas.<br><br>Across each phase, communications experts will lead the development of distinct messaging, clearly outlining what the plans will deliver and which services will be available at Weston General Hospital. This also takes on board feedback from the public engagement period around defining specific references e.g 'centre of excellence' and 'frail', with plans in place to test future messaging with public and staff |

| | |
|---|---|
| details about how patient transport will work | stakeholders to ensure accessibility and transparency. |
| Many told us that more needs to be done to **enhance the reputation and trust in Weston General Hospital.** This would help encourage people to choose Weston General Hospital for planned surgery and build trust in the quality and safety of all services. Suggestions included an extensive promotional campaign to showcase the hospital, alongside using patient stories about experience of care, sharing data about waiting times and surgical outcomes compared to other sites and using photos so people can see what the hospital looks like. | UHBW is committed to working with colleagues, patients and the public to celebrate their workforce, highlighting achievements and demonstrating their journey of improvement, both internally and externally, ensuring staff feel recognised and local communities informed, enabling them to act as ambassadors for the Trust.<br><br>The Trusts progress and performance, alongside their achievements, are regularly reported and discussed at public Trust Board meetings. Key milestones in their improvement journey will continue to be shared publicly alongside celebrating awards and successes, striving to be better and taking ownership of living their values, representing UHBW as the best place to work and to receive care.<br><br>This will be evident through press releases, recruitment campaigns, social media and our engagement work with stakeholders locally, regionally and nationally. |

# 7 Workforce strategy and recruitment plan

## 7.1 Healthy Weston 2 Phase 1 Workforce Strategy

The workforce required at Weston General Hospital to operate the new service model has been based on the 2021/22 bed and activity model. Workforce requirements can be scaled in the same way as the activity changes, however there are important adjustments that have been included to ensure that the national standards for clinical services can be met under the new model set out in this Business Case.

This workforce plan relates to Phase 1 of Healthy Weston 2 which focusses on introducing and enhancing the following urgent care services:

1. SDEC
2. GEMS
3. AMU
4. OPAU

### 7.1.1 Approach

A Workforce subgroup lead the development of this plan and reported into the Healthy Weston Programme Group. Its purpose was to support the design, development, and delivery of a sustainable workforce model that enables the new clinical model set out within this Full Business Case.

The membership of this group comprised of:

- UHBW Chair (Associate Director HR Operations),
- UHBW Clinical Representation (Deputy Medical Director, Deputy Chief Nurse, Weston Division Therapies Lead)
- UHBW HR / Finance / Communications/ (HR Business Partner, Head of Workforce Planning, Senior Financial Planning Accountant, Communications Manager)
- BNSSG Support (Head of Programme, Programme Director, Workforce Redesign Facilitator)

The group met bi-weekly from May 2022, initially supporting the development of the Outline Business Case; and then to develop the workforce plan for Phase 1 implementation. Nominated professional leads from across UHBW were identified and have assessed and determined the workforce requirements based on the clinical models for Phase 1 for their own professional areas. In addition to this group, specific workforce planning sessions with key stakeholders considered all plans in October and November allowing plans to be further refined.

The final workforce numbers were tested with professional leads through January 2023 to gain sign off in a sequence of challenge sessions. This enabled any final changes to be incorporated into the workforce plan.

The Finance Lead assessed current staffing baselines based on 21/22 actuals – identified funding and actuals (staff in post) via ledger information and undertook further discussion with professional leads to understand the 'on the ground' deployment of staff against establishment and the true vacancy position.

Further assessment of current workforce verses future requirement has created the final workforce plan. This includes additional expansion to Phase 1 plans and any required recruitment to existing vacancies.

Understanding of this baseline workforce position is essential in understanding how existing staff will shift into the roles identified in each new clinical model, to staff appropriately according to any changes in activity or working hours and ensure that posts are not duplicated therefore over inflating the overall workforce ask. This process led to the numbers in the workforce plan and those in the recruitment plan not exactly aligning (in some cases) as the resourcing into roles will have taken account of existing staff and delegation of tasks and activities that do not require recruitment to a specific new role. In some areas, this has been a more difficult task as roles sometimes work across multiple areas and this makes it hard to split out, but this has been done where possible. Where this has not been possible assumptions have been made and are indicated accordingly.

Inclusion of unfilled/vacant posts is essential to the development of the financial case and workforce plan in order that all funding is available for the workforce model and to drive the ambition to recruit to establishment.

Identification of resourcing approach, i.e. if a role is staffed substantively, via a locum or agency has also been considered and the recruitment plan will consider how and when roles shift from temporary to permanent staffing in order that efficiencies can be made as outlined in this full business case.

Go live date is stated as April 2023, therefore the recruitment plan needs to reflect the time taken to recruit roles into role with this date in mind and which posts need to be in place on day one and which can be phased in after Q1 2023.

## 7.2 Workforce assumptions driving this workforce plan

- Clinical model states that SDEC / AMU will be aligned to ED opening hours 8am – 10pm,
- The medical workforce is resourced to midnight to allow for 2-hour post closure mop up.
- GEMS have put forward a future workforce model based on 8am – 8pm hours of operation.
- Therapies have put forward a future workforce model based on 8am – 10pm, aligned with ED opening hours.
- Radiology have put forward a future workforce model based on clinical demand, benchmarked against current operating hours and demand across both UHBW sites
- It is assumed that the existing workforce is sufficient to cover Hospital @ Night rotas in the Phase 1 FBC. This will need to be re-considered as part of Phase 2 alongside changes to inpatient medical care.
- OPAU workforce model for medical and nursing is based on the BRI's existing OPAU model.

## 7.3 Workforce expansion by professional group

### 7.3.1 Medical Workforce

The baseline staffing has been assessed from 2021/22 baseline costing aligned to the financial baseline. Assumptions have been made to assess and include the equivalent whole time equivalent (WTE) resourced through locum/agency staffing which is included within the financial baseline costing.

Front Door/ED consultants include an increase to meet the Royal College of Emergency Medicine (RCEM) guidelines on staffing for an ED with 1 WTE consultant per 3,600-4,000 attendances. Consultant cover will be 16 hours 7days a week. The ED consultants will also provide oversight of AMU.

*Table 18 - Summary expansion of the medical workforce*

| Medical | ED | GEMS | AMU/SDEC | OPAU | Radiology |
|---|---|---|---|---|---|
| **Consultants** | 2 | 2 | 2 | 2.75 | 2.24 |
| **Middle** | 2.43 | 0.87 | 1.95 | | |
| **Junior** | | | | | |
| **Physician Associate** | 3 | | 0.09 | | |

#### 7.3.1.1 Emergency Department, GEMS, AMU/SDEC, OPAU Medical Staff

Medical staffing numbers are based on the future state of 12 WTE consultants. This is an increase of 2 WTE against March 2022 baseline. It should be noted that due to current vacancies and ongoing recruitment challenges, the existing consultant workforce of 10 WTE comprises of 3.75 WTE who are substantive staff. 5.38 WTE are locum medics and 2.87 WTE are agency which outlines the current resourcing approach. The financial model reflects this. It is assumed that this approach will continue for year 1 therefore no agency savings, with the plan to switch to substantive resourcing as reflected in the recruitment plan from year 2.

Emergency Department middle grade cover is comprised of 15 middle grades, 12 juniors and 3 Physician Associates (PA's) which has been tested and agreed at senior clinical level. Based on current staffing, an additional 2.43 WTE middle grades are required and 3 WTE PA's.

The future medical GEMS workforce requires 2 WTE consultants, alongside 2 WTE middle grades / Associate Specialists. There is no additional requirement for middle grade staff and junior roles as these will overlap and rotate from ED staff. Middle grades would rotate on a principle of 1:3 ED: GEMS and juniors would be allocated as required

AMU/SDEC future model requires 6 WTE consultants therefore requiring an additional 2 WTE against current staffing. To reflect current resourcing approaches this is costed as 3 substantive, 1 locum and 2 agency. Middle grade requirements rise to 6 WTE, with 1 assumed to be agency.

The calculations for the future OPAU workforce requirements are based on the workforce model at Bristol Royal Infirmary (BRI). The OPAU medical consultant future state requires an additional 2.75 WTE with existing 4 WTE middle and junior staffing transferring into the service with no change in numbers.

#### 7.3.1.2 Radiology Medical staffing

The increased Radiology Medical Staff requirement to support Healthy Weston 2 Phase 1 is an additional 2.24 WTE. Recruitment to Consultant Radiologist posts at Weston has been challenging for more than a decade which has led the department to make use of outsourcing to close the reporting capacity gap.

### 7.3.2 Nursing Workforce

*Table 19 - Summary expansion of the nursing workforce*

| | GEMS | SDEC | AMU | OPAU |
|---|---|---|---|---|
| **All Nursing** | 8.14 | 6.20 | 0 | 2.56 |

The workforce plan for nursing differs from numbers in the Healthy Weston 2 OBC as whilst the wards have not changed, the new services and models of care require higher staffing ratios and increased cover. This has led to the increased staffing requirements to deliver the clinical models of care.

Nursing numbers for the workforce plan covers GEMS, SDEC, AMU and OPAU and excludes the Emergency Department.

Expansions in nursing numbers across all bands reflects the increased opening hours of the GEMS service to better align to ED as well as extension of other services to 7 days per week

12.14 WTE nursing posts are required to staff the GEMS service. This is across a range of nursing grades and includes additional education capacity with a band 6 practice educator role. Expansion against existing staffing totals 8.14 WTE.

SDEC requires a workforce of 12.96 WTE of this 2.05 WTE is administrative capacity (therefore 10.91 are nursing roles). The overall expansion in nursing against existing staff is 6.2 WTE.

There is no additional staffing requirement for AMU as existing staff transfer into the new service.

As there is no current OPAU at Weston, the financial comparator for the 14 OPAU beds is the 14 beds on Sandford ward where the OPAU is planned to move to. Sandford is 24 bedded therefore a proportion of the staffing against this bed base is applied.

The required workforce for OPAU is 30.59 WTE with 2.05 identified as administrative capacity (therefore 28.54 WTE are nursing roles). These nursing roles are across all bands and includes 2.48 WTE 8a Advanced Clinical Practitioners.

The overall required nursing expansion is 16.9 WTE.

Existing staff will work across services for example an 8a matron will work across GEMS, AMU and OPAU.

The nursing skill mix does not incorporate the emerging band 4 Nurse Associates that will be completing training towards the end of 2023 and volumes of these will increase as part of the overall programme of Nurse Associate training at UHBW. This will be further developed overtime and fed into the workforce plan but will maintain the WTE within the agreed financial envelope.

In addition to substantively employed staff, we are seeking to increase the volume of support from the voluntary and 3rd sector. This will link into the UHBW volunteer strategy.

### 7.3.3 Radiology Workforce

The radiology staff working within Weston General Hospital will be reorganised to focus on radiography at the start of the patient journey within the new enhanced ‘front door’ model of care. This will ensure rapid access to the radiology input required to support the delivery of SDEC and acute monitoring.

The service will be enhanced and move to 7 days working to ensure rapid access so radiology can be provided across the week. The workforce has been strengthened to include the right mix of workforce including additional radiologists, radiographers, sonographers, and health care assistants.

*Table 20 - Summary expansion of radiology*

| Radiology | WTE |
|---|---|
| Plain film Radiology | 3.38 |
| CT/MRI Radiographer | 9.44 |
| Ultrasonographer | 0 |
| Health Care Support Worker | 4.6 |
| Administrative Staff | 1.49 |

There are difficulties with the supply and recruitment of this workforce group nationally, however a recent combination of integration with UHBW and enhanced cross site working has enhanced Weston General Hospitals ability to recruit to vacant posts within this workforce group. New innovative recruitment plans being put in place will enhance training and development to support a predominately home-grown workforce.

Development of the workforce plan for radiology staff focuses on the 3 modalities of Band 5 Plain film radiographers, Band 6 CT and MRI Radiographers and Band 7 Ultrasonographers. BI data for 2021/22 has been used in varying proportions to determine the baseline and normal shifts against each of these professions in the plan for Phase 1.

To meet the needs of Phase 1, there is an increased staffing requirement of band 5 and 6 Radiography roles. This increased capacity enables cover over the early, day and late shifts and consideration has been given to the hours of work for each modality and the known clinical requirements to deliver the new model of care. Staff baselines have been extrapolated using Business Intelligence (BI) data for 21/22 and a proportion applied of the existing staff baseline who are calculated to already be contributing to the existing service.

Health care support worker capacity is increased due to the requirement to have a HCSW on every shift and an additional 1.49 WTE of administrative staff capacity to accommodate the extended hours.

Radiology support will be available across the hours outlined in the table below

*Table 21 - Availability of diagnostic input*

| Modality | Days available | Hours available |
|---|---|---|
| MRI | Monday - Friday | 9am – 5pm with an on-call rota to 9pm and at weekends this is on-call from home only 8am - 9pm. |
| CT | Monday - Friday | 9am – 8pm<br>On call from home 8pm until 8am |
| Plain Film | 7 days a week | 8am – midnight<br>On call on-site midnight until 8am. (currently this element of on-call is being covered by CT radiographers so could be on-call from home) |
| Ultrasound | Monday - Friday | 9am – 5pm<br>Ringfenced slots provided for patients coming back the next working day for ultrasound. No cover at weekends |

### 7.3.4 Pharmacy

The total number of additional pharmacy staff required is 3 WTE against a total requirement of 4 WTE. There is an existing band 8a in post who will transfer into the new service and form part of the 4 WTE team.

The staffing model mirrors those in existence in similar sized services across UHBW.

The pharmacy workforce figures are based on a 5-day model. The 7-day workforce model will be explored following UHBW move to 7-day pharmaceutical model. All positions would be working a 7.5 hr day, Monday to Friday, and hours would be used to service the best needs of the specialisms.

This working model will enable the development of a team approach to the wards. By having two Pharmacists within each field, it will ensure holiday/sick cover and support to each other is available.

The model is based on what is required to deliver an optimum, safe and effective clinical pharmacy service within the Care of the Elderly / GEMS / Front door specialities. All positions that are planned to be situated at the front door, will cover both front door activities and the frailty service, giving resilience as part of a team approach. The last CQC report as Weston Area Health Trust in 2019 had a must do to 'Ensure pharmacy staffing levels meet demand and Carter model hospital indicators, and therefore, protect patient safety'. At that point, Weston General Hospital had one of the lowest ratios of pharmacy staffing numbers to bed numbers nationally.

Pharmacy has an enormous influence on patient flow within any hospital, and if medication can be delivered correctly on admission, it ensures safe and effective care for in-patients, whilst preparing them to have quick and successful discharge.

**Consultant Pharmacist 8b - Care of the Elderly**
The Head of Medicines Management at BNSSG ICS, and Director of Pharmacy at UHBW, have recommended that Weston General Hospital be a suitable host site for a Care of the Elderly Consultant Pharmacist position, to be both a regional lead and to lead the Care of the Elderly / GEMS / Front door at Weston. This post will also contribute to further development of services in Healthy Weston 2 Phase 2. Consultant Pharmacists are leaders in the profession as well as senior clinical experts delivering care and driving change across the healthcare system. It would be expected that this position would be active within the UK Clinical Pharmacy Association Care of the Elderly group.

**Frailty and ED Pharmacy Team**
Within the new clinical structure, the Lead Frailty and ED Pharmacist is currently already in position. This role has been key in developing the GEMS service and this is the first time Weston General Hospital Pharmacy workforce have had a role embedded within the ED team. This role has exposed that there is a huge requirement for more pharmacy staff to be active within these teams. The post holder has led on medicines management, medicines governance and safety matters within these specialities, and has identified further work that would need an expanded base of staffing. Having both a dedicated band 7 Pharmacist and a band 6 Medicines Management Technician within the team, would assist in cover (sickness / holidays), support for each other and greater output of work. This would also result in:

- Improved medicines reconciliation rates on admission – improving safe and effective care

- Increased usage of patient's own medication – reducing waste and cost
- Tighter governance of medication and learning and feedback from medication incidents
- Greater opportunities for medicines teaching

The Royal Pharmaceutical Society[6] has recommended that *'all A&E departments should incorporate a pharmacist to manage medicine-related issues'* and NICE guidance on Frailty pharmacist[7] helps to explain the role further.

### 7.3.5 Therapies

Delivery of the model of care for Weston General Hospital necessitates robust therapy staffing. This includes enhancing provision to 'front door' services to support admission avoidance where possible. To support short stay models and expected reduced length of stay, therapy provision will need to be available over 7 days. The current provision at Weston General Hospital is very limited over weekends.

The therapy workforce models will provide opportunities for both static and rotational positions. As a teaching hospital with a wide range of services, recruitment of more junior / rotational staff to therapies has historically been achievable. The aim is to work closely with community providers to see where roles can be shared and to continue to work on 'blurring' of the front and back door at Weston to aid provision of a seamless pathway of care for Weston area patients.

The total number of additional Occupation Therapy staff required 4.2 WTE and for Physiotherapy it is 8.32 WTE. This is all additional capacity.

Across Dietetics and Speech and Language Therapy the total additional requirement is 5.76 WTE. This is all additional capacity which is required to support the additional hours. All expansion per profession is below 1 WTE so consideration could be given to working with other community and independent providers in appointing to joint roles.

*Table 22 - Summary expansion of therapies workforce*

| | WTE |
|---|---|
| **Occupational Therapy** | **4.2** |
| **Physiotherapy** | **8.32** |
| **Dietetics** | **3.88** |
| **Speech and Language Therapy** | **1.88** |

[6] The Royal Pharmaceutical Society – Accessed: https://www.rpharms.com/recognition/all-our-campaigns/policy-a-z/urgent-and-emergency-care

[7] NICE guidance on Frailty pharmacist – Accessed: https://www.nice.org.uk/sharedlearning/integrated-care-clinical-pharmacist-for-frail-older-people-case-management-and-enhanced-rapid-response.

**Front door and GEMS Therapies provision**

There are a number of drivers that support the need for therapy presence at the front door:

- Expectation set out by NHS Improvement 2018/19 was for all Trusts with Type 1 Eds to provide an acute frailty service requiring input from Occupational Therapists and Physiotherapists (Same Day Acute Frailty Services, NHS England and NHS Improvement, May 2019)
- The Royal College of Occupational Therapists (RCOT) identified that the presence of Occupational Therapist in Emergency Departments and frontline emergency services can reduce hospital admissions by 70-80% (Occupational Therapy proves crucial for reducing hospital admission in England, RCOT, 2016).
- The Chartered Society of Physiotherapy (CSP) identifies the benefits that Physiotherapists can provide in Emergency Departments – undertaking a range of roles delivering "cost and clinically effective patient centred care" (Physiotherapy Works – A&E)
- Getting It Right First Time (GIRFT) recommendations for Emergency Care identify that at least a third of Accident and Emergency attendances can be "managed by clinicians other than emergency physicians". The multidisciplinary teams should include Physiotherapists and Occupational Therapists suggesting that they should support A&E departments and acute medical units on a 12 hour, 7 day a week basis (Getting It Right In Emergency Care, GIRFT, 2018)
- Emergency Care Intensive Support Team (ECIST) recommend the "involvement of relevant Allied Health Professional (AHPs) in the assessment of patients as close to the time of their arrival (rather than admission) as possible" (Getting It Right In Emergency Care, GIRFT, 2018)
- Improving rehabilitation has been a focus for NHS improvement for a number of years. It is acknowledged that rehabilitation should be commenced at the earliest opportunity (Principles and expectations for good adult rehabilitation, NHS Wessex Strategic Clinical Networks 2015). Access to therapies within the ED enables this to happen and can reduce the risk of deconditioning associated with inpatient stays if patients are admitted.
- Approximately 30% of the population is at risk of malnutrition. To provide appropriate care for this population without need for admission, dieticians should be accessible within the Emergency Department setting. The British Diabetic Association outlines that dieticians, as part of a multidisciplinary team, can help reduce inpatient days for frail patients should they be admitted.
- Following local discussion within BNSSG, there is recognition that there is an unmet need with dysphagia related to dementia, long-term conditions, etc. Issues relating to dysphagia can lead to ED admissions. Support and advice from Speech and Language Therapy (SLT) staff at the front door would help to address these issues. Additionally, SLT are qualified to assess an individual's ability to understand and communicate that understanding to optimise individual choice, degree of control and capacity to consent to care and treatment (Royal College Speech and Language Therapy 2018, Response to NHS Long Term Plan). Access to this resource as soon as possible will improve quality of care for patients.

**Benchmarking of Therapies provision**
The majority of neighbouring acute trusts to Weston General Hospital have an established and embedded front-door therapy service:

- North Bristol Trust via their Complex Assessment and Liaison Service (CALS)
- Royal United Hospital, Bath, have a ED therapy service funded by their ED (DAT), in addition to their front-door frailty service (FFS) which included Physiotherapists and Occupational Therapists
- Musgrove Park Hospital, Taunton, have a dedicated front-door therapy service (JETT)
- Within UHBW, the BRI have senior Occupational Therapists and Physiotherapists as part of the older person's rehabilitation team that provide input to the front door 7 days a week. This includes a frailty clinical specialist Occupational Therapist and Physiotherapist

Additionally, NHS Benchmarking Older People 2016 outlined that 93% of Trusts had a dedicated therapy team available in A&E, further supporting the therapies workforce requirements described for Healthy Weston 2 Phase 1.

**OPAU:**
The OPAU Therapies workforce figures are based on the number of beds in the OPAU (14). A whole time equivalent weighting is used for each profession per bed. The WTE replicates that which is used for other new business cases for therapy provision to medical patients within UHBW NHS Foundation Trust. The total calculation covers sickness and annual leave and provision of service over 7 days. The 7 day level of service is higher than that for inpatient wards to enable a similar level of therapy provision to the OPAU every day given the high turnover rate within this type of ward.

**Outpatient clinics:**
OPAU and Front Door therapy staff would be available to support Frailty outpatient clinics as appropriate.

**Non-clinical roles:**
Additional managerial and administrative figures are also included. The calculations for these roles are based on the WTE staff numbers that these roles would support.

**7-Day (level) of service:**
Seven Day Hospital Services has been a key workstream for NHS England for a number of years, setting out an ambition of providing patients with consistent high quality, safe care every day of the week. Clinical standards established by this workstream, updated in 2022, highlight the need for all emergency inpatients to be assessed for complex or ongoing needs within 14 hours by a multi-professional team that includes Physiotherapists, Occupational Therapists, Dieticians and Speech and Language Therapists (NHS Seven Day Services Clinical Standards). It also highlights the need for appropriate staff to be available to carry out treatment / management plans.

The CSP notes the role that therapies play in "enabling timely and safe discharge as soon as clinically indicated, avoiding delays or interruptions to patient care" as well as improving patient outcomes and experience when available 7 days a week (Physiotherapy Works: Seven Day Services, CSP, updated 2017). There are a variety of case studies of services establishing 7-day services that demonstrate reduction in length of stay that is achieved with therapy provision over 7days rather than 5 (Physiotherapy Works: Seven Day Services, CSP, updated 2017; Equality for all: Delivering safe care – seven days a week, NHS Improvement, 2012)

There is acknowledgment that appropriate resources are required to enable therapy services to be provided over weekends without adversely affecting provision Monday-Friday.

## 7.4 Staff Retention

Making the NHS the best place to work is a key commitment in both the NHS Long Term Plan and the NHS People Plan, with a vision to create a more supportive working environment and provide greater development opportunities. The UHBW People Strategy also commits to the improvement in staff retention alongside improving vacancies and turnover as part of its commitment to 'Look after its People'. The vision is to develop UHBW and the Weston Division as an employer of choice, providing high quality employment for the local population and promoting the value, support and investment offered to everyone who works there. The plans for change at Weston General Hospital are a key component of the workforce vision. Uncertainty about the future of the hospital has impacted the ability to retain staff who have career aspirations that they are not clear that Weston General Hospital can meet.

Historically, recruitment has not improved the workforce position at Weston General Hospital sufficiently to make significant service improvements. Equally, staff are leaving the hospital because of the challenges of delivering care under the pressure of workforce deficits. In response to these challenges, a number of interventions have been put in place with the objective of improving retention:

- The Management team at Weston and the wider UHBW leadership team have ensured that listening events are commonplace, enabling staff to raise concerns and questions directly with leaders who have committed to addressing these concerns and communicating actions on a regular basis. IT infrastructure has been developed to support internal communications so that staff are aware of the future vision for Weston and have been involved in how this is shaped. Post- merger, it has been a priority that staff feel secure in their positions, to support this there has been a large exercise to convert many fixed term posts into permanent positions.
- As roles have been aligned within merged teams, work has been completed to review roles and harmonise salaries resulting in some employees at Weston benefiting from a salary review and associated increase.
- Staff have benefitted from increased access to learning and development opportunities and development of staff is key to retaining our workforce and ensuring we have the people we need for the future.
- Secondments across UHBW are common and cross site working opportunities will be supported with the new bus service linking the two sites together.
- Flexible working opportunities are being promoted across the site and requests to reduce hours are supported. Many employees have been retained with initiatives such as retire and return applications combined with redeployment options. The focus will continue to be on what we can be done differently to support the workforce and how skills and experience can be retained at Weston.

## 7.5 Management of Change

It is acknowledged that existing staff at Weston have experienced uncertainty and change over many years so further plans for change could be met with concern or resistance. In order to ensure staff are engaged and well informed regarding the plans and intention of the Healthy Weston 2 programme, a robust communications strategy has been deployed and has included the following activities:

- All available internal communications channels have been used to share updates on the Healthy Weston 2 programme to ensure staff know about it and where to find out more and how to have their say – these channels include both staff newsletters, both intranets, posters, screensavers (at WGH), all-staff emails, desk-top alerts, briefings for professional staff group meetings and divisional email cascades.

- A staff reference group was established with approximately 30 members of staff, this meant that at least 10 were present at each meeting. The SRG were given the opportunity to comment on how we would engage with staff (and reviewed and commented on the communication and engagement plan), while also sharing their feedback on the plans. The ICB produced a survey which was open to all staff and the public.

- Regular online (MS Teams) staff briefing sessions were held so staff could find out more about the plans and share their feedback, and in particular, staff were asked to feedback on specific questions

- The online sessions were recorded so staff who were not able to attend could watch them at their own convenience.

- Four talking head videos were produced to give an overview of the Healthy Weston programme, care of older people, emergency care and planned care, delivered by lead staff in the respective area

UHBW has a robust process to managing staff change and where it is necessary the Management of Change Policy will be used to ensure any staff affected are suitably consulted with and any changes proposed and introduced fairly and appropriately.

## 7.6 Recruitment to existing vacancies

A vacancy factor exists across all professions in the current workforce in Weston and this has been identified by the finance lead as part of the development of the workforce plan. It should be noted that this has been based on the April 2021 outturn staff position so the vacancy may have shifted in the following months to the date of writing of this plan. Recruitment to vacancy will need to be addressed to realise the benefits of the Healthy Weston 2 developments and the recruitment plan makes reference to where this issue is most pronounced and incorporates recruitment to these vacancies into the recruitment plan alongside those identified as part of the agreed expansion numbers for Healthy Weston 2.

## 7.7 Deployment of new and advanced roles

As part of the development of the workforce plan, professional leads were challenged to consider resourcing beyond traditional NHS roles and where appropriate via new and alternate roles. Appendix 9 provides more detail and explanation on the definitions and range of roles referred to. A number of additional Physician Associates (PA's) have been identified as part of the medical workforce plan and Advanced Clinical Practitioners (ACP's) volumes included in the nursing workforce plan. The recruitment plan will need to identify the approaches to recruiting to those roles and if there is an adequate supply of trained staff available via domestic recruitment or if there are staff currently in training and education who could be appointed into those roles when required. Reconsideration of the recruitment plan and increasing of the new and advanced workforce may be necessary should recruitment to

certain roles prove more difficult in the current market. These options could be considered with further input from the Trust lead for Advanced Clinical Practice, Director of Allied Health Professionals, members of both the senior nursing team and medical leads.

## 7.8 Healthy Weston 2 Phase 1 Recruitment Plan

This section outlines the key work-streams to create a comprehensive action plan for the recruitment of workforce to deliver the proposed care model for Healthy Weston 2 (HW2) and the reduction of the underlying vacancy position at Weston.

### 7.8.1 Context & Challenges

The improvement of the services at Weston General Hospital (WGH) and the proposed model of a centre of excellence for care of the elderly and for surgery at later date, provides an opportunity to create a step-change in the attraction and retention of talent. However, any recruitment & retention efforts need to be in the context of a number of national, international and regional challenges such as staff shortages across a range of NHS staff groups, with the main challenges being the current shortage of Doctors, registered Nurses, Radiographers and Occupational Therapists.

The local, national and international challenges highlight that the gap between supply and demand is not going to improve for the registered nursing and medical workforce in the wider healthcare system in the foreseeable future.
These challenges include:

- Reduced supply of newly trained nurses through undergraduate nursing degree courses, and poor attrition from training.
- Whilst a pipeline of international recruitment of nurses has been established through NHS Professionals, the nurses recruited do not arrive in receipt of their NMC registration and can take up to four months to become registered nurses.
- Whilst a pipeline of registered nurses has been seen through the HEE Return to Practice programme, good retention has not always been realised and numbers need to be further boosted.
- The details of the ambitions of the Healthy Weston 2 programme, particularly Phase 2 onwards, are still being developed and could affect the models of clinical care for Weston and its workforce numbers. This could have a negative impact on retention and candidate attraction.

There are similar challenges with the Medical & Dental workforce, as detailed below:

- There is a national shortage of the vast majority of medical specialisms.
- Despite efforts to actively recruit to all medical grades, the Trust has seen a reduction in the ability to retain medical candidates during the recruitment process whilst they continue to look for more attractive or lucrative offers.
- Reduced level of Consultants in Weston is restricting the ability to take on further Junior Doctors (Clinical Fellows ST1/2 & ST3+), especially International Medical Graduate's (IMG's) who require further support; and the ability to shortlist vacancies and facilitate interviews for these grades in a timely manner.
- Reliance on locally employed doctors to mitigate gaps within the national training programme creates another supply problem as there are a limited number of these doctors available nationally and internationally. In addition, once appointed, these

doctors are employed under clinical fellow 12 months fixed term contracts. This results in a high level of turnover and the need to constantly recruit to these posts.

- Recruiting international doctors is not a speedy solution to vacant posts due to the time-consuming nature of the visa process and GMC registration.
- Nationally, hospitals in rural and coastal Britain are struggling to recruit senior medical staff. Local demographic challenges and existing doctor shortages put extra pressure on those who opt to work there, and the fact that WGH is a small hospital, present further challenge to attraction and recruitment.
- Experience to date has shown that sharing Bristol resource with Weston via rotational posts has not been successful and may compromise the recruitment and retention efforts in the Bristol sites.

Other challenges include:

- National and international shortages of Allied Healthcare Professionals (AHPs), specifically Radiographers, Sonographers and Occupational Therapists, staff groups for which the Trust's international recruitment programme is still in the first stages and has not proven to be an effective and reliable source of talent to date.
- The creation of new senior roles across all staff groups is likely to result in internal promotions, creating new vacancies at lower banded/entry level positions which will require further recruitment interventions and may be less attractive to external candidates.
- Members of Resourcing who currently support Weston recruitment are funded by the Integration Programme Board until March 2023 when their fixed term contracts will come to an end. These posts include the Deputy Clinical Talent Acquisition Manager (B7), Relocation and Pastoral Manager (B5) and two Recruitment Coordinators. These roles will need to be extended for a two-year period to deliver the Healthy Weston 2 recruitment plans.
- The financial aspect of the Healthy Weston project is not likely to be approved until April 2023 which will delay the commencement of the recruitment activity and therefore will impact on the delivery of the recruitment plan unless authorisation is approved to start recruiting at risk prior to the financial approval with an understanding that candidates will not commence until the financial approve is secured. As conditional offers are legally binding any offers made prior to the funding approval will need to be followed through to avoid a reputational risk, however, due to the existing vacancy position the financial risk is minimal.
- The creation of split posts Bristol-Weston will incur an additional cost to cover the transport between sites for staff members.
- Some of the services will be moving from a five-day to a seven-day week service in the future model, this can result less attractive to internal members of staff who will now be expected to work some weekends and to external candidates who may prefer Monday-Friday posts.
- Other programmes of work within the Trust and the system will also involve a significant workforce expansion of the same staff groups and therefore these will need to be taken into consideration to make sure the recruitment campaigns don't conflict with each other.

Consequently, there needs to be a significant focus on recruitment and commitment from clinical leads as well as recruitment colleagues to see positive results within the planned timeline.

### 7.8.2 Recruitment Plan by Workforce Group

The vision is for Weston to become an employer of choice, attracting talent by becoming a centre of excellence for the local community with a focus on care of the older people, and with the creation of new and innovative roles.

The strategy is differentiated by workforce group as follows:

**General initiatives**

- Identify whether there is scope for existing staff to move into the new roles by either internal promotions, increase of working hours if part time and/or retention of temporary staff, however, this will create new vacancies at lower banding positions which could be harder to fill.
- Extend the Resourcing roles that will support this recruitment for a further two years, currently being funded as part of the IBP until the end of March 2023. This includes the Pastoral and Relocation Manager for Weston (1WTE) and the Deputy Clinical Talent Acquisition Manager (1WTE); and include 2WTE additional recruitment coordinators fully dedicated to HW2.
- Develop a marketing strategy focusing on supporting the workforce supply challenges and promote Weston as a centre of excellence for care of the elderly and as an employer of choice (see section 4).
- Grow the Registered Nurse, AHP and doctor bank for Weston. This will help reduce agency spend and give greater compliance with framework and NHSI Standards.
- Agree and implement a bespoke fast track recruitment process for HW2 candidates to improve recruitment times and avoid unnecessary delays.
- Develop a competitive offer for new recruits. Current recruitment and reward interventions for medical and nursing staff will be reviewed and enhanced where possible and should be extended to other staff groups such as AHPs due to the recruitment challenges faced within these critical roles.
- Focus on communication with line managers and candidates to offer a comprehensive on-boarding process and keep communication strong throughout all stages of the recruitment process. This can develop through to an enhanced and individualised pastoral support offer to successfully welcome new joiners.
- Work with clinical colleagues to define the specifications and criteria for each of the roles to recruit to, and agree the level of flexibility e.g. NHS Experience essential or desirable, development roles, etc.
- Work with the departments to name a dedicated recruitment lead for each staff group or specialty and to commit to have protected weekly time for shortlisting, interviewing and other ad-hoc recruitment responsibilities.
- Create a dedicated Task and Finish group with weekly meetings to keep the pace and momentum of the recruitment plan and provide updates on progress, resolve queries and offer support to move the plan forward.
- Attend relevant local and national career events to promote the future model of Healthy Weston and engage with potential candidates and establish relationships

with external recruitment providers. Continue to take part in the Trust recruitment open days and organise new Weston specific events as and when required.

- The Bristol site is a regional tertiary referral centre with many specialist units; posts that involve placements in specialist services at Bristol should be made available to workers on Weston site. This could be a successful attraction tool and the upskilling of staff would also benefit the care delivered at Weston. It would also provide individuals with career progression and help support staffing shortages within specialist areas at UHBW.
- Progress recruitment opportunities with other local health care providers including the concept for the 'Pier Academy' approach and the Additional Roles Reimbursement Scheme [ARRS] supporting the development of multi-disciplinary teams.

**Nursing Recruitment**

- In general, the Trust already has a strong ongoing recruitment campaign and process for Registered and Unregistered Nurses which can readily be scaled up to resource HW2 as well.
- Some of the band 5 registered nurses (RN) recruitment to the specialised areas will be via internal recruitment, however, the great majority of this recruitment will be through the International Nurse Recruitment Programme (subject to the 2023/2024 IEN business case approval). The Trust's supplier, NHS Professionals, will source the candidates, and subject to interview could be in post within four months. These international nurses will require a supernumerary period of four weeks followed by a period as band 4 pre-registered nurses while they prepare their OSCE and obtain their NMC registration. This process can take up to a maximum of four months, from arrival to become band 5 RNs. See associated costs of international recruitment of nurses in section 7.8.5.
- For senior nursing positions (band 6 and 7), internal recruitment will be the main source of candidates. This will have an impact on the underlying vacancy position at band 5 and band 6 level. Recruitment campaigns will be promoted to attract domestic nurses wishing to relocate to the South West / countryside / seaside, moving out of big cities.
- Unregistered nursing roles will be recruited through the current Health Care Support Worker recruitment workstream based on monthly assessment centres. There will be a mixture of experienced HCSW's and apprentices who will require a level of supervision whilst they complete their apprenticeship.
- The Trust will identify, support and encourage more nurses to return to practice, sharing the success of the programme, and using the system wide project to improve the "NHS Offer" through a collaborative approach to flexible working, career development and flexible working alongside wellbeing initiatives.
- Work to continue in the Trust offering of pastoral and relocation support to new nurses arriving in Weston to provide an outstanding onboarding experience.
- The recruitment of 4.96 WTE ACPs will be a combination of internal and external recruitment through a trainee programme by which the candidates will undertake a 2-year university course in Advanced Clinical Practice while working at band 6/7 level, to then progress to Band 8a once they achieve their qualification. The recruitment will be planned around the intake dates of the university course (March / September).

**Medical Recruitment**

- Medical recruitment for Weston is a challenge and the recommendation would be a phased approach; recruiting Specialty Doctors and fixed term Consultants as a contingency when permanent consultant recruitment is not immediately successful, with the view of supporting them in to obtaining their Specialty registration to potentially apply for permanent posts in the future.
- Active promotion of the recruitment incentive already in place such as the £15K RRP over three years for new permanent consultants or £5K for locum consultants (fixed term contract) and extension to middle grade doctors.
- Work will continue with several head-hunter agencies to source CVs with a focus on the recruitment of international medical graduates (IMGs). This recruitment will take place alongside the advertisement of vacancies on the Trust careers website and other online platforms (LinkedIn, Indeed, etc.). The use of head-hunters involves an introductory fee for each appointed candidate. These fees are on average as follows:

*Table 23 - Head-hunter fees for each role*

| Grade | Cost |
|---|---|
| Junior Clinical Fellow (ST1/2) | £6,000 |
| Senior Clinical Fellow (ST3+) | £8,000 |
| Specialty Doctor | £8,000 |
| Consultant | £11,000 |

- Development of a robust marketing plan with presence in national and international online medical platforms and paper publications to target the widest audience of potential candidates. See more detail in the Marketing section below.
- Establish dedicated recruitment leads per specialty with weekly protected time to support all the recruitment processes: shortlisting, interviews, review of references, etc.
- Due to the time constraints associated with international recruitment and lengthy notice periods, as well as the expected difficulty in recruiting to these roles, the recommendation is to commence medical recruitment in January 2023 ahead of the financial approval of the project, which will require authorisation by the relevant senior management.
- Special focus on onboarding new doctors and to support them through the recruitment process and relocation to Weston, offering the following financial package which can be lifted to a maximum of £5K at the division's discretion for hard to fill roles in accordance with the Trust policy:

*Table 24 - Financial packages for recruitment and relocation process*

| Items | International Relocation | Domestic Relocation |
|---|---|---|
| Accommodation (2 months) | Up to £1300 | Up to £1300 |

| | | |
|---|---|---|
| Flights | Up to £600 | N/A |
| Airport transfer | Up to £300 | N/A |
| Essential groceries on arrival | Up to £50 | Up to £50 |
| TOTAL: | £2,250 | £1,350 |

**Diagnostic Radiology**

- The proposed model for Radiology involves recruitment for various staff groups: medical, radiographers, admin staff and radiographic assistants. There is a national shortage of both Radiologists (medics) and radiographers/sonographers (AHP's) and recruitment to these positions has been challenging in the Trust for a number of years. For this reason, the plan is a phased recruitment over the 12 months period, with the first arrivals from Q2 (23/24).
- The recruitment to B5 radiographers will be a combination of the Trust's established recruitment campaigns, the collaborative international AHP recruitment programme with the ICB system partners, and work with head-hunter agencies (see associated costs of international recruitment of AHPs in section 7.8.5. In addition, a strong marketing campaign will focus on attracting UK experienced radiographers who wish to relocate to Weston.
- The Trust will also continue to recruit final year students. This seasonal recruitment of radiographers starts in November however the students will not be fully qualified and therefore not able to join the Trust until the following summer 2024.
- The Radiology team will continue to develop existing staff into CT and MRI specialisms with the B6 radiographer positions likely to be attractive to internal staff as a development opportunity. The training required for these modalities is a 12-month course which starts in January and recruitment will be timed accordingly. Internal promotions to these roles will create an underlying vacancy position at band 5 level which will need to be backfilled with the seasonal and international recruitment campaigns mentioned above.
- The recruitment of B3 radiographic assistants will be based on an assessment centre model, using the resources already in place for Healthcare Support Workers, which has proven successful in the past.
- For recommendations on the recruitment of Radiologists please see medical recruitment section above.

**Therapies**

- As with the existing B5 and B6 Physiotherapist (PT) and Occupational Therapist (OT) positions, the additional posts in the future model of HW2 will also be rotational posts between Bristol-Weston. This will help to attract candidates and support recruitment. The creation of one static (Weston based only) B6 OT and one B6 PT will also be considered if there is an appetite for this among the pool of candidates.
- The national shortage of OTs poses a challenge to recruit to this staff group and work to recruit internationally through the collaborative AHP IR will continue to support filling some of these vacancies.

- There is also an expectation of internal moves to fill the Occupational Therapy and Physiotherapy senior roles (B7) as seen as opportunities for promotion of internal staff.
- Both B8a and B8b PT requirements are already in post as a cost pressure and will be converted to the new HW2 posts.
- Dietitians and Speech and Language Therapists (SLTs) have been consistently harder to recruit over the last years. The part time nature of the posts in the future model will also be a challenge to attract candidates. For this reason, one of the strategies will be to offer split roles (Bristol-Weston) and to merge both band 4 assistants (dietetics and SLT assistants) in one role to create a nearly full-time position.
- Band 6 and band 7 dietitians and SLTs will be recruited externally, and these posts will be offered as either full or part time to attract a larger pool of candidates, combining them with existing vacancies if needed.
- Both Band 8a Pathway Lead roles in dietetics and speech and language therapy are 0.2 WTE each and therefore unlikely to attract external interest. To mitigate this, they will be offered as development opportunities to existing members of staff to combine with their existing roles.

**Pharmacy**

- The Pharmacy proposed model for the first phase of Healthy Weston 2 consists of 3WTE additional staff. Two of the positions, one band 6 pharmacy therapist and a band 7 Medicine pharmacist, are expected to be attractive to both internal and external candidates and the department will also consider offering these posts as a development opportunity.
- The third new position is a highly specialist Consultant Pharmacist band 8b. There are not many pharmacists with the relevant training nationally, and none currently in the Trust, but the department will offer this as a development role and will support the appointed individual through the relevant training.
- All pharmacy vacancies will be externally advertised to attract the most qualified candidates and will be promoted on the Trust social media.
- As it is expected that part of the new positions will be filled by existing members of staff, this will leave an underlying vacancy position at band 6 level that will be filled by the seasonal recruitment of newly registered pharmacists. This recruitment usually takes place in May and the new pharmacists join the organisation around August/September time.

### 7.8.3 Marketing

As part of the recruitment strategy, there will be a special focus on developing a marketing plan to support the workforce supply challenges and promote Healthy Weston 2. The estimated cost for this marketing activity to support the recruitment plan is £50k.
Some of the actions include:

- Promote Weston as a centre of excellence for care of the elderly and as an employer of choice.
- The Weston site is located in a beautiful part of the country with lots of socio-economic factors which need to be actively marketed including more affordable property than in Bristol, seaside location, affordable onsite parking available for staff.

- Marketing plans can further develop the new Employer brand for UHBW when this becomes available.
- Design and develop a Healthy Weston specific website linked into UHBW's recruitment site, to showcase the future of Weston General Hospital, providing a cost-effective online approach to marketing.
- Tailor the current Weston recruitment marketing plan to include global advertising campaigns to help promote hard to fill roles. An outline of the proposed interventions is detailed below.

*Table 25 - Targeted recruiting advertising plan*

| Publication/ media | Rationale | Formats | Cost* |
|---|---|---|---|
| **British Medical Journal** | The BMJ is read by hospital doctors of all grades and medical specialties of UK hospital doctors. The BMJ website has global reach as it attracts a large volume of international doctors looking for jobs in the UK. | BMJ Annual Package provides yearly saving versus paying adhoc.<br>BMJ Online listing for all Weston medical vacancies. Enhanced listings so jobs appear higher up search results – added on key vacancies. Quarterly 'splash' print adverts. Online banners targeting global traffic. | £28,000 |
| **Facebook and Twitter** | Social media targeting using job title, location and interests. This media allows us to cost effectively reach large audiences across the world. Example: Target twitter followers of the Royal College of Anaesthetists. | Facebook and Twitter newsfeed advert to direct to website landing page featuring Trust medical vacancies. | £2,500 |
| **Google Adwords** | Actively target all doctors searching for vacancies from across the world. Advantages include being able to target active jobseekers and relatively low cost per click compared with publications and journals. | Key search terms to mirror current vacancies. Banners to also appear through Google Adnetwork on sites visited following the search. | £3,000 |
| **LinkedIn** | Targeting of adverts by job title across the world. This media allows us to cost effectively reach large audiences across the world | Newsfeed adverts and blogs to direct candidates to website landing page with vacancies. | £1,500 |
| **International Medical Recruitment Websites** | International websites and publications:<br>- The Medical Journal of Australia (MJAJobs) Online (Australia)<br>- The Lancet (Global – specialty specific)<br>- https://medical.careers.global/ (Australasia)<br>- https://au.jora.com/ (Australia)<br>- https://www.naukri.com/doctor-jobs-in-uk (India)<br>- globalhealthjobs.com (Global) | General Job listings across global medical jobs boards. | £6,000 |

| | | | |
|---|---|---|---|
| | - Indeed (International – General) | | |
| **Events** | Conferences and recruitment events to be confirmed | Exhibition stands x 3 events | £9,000 |
| **Total Costs (not including VAT)** | | | **£50,000** |

*Indicative prices, subject to change

### 7.8.4 Risks to delivery

The risk register found in Appendix 1 outlines the risk to workforce deliverability (no.3), with the detail below describing the specific risks being considered:

- The recruitment plan cannot be delivered or is delayed due to the difficulty to recruit to certain staff groups and the complexity around international recruitment.
- The current high vacancy rates and the continued agency reliance could limit the level of support received from the clinical leads to shortlist and interview potential candidates.
- An increase in turnover could increase the vacancy position and the recruitment required to deliver HW2.
- Following the recent clinical integration, there is a risk of exacerbating existing low morale following a prolonged period of changes within the organisational structure which could affect candidate attraction.
- The Trust fails to attract candidates due to the very limited Trust accommodation available for new staff members and the difficulty in finding long-term private accommodation.
- The recruitment plan cannot be delivered due to the funding not being available to extend the corporate roles required.
- Sufficient candidates are not generated due to the marketing budget not being agreed.

### 7.8.5 Summary of costs associated to recruitment

Table 48 [Section 8.9] provides a summary of the costs involved in the marketing plan of £50,000, the cost of the fixed term roles in recruitment for two years, and the international recruitment of nurses, AHPs and doctors, assuming that all the medical recruitment will incur a head-hunter finders' fee. This table includes HW2 additional staff only and excludes the cost to recruit to the existing vacancies.

### 7.8.6 Proposed Phasing

The majority of the recruitment to the additional posts in the future model will take place over the initial 12 months of the project (2023/2024). The focus will be on recruiting substantively to the new posts, whilst maintaining the existing temporary workforce in order to expand the services. During this period the Trust will need to accept the ongoing cost of agency fill. See table 26 below (HW2 Recruitment plan to future model).

In the following year (2024/2025) the recruitment efforts will be on addressing the underlying vacancy position currently covered by bank and agency staff, and also the vacancies created as a result of the internal promotions in year 1. The conversion of the temporary arrangements into substantive posts will result in a cost saving. This will only apply to medical posts as the other staff groups will recruit substantively to the additional HW2 posts in the first year.

The intent is to progress implementation of the Phase 1 recruitment plan as part of the system workforce plan, ensuring the opportunities for joint/blended posts are maximised and recognising the likely need for agreed prioritisation of where workforce is directed to secure maximum benefit for the overall system/population. Healthy Weston offers a unique opportunity for innovative integrated workforce possibilities, e.g., Geriatric consultants could undertake a joint role with Sirona and Pier health care home hub PAs, strengthening the individual's career progression, whilst maximising integration and collaboration with local services.

## *Table 26 - Recruitment plan to future model*

| | | | | Staff in post - 2023/2024 | | | | 2024/2025 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | RAG | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 |
| **Front Door Services** | | | | | | | | | | | |
| **Staff** | **Band** | **WTE** | | | | | | | | | |
| **Medical Staff** | | | | | | | | | | | |
| **ED** | | | | | | | | | | | |
| Consultant | Consultant | 2 | A | | 1 | | 1 | | | | |
| Middle Grade | ST3+ | 2.43 | A | | 1 | 1 | 0.43 | | | | |
| Physician Associate | Band 7 | 3 | A | | 1 | 1 | 1 | | | | |
| **Frailty Service (GEMS) including cover for Frailty SDEC** | | | | | | | | | | | |
| Consultant | Consultant | 2 | A | 1 | | 1 | | | | | |
| Specialist Grade Doctors | Specialist grade | 0.87 | A | | | 0.87 | | | | | |
| **Ambulatory Emergency Care (AEC) / AMU** | | | | | | | | | | | |
| Consultant | Consultant | 2 | A | | 1 | | 1 | | | | |
| Middle Grade | ST3+ | 2 | A | | | 1 | 1 | | | | |
| **Pharmacy** | | | | | | | | | | | |
| Pharmacy Technician | Band 6 | 1 | A | | 1 | | | | | | |
| Pharmacist (development role B6/7) | Band 7 | 1 | A | | | | 1 | | | | |
| Consultant Pharmacist | Band 8b | 1 | A | | | 1 | | | | | |
| **Radiology** | | | | | | | | | | | |
| Consultants | Consultant | 2.24 | A | | | 1 | | | | 1.24 | |
| Admin & Clerical | Band 3 | 1.49 | A | 1 | 0.49 | | | | | | |
| Radiographic Assistants | Band 3 | 4.6 | A | 2 | 2.6 | | | | | | |
| Radiographer | Band 5 | 3.38 | A | | 2 | 1.38 | | | | | |
| MRI/CT Radiographer | Band 6 | 9.44 | A | | | | 9.44 | | | | |
| Radiographer (Backfilling for Band 6 MRI/CT internal promotions) | Band 5 | 9.44 | A | | | | | | 9.44 | | |
| **Therapies** | | | | | | | | | | | |
| Occupational Therapist | Band 5 | 1 | A | | 1 | | | | | | |
| Occupational Therapist | Band 6 | 1 | A | | 1 | | | | | | |
| Occupational Therapist | Band 7 | 1 | A | | 1 | | | | | | |
| Physiotherapist | Band 5 | 1 | A | | 1 | | | | | | |
| Physiotherapist | Band 6 | 2 | A | | 2 | | | | | | |
| Physiotherapist | Band 7 | 1 | A | | 1 | | | | | | |
| Physiotherapist | Band 8a | 0.22 | A | 0.22 | | | | | | | |
| Physiotherapist | Band 8b | 0.12 | A | 0.12 | | | | | | | |
| Dietician Assistant | Band 4 | 0.44 | A | | | 0.44 | | | | | |
| Dietitian | Band 6 | 0.8 | A | | 0.8 | | | | | | |
| Dietitian Team Lead | Band 7 | 0.8 | A | | 0.8 | | | | | | |
| Dietitian Pathway Lead | Band 8a | 0.2 | A | | 0.2 | | | | | | |
| SLT Assistant | Band 4 | 0.44 | A | | | 0.44 | | | | | |
| SLT | Band 6 | 0.8 | A | | 0.8 | | | | | | |
| SLT Team Lead | Band 7 | 0.8 | A | | 0.8 | | | | | | |
| SLT Pathway Lead | Band 8a | 0.2 | A | | 0.2 | | | | | | |
| **Nursing** | | | | | | | | | | | |
| **Frailty Service (GEMS)** | | | | | | | | | | | |
| HCSW (Unregistered) | Band 3 | 2.48 | A | | 1 | 1.48 | | | | | |
| Registered Nurse | Band 5 | 3.97 | A | | 2 | 1 | 0.97 | | | | |
| PEF | Band 6 | 1 | A | | 1 | | | | | | |
| Registered Nurse | Band 7 | 0.69 | A | | 0.69 | | | | | | |
| **Medical Assessment Unit (AMU)** | | | | | | | | | | | |
| Admin & Clerical | Band | 0.62 | A | | 0.62 | | | | | | |
| HCSW (Unregistered) | Band 3 | 0.65 | A | | | | 0.65 | | | | |
| Registered Nurse | Band 5 | 1.32 | A | | 1 | 0.32 | | | | | |
| Registered Nurse | Band 6 | 0.17 | A | | | 0.17 | | | | | |
| ACP / ANP | Band 8a | 2.48 | A | | | 2.48 | | | | | |
| **Ambulatory Emergency Care (SDEC)** | | | | | | | | | | | |
| Admin & Clerical | Band 2 | 1.18 | A | | 1.18 | | | | | | |
| HCSW (Unregistered) | Band 3 | 2.48 | A | | 1 | 1 | 0.48 | | | | |
| Registered Nurse | Band 5 | 3.48 | A | | 1 | 1.48 | 1 | | | | |
| Registered Nurse | Band 6 | 1.67 | A | | 1 | 0.67 | | | | | |
| Registered Nurse | Band 7 | 1 | A | | | 1 | | | | | |
| **14 beds OPAU Q3 2023/2024** | | | | | | | | | | | |
| **Staff** | **Band** | **WTE** | | | | | | | | | |
| **OPAU Medical Staff** | | | | | | | | | | | |
| Consultant | Consultant | 2.75 | A | | | 1 | | 1 | | 0.75 | |
| **Nursing** | | | | | | | | | | | |
| Admin & Clerical | Band 2 | 0.34 | A | | | 0.34 | | | | | |
| Registered Nurse | Band 7 | 0.08 | A | | | 0.08 | | | | | |
| ACP / ANP | Band 8a | 2.48 | A | | | 2.48 | | | | | |
| **Therapies** | | | | | | | | | | | |
| Occupational Therapist | band 6 | 1.2 | A | | | 1.2 | | | | | |
| Therapy Technician | Band 4 | 0.8 | A | | | 0.8 | | | | | |
| Physiotherapist | Band 5 | 1 | A | | | 1 | | | | | |
| Physiotherapist | Band 6 | 1.5 | A | | | 1.5 | | | | | |
| Physiotherapist | Band 7 | 0.5 | A | | | 0.5 | | | | | |
| Physiotherapist | Band 8a | 0.1 | A | | | 0.1 | | | | | |
| Physiotherapist | Band 8b | 0.08 | A | | | 0.08 | | | | | |
| Dietitian | Band 6 | 0.64 | A | | | | 0.64 | | | | |
| SLT | Band 6 | 0.64 | A | | | | 0.64 | | | | |

*Table 27 - Recruitment to existing vacancies*

| | | | | Staff in post - 2023/2024 | | | | 2024/2025 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | RAG | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 |
| EXISTING VACANCIES | | | | | | | | | | | |
| Staff | Band | WTE | | | | | | | | | |
| Medical Staff | | | | | | | | | | | |
| ED | | | | | | | | | | | |
| Consultant | Consultant | 2 | R | | | | | | 1 | | 1 |
| Middle Grade | ST3+ | 2.47 | R | | | | 0.47 | 1 | | 1 | |
| Junior Doctors | ST1/2 | 2 | R | 1 | | 1 | | | | | |
| General Medicine | | | | | | | | | | | |
| Consultant | Consultant | 2 | R | | | | | | 1 | | 1 |
| Middle Grade | ST3+ | 3 | R | 1 | | | | 1 | | 1 | |

# 8 Funding and affordability

## 8.1 Finance and affordability – Capital and Revenue

The financial case for HW2 builds on the methodology and assumptions used in the Outline Business Case published in June 2022.

The financial case sets out the capital requirements and revenue consequences of the future model of care for the front door enhancements at the Weston Hospital Site. This is referred to as "Phase 1". The recurring revenue financial impact assessment (pay and non-pay) have been based on the following modelling assumptions for the front door enhancements;

- **Geriatric Emergency Medicine Service (GEMS)** – an extension of the existing GEMS service to a 12 hour day 8am – 8pm, 7 days per week to better align to the current Emergency Department (ED) opening hours and is assumed to see approximately 21 patients per day
- **Older Persons Assessment Unit (OPAU)** – a new OPAU, consisting of a new short stay 72 hour 14 bedded ward open 7 days per week
- **Acute Medical Unit (AMU)** – a remodel of the existing medical assessment unit (MAU) to create a 15 bedded ward, open 24 hours per day 7 days a week and to see approximately 16 patients per day
- **Same Day Emergency Care (SDEC)** – an SDEC open 7 days per week. The current Ambulatory Emergency Care Area (AEC) will be reconfigured to create the SDEC

### 8.1.1 General Assumptions and the Baseline Assessment for the phase 1 revenue assessment

- The revenue assessment has been assessed based on the agreed clinical operating model and associated agreed workforce plan for each of the front door areas described above. This involved working closely with clinicians and workforce planning

colleagues. Therefore, the financials are dependent on the success of the workforce and recruitment plan. This is described in Section 7 of this business case.

- The workforce model has been peer reviewed within UHBW for reasonableness.
- The revenue assessment has been phased in line with the recruitment plan over the period 2023/24 to 2025/26. 2025/26 is the recurring revenue position and includes medical agency staff savings realised by this point. 2023/24 represents the start of the phased recruitment plan with completion by 2025/26.
- A subset of the 2021/22 actual costs and WTEs in post for WGH for the services that are within the scope of this phase one case has been used for the financial baseline. This baseline forms the comparison to assess the financial impact or cost to change of the proposed clinical model.
- The total 2021/22 quantum for Weston Hospital is £112m of which £75m is in scope for the Healthy Weston Programme and £37m is out of scope. Of the £75m, the expenditure baseline for phase one is £10.5m (£10.1m pay and £0.4m non pay). It is this baseline that the cost to change/financial impact of HW Phase 1 has been calculated.
- Pay costs have been calculated using agenda for change (AFC) pay rates. Medical staffing are based on substantive rates of pay at 2022/23 prices and are costed at midpoint of scale.
- Nursing, diagnostics, therapies and administration staff include a calculation to cover sickness and annual leave at 21%.
- Non pay costs have been estimated for the areas described with reference to the increase in WTEs.

## 8.2 Capital cost and affordability

### 8.2.1 Capital Cost

The capital investment for the phase one front door enhancements are minimal. The total capital works and equipment is estimated at £154k. There is an estimated:

- £12k for minor changes required to create office space in the existing AEC area to create the SDEC
- £112k is estimated for 10 reporting workstations, desks and chairs for radiology
- £30k for additional therapeutic equipment including seating for older patients, re-turns and standing hoists.

A summary of the capital costs are shown in the table below.

*Table 28 - Summary capital expenditure*

| Description | Cost (Excluding VAT) | VAT 20% | Gross Capital Cost |
|---|---|---|---|
| | £'000 | £'000 | £'000 |
| Works costs to create office space for the new SDEC area | 10 | 2 | 12 |
| Radiology Office Reporting Equipment | 94 | 19 | 112 |
| Additional Therapy Equipment | 25 | 5 | 30 |
| **Total capital cost** | **129** | **26** | **154** |

The associated capital charges are £20k per year and are in included in the recurring revenue assessment described in section 3.6 below. Depreciation is calculated on equipment over ten

years and works costs over thirty years. The public dividend capital (PDC) is calculated at 3.5%.

### 8.2.2 Capital Affordability and Source of Funding

It is anticipated that the capital will be prioritised as part of the wider Health Weston project. The cash requirement will be met from UHBW's retained cash balances. Table 29 below shows the source and application of capital funds.

*Table 29 - Source and application of capital funds*

| Source and Application of Funds | |
|---|---|
| | £'000 |
| **Source of funding** | |
| UHBW Retained Cash Balances | 154 |
| | |
| **Application of funds** | |
| Capital cost | (154) |
| | |
| **Total capital funding** | - |

### 8.2.3 Revenue Assessment

2025/26 is the recurring revenue position. This is the estimated position including the medical agency savings as it is planned that the majority of the recruitment is assumed to take place in 2023/24 on a phased trajectory in line with the recruitment plan. The total cost of the phase one front door enhancements is £13.1m, an increase of £2.6m in 2025/26 against the 2021/22 baseline of £10.5m. Of the estimated increase of £2.6m, pay costs increase by £3.4m relating to an increase of circa 76wtes. The remainder of the increase is non-pay costs at £0.4m. Agency savings of £3.3m in 2025/26 and savings of £1.1m in 2025/26 in relation to the estimated phase 1 benefits of the Front Door investments due to reduced bed escalation costs are also included.

The estimated increase in costs in year one 2023/24 is £2.5m and includes £0.6m non-recurring costs mainly relating to recruitment.

Table 30 below shows a summary position of the financial impact against the 2021/22 baseline. The total financial impact (including the associated non-recurring costs) in 2023/24 is £2.5m, £4.2m in 2024/25, reducing to £2.6m in 2025/26 (the recurring position).

*Table 30 Summary position of the financial impact against the 2021/22 baseline*

| Summary Revenue Assessment | 2021/22 Baseline Subset | | 2023/24 | | | 2024/25 | | | 2025/26 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | In Post WTE | Actual Cost | WTE | Cost £'000 | Impact £'000 | WTE | Cost £'000 | Impact £'000 | WTE | Cost £'000 | Impact £'000 |
| **Recurring Costs** | | | | | | | | | | | |
| Pay | 142.94 | 10,068 | 216.72 | 11,591 | 1,523 | 218.96 | 13,837 | 3,769 | 218.96 | 13,488 | 3,420 |
| Non Pay | | 434 | | 816 | 382 | | 816 | 382 | | 816 | 382 |
| **Subtotal Recurring Costs** | **142.94** | **10,502** | **216.72** | **12,407** | **1,905** | **218.96** | **14,654** | **4,151** | **218.96** | **14,304** | **3,802** |
| **Non Recurring Costs** | | | | **616** | **616** | | **393** | **393** | | **0** | **0** |
| **Total Costs** | **142.94** | **10,502** | **216.72** | **13,024** | **2,522** | **218.96** | **15,046** | **4,544** | **218.96** | **14,304** | **3,802** |
| **Estimated P1 benefits of Front Door Enhancements** | | | | **-** | **-** | | (290) | (290) | | (1,159) | (1,159) |
| **Total net cost / (saving)** | | | | **13,024** | **2,522** | | **14,756** | **4,255** | | **13,145** | **2,643** |

A high level summary of the revenue assessment is shown in table 31 below with further detail included in Appendix 10 attached.

*Table 31 - Phased Revenue Assessment - 2023/24 to 2025/26*

| | | | HW2 Impact - Phase 1 | | | | | | | | 2023/24 | | | 2024/25 | | | 2025/26 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2021/22 Baseline Subset | 2021/22 Baseline Subset | Front Door Staffing Requirement - | | OPAU 14 bedded Unit | | Other in post to consider | | | | Total WTEs | Total Cost | Impact | Total WTEs | Total Cost | Impact | Total WTEs | Total Cost | Impact |
| | In Post WTE | £'000 | WTE | £'000 | WTE | £'000 | WTE | £'000 | Total WTE | Incr WTE | WTEs | £'000 | £'000 | WTEs | £'000 | £'000 | WTEs | £'000 | £'000 |
| **Pay** | | | | | | | | | | | | | | | | | | | |
| **Medical Staff** | | | | | | | | | | | | | | | | | | | |
| Emergency Department (ED) | 34.57 | 4,294 | 42.00 | 4,628 | 0.00 | 0 | 0.00 | 0 | 42.00 | 7.43 | 42.00 | 4,289 | (5) | 42.00 | 4,241 | (53) | 42.00 | 3,786 | (508) |
| Geriatric Emergency Medicine / Frailty Service (GEMS) | 1.13 | 163 | 4.00 | 465 | 0.00 | 0 | 0.00 | 0 | 4.00 | 2.87 | 4.00 | 328 | 165 | 4.00 | 465 | 301 | 4.00 | 465 | 301 |
| Same Day Emergency Care (SDEC) & Acute Monitoring | 9.65 | 1,515 | 12.00 | 1,692 | 0.00 | 0 | 1.69 | 101 | 13.69 | 4.04 | 13.69 | 1,519 | 4 | 13.69 | 1,740 | 226 | 13.69 | 1,652 | 138 |
| Older Persons Assessment Unit (OPAU) | 4.00 | 249 | 0.00 | 0 | 6.75 | 605 | 0.00 | 0 | 6.75 | 2.75 | 5.75 | 292 | 43 | 6.75 | 518 | 269 | 6.75 | 605 | 356 |
| Radiologists | 0.69 | 98 | 2.93 | 379 | 0.00 | 0 | 0.00 | 0 | 2.93 | 2.24 | 1.69 | 138 | 40 | 2.93 | 272 | 174 | 2.93 | 379 | 281 |
| **Subtotal medical staff** | **50.04** | **6,319** | **60.93** | **7,164** | **6.75** | **605** | **1.69** | **101** | **69.38** | **19.34** | **67.13** | **6,567** | **248** | **69.37** | **7,236** | **917** | **69.37** | **6,887** | **568** |
| **Nursing Staff** | | | | | | | | | | | | | | | | | | | |
| Geriatric Emergency Medicine / Frailty Service (GEMS) | 4.00 | 150 | 12.14 | 563 | 0.00 | 0 | 0.00 | 0 | 12.14 | 8.14 | 12.14 | 357 | 206 | 12.14 | 563 | 413 | 12.14 | 563 | 413 |
| Same Day Emergency Care (SDEC) | 5.58 | 212 | 12.96 | 546 | 0.00 | 0 | 0.00 | 0 | 12.96 | 7.38 | 12.96 | 292 | 80 | 12.96 | 546 | 333 | 12.96 | 546 | 333 |
| Acute Monitoring Unit (AMU) | 32.52 | 1,368 | 30.59 | 1,402 | 0.00 | 0 | 0.00 | 0 | 30.59 | -1.93 | 30.59 | 1,225 | (143) | 30.59 | 1,402 | 34 | 30.59 | 1,402 | 34 |
| Older Persons Assessment Unit (OPAU) | 46.69 | 1,817 | 0.00 | 0 | 30.59 | 1,402 | 19.00 | 610 | 49.59 | 2.90 | 49.59 | 1,889 | 73 | 49.59 | 2,012 | 195 | 49.59 | 2,012 | 195 |
| **Subtotal Nursing Staff** | **88.79** | **3,547** | **55.69** | **2,511** | **30.59** | **1,402** | **19.00** | **610** | **105.28** | **16.49** | **105.28** | **3,763** | **216** | **105.28** | **4,522** | **975** | **105.28** | **4,522** | **975** |
| **Pharmacy, Therapies and Diagnostic Staff** | | | | | | | | | | | | | | | | | | | |
| Pharmacy Staff | 1.00 | 62 | 4.00 | 234 | 0.00 | 0 | 0.00 | 0 | 4.00 | 3.00 | 4.00 | 117 | 55 | 4.00 | 234 | 172 | 4.00 | 234 | 172 |
| Occupational (OT) / Physiotherapy (PT) Staff | 0.00 | 0 | 7.34 | 355 | 5.18 | 232 | 0.00 | 0 | 12.52 | 12.52 | 12.52 | 357 | 357 | 12.52 | 587 | 587 | 12.52 | 587 | 587 |
| Dietetics / Speech & Language Therapy (SLT) Staff | 0.00 | 0 | 4.48 | 223 | 1.28 | 60 | 0.00 | 0 | 5.76 | 5.76 | 5.76 | 165 | 165 | 5.76 | 283 | 283 | 5.76 | 283 | 283 |
| Diagnostic Staff | 3.11 | 140 | 22.02 | 975 | 0.00 | 0 | 0.00 | 0 | 22.02 | 18.91 | 22.02 | 622 | 483 | 22.02 | 975 | 835 | 22.02 | 975 | 835 |
| **Subtotal Pharmacy, Therapies and Diagnostic Staff** | **4.11** | **202** | **37.84** | **1,787** | **6.46** | **292** | **0.00** | **0** | **44.30** | **40.19** | **44.30** | **1,261** | **1,059** | **44.30** | **2,079** | **1,877** | **44.30** | **2,079** | **1,877** |
| **Subtotal Pay** | **142.94** | **10,068** | **154.47** | **11,461** | **43.80** | **2,299** | **20.69** | **711** | **218.96** | **76.02** | **216.72** | **11,591** | **1,523** | **218.96** | **13,837** | **3,769** | **218.96** | **13,488** | **3,420** |
| **Non Pay** | | | | | | | | | | | | | | | | | | | |
| **Direct nonpay costs** | | 409 | | 554 | | | | | | | | 554 | 145 | | 554 | 145 | | 554 | 145 |
| **Diagnostics & Therapies Outsourcing Costs** | | 0 | | 215 | | | | | | | | 215 | 215 | | 215 | 215 | | 215 | 215 |
| **Facilities management costs** | | | | | | | | | | | | | | | | | | | |
| Soft FM Costs | | 25 | | 29 | | | | | | | | 29 | 4 | | 29 | 4 | | 29 | 4 |
| **Capital Charges** | | 0 | | 15 | | | | | | | | 20 | 20 | | 20 | 20 | | 20 | 20 |
| **Subtotal Nonpay and Capital Charges** | **0.00** | **434** | **0.00** | **812** | **0.00** | **0** | **0.00** | **0** | **0.00** | **0.00** | **0.00** | **816** | **382** | **0.00** | **816** | **382** | **0.00** | **816** | **382** |
| **Total Recurring Cost** | **142.94** | **10,502** | **154.47** | **12,273** | **43.80** | **2,299** | **20.69** | **711** | **218.96** | **76.02** | **216.72** | **12,407** | **1,905** | **218.96** | **14,654** | **4,151** | **218.96** | **14,304** | **3,802** |
| **Non Recurring Costs** | | | | | | | | | | | | | | | | | | | |
| Project Management Costs | | | | | | | | | | | | 73 | 73 | | 0 | 0 | | 0 | 0 |
| Recruitment Costs | | | | | | | | | | | | 543 | 543 | | 393 | 393 | | 0 | 0 |
| **Total Non Recurring Costs** | | | | | | | | | | | | **616** | **616** | | **393** | **393** | | **0** | **0** |
| **Grand Total Costs** | | | | | | | | | | | | **13,024** | **2,522** | | **15,046** | **4,544** | | **14,304** | **3,802** |
| **Estimated Ph1 benefits of Front Door Enhancements** | | | | | | | | | | | | **0** | **0** | | **(290)** | **(290)** | | **(1,159)** | **(1,159)** |
| **Total net cost / (saving)** | | | | | | | | | | | | **13,024** | **2,522** | | **14,756** | **4,255** | | **13,145** | **2,643** |

## 8.2.4 Agency Savings

The agency savings are shown in the table below. The agency costs in phase one in 2021/22 are £3.5m, 90% (£3.2m medical agency) and 10% (£0.3m nursing agency). In 2023/24 the level of agency costs will reduce by £0.9m (26%) as the recruitment plan is delivered. In 2024/25 and 2025/26 further agency savings will be realised - 2024/25 £2.0m (61% reduction) and in 2025/26 £3.3m (94%).

*Table 32 - Agency savings*

| | Baseline Subset | | Phased Future State - HW Phase 1 | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Summary Agency Savings** | **2021/22** | | **2023/24** | | **2024/25** | | **2025/26** | |
| | **£'000** | **%** | **£'000** | **Saving** | **£'000** | **Saving** | **£'000** | **(Saving)** |
| **Medical Agency** | | | | | | | | |
| ED Consultants | 909 | | 909 | 0 | 568 | (341) | 0 | (909) |
| ED Middle Grades | 428 | | 424 | (4) | 209 | (219) | 0 | (428) |
| ED Juniors | 969 | | 281 | (688) | 0 | (969) | 0 | (969) |
| AMU/SDEC Consultants | 579 | | 568 | (11) | 379 | (200) | 0 | (579) |
| AMU/SDEC Middle Grades | 241 | | 184 | (56) | 0 | (241) | 0 | (241) |
| **Subtotal medical agency** | **3,126** | **90%** | **2,366** | **(759)** | **1,155** | **(1,970)** | **0** | **(3,126)** |
| **Nursing Agency** | | | | | | | | |
| AMU | 132 | | 0 | (132) | 0 | (132) | 0 | (132) |
| OPAU | 213 | | 213 | 0 | 213 | 0 | 213 | 0 |
| **Subtotal nursing agency** | **345** | **10%** | **213** | **(132)** | **213** | **(132)** | **213** | **(132)** |
| **Total Agency - Phase 1** | **3,471** | | **2,580** | **(891)** | **1,369** | **(2,102)** | **213** | **(3,258)** |
| **% Reduction against baseline** | | | | **-26%** | | **-61%** | | **-94%** |

### 8.2.5 Estimated Benefits of the Phase 1 Investments

The estimated benefits of the phase 1 investment are included in the recurring revenue position with a total saving in 2025/26 of £1.2m. This is based on an assessment of a reduced requirement for bed escalation capacity in the following areas:

- Closure of day surgery ward escalation capacity - £0.6m saving in 2025/26
- Closure of overnight ED escalation beds - £0.3m saving in 2025/26
- Closure of Waterside ward escalation beds - £0.3m saving in 2025/26

Table 33 below summarises the position

*Table 33 - Estimated benefits of front door enhancements*

| Healthy Weston Phase 1 | | | |
|---|---|---|---|
| Estimated Benefits of Front Door Enhancements | | | |
| | | | |
| | | (Q4) | FYE |
| | 2023/24 | 2024/25 | 2025/26 |
| **Bed Closures** | **£'000** | **£'000** | **£'000** |
| Day Surgery Ward | 0 | (149) | (596) |
| ED Escalation Beds | 0 | (68) | (274) |
| Waterside Costs | 0 | (72) | (289) |
| **Total** | **0** | **(290)** | **(1,159)** |

## 8.3 Overall Medical Staff

The overall increase in Medical Staff is 19.3wte with a net cost (after agency savings) of £0.2m in 2023/24, £0.9m in 2024/25 and £0.6m in 2025/26. The detail by functional area or department is described in the sections below.

The medical workforce WTEs have been reviewed and signed off by the Healthy Weston Medical Workforce Challenge session which included the Weston Clinical Chair and other senior Healthy Weston clinicians in January 2023.

### 8.3.1 Medical Staff - Emergency Department (ED)

The 2021/22 total ED baseline is 34.57wte, a cost of £4.3m. The phase 1 requirement is 42wte, an increase of 7.43wte. The financial impact in 2023/24 and 2024/25 is cost neutral with a reduction in cost of £0.5m estimated in 2025/26 as all agency savings are realised. Table 34 below shows the financial cost and impact over the three years 2023/24 to 2025/26.

*Table 34 - Financial cost and impact over 2023/24 to 2025/6*

| | | 2021/22 Baseline | | HW2 | 2023/24 | | | 2024/25 | | | 2025/26 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Staff Type / Grade | In Post WTE | Actual Cost £'000 | WTE Increase | WTE | Total Cost £'000 | Impact | WTE | Total Cost £'000 | Impact | WTE | Total Cost £'000 | Impact |
| **ED Medical Staff** | Consultant | 1.75 | 298 | 2.00 | 3.75 | **355** | **58** | 6.62 | **591** | **293** | 6.62 | **855** | **558** |
| | Locum consultant | 5.38 | 715 | 0.00 | 5.38 | **715** | **0** | 5.38 | **715** | **0** | 5.38 | **715** | **0** |
| | Agency consultant | 2.87 | 909 | 0.00 | 2.87 | **909** | **0** | 0.00 | **568** | **(341)** | 0.00 | **0** | **(909)** |
| **Subtotal consultants** | | **10.00** | **1,921** | **2.00** | **12.00** | **1,979** | **58** | **12.00** | **1,874** | **(48)** | **12.00** | **1,570** | **(351)** |
| | Middle grades | 8.03 | 539 | 2.43 | 10.46 | **793** | **254** | 10.46 | **1,080** | **541** | 10.46 | **1,137** | **598** |
| | Locum Middle grades | 4.54 | 428 | 0.00 | 4.54 | **424** | **(4)** | 4.54 | **209** | **(219)** | 4.54 | **0** | **(428)** |
| **Subtotal middle grades** | | **12.57** | **967** | **2.43** | **15.00** | **1,217** | **251** | **15.00** | **1,289** | **322** | **15.00** | **1,137** | **171** |
| | Junior Doctors | 6.24 | 436 | 3.76 | 10.00 | **754** | **318** | 12.00 | **905** | **469** | 12.00 | **905** | **469** |
| | Agency Junior Doctors | 5.76 | 969 | -3.76 | 2.00 | **281** | **(688)** | 0.00 | **0** | **(969)** | 0.00 | **0** | **(969)** |
| **Subtotal junior doctors** | | **12.00** | **1,406** | **0.00** | **12.00** | **1,035** | **(371)** | **12.00** | **905** | **(501)** | **12.00** | **905** | **(501)** |
| | Physician Associate (Band 7) | **0.00** | **0** | **3.00** | 3.00 | **58** | **58** | 3.00 | **173** | **173** | 3.00 | **173** | **173** |
| **Subtotal ED Medical Staff** | | **34.57** | **4,294** | **7.43** | **42.00** | **4,289** | **(5)** | **42.00** | **4,241** | **(53)** | **42.00** | **3,786** | **(508)** |

**Agreed Key Workforce Requirement**

- The overall ED requirement is 12wte consultants, 15wte middle grades, 12wte juniors and 3 band 7 physician associates, an increase in cost of £3.8m in 2025/26.
- 2.87wte Agency consultants to remain in post for 2023/24 in line with the recruitment plan. These will be converted to substantive posts in 2024/25.
- 4.54wte locum middle grades to remain in post for 2023/24 and by the end of 2024/25 it is assumed that 15wte middle grades will be substantively recruited to.
- 2.00wte junior doctors agency posts remain for 2023/24 and by the end of 2024/25 it is assumed that 12wte junior doctors will be recruited substantively.

### 8.3.2 Medical Staff - GEMS/Frailty

The total GEMS medical staffing requirement is 4.0wtes of which 2.0wte are consultants and 2.0wtes are associate specialists. The phased recruitment of the 2wte consultants and the 0.87wte associate specialist vacancy results in a phased increase in financial cost of £0.16m in 2023/24 and £0.46m in 2024/25 and 2025/26. Table 35 below shows the costs phased over the three years.

*Table 35 - Medical staff - GEMS/Frailty costs phased over 3 years*

| | | 2021/22 Baseline | | HW2 | 2023/24 | | | 2024/25 | | | 2025/26 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Staff Type / Grade | In Post WTE | Actual Cost £'000 | WTE Increase | WTE | Total Cost £'000 | Impact | WTE | Total Cost £'000 | Impact | WTE | Total Cost £'000 | Impact |
| **GEMS / Frailty Service Medical Staff** | Consultant | 0.00 | 0 | 2.00 | 2.00 | **151** | **151** | 2.00 | **258** | **258** | 2.00 | **258** | **258** |
| | Associate Specialists | 1.13 | 163 | 0.87 | 2.00 | **178** | **14** | 2.00 | **206** | **43** | 2.00 | **206** | **43** |
| **Subtotal GEMS Medical Staff** | | **1.13** | **163** | **2.87** | **4.00** | **328** | **165** | **4.00** | **465** | **301** | **4.00** | **465** | **301** |

**Agreed Key Workforce Requirement**

- All posts to be recruited to substantively
- The medical staffing assumes working 8am-8pm 5 days per week. This also included 1PA per day for frailty SEDC slot/clinic 9am - 1pm (Monday to Friday). A proposed job plan of 10PAs, 6.5 (direct clinical care) DCC, 1.5 Supporting PA, 1.0 PA for admin and 1PA for a specialty clinic.

- Assumes working 8am-10pm 7 days per week.
- Job plan of 10PAs, 7.5 DCC, 1.5 SPA, 1.0 Leadership PA.
- Excludes Virtual Ward GEMS consultant as this is funded elsewhere.

### 8.3.3 Medical Staff - Acute Monitoring Unit (AMU) and Same Day Emergency Care (SDEC)

The total AMU and SDEC medical staffing requirement is 13.69wtes an increase of 4.04wte against the baseline. The phased recruitment of the 6wte consultants and 6wte middle grades results in a cost neutral position in 2023/24, a cost increase of £0.15m in 2024/25 and £0.14m in 2025/26. Table 36 below shows the costs phased over the three years.

*Table 36 - Medical staff - AUMU and SDEC costs over 3 years*

| | | 2021/22 Baseline | | HW2 | 2023/24 | | | 2024/25 | | | 2025/26 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Staff Type / Grade | In Post WTE | Actual Cost £'000 | WTE Increase | WTE | Total Cost £'000 | Impact | WTE | Total Cost £'000 | Impact | WTE | Total Cost £'000 | Impact |
| **AMU/SEDEC Medical Staff** | Consultant | 1.00 | 200 | 2.00 | 3.00 | **248** | **47** | 5.00 | **625** | **424** | 5.00 | **915** | **715** |
| | Locum Consultant | 1.00 | 129 | 0.00 | 1.00 | **129** | **0** | 1.00 | **129** | **0** | 1.00 | **129** | **0** |
| | Agency Consultant | 2.00 | 579 | 0.00 | 2.00 | **568** | **(11)** | 0.00 | **308** | **(271)** | 0.00 | **0** | **(579)** |
| **Subtotal consultants** | | **4.00** | **909** | **2.00** | **6.00** | **945** | **37** | **6.00** | **1,062** | **153** | **6.00** | **1,045** | **136** |
| | Specialty Doctor | 0.00 | 0 | 0.00 | | | | | | | | | |
| | St 3 To 8 | 3.00 | 203 | 2.00 | 5.00 | **289** | **86** | 6.00 | **507** | **304** | 6.00 | **507** | **304** |
| | Locum Middle Grades | 0.05 | 56 | -0.05 | | **0** | **(56)** | | **0** | **(56)** | | **0** | **(56)** |
| | Agency Middle Grades | 1.00 | 184 | 0.00 | 1.00 | **184** | **0** | 0.00 | **0** | **(184)** | 0.00 | **0** | **(184)** |
| | Other | 0.00 | 0 | 0.00 | | **0** | **0** | | **0** | **0** | | **0** | **0** |
| **Subtotal middle grades** | | **4.05** | **444** | **1.95** | **6.00** | **473** | **29** | **6.00** | **507** | **63** | **6.00** | **507** | **63** |
| | Junior Doctors | 0.00 | 61 | 0.00 | | **0** | **(61)** | | **0** | **(61)** | | **0** | **(61)** |
| | Physician Associate (Band 7) | 1.60 | 101 | 0.09 | 1.69 | **101** | **()** | 1.69 | **101** | **()** | 1.69 | **101** | **()** |
| **Subtotal AMU/SEDEC Medical Staff** | | **9.65** | **1,515** | **4.04** | **13.69** | **1,519** | **4** | **13.69** | **1,669** | **155** | **13.69** | **1,652** | **138** |

**Agreed Key Workforce Requirement**

- Overall requirement of 6wte consultants, 6wte middle grades and 1.69 physician associates.
- The requirement of 6wte consultants is based on 1 consultant in AMU working 9am to 5pm Monday to Friday, 1 consultant in SDEC working 11am - 7pm Monday to Friday and 1 consultant working 9am - 5pm on Saturday and Sunday. The proposed job plan is 5.5 PA DCC, 1.5 SPA, 1 PA admin, 1 PA on call, 1 PA specialty clinic, 1PA leadership education & governance.
- It is planned that by the end of Q2 (2024/25) 1wte agency consultant will be converted a substantive post and a further 1wte converted by the end of Q4 (2024/25).
- 1.69wte physician associates assumed to remain in post.

### 8.3.4 Medical Staff - Older Persons Assessment Unit (OPAU)

The total OPAU medical staffing requirement is 6.75wte. This is an increase of 2.75wte consultant posts. 4wte middle grade and junior doctors are in post already and has no financial impact. The phased recruitment of the consultant posts result in a £0.06m cost impact in 2023/24 and £0.36m in 2024/25 and 2025/26. The OPAU recruitment is planned to take place in quarter 3 in 2023/24 and in 2024/25. The detail is shown in table 37 below.

*Table 37 - OPAU recruitment*

| | | 2021/22 Baseline | | HW2 | 2023/24 | | | 2024/25 | | | 2025/26 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Staff Type / Grade | In Post WTE | Actual Cost £'000 | WTE Increase | WTE | Total Cost £'000 | Impact | WTE | Total Cost £'000 | Impact | WTE | Total Cost £'000 | Impact |
| **Older Persons Assessment Unit** | Consultant | 0.00 | 0 | 2.75 | 1.75 | **62** | **62** | 2.75 | **356** | **356** | 2.75 | **356** | **356** |
| | St 3 To 8 | 1.00 | 65 | 0.00 | 1.00 | **65** | **0** | 1.00 | **65** | **0** | 1.00 | **65** | **0** |
| | Mid point between FY2 and STA2 | 3.00 | 185 | 0.00 | 3.00 | **185** | **0** | 3.00 | **185** | **0** | 3.00 | **185** | **0** |
| **Subtotal OPAU Medical Staff** | | **4.00** | **249** | **2.75** | **5.75** | **311** | **62** | **6.75** | **605** | **356** | **6.75** | **605** | **356** |

**Agreed Key Workforce Requirement**

- Overall requirement of 2.75wte consultants, 1wte middle grades and 3wte juniors.
- The requirement of 2.75wte is based on a working pattern for one consultant 9am-5pm, 5 days per week. The proposed job plan of 4.5 PA DCC, 1PA Admin, 1.5 SPA,1 PA on call,1 PA for a speciality clinic and 1PA for leadership, Governance, Education.
- Recruit to 2.75wte consultants substantively and therefore no agency is assumed for the OPAU medical model
- Middle grades and juniors in post already

### 8.3.5 Radiology - Medical Staff

There is an estimated increase of 2.2wte consultant radiologists at a recurring cost of £0.3m in 2025/26. This is based on a consultant being required on site 8am to 8pm Monday to Friday and 8am to 2pm on the weekend. It is assumed that 1 WTE radiologist on a 10PA job plan will be available to undertake 4.5 PAs of reporting.

There is an allowance for outsourcing radiology reporting outside these hours until midnight seven days a week. The outsourcing costs are £0.2m based on 8 scans per day at £75 per scan. These costs are included under the non-pay Section 8.6 of the financial assessment.

## 8.4 Overall Nursing Staff

The overall increase in Nursing Staff is 16.49wte, with an estimated cost impact of £0.2m in 2023/24, £1.0m in 2024/25 and 2025/26. The detail by functional area or department is described in the sections below.

The workforce and hence the finance model has been developed with lead clinicians, workforce and recruitment colleagues and the recruitment phasing of the WTEs and the delivery of agency savings are in line with the recruitment plan described in section 7.8 of this business case.

The nursing workforce WTEs have been reviewed and signed off by the Healthy Weston Nursing Challenge session which included the UHBW Deputy Chief Nurse and other senior nurse practitioners in January 2023.

### 8.4.1 Nursing - GEMS

A total nursing requirement of 12.14wte is required for GEMS. This is an increase in cost of £0.4m compared with to 2021/22. These have been agreed and signed off at the nursing workforce check and challenge session held on Monday the 9th January.

There are two posts included under the GEMS service heading as a placeholder which actually cover GEMS, AMU and OPAU – these are:

- 1 WTE Band 8a Matron covering GEMS, AMU and the OPAU
- 1 WTE Band 6 Practice Education Facilitator (PEF) role. The role of the PEF is crucial in the continuous development of the nursing teams, ensuring that clinical practice is kept up to date and is evidence based. It provides training and education to clinical teams and supports both new starters and staff that have been in post for some time and is proven to support the retention of staff.

*Table 38 - Nursing workforce requirement for GEMS*

| | | 2021/22 Baseline | | HW2 | 2023/24 | | | 2024/25 | | | 2025/26 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Staff Type / Grade | In Post WTE | Actual Cost £'000 | WTE Increase | WTE | Total Cost £'000 | Impact | WTE | Total Cost £'000 | Impact | WTE | Total Cost £'000 | Impact |
| GEMS / Frailty Service | Nurse Band 2 | 0.00 | 0 | 0.00 | 0.00 | 0 | 0 | | 0 | 0 | | 0 | 0 |
| | Nurse Band 3 | 0.00 | 0 | 2.48 | 2.48 | 38 | 38 | 2.48 | 83 | 83 | 2.48 | 83 | 83 |
| | Nurse Band 5 | 1.00 | 28 | 3.97 | 4.97 | 80 | 52 | 4.97 | 205 | 177 | 4.97 | 205 | 177 |
| | Band 6 PEF | 0.00 | 0 | 1.00 | 1.00 | 26 | 26 | 1.00 | 45 | 45 | 1.00 | 45 | 45 |
| | Nurse Band 7 | 1.00 | 12 | 0.69 | 1.69 | 88 | 77 | 1.69 | 106 | 95 | 1.69 | 106 | 95 |
| | Nurse Band 8a (Matron) | 1.00 | 51 | 0.00 | 1.00 | 62 | 11 | 1.00 | 62 | 11 | 1.00 | 62 | 11 |
| | Nurse - Bank and Overtime | 0.00 | 0 | 0.00 | 0.00 | 0 | () | 0.00 | 0 | () | 0.00 | 0 | () |
| | Advanced Care Practioners (A( | 1.00 | 59 | 0.00 | 1.00 | 62 | 3 | 1.00 | 62 | 3 | 1.00 | 62 | 3 |
| Subtotal GEMS/Frailty Service | | 4.00 | 150 | 8.14 | 12.14 | 357 | 206 | 12.14 | 563 | 413 | 12.14 | 563 | 413 |

**Agreed Key Workforce Requirement**

Working with the Head of Nursing for the Weston site the WTEs have been calculated using the Trust's nursing establishment model based on the following shift times and working patterns;

- 1 band 3 Health Care Support Worker (HCSW) on long day (8am - 8pm) 7 days per week.
- 2 band 5 registered nurses on long day (8am - 8pm) 7 days per week. 1:3 Ratio.
- No band 6 requirement.
- Assumes 1 nurse everyday 8am - 4pm - 7 days per week - assumed backfill 0.29wte will be at band 7.
- 1 ACP band 8A (8am - 4pm) 5 day per week Monday – Friday.

### 8.4.2 Nursing - SDEC

A total nursing requirement of 12.96wte at £0.55m, an increase of 7.38wte at an additional cost of £0.33m in 2025/26 compared with 2021/22.

*Table 39 - Nursing workforce requirement for SDEC*

| | | 2021/22 Baseline | | HW2 | 2023/24 | | | 2024/25 | | | 2025/26 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Staff Type / Grade | In Post WTE | Actual Cost £'000 | WTE Increase | WTE | Total Cost £'000 | Impact | WTE | Total Cost £'000 | Impact | WTE | Total Cost £'000 | Impact |
| **Same Day Emergency Care (SDEC)** | Agency Nursing & Midwifery | 0.00 | 1 | 0.00 | 0.00 | **0** | **(1)** | 0.00 | **0** | **(1)** | 0.00 | **0** | **(1)** |
| | A&C Coordinator Band 2 | 0.87 | 22 | 1.18 | 2.05 | **49** | **27** | 2.05 | **65** | **43** | 2.05 | **65** | **43** |
| | Nurse Band 2 | 0.00 | 0 | 0.00 | 0.00 | **0** | **()** | 0.00 | **0** | **()** | 0.00 | **0** | **()** |
| | Nurse Band 3 | 0.00 | 0 | 2.48 | 2.48 | **33** | **33** | 2.48 | **87** | **87** | 2.48 | **87** | **87** |
| | Nurse Band 4 | 1.96 | 67 | -1.96 | 0.00 | **0** | **(67)** | 0.00 | **0** | **(67)** | 0.00 | **0** | **(67)** |
| | Nurse Band 5 | 1.47 | 63 | 3.48 | 4.95 | **106** | **42** | 4.95 | **208** | **145** | 4.95 | **208** | **145** |
| | Nurse Band 6 | 0.81 | 39 | 1.67 | 2.48 | **85** | **46** | 2.48 | **130** | **91** | 2.48 | **130** | **91** |
| | Nurse Band 7 | 0.00 | 0 | 1.00 | 1.00 | **18** | **18** | 1.00 | **55** | **55** | 1.00 | **55** | **55** |
| | Nurse - Bank and Overtime | 0.47 | 19 | -0.47 | 0.00 | **0** | **(19)** | 0.00 | **0** | **(19)** | 0.00 | **0** | **(19)** |
| **Subtotal Same Day Emergency Care (SDEC)** | | **5.58** | **212** | **7.38** | **12.96** | **292** | **80** | **12.96** | **546** | **333** | **12.96** | **546** | **333** |

### Agreed Key Workforce Requirement

Working with the Head of Nursing for the Weston site the WTEs have been calculated using the Trust's nursing establishment model based on the following shift times and working patterns;

- 1 band 2 Admin Co-Ordinator (EL Shift) 10am – 10pm 7 days per week.
- 1 band 3 HCSW (Early (EL) Shift)) 10am-10pm 7 days per week.
- 2 band 5s 1 on (EL Shift) 10am-10pm 7 days per week and 1 on a (Long Day (LD) Shift) 7:30am to 6pm 7 days per week.
- 1 band 6 (EL Shift) 10pm - 10pm 7 days per week.
- 1 band 7 Normal working hours Monday - Friday (8am - 4pm) - assumed backfill on band 5.

## 8.4.3 Nursing - Acute Monitoring Unit (AMU)

A total nursing requirement of 30.59wte at £1.4m, is broadly no change when compared with 2021/22 baseline. This includes an agency saving of £0.13m.

*Table 40 - Nursing workforce requirement for AMU*

| | | 2021/22 Baseline | | HW2 | 2023/24 | | | 2024/25 | | | 2025/26 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Staff Type / Grade | In Post WTE | Actual Cost £'000 | WTE Increase | WTE | Total Cost £'000 | Impact | WTE | Total Cost £'000 | Impact | WTE | Total Cost £'000 | Impact |
| **Acute Medical Assessment Unit (AMU)** | Agency Nursing | 0.38 | 132 | -0.38 | 0.00 | **0** | **(132)** | 0.00 | **0** | **(132)** | 0.00 | **0** | **(132)** |
| | A&C Band 2 | 1.43 | 43 | 0.62 | 2.05 | **56** | **14** | 2.05 | **65** | **22** | 2.05 | **65** | **22** |
| | Nurse Band 2 | 8.29 | 257 | -8.29 | 0.00 | **0** | **(257)** | 0.00 | **0** | **(257)** | 0.00 | **0** | **(257)** |
| | Nurse Band 3 | 1.00 | 14 | 8.94 | 9.94 | **349** | **335** | 9.94 | **371** | **357** | 9.94 | **371** | **357** |
| | Nurse Band 4 | 2.00 | 23 | -2.00 | 0.00 | **0** | **(23)** | 0.00 | **0** | **(23)** | 0.00 | **0** | **(23)** |
| | Nurse Band 5 | 8.83 | 388 | 1.32 | 10.15 | **436** | **48** | 10.15 | **461** | **73** | 10.15 | **461** | **73** |
| | Nurse Band 6 | 4.80 | 236 | 0.17 | 4.97 | **271** | **34** | 4.97 | **277** | **40** | 4.97 | **277** | **40** |
| | Nurse Band 7 | 1.00 | 50 | 0.00 | 1.00 | **55** | **6** | 1.00 | **55** | **6** | 1.00 | **55** | **6** |
| | Nurse Band 8a - ACPs | 0.00 | 0 | 2.48 | 2.48 | **58** | **58** | 2.48 | **173** | **173** | 2.48 | **173** | **173** |
| | Nurse - Bank and Overtime | 4.79 | 224 | -4.79 | 0.00 | **0** | **(224)** | 0.00 | **0** | **(224)** | 0.00 | **0** | **(224)** |
| **Subtotal Acute Monitoring Unit (AMU)** | | **32.52** | **1,368** | **-1.93** | **30.59** | **1,225** | **(143)** | **30.59** | **1,402** | **34** | **30.59** | **1,402** | **34** |

**Agreed Key Workforce Requirement**

- 2 band 3 HCSW 24/7, 7 days per week (2 nurses on a long day 2 long night).
- 2 band 5 Registered Nurses 24/7 7 days per week (2 nurses on a long day and 2 long night).
- 1 band 6 Nurse 24/7 7 days per week (1 long day and 1 long night) - Ratio 1:4 (assessment area).
- 1 band 7 Normal working hours Monday - Friday - assumed backfill on band 5.
- 1 ACP on Mon to Sun Long Day (1 ACP on a Long Day) (7 days per week - Monday to Sunday).

### 8.4.4 Nursing - Older Persons Assessment Unit (OPAU)

A total nursing requirement an increase of 2.90wte at an additional cost of £0.19m in 2025/26. This increase in cost is as a result of investment in the ACP roles. It should be noted that for the baseline, the cost comparator is the cost of 14 beds of the Sandford ward. The remaining beds maintain the existing staffing.

*Table 41 - Nursing workforce requirement for OPAU*

| | | 2021/22 Baseline | | HW2 | 2023/24 | | | 2024/25 | | | 2025/26 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Staff Type / Grade | In Post WTE | Actual Cost £'000 | WTE Increase | WTE | Total Cost £'000 | Impact | WTE | Total Cost £'000 | Impact | WTE | Total Cost £'000 | Impact |
| **Older Persons Assessment Unit (OPAU)** | Agency Nursing & Midwifery | 1.29 | 213 | 0.00 | 1.29 | **213** | **0** | 1.29 | **213** | **0** | 1.29 | **213** | **0** |
| | A&C Band 2 | 1.71 | 42 | 0.34 | 2.05 | **57** | **16** | 2.05 | **65** | **23** | 2.05 | **65** | **23** |
| | Nurse Band 2 | 17.10 | 541 | -9.94 | 7.16 | **170** | **(371)** | 7.16 | **170** | **(371)** | 7.16 | **170** | **(371)** |
| | Nurse Band 3 | 0.00 | 0 | 9.94 | 9.94 | **371** | **371** | 9.94 | **371** | **371** | 9.94 | **371** | **371** |
| | Nurse Band 4 | 2.00 | 58 | 0.00 | 2.00 | **58** | **0** | 2.00 | **58** | **0** | 2.00 | **58** | **0** |
| | Nurse Band 5 | 14.20 | 452 | 0.00 | 14.20 | **452** | **0** | 14.20 | **452** | **0** | 14.20 | **452** | **0** |
| | Nurse Band 6 | 4.53 | 181 | 0.00 | 4.53 | **181** | **0** | 4.53 | **181** | **0** | 4.53 | **181** | **0** |
| | Nurse Band 7 | 0.92 | 55 | 0.08 | 1.00 | **55** | **0** | 1.00 | **55** | **0** | 1.00 | **55** | **0** |
| | Nurse Band 8a - ACPs | 0.00 | 1 | 2.48 | 2.48 | **58** | **57** | 2.48 | **173** | **172** | 2.48 | **173** | **172** |
| | Nurse Band 8a (Matron) | 0.00 | 0 | 0.00 | 0.00 | **0** | **0** | 0.00 | **0** | **0** | 0.00 | **0** | **0** |
| | Nurse - Bank and Overtime | 4.94 | 274 | 0.00 | 4.94 | **274** | **0** | 4.94 | **274** | **0** | 4.94 | **274** | **0** |
| **Subtotal Older Persons Assessment Unit (OPAU)** | | **46.69** | **1,817** | **2.90** | **49.59** | **1,889** | **73** | **49.59** | **2,012** | **195** | **49.59** | **2,012** | **195** |

**Agreed Key Workforce Requirement**

- 2 band 3 HCSWs 24/7 7 days per week (2 long day 2 long night).
- 2 band 5 RNs 24/7 7 days per week (2 long day and 2 long night).
- 1 band 6 24/7 7 days per week (1 long day and 1 long night) - Ratio 1:4 (assessment area).
- 1 band 7 Normal working hours Monday - Friday - assumed backfill on band 5.
- 1 ACP on Mon to Sun Long Day (1 ACP on a Long Day) (7 days per week - Monday to Sunday).

## 8.5 Pharmacy, Therapies and Diagnostic Staff

For these staff groups the operating model will involve in reaching into the services described earlier.

### 8.5.1 Pharmacy

In 2021/22 there is 1.0wte pharmacist in the baseline contributing to the ED. The total requirement is 4.00wte at a total cost of £0.23m. The additional cost impact is £0.17m and includes the following staffing:

- 1wte band 6 frailty and ED lead pharmacy technician.
- 1wte band 7 specialist frailty and ED pharmacist.
- 1wte band 8a lead frailty and ED pharmacist (which is currently in post).
- 1wte band 8b lead pharmacist, an overall increase of 3.0wte cost of 0.2m.

*Table 42 - Pharmacy workforce requirement*

| | | 2021/22 Baseline | | HW2 | 2023/24 | | | 2024/25 | | | 2025/26 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Staff Type / Grade | In Post WTE | Actual Cost £'000 | WTE Increase | WTE | Total Cost £'000 | Impact | WTE | Total Cost £'000 | Impact | WTE | Total Cost £'000 | Impact |
| **Pharmacy Staff** | Band 6 - Frailty and ED Lead Pha | 0.00 | 0 | 1.00 | 1.00 | 26 | 26 | 1.00 | 45 | 45 | 1.00 | 45 | 45 |
| | Band 7 - Specialist frailty and ED | 0.00 | 0 | 1.00 | 1.00 | 5 | 5 | 1.00 | 55 | 55 | 1.00 | 55 | 55 |
| | Band 8a - Lead frailty and ED Pha | 1.00 | 62 | 0.00 | 1.00 | 62 | 0 | 1.00 | 62 | 0 | 1.00 | 62 | 0 |
| | Band 8b - Care of Elderly Pharma | 0.00 | 0 | 1.00 | 1.00 | 24 | 24 | 1.00 | 72 | 72 | 1.00 | 72 | 72 |
| **Subtotal Pharmacy** | | **1.00** | **62** | **3.00** | **4.00** | **117** | **55** | **4.00** | **234** | **172** | **4.00** | **234** | **172** |

**Agreed Key Workforce Requirement**

The future state WTEs are based on the following working a 7.5 hours per day, Monday to Friday, and these hours are required to deliver an optimum, safe and effective clinical pharmacy service within the enhanced front door which addresses 'a must do' in the last CQC report for Weston Hospital in 2019 which was to *'Ensure pharmacy staffing levels meet demand and Carter model hospital indicators, and therefore, protect patient safety'*.

The workforce described above will be situated at the front door covering front door activities and the frailty service. This will give the resilience and team approach needed.

The 8b Consultant Pharmacist position will oversee these activities on site at WGH and to work at a ICB and regional level.

### 8.5.2 Physiotherapy and Occupational Therapy

There is no 2021/22 baseline for the physiotherapy and occupational therapy input to the front door. The investment therefore in physiotherapy and occupational therapy is in total an additional 12.52wte, at an additional cost of £0.59m from 2024/25, of which 7.34wte, £0.35m is in reaching into ED, GEMS, SDEC, AMU and 5.18wte, £0.23m will deliver the OPAU service.

*Table 43 - Therapy workforce requirement*

| | | 2021/22 Baseline | | ED (In Part) / GEMS / SDEC / | | OPAU 14 bedded Unit | | HW2 | 2023/24 | | | 2024/25 | | | 2025/26 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Staff Type / Grade | In Post WTE | Actual Cost £'000 | WTE | £'000 | WTE | £'000 | WTE Increase | WTE | Total Cost £'000 | Impact | WTE | Total Cost £'000 | Impact | WTE | Total Cost £'000 | Impact |
| **Occupational (OT) / Physiotherapy (PT) Staff** | Occupational Therapist Band 5 | 0.00 | 0 | 1.00 | 38 | | 0 | 1.00 | 1.00 | 22 | 22 | 1.00 | 38 | 38 | 1.00 | 38 | 38 |
| | Occupational Therapist Band 6 | 0.00 | 0 | 1.00 | 47 | 1.20 | 56 | 2.20 | 2.20 | 60 | 60 | 2.20 | 103 | 103 | 2.20 | 103 | 103 |
| | Occupational Therapist Band 7 | 0.00 | 0 | 1.00 | 58 | | 0 | 1.00 | 1.00 | 34 | 34 | 1.00 | 58 | 58 | 1.00 | 58 | 58 |
| | Physiotherapist Band 4 | 0.00 | 0 | | 0 | 0.80 | 27 | 0.80 | 0.80 | 16 | 16 | 0.80 | 27 | 27 | 0.80 | 27 | 27 |
| | Physiotherapist Band 5 | 0.00 | 0 | 1.00 | 38 | 1.00 | 38 | 2.00 | 2.00 | 44 | 44 | 2.00 | 76 | 76 | 2.00 | 76 | 76 |
| | Physiotherapist Band 6 | 0.00 | 0 | 2.00 | 93 | 1.50 | 70 | 3.50 | 3.50 | 95 | 95 | 3.50 | 163 | 163 | 3.50 | 163 | 163 |
| | Physiotherapist Band 7 | 0.00 | 0 | 1.00 | 58 | 0.50 | 29 | 1.50 | 1.50 | 51 | 51 | 1.50 | 87 | 87 | 1.50 | 87 | 87 |
| | Physiotherapist Band 8a | 0.00 | 0 | 0.22 | 14 | 0.10 | 6 | 0.32 | 0.32 | 21 | 21 | 0.32 | 21 | 21 | 0.32 | 21 | 21 |
| | Physiotherapist Band 8b | 0.00 | 0 | 0.12 | 9 | 0.08 | 6 | 0.20 | 0.20 | 14 | 14 | 0.20 | 14 | 14 | 0.20 | 14 | 14 |
| **Subtotal Occupational Therapy and Physiotherapy** | | **0.00** | **0** | **7.34** | **355** | **5.18** | **232** | **12.52** | **12.52** | **357** | **357** | **12.52** | **587** | **587** | **12.52** | **587** | **587** |

**Agreed Key Workforce Requirement:**

**Enhanced Front Door and GEMS**

- The therapy workforce provides "in reaching" based on the predicted number of patients presenting to front door services at Weston.
- Total figures also include a calculation to cover sickness and annual leave at 21% and provision of service over 7 days;
- For occupational therapy and physiotherapy, the figures are calculated to enable 10 hour therapy provision per day 7 days per week.

**OPAU**

- For the OPAU the figures are based on the 14 beds in the OPAU, a short stay 72 hour unit;
- A whole time equivalent (wte) weighting is used for each profession per bed;
- The wte replicates that which is used for other new business cases for therapy provision to medical patients within UHBW NHS Foundation Trust (such as those for the new beds within wards A700 and A800);
- The total calculation covers sickness and annual leave at 21% and provision of service over 7 days;
- The 7 day level of service is higher than that for inpatient wards to enable a similar level of therapy provision to the OPAU every day given the high turnover rate within this type of ward.

The workforce wte calculations and cost were signed off at the Therapies "check and challenge" session on the 11th January 2023.

### 8.5.3 Speech and Language Therapy and Dietetics

There is no current 2021/22 baseline for the speech and language therapy and dietetics input to the front door. The investment therefore is a total additional 5.76wte and an additional cost of £0.28m from 2024/25. 4.48wte, £0.22m is in reaching into ED, GEMS, SDEC and the AMU and 1.28wte, £0.06m will deliver the OPAU service.

The detail by band is provided in the table below.

*Table 44 - SLT and Dietetics workforce requirement*

| | | 2021/22 Baseline | | ED (In Part) / GEMS / SDEC / | | OPAU 14 bedded Unit | | HW2 | 2023/24 | | | 2024/25 | | | 2025/26 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Staff Type / Grade | In Post WTE | Actual Cost £'000 | WTE | £'000 | WTE | £'000 | WTE Increase | WTE | Total Cost £'000 | Impact | WTE | Total Cost £'000 | Impact | WTE | Total Cost £'000 | Impact |
| Dietetics / Speech & Language Therapy (SLT) Staff | Dietician Band 4 Assistant | 0.00 | 0 | 0.44 | 15 | | 0 | 0.44 | 0.44 | 9 | 9 | 0.44 | 15 | 15 | 0.44 | 15 | 15 |
| | Dietician Band 6 | 0.00 | 0 | 0.80 | 37 | 0.64 | 30 | 1.44 | 1.44 | 39 | 39 | 1.44 | 67 | 67 | 1.44 | 67 | 67 |
| | Dietician Band 7 - Team Lead | 0.00 | 0 | 0.80 | 46 | | 0 | 0.80 | 0.80 | 27 | 27 | 0.80 | 46 | 46 | 0.80 | 46 | 46 |
| | Dietician Band 8a - Pathway Lead | 0.00 | 0 | 0.20 | 13 | | 0 | 0.20 | 0.20 | 7 | 7 | 0.20 | 13 | 13 | 0.20 | 13 | 13 |
| | Speech Therapist Band 4 Assistant | 0.00 | 0 | 0.44 | 15 | | 0 | 0.44 | 0.44 | 9 | 9 | 0.44 | 15 | 15 | 0.44 | 15 | 15 |
| | Speech Therapist Band 6 | 0.00 | 0 | 0.80 | 37 | 0.64 | 30 | 1.44 | 1.44 | 39 | 39 | 1.44 | 67 | 67 | 1.44 | 67 | 67 |
| | Dietician Band 7 - Team Lead | 0.00 | 0 | 0.80 | 46 | | 0 | 0.80 | 0.80 | 27 | 27 | 0.80 | 46 | 46 | 0.80 | 46 | 46 |
| | Dietician Band 8a - Pathway Lead | 0.00 | 0 | 0.20 | 13 | | 0 | 0.20 | 0.20 | 7 | 7 | 0.20 | 13 | 13 | 0.20 | 13 | 13 |
| **Subtotal - Dietetics / Speech & Language Therapy (SLT) S** | | **0.00** | **0** | **4.48** | **223** | **1.28** | **60** | **5.76** | **5.76** | **165** | **165** | **5.76** | **283** | **283** | **5.76** | **283** | **283** |

The workforce wte calculations and cost were signed off at the Therapies "check and challenge" session on the 11th January 2023.

### 8.5.4 Radiology

The total radiology cost of the front door enhancements including the OPAU is a total of 22.02wte, a total cost of £0.97m, an additional 18.91wte, at an additional cost of £0.83m in 2025/26. The detail by band is shown in the table below.

*Table 45 - Radiology workforce requirement*

| | | 2021/22 Baseline | | HW2 | 2023/24 | | | 2024/25 | | | 2025/26 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Staff Type / Grade | In Post WTE | Actual Cost £'000 | WTE Increase | WTE | Total Cost £'000 | Impact | WTE | Total Cost £'000 | Impact | WTE | Total Cost £'000 | Impact |
| **Diagnostic Staff** | Plain film imaging radiographers-Band 5 | 0.56 | 28 | 3.38 | 3.94 | **113** | **85** | 3.94 | **176** | **147** | 3.94 | **176** | **147** |
| | CT&MRI Radiographers - Band 6 | 1.55 | 76 | 9.44 | 10.99 | **366** | **290** | 10.99 | **544** | **468** | 10.99 | **544** | **468** |
| | Ultrasonographers - Band 7 | 0.12 | 7 | 0.00 | 0.12 | **7** | **0** | 0.12 | **7** | **0** | 0.12 | **7** | **0** |
| | Healthcare support workers - Band 3 | 0.83 | 27 | 4.60 | 5.43 | **102** | **75** | 5.43 | **190** | **164** | 5.43 | **190** | **164** |
| | Reception staff - Band 3 | 0.06 | 2 | 1.49 | 1.55 | **34** | **33** | 1.55 | **57** | **56** | 1.55 | **57** | **56** |
| **Subtotal Diagnostic Staff** | | **3.11** | **140** | **18.91** | **22.02** | **622** | **483** | **22.02** | **975** | **835** | **22.02** | **975** | **835** |

**Agreed Key Workforce Requirement**

- The radiology provision relates to the whole of the front door (i.e. ED, GEMs, AMU, SDEC) and not just individual elements.
- The radiology workforce for elective inpatients and general practitioner work are excluded
- This model has been calculated on a 52 week a year basis.
- **Plain film and CT**: the service will run 8am to midnight 7 days a week. After 5pm there is currently only 1 member of staff to support the front door per modality our assumptions to support fast flow we required additional staff as detailed in the model. We have included a HCSW to support safe patient transfer and chaperoning out of

core hours. The exact hours are, 1 band 5 radiographer on each shift, Early (8am - 4pm), Late (4pm to midnight), Normal Day 9am - 5pm.

- **MRI:** The only increase to front door work is assumed to be cauda equina patients which requires access to imagining 8am – 9pm 7 days a week. The establishment has been increase to provide for an on-call services 5pm – 9pm M – F and 8am – 9 pm on weekends. This also accommodates an 8am start for patients that have arrived after 9pm the previous day. There is a HCSW Monday to Friday until 9pm (patient transfer). However, on weekends a HCSW is not provided and patient transfer and support of radiographer would be required from ED (same as BRI).
- **Ultrasound**: no change to the service provision. Out of hours activity will be accommodated the next working day in ring fenced slots.
- **Reception staff:** Assumption is that patients will arrive in ambulatory fashion and thus will need to be directed to the relevant waiting area. This is therefore staffed until midnight in the new model. The reception staff shift patterns are for 7 days of the week , Early (8am-4pm), Late (4pm to midnight)

## 8.6 Non Pay

The 2021/22 non pay baseline relating to phase one is £0.4m. The total non-pay for phase one is estimated at £0.55m, an increase of £0.15m. Non pay has been summarised across the common non pay subjective headings relative to the increase in WTEs. A summary of the non-pay costs are shown in the table below.

*Table 46 - Non-pay summary*

| Description | 2021/22 Baseline Subset | Estimated Cost | Cost Impact |
|---|---|---|---|
| | £'000 | £'000 | £'000 |
| Clinical Supplies & Services | 115 | 168 | 53 |
| Drugs and Blood Expenditure | 246 | 295 | 49 |
| Establishment Expenses | 2 | 6 | 4 |
| General Supplies & Services | 20 | 24 | 4 |
| Other Expenditure | 16 | 45 | 28 |
| Premises And Fixed Plant | 10 | 17 | 7 |
| **Total non pay** | **409** | **554** | **145** |

## 8.7 Facilities Management Costs (FM Costs)

The additional FM costs only relate to the increased provision of the existing GEMS service. The existing space of 42sqm is a dedicated 3 bed unit with good adjacencies to ED and AMU. The space is in good condition and has the required facilities to function.
The increase in operating hours will require additional soft FM costs. The estimated increase in soft FM costs is £3.5k, this includes cleaning, cleaning materials, cleaning supervision, portering, linen, waste and patient catering and is based on the current model hospital benchmark of £136/m2.

## 8.8 Capital Charges

The recurring capital charges for phase one and are estimated at £0.02m per annum, £0.015m for depreciation and £0.005m for PDC. These are calculated based on the estimated capital

cost for the works cost for the new SDEC area office space and additional capital equipment required for radiology and therapies as described in section 2 above which in total is £0.1m.

The following assumptions have been used to calculate the capital charges and are in accordance with UHBW's accounting policies:

- Buildings depreciated over a 30 year life;
- Equipment depreciated over a 10 year life;
- PDC calculated on the written down value (WDV) at 3.5%;

Table 47 below show a breakdown of the capital charges included in the recurring revenue assessment.

*Table 47 - Capital charges*

| Capital Charges | £'000 |
|---|---|
| Depreciation | 15 |
| Public Dividend Capital (PDC) | 5 |
| **Total capital funding** | **20** |

### 8.8.1 Contingency

There is no contingency provided in this financial assessment

## 8.9 Non-recurring costs

The non-recurring costs are estimated at £1.0m, £0.6m in 2023/24 and £0.4m in 2024/25. These are summarised in the table below. The non-recurring costs are associated with delivering the recruitment plan and some project management support included for the phase one implementation in 2023/24.

*Table 48 - Non-recurring costs*

| Description | Year 1 - 2023/24 | Year 2 - 2024/25 | Total |
|---|---|---|---|
| | £'000 | £'000 | £'000 |
| **Project Management Costs** | | | |
| 1 Band 8a - Lead project manager for implementation | 61 | | 61 |
| 2 Medical PAs for implementation | 13 | | 13 |
| **Recruitment Costs** | | | 0 |
| Recruitment Co-ordinators | 57 | 57 | 114 |
| Pastoral & Relocation Leads | 36 | 36 | 72 |
| Talent Acquisition Manager | 55 | 55 | 110 |
| Overseas recruitment costs | 178 | 101 | 279 |
| Medical Recruitment costs | 177 | 134 | 311 |
| Advertising / Communication costs | 40 | 10 | 50 |
| **Total** | **616** | **393** | **1,009** |

## 8.10 Impact on other providers

Sirona have considered the impact of the phase one proposals for the Healthy Weston two programme on community services.

The impact of the further strengthening the Home First admissions avoidance services, SDEC, AMU and GEMS, is not currently quantifiable and at this stage we are assuming these patients will largely enter the P0 pathway and impact on the community will be minimal.
The impact of the strengthening the Care of the Elderly Services and establishing an Older Persons Assessment Unit (OPAU) will result in patients having a reduced length of stay in Hospital. This is likely to see the same number of patients coming into the Discharge to Assess (D2A) pathway but it is likely that these patients may be less medically stable as they have stayed in hospital for less time. This may be partially offset by the patients being less decompensated i.e. deconditioning through being in hospital for a longer period of time without access to rehabilitation services. At this stage Sirona consider that there would be minimal impact on the community D2A service from a financial perspective except maybe during the initial stages when length of stay reduces as there may be more people on the caseload during this transition. At this stage we are assuming the numbers of people to each part of the pathway (P1, P2 and P3) will remain the same.

The full impact of these services, in particular the impact of the OPAU will need to be further considered once these services have been established and piloted. The resulting data will then enable any financial consequences to be quantified and this will need to be built into phase 2 of the business case.

## 8.11 Financial Risks

The following section describes a number of project risks associated with phase one of the development. These risks will need to be monitored and reviewed during project implementation phase.

- The risk that if the 2022/23 costs are materially lower than the 2021/22 baseline then the price to change will increase resulting in the project becoming more expensive. This is considered to be a moderate risk.
- The risk that if the recruitment plan does not deliver the planned recruitment into substantive posts then the agency savings will not be realised potentially resulting in the project becoming more expensive. This is considered to be a high risk.
- The risk that the current vacancy position at Weston deteriorates therefore increasing the recruitment requirement then the agency expenditure may increase beyond that assumed in the case potentially resulting in the project becoming more expensive. This is considered to be high risk.
- The risk that the escalation bed capacity cannot be closed due to increasing non elective and emergency care demand at Weston General Hospital. This is considered to be high risk.

## 8.12 Conclusion

In summary the additional recurring revenue cost of phase one is £2.6m in 2025/26. The additional revenue cost in 2023/24 is £2.5m (including non-recurring costs of £0.6m). The capital consequences of phase one is £0.15m and will need to be considered in the context of the £40m capital requirement per the Healthy Weston 2 OBC as part of the system capital prioritisation process.

# 9 Delivery arrangements

*Describe what arrangements have been put in place to ensure the successful delivery of the investment proposal, including:*

## 9.1 Implementation plan

Implementation of the service enhancements will commence from April 2023, following system approval of, and investment in this Phase 1 Full Business Case, as well as the successful implementation of the Phase 1 pilots through winter plan investment.

Implementation will start with the phased delivery of the front door enhancements (GEMS, SDEC and AMU), with OPAU delivery following once sufficient bed capacity has been released, around January 2024.

UHBW will be responsible for the implementation of Phase 1, with BNSSG ICB providing ongoing system support and programme coordination.

The strategic timeline, including the required governance for implementation of the Phase 1 clinical model, is presented below. The timeline also highlights that the Phase 1 clinical model will be fully implemented by April 2024, with recruitment to fill existing vacancies with substantive staff ongoing until March 2025.

*Table 49 - High level implementation plan*

| | **22/23** | **23/24** | | | | **24/25** | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 |
| System Governance and sign off - Phase 1 Full Business Case | | | | | | | | | |
| Inclusion of transitional investment in 22/23 operational planning | | | | | | | | | |
| ED, AMU, SDEC & GEMS workforce recruitment to future model | Medical recruitment to commence from Jan 2023 (subject to approval) | Nursing, Therapies, Pharmacy & Diagnostic recruitment to commence | | | Majority of workforce recruited by Q4 23/24 | | | | |
| Phased implementation of front door enhancements - AMU, SDEC, GEMS | | | | | | | | | |
| OPAU recruitment | | | | | | | | | |
| OPAU implementation | | | | | | | | | |
| Recruitment to existing vacancies | | | | | | | | | |

A full implementation plan, found in Appendix 11, has been developed for each service area, detailing plans for recruitment, operational policy development, estates, communications and launching the new service model. The plan has been developed by UHBW (WGH) senior leaders, service leads and clinicians, who will lead the work in operationalising new and enhanced urgent care services, ensuring the achievement of deliverables and benefits as set out in Section 5. The monitoring of these deliverables, alongside the monitoring of

benefits, will facilitate the programme in managing change, with appropriate action being taken where needed to address any barriers.

### 9.1.1 Implementation plan arrangements

*This section should describe the impact of the change on the organisational culture, systems, processes, and people and should be linked to the benefits realisation.*

The delivery of Healthy Weston 2 Phase 1 will bring about a range of organisational changes to Weston General Hospital, positively impacting the hospital, the wider system and those accessing services.

Considerations around how the changes will impact processes, systems, staff, and patients have been extensively built upon and tested by the Healthy Weston programme through ongoing engagement and communications with key stakeholders including staff and patient and public. This has ensured that the implementation plan, communications plan, and process for planning, testing, and evaluating change has been informed and led by professional experts, whilst incorporating feedback from those likely to be affected by the changes.

For example, the communications plan has been developed by communications leads at UHBW and BNSSG ICB, whilst incorporating feedback gathered as part of the public engagement period which took place June – August 2022. During this engagement period, staff and the public were asked how they would best like to receive communications about the changes, and if there were any areas, they would like more information on. This feedback has informed the Phase 1 implementation communications plan and will continue to be built upon as the programme continues to develop.

The impact of the changes delivered will be measured through the assessment of programme benefits. The benefits realisation section in Section 5 details the framework around which the programme will manage, monitor, and assess benefits realisation.

### 9.1.2 Implementation plan governance framework

*This section should confirm the change management arrangements to manage anticipated and unexpected change and should include:*

- *Confirmation that the Project Board is accountable for change management*
- *Details of any Change Board arrangements including key roles and responsibilities and governance arrangements*
- *Change reporting arrangements*

Responsibility of the delivery of Phase 1 will lie with University Hospitals Bristol and Weston NHS Foundation Trust (UHBW), with BNSSG ICB providing ongoing system and programme coordination. The programme governance structure will remain as before, as described in Section 9.2.2. Regular reporting on change will be provided to the Healthy Weston Programme Group and Healthy Weston Steering Group to ensure detailed and rigorous oversight is applied to change management as well as internal UHBW change management reporting mechanisms.

### 9.1.3 Implementation communication and engagement

Following approval of this Full Business Case, ongoing work is planned to continue to inform staff, the public and wider stakeholders about the Healthy Weston 2 programme and Phase 1 implementation. Guiding the communications and engagement through the Phase 1

implementation period are the outcomes from the public engagement exercise (June – August 2022), where respondents fed back how they would best like to receive information, the type of information they would like to receive, and who the Healthy Weston Programme should target with additional engagement activity, including those living in areas of deprivation, older people and people with mental health issues. Alongside the broad public communications and engagement approach, a targeted tactic will be applied through working with partners, local authority and voluntary and community sector organisations to these reach specific cohorts, as identified in the Equalities Impact Assessment (Appendix 7) and in the public engagement themes report (Appendix 8).

A dedicated plan to inform and involve staff through Phase 1 implementation, particularly those who will be affected by the plans, will be designed by UHBW communications leads. This builds on the dedicated programme of staff activity to date, including staff drop-in sessions, programme updates at team meetings, communications through the staff intranet and newsletter, and printed materials distributed around the Hospital site.

The staff communications and engagement plans will be closely linked to the implementation plan (Appendix 11), correlated with key milestones and delivery dates to ensure staff are aware of any changes in advance and have the opportunity to share any feedback. This will facilitate a smooth transition period for those working at Weston General Hospital and ensure good morale, ultimately supporting positive staff satisfaction and retention levels.

Through the programmes governance structures and membership, system partners and wider system stakeholders have been extensively engaged with and informed of the plans for Healthy Weston 2. This will aid the mitigation of any risk due to change within the system and facilitate the smooth transition between Phase 1 planning and Phase 1 implementation. The programme will continue to communicate and engage with the system and external stakeholders throughout the delivery of the Phase 1 clinical model, particularly with those likely to be most affected by the plans.

### 9.1.4 Implementation Sustainability

As part of a long term plan of service improvement, it is particularly important to consider the sustainability impact of the plans being implemented. This is to ensure that where identified, mitigating actions are put in place to limit any potential negative impacts on sustainability, whist also promoting positive sustainable opportunities. The Sustainability Impact Assessment found in Appendix 12 considers the sustainability impact of the Healthy Weston plans put forward in line with the wider ICS sustainability ambitions.

## 9.2 Project management

### 9.2.1 Project management arrangements

*The FBC should confirm the project and / or programme management the Trust is using to manage this scheme. Examples include Managing Successful Programmes (MSP) and PRINCE2 Projects IN Controlled Environments.*

The Healthy Weston 2 programme is managed through agreed ICB project and programme management policy and protocol including the VERTO project management system. BNSSG ICB VERTO project management system enables regular governance checks and reporting, with oversight from the Project Management Office (PMO), to ensure the programme remains viable and on track. Regular project management updates are also provided throughout the Healthy Weston governance arrangements, as described in Section 9.2.2.

### 9.2.2 Project Governance

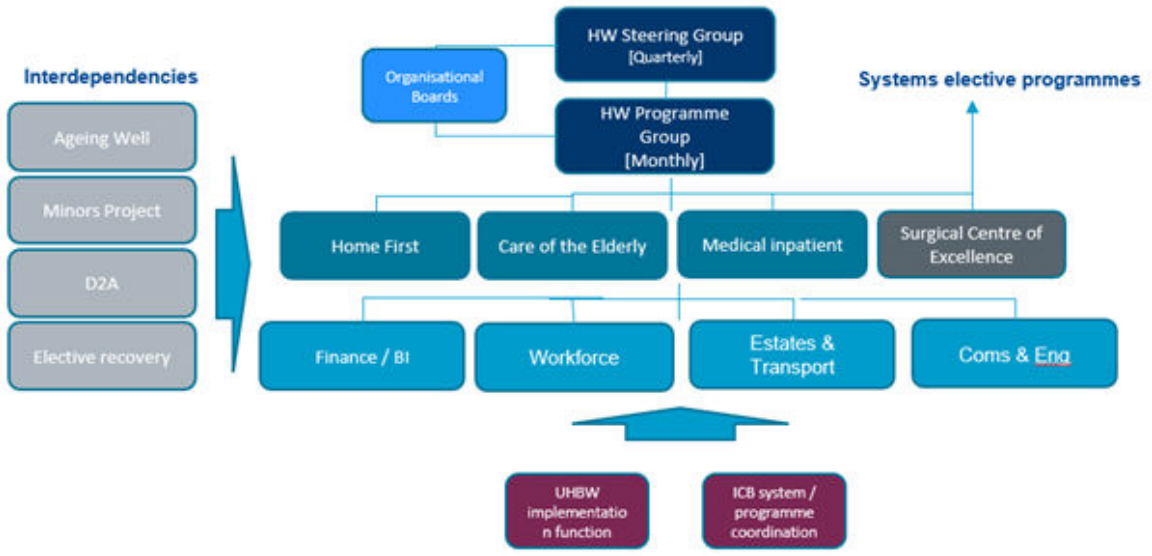
*This section should confirm the governance arrangements for the project including:*

- *Project Board, Structure and Reporting and Governance arrangements (including governance chart)*
- *Confirmation of the Senior Responsible Officer (name and job title)*
- *Appointed personnel (e.g., SRO, members of Project Board, Project Director, Project Manager, Project Team members) and key project roles and responsibilities*
- *Assurance of the SRO and Project Team's experience and capability*
- *Project management resources being used on this scheme (e.g., project plan, RAID log, highlight reports etc)*
- *Details of any specialist advisors involved in the project*

The Healthy Weston 2 programme sits under the BNSSG Integrated Care System, comprised of commissioning organisations and health and social care delivery partners. The assurance requirements for the delivery of the clinical model are rigorous. To enable this and facilitate the governance and assurance process, the programme has a robust governance structure to ensure that delivery of the clinical model is assured by both system governance and the local community affected by these changes.

The figure below sets out the system governance of Healthy Weston 2. The structure provides appropriate system leadership, oversight and coordination, executive level buy-in as well as clinical leadership and patient and public involvement. It also ensures finance, workforce and estates expertise and input is provided throughout the programme.

*Figure 18 - Governance*




The Healthy Weston Steering Group meets quarterly and provides system leadership, decision making and oversight to drive the development of Healthy Weston 2 full business cases, as well as overseeing the full implementation of Healthy Weston 2 Phase 1. The membership of the Steering Group is Chief Executives from the ICS system, Healthwatch BNSSG, Somerset FT and North Somerset Council. The Steering Group is chaired by the CEO of the Integrated Care Board.

The Healthy Weston 2 Programme Group drives and oversees the development of Healthy Weston 2 business cases and implementation plans, as well as the day-to-day delivery of Healthy Weston 2 Phase 1 business case. The membership of the Board is executive members from the BNSSG system, Healthwatch North Somerset, Somerset Foundation Trust (SFT) and North Somerset Council. The Programme Group is chaired by the Executive Managing Director of Weston General Hospital, the programme's Senior Responsible Officer.

The four project groups (home first, care of the elderly, medical inpatients and Surgical Centre of Excellence) focus on the development of business plans, clinical specifications, phasing and interdependencies and workforce requirements for each of the clinical areas. The Surgical Centre of Excellence group will be system supported ensuring aspirations for the Centre are met and that it plays a full part in BNSSG elective system planning and recovery.

*Table 50 - Healthy Weston Steering Group membership*

| **Core Members** | **Role** |
|---|---|
| Chair | Chief Executive (BNSSG ICB) |
| UHBW | Chief Executive & WGH Managing Director |
| BNSSG CCG / ICB | Director of Strategy, Partnerships and Population |
| Brisdoc / Severnside | Medical Director |
| AWP | Chief Executive |
| North Sedgemoor PCN | Clinical Director |
| North Somerset Council | Chief Executive |
| North Bristol Trust | Chief Executive |
| Pier Health | Clinical Director |
| Sirona CIC | Chief Executive |
| Somerset CCG / ICB | Chief Executive |
| Somerset FT | Chief Executive |
| SWASFT | Chief Executive |
| DoF Lead | Director of Finance UHBW |

*Table 51 - Appointed Personnel*

| **Name** | **Role** | **Organisation** |
|---|---|---|
| Paula Clarke | Senior Responsible Officer<br><br>Executive Managing Director of Weston General Hospital | UHBW |
| Shane Devlin | Chief Executive | BNSSG ICB |
| Deborah El-Sayed | Director of Transformation | BNSSG ICB |
| Rebecca Dunn | Deputy Director of Transformation | BNSSG ICB |
| Helen Edelstyn | Head of Programme – Healthy Weston | BNSSG ICB |
| Sian Barry | Programme Director – Large Scale Change | BNSSG ICB |

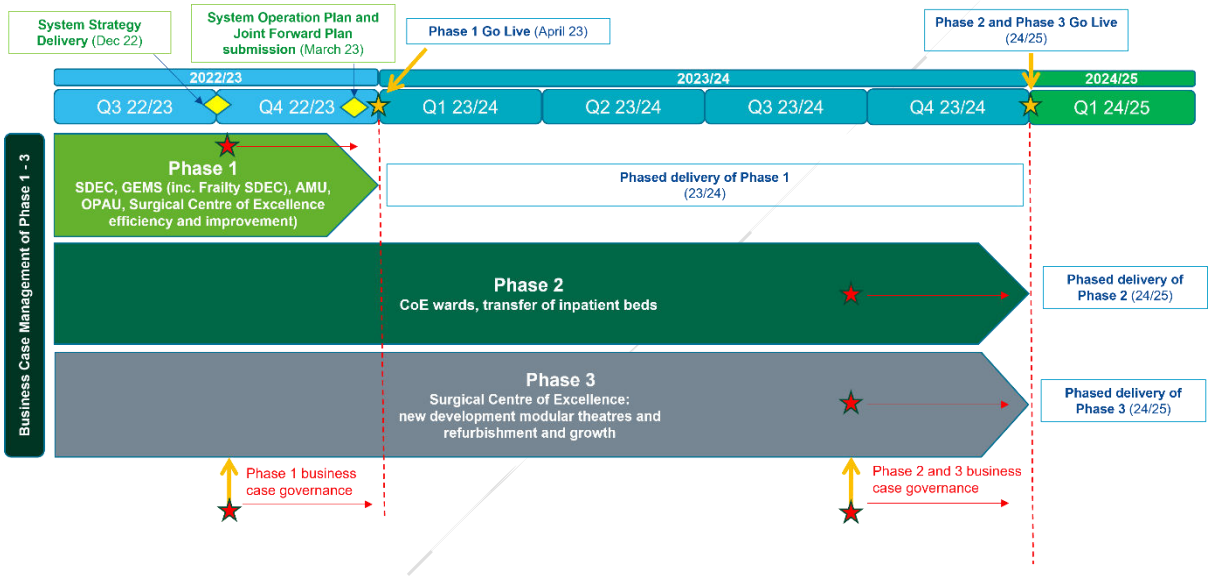
### 9.2.3 Project plan

*The FBC is required to set out the full project plan, including delivery milestones, timescales, responsibility, products / deliverables, activities, dependencies, constraints, and Gateway Reviews.*

The improvement plans set out in the Healthy Weston 2 OBC have been agreed for delivery over three phases, with three interlinked full business cases. Phase 1 implementation is planned to commence from April 2023 following approval of this Full Business Case through governance, with a phased approach to delivery being adopted. Phase 2 and Phase 3 are sequentially dependent on Phase 1, and the development of the sequential full business cases will follow as capacity and benefits are released.

Figure 19 below provides the timeline for the Healthy Weston 2 business case development and delivery, with further details on the Healthy Weston 2 Phase 1 programme plan found throughout this business case and in Appendix 13.

*Figure 19 - Healthy Weston programme timeline*




### 9.2.4 Project handover

*This section should set out and confirm the formal handover plans from the business case development project team to the Capital Estates project team, including:*

- *Timescale for the handover*
- *Processes for identifying and capturing snagging list*
- *Name and job title of the Project Manager for the mobilisation / construction phase*
- *Review of Terms of Reference / creation of ToR for mobilisation phase*
- *Confirmation of membership required (names and job titles) for the mobilisation phase*

Responsibility for the delivery of Healthy Weston 2 Phase 1 will lie with UHBW, with BNSSG ICB providing ongoing system support and programme coordination. The role of Programme Manager will remain with BNSSG ICB, with the governance structures outlined in 6.1.2 continuing as the service improvements are implemented. Effective communication and engagement with UHBW, the system and wider stakeholders throughout the implementation planning period will support the smooth transition between Phase 1 planning and Phase 1 implementation, with minimal interference expected because of the handover.

### 9.2.5 Learning from winter pilots

In preparation for Phase 1 implementation and to help reduce winter pressures, the first step in the Phase 1 enhancements have been introduced and funded on a short-term basis through winter funding. This includes Same Day Emergency Care pathways, enhancement to the Acute Monitoring Unit and the introduction of ED Observation beds. These early Phase 1 improvements will offer early insight into implementation, change management and benefits realisation, and will be incorporated in the programme plan.

## 9.3 Risk management

### 9.3.1 Risk management arrangements

*This section should confirm arrangements for identification and management of risks and demonstrate how the project will have:*

- *A process for identification of possible risks in advance*
- *Put mechanisms in place to minimise the likelihood of the risks materialising with adverse effects*
- *Processes in place to monitor risks, and access to reliable, up-to-date information about risks*
- *The right balance of control to mitigate against adverse consequences of the risks, should they materialise*
- *A decision-making process supported by a framework for risk analysis and evaluation*
- *Documented roles, responsibilities, and reporting lines for risk management*

The governance and assurance arrangements of the Healthy Weston 2 Programme were established to ensure rigorous oversight of the Programme, and its development of plans for improvement and change. Programme risk is managed by the Healthy Weston 2 Programme Manager, with the Senior Responsible Officer (SRO) holding overall accountability. It is the responsibility of Programme Management to escalate any new risks or change in risk status to the SRO for review, and to share regular risk updates via the Programme risk register with the Healthy Weston Programme Group and Healthy Weston Steering Group. It is also the responsibility of those supporting the Healthy Weston Programme to share any possible risks with Programme Management as quickly as possible.

The Programme risk register is held on BNSSG ICB VERTO project management system, securely storing accurate and up to date records of risk. Regular highlight reporting to the Healthier Together Project Management Office (PMO) allows additional oversight from the Healthier Together PMO to confirm the Programme is managing and mitigating risk effectively. The Healthy Weston Programme Manager is responsible for regularly monitoring and reviewing the risk register, evaluating the likelihood of the risk materialising and the impact this could have on the delivery of the Programme. The Programme Manager must also assess the mitigations in place and ensure that the appropriate actions are being carried out to mitigate against the consequences of the risks, should they materialise.

### 9.3.2 Information Governance (IG) and privacy impact assessment

Following specialist IG advice, the Data Protection Impact Assessment (DPIA) presented in Appendix 14 has been produced on the basis that there should be no change to any patient data flows, and that at no time will any patient identifiable data be held by the programme. The plans also do not alter the provider of the services nor are there changes to clinical systems or record keeping specific to the programme.

The data that will be held by the programme during Phase 1 is as follows:

- Project Management documentation
- Programme Governance documentation
- Engagement documentation and feedback

The DPIA describes:

- the data, data flows, and retention period
- any data protection and privacy risks identified
- the risk management measures agreed

### 9.3.3 Contingency arrangements and plans

*This section should describe the contingency plan in the event that the scheme / service is not delivered to the required availability (timeframe) and performance (quality).*

The continual assessment of risk and issues will allow the Healthy Weston programme to monitor, evaluate and react on any variance to the planned delivery of Healthy Weston 2 Phase 1 beyond the defined levels of tolerance.

In the event that risks cannot be mitigated, and the programme is unable to deliver the plans to the required availability and performance, the following action will be taken.

*Table 52 - Contingency arrangements*

| Situation | Contingency arrangement |
|---|---|
| UHBW are unable to recruitment sufficient workforce to staff the new service models | Signpost and promote the opportunity for bank and agency staff to fill these posts whilst ongoing recruitment strategies are developed |
| The programme is unable to get the required transitional revenue investment to progress with the implementation of the planned changes | The programme will be paused whilst alternative investment is sourced, or until the next financial year when transitional revenue investment will be sought again |
| The Discharge to Assess Business Case is not implemented, resulting in the loss of capacity to accommodate non-elective bed transfers to the BRI and Southmead | Bed modelling based on the 21/22 activity data has been calculated including both D2A and no D2A, to allow forecasting and appropriate planning of services if D2A Business Case is not implemented |

# 10 Recommendations

*Summary of the recommendation of the Full Business Case.*

Healthy Weston 2 has galvanised stakeholders from all backgrounds and professions around a shared vision for Weston General Hospital to be a vibrant and dynamic hospital at the heart of our community. A single model of care that strengthens local services, has been agreed. This Full Business Case puts forward the case for revenue investment in Phase 1 – high quality, sustainable urgent care Weston General Hospital, that is in line with national and local standards, and ensures that local people have equity of access to the best urgent care

The proposals align to commitments within the Long Term Plan for emergency care and help reduce health inequalities by better meeting local need. They are centred around the needs of the Weston population and improving health equality is at the heart of the service reforms proposed.

The proposals will ensure that the local population continues to benefit from all-age general hospital services including a local Emergency Department, open from 8am – 10pm, as now. The introduction of new same day care and short stay pathways will reduce the amount of time people spend in hospital and specialist services for older people, that are integrated with the community, will provide a high standard of care that delivers the best possible outcomes.

Most importantly, the changes will ensure services at Weston General Hospital are sustainable and are able to consistently meet national and local clinical quality standards as workforce challenges will be addressed through new opportunities and investment. The plans are a step change in provision and will help put the hospital on a sustainable financial footing for the future.

This is an exciting time Weston General Hospital and the local community. This Full Business Case presents the opportunity for the system to invest in Weston General Hospital, and significantly improve the quality of emergency care services in Weston, Worle and the surrounding villages.

Healthier Together

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

# Appendix 1 – Healthy Weston 2 Phase 1

# Risk Register

Date: January 2023

Healthier Together

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

| | Risk | Description | Category | Initial Risk Score | Mitigating Action | Target Risk Score | Progress on Actions | Current Risk Score | Owners | Status |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | System Pressures | There is a risk that system pressures impact on the ability to secure the right clinical/system input to develop HW2 full business cases resulting in delay to delivery, a lack of engagement, and impact on timeline | Strategic - Threat | 9 | 1) Clinically led programme teams and good engagement with Clinical System Leaders<br>2) Commitment of clinical leaders established through HWSG<br>3) ICB working closely with wider clinical colleagues.<br>4) PMO considers and adapts according to system guidance in programme plan / governance schedule<br>5) Regular engagement meetings with UHBW and other partners regarding capacity and programme involvement<br>6) Healthy Weston Steering Group members have made clear their commitment to ensure their teams prioritise the development of the model within the timelines required<br>7) Programme resource | 4 | 1) Clinical pressures at UHBW continue [as a result of winter pressures and some vacancies]<br>2) HWSG members are asked to ensure input from their organisations, particularly around Governance. | 6 | Programme Manager | Open |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | request including clinical time | | | | | |
| 2 | Local Elections | There is a risk that the programme is used in local election campaigning and politicians campaign against change resulting in a lack of political and public support for planss which creates delay. | Political | 9 | 1) Ongoing engagement with HOSP, HWB and other local politicians and council officers on plans<br>2) Ongoing engagement with MPs and local political groups on plans<br>3) 8 week public engagement exercise raised public awareness of improvement plans | 4 | 1) HW programme continues to keep good communication with NSC via meetings and emails. ICB meetings with NS Director of Public Health and CEO.<br>2) Regular briefing letters and meeting requests go out to council and MP members to keep them informed of the programme.<br>3) PMO provide regular checks against progress and timeline, escalating as needed.<br>4) The HOSP decision on model not considered substantial variation gives more flexibility and control with the timeline as NHSE deadlines are no longer in place.<br>5) Continue to deliver the agreed public engagement plan<br>6) Continue to engage HOSP on outcome of public engagement | 6 | Programme Manager | Open |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| 3 | Workforce deliverability | There is a risk that potential solutions do not give sufficient consideration to workforce deliverability which may result in an un-viable clinical model, meaning that the model cannot be implemented. | Operational - Threat | 9 | 1) Consideration of Workforce included in implementation work<br>2) Ongoing work between Workforce and Finance sub-groups to refine and test the activity and workforce modelling<br>3) Workforce group developed considered workforce recruitment and retention plans - that are fit with other system initiatives | 4 | 1) Future workforce state is a key focus of the programme - regular meetings with clinicians to progress<br>2) Workforce group stood up April 2022 and continues to meet regularly | 9 | Programme Manager | Open |
| 4 | Engagement | There is a risk that insufficient engagement with the general public and wider stakeholders will result in ill-informed implementations plans, reputational damage, impaired relationships, negative publicity and prevent progression to decision points. | Strategic - Threat | 9 | 1) A Comms and Engagement plan has been developed and agreed<br>2) 8 week public engagement exercise is complete with final report available for sharing<br>3) Feedback from the engagement period is being incorporated in to implementation planning | 6 | 1)The final report from the 8 week engagement period now available. This is being used to inform next steps around future comms and engagement, and feedback being incorporated in to plans for programme implementation. | 9 | Programme Manager | Open |
| 5 | Finance Deliverability | There is a risk the 2019/20 baseline for the acute sites understates the "cost to change" | Finance including claims | 12 | 1) Appointed finance lead<br>2) Finance group established.<br>3) Work to bridge the 2019/20 baseline to current year has commenced.<br>4) Revenue cost | 6 | 1) Risk continues to be discussed and mitigated at BI/finance group. Will require oversight of the Healthy Weston Steering Group.<br>2) The next business case stage with use | 9 | Programme Manager<br><br>[Risk owner UHBW Chief Finance Officer] | Closed |

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| | | | | | contingency included at £1m in OBC financial assessment.<br>5) Capital cost of £6m included for the non-elective bed transfer to Musgrove Park Hospital. | | 2021/22 as the finance baseline hence risk is closed. | | | |
| 6 | Reliance on D2A | There is a risk that the programme is reliant on the system approved Discharge to Assessment Business Case being implemented and delivered by all partners in accordance with the Business Case, in order to release the bed capacity to accommodate the non-elective bed transfer to the BRI and Southmead Hospitals. | Finance including claims | 9 | 1) Discharge to Assess operational delivery must be tracked and understood in the System via the D2A Project Board and reported into the HW Finance & BI Group.<br>2) Discharge to Assess operational delivery programme pending. | 6 | 1) Risk continues to be discussed and mitigated at BI/finance group. Will require oversight of the Healthy Weston Steering Group.<br>2) D2A Delivery Board in place to drive delivery and measure impact. Awaiting output from Board to assess early impact. | 12 | Programme Manager | Open |
| 7 | Capital investment | There is a risk that the capital investment required is not sourced, resulting in the implementation of the model stalling, leading to ongoing exposure to risk of unsustainable clinical services needing to be suspended at short notice | Finance including claims | 12 | 1) Work ongoing with Finance and BI group to identify opportunities for capital investment<br>2) Implementation strategy that sees certain elements of the model being implemented earlier (e.g. SDEC) in place | 4 | 1) Risk continues to be discussed and mitigated at BI/finance group. Will require oversight of the Healthy Weston Steering Group.<br>2) The BNSSG system CDEL is over-committed by in excess of £100m on a 5 year CDEL of c£400m. Position now | 16 | Programme Manager | Open |

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| | | | | | | | subject to urgent BNSSG strategic capital prioritisation. HWP2 included as £40m scheme per PCBC/OBC | | | |
| 8 | HW 1 implementation | There is a risk that failure to deliver all of Healthy Weston 1 Programme undermines confidence and support for Healthy Weston Phase 2, resulting in a failure to deliver the model and reputational damage. | Operational - Threat | 9 | 1) The key outstanding change in Healthy Weston Phase 1 (enhanced paediatric services on the site 14/7) is now being addressed by UHBW, with the Healthy Weston Steering Group receiving regular progress updates | 4 | 1) HW Steering Group and HW Programme Group continues to oversee the implementation of HW Phase 1 including paediatrics | 6 | Programme Manager | Open |
| 9 | Programme resourcing | There is a risk that insufficient programme and provider resourcing impacts on the ability to provide programme governance, oversight, assurance, and the right clinical input into implementation plans resulting in a failure to deliver implementation plans, the proposed changes, and long term sustainability of Weston General Hospital. | Strategic - Threat | 9 | 1) Some PMO resource in place [temporary contracts] | 4 | 1) Some PMO resource until November 2023<br>3) Clinical capacity needs to be considered | 9 | Programme Manager | Open |

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| 10 | Clinical pressures | There is a risk that clinical and system pressures impact on the ability to provide high quality services that meet the required standard at Weston General Hospital resulting in intervention, the closure of services and a failure to deliver HW2 plans and the long term sustainability of Weston General Hospital. | Operational - Threat | 12 | 1) Well led WGH and good engagement with Clinical System Leaders<br>2) Regular engagement meetings with UHBW and other partners regarding capacity and operational challenges | 4 | 1) Regular engagement meetings with UHBW and other partners regarding capacity, operational challenges and issues | 6 | Programme Manager | Open |
| 11 | Reliance on system strategy for elective care | There is a risk that the programme is reliant on a whole system strategic plan for elective care, in order to identify elective activity for the Surgical Centre of Excellence resulting in a failure to secure buy-in to plans and deliver the plans. | Strategic - Threat | 12 | 1) Regular reporting to the BNSSG Elective Care Steering Group<br>2) Escalation through internal governance routes<br>3) Regular reporting to HW Programme Group<br>4) Phase 1 focused on increasing productivity with existing capacity | 4 | 1) Regular reporting to HW Programme Group and Elective Care Steering Group | 9 | Programme Manager | Open |
| 12 | Phase 1 revenue investment | There is a risk that the non-recurrent revenue investment required in the Phase 1 Full Business Case is not sourced, resulting in the implementation of the model stalling, | Finance including claims | 12 | 1) Work ongoing with BNSSG system to identify opportunities for non-recurring revenue investment in HW2 Phase 1 Full Business Case<br>2) Develop a benefits realisation plan that will | 4 | 1) Regular engagement meetings with UHBW and system DOFs regarding the invest to save investment required in HW2 Phase 1 Full Business Case | 9 | Programme Manager<br><br>[Risk owner UHBW Chief Finance Officer] | Open |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | leading to ongoing exposure to risk of unsustainable clinical services needing to be suspended at short notice | | | help identify when invest to save benefits will be realised | | | | | |
| 13 | Activity model and NHSE bed compliance requirements | There is a risk that changes to NHSE bed compliance requirements will reduce the number of beds that are permittable in each ward resulting in fewer beds and a failure to deliver the bed requirement set out within the Healthy Weston Outline Business Case. | Operational - Threat | 12 | 1) Work UHBW estates to understand estates and compliance requirements<br>2) Regular reporting to Programme Group on impact | 4 | 1) Regular engagement meetings with UHBW estates regarding the estates and compliance requirements and impact on bed numbers | 9 | Programme Manager<br><br>[Risk owner SRO] | Open |

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# Appendix 2 - Healthy Weston 2 Phase 1

# Evaluation record of workshop

Version: 0.2
Date: May 2022

# Healthy Weston Phase 2 - Evaluation Workshop

**Record of Workshop**

**Date:** 21 April 2022
**Time:** 9.00am – 11.00am
**Venue:** MS Teams
**Chair:** Professor Andrew Cant

**Attendees:**

| Attendees | Title |
|---|---|
| Annabel Plaister | Patient representative |
| Anne Frampton, Paediatric Consultant | Deputy Medical Director and Consultant in Paediatric Emergency Medicine, UHBW |
| Dr John Heather | Clinical Director, Pier Health PCN |
| Kevin Haggerty | General Practitioner, Pier Health |
| Mark Goninon | Deputy Head of Nursing, UHBW |
| Matt Hayman | Deputy Chief Medical Officer, SFT |
| Rebecca Dunn, Deputy Director of Transformation | Deputy Director of Transformation, BNSSG CCG |
| Teresa Candfield | Associate Locality Director, Sirona |
| Andy Hollowood | Consultant Surgeon & Clinical Lead for Strategy, UHBW |
| Colin Bradbury | Area Director, BNSSG CCG |
| Helen Edelstyn | Head of Programme, BNSSG CCG |
| Steph Hood | Director, Hood and Woolf |
| Ian Barrington | Managing Director, Weston General Hospital |
| Rachael Morris-Smith | Associate Specialist Acute Frailty & Frailty Service Lead, UHBW |
| Sanjoy Shah | NBT |
| Jonathan James | Deputy Chief Finance Officer, SWAST |
| Tim Evans | Patient representative |
| Adekoyejo Odutola | Divisional Clinical Director, Surgical Directorate, UHBW |
| Sian Barry | Director, Major Service Change, BNSSG CCG |
| Naomi Chalk | Lead Therapist, UHBW |
| Will Hicks | Consultant Radiologist, UHBW |
| David Crossley | Consultant, Intensive Care, UHBW |

**Summary outcomes of workshop**

| | Option 1 | Option 2 |
|---|---|---|
| **Quality of care** | | |
| Clinical effectiveness | -1 | 2++ |
| Patient and carer experience | -1 | 2++ |
| Patient safety | 0 | 2++ |
| **Access to care** | | |
| Impact on patient choice | 1+ | 1+ |
| Distance, cost, and time to access services | 0 | 1+ |
| Service operating hours | 0 | 2++ |
| **Workforce** | | |
| Strategic alignment | 0 | 1+ |
| Impact on recruitment, retention, skills | 0 | 2++ |
| **Finance / value for money** | | |
| Costs and income | 1+ | 2++ |
| Transition costs | 0 | 0 |
| **Deliverability** | | |
| Expected time to deliver | 0 | 1+ |
| Co-dependencies | 1+ | 2++ |

## 1) Welcome and introduction

Professor Andrew Cant opened the workshop, welcomed attendees and set out the objectives of the session:

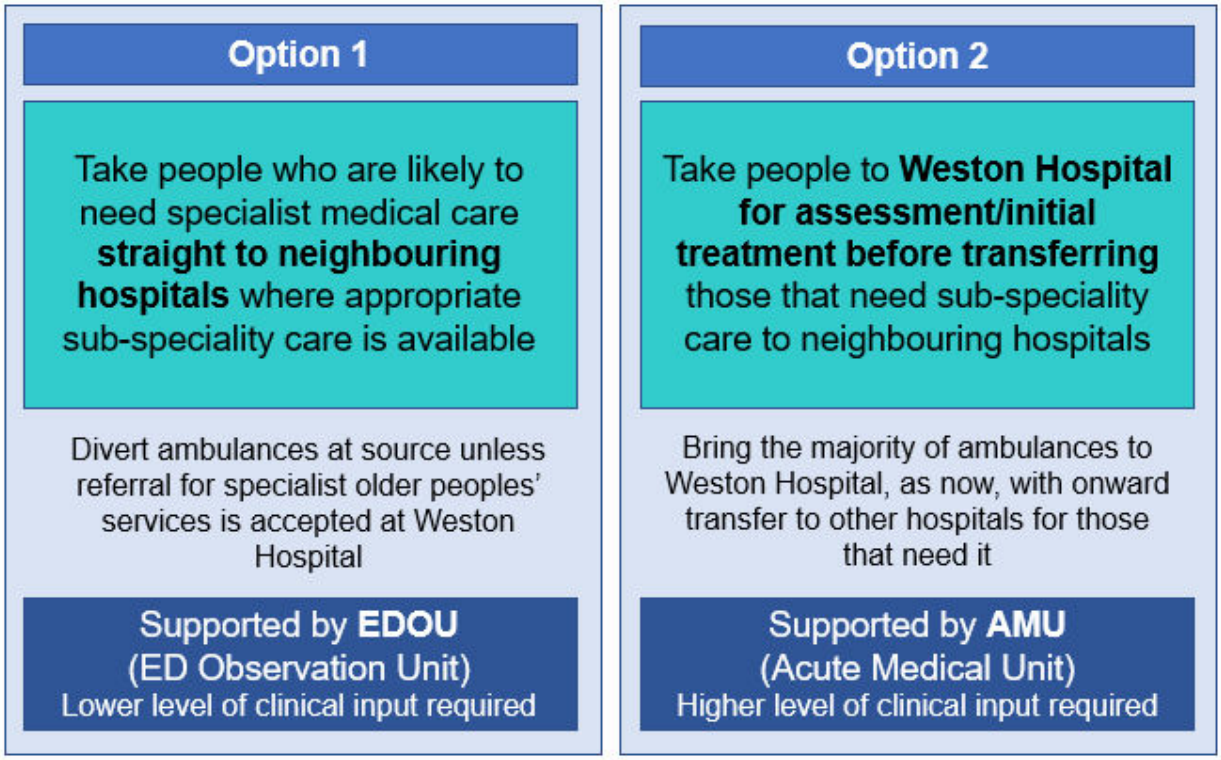
- To objectively appraise each clinical model proposal
- To assess the options against the agreed evaluation criteria
- To achieve a full understanding of the impact and outcomes of each option against these criteria
- To assure that the proposals can meet clinical and local standards and that the options are safe, viable and meet patient outcomes.

Sian Barry set out the housekeeping rules and guidance for input:

- This is an **open forum** with **equal opportunity** for all involved to reach **consensus-based recommendations** for decision making process
- **Confidential conversations** with agreed **shared lines of communication** to be created
- Please **leave organisational 'hats' behind** and focus on the clinical view
- Please consider how an option compares **based on rating scale description**
- The rating scale should **compare the option to the current model**
- Please **draw from best practice guidance and other supporting inputs** to support evaluation
- Please **share rationale and comments** on the questions
- Please be prepared to **share any additional data or sources** used to guide your rationale
- Please highlight where they may be **specific impact on protected groups** under the equalities act (An EIA has been provided and will remain iterative)

## 2) Clinical options and evidence overview

Andrew Hollowood introduced the new clinical model and options for ambulance conveyance, as per the diagram set out below.




In addition to the options for ambulance conveyance the new clinical model sets out several service improvements in line with national recommendations and standards:

- **Enhanced Geriatric Emergency Medicine Services (GEMS)** as an integrated team working alongside the Emergency Department and working closely with the community ageing well services.

- Develop the existing Ambulatory Emergency Care to a contemporary **Same Day Emergency Care (SDEC) model,** which will work closely with Primary Care and Community to support them to refer patients of all ages (>16) would be accepted and there would be streaming from Emergency Department to support admission avoidance.

- **24-hour support for immediate acute care needs** as an Acute Monitoring Unit

- **Critical care** provision for medical patients would be adjusted to correspond to the provision of 24 hours of care following admission.

- The introduction of **specialist care for older people** that is integrated with Primary Care and Community including:

    - **Rapid Assessment Clinics for Older People (RACOP)** The service will support referrals to GEMS and admission prevention of patients identified in the community, a new frailty "hot" clinic (RACOP) will also be available daily. The aim of RACOP is to provide outpatient assessment including rapid diagnostics/diagnosis and prognosis for patients who do not necessarily require hospital admission but who are in subacute decline which may lead to admission if not addressed.

    - **Older peoples' assessment unit (OPAU) 72-hour short stay** This unit will provide rapid clinical assessment, investigations, and interventions to support early discharge, therefore minimising risks associated with longer inpatient stays such as deconditioning and delirium.

    - **Care of the elderly wards -** Specialist Care of the Elderly model will oversee a number of inpatient wards and include dedicated space for patients who have experienced trauma

- **A hospital at night model** which will give more resilience to the hospital operating model outside of daytime, weekday operating hours.

- **Surgical centre of excellence for people aged 18 plus –** The proposed model of care will enable capacity to be available for the population of the Weston area and wider system to be dedicated to the delivery of surgical procedures.

- **Care of children -** Increase the provision of paediatric Same Day Emergency Care [SDEC] coupled with clear links and agreements with the Bristol Royal Hospital for Children.

### 3) Options evaluation

Professor Andrew Cant introduced the options evaluation item and facilitated group discussions against each evaluation criteria. The table below provides a summary of the discussion and agreed score.

| Domain | Summary Outputs |
|---|---|
| **Quality of care** | |
| **Clinical effectiveness**<br>(Option 1: -1)<br>(Option 2: 2++) | Consensus that both options improve clinical effectiveness, however option 2 cares for more people locally, reduces impact on SWAST and associated risk.<br>Option 2 also encourages improved staff recruitment and retention. There is a risk with option 1 that skills may become eroded as attendance / presenting conditions change. |
| **Patient & Carer Experience**<br>(Option 1: -1)<br>(Option 2: 2++) | Option 2 is stronger from a patient / carer perspective and offers more care locally. Option 1 may have a negative impact on patient / carer experience. |
| **Patient Safety**<br>(Option 1: 0)<br>(Option 2: 2++) | Easier to recruit to option 2 which will lead to increased staffing stability and in turn patient safety.<br>Option 2 will give the hospital the ability to develop advanced roles and by having these structures in place, it will be easier to attract and recruit staff [than option1]<br>Also noted that option 2 allows greater ability to accommodate a major incident. |
| **Access to care** | |
| **Patient Choice**<br>(Option 1: 1+)<br>(Option 2: 1+) | Both options ensure patients receive the right treatment in the right place to get the best outcomes. Both options will enhance the current patient service offer.<br>Noted that the non-elective patient pathway does not negatively impact patient choice in both options. |
| **Distance, cost and time to access services**<br>(Option 1: 0)<br>(Option 2: 1+) | A greater negative environmental impact associated with option 1. Will take ambulances out of area and in turn have a greater impact on SWAST.<br>More disruption to current services associated with option 1. Both options would be better due to improved elective offer. |
| **Service operating hours**<br>(Option 1: 0)<br>(Option 2: 2++) | Option 2 provides increased service / workforce resilience. |
| **Workforce** | |
| **Strategic alignment**<br>(Option 1: 0)<br>(Option 2: 1+) | Drive to provide care as close to home / lesser impact on the wider system is stronger in option 2. |
| **Recruitment / retention**<br>(Option 1: 0)<br>(Option 2: 2++) | Emphasised that there has been a lot of work undertaken to date to improve recruitment and retention. Consensus that the success of this programme is underpinned by the workforce. Option 2 presents the best opportunity to improve recruitment and retention and to attract a skilled workforce to Weston. |
| **Finance / value for money** | |

| | |
|---|---|
| **Cost and income**<br>(Option 1: 1+)<br>(Option 2: 2++) | Better value for money is achieved through both options as status quo is continuing deterioration. Both options require the same workforce model at the front door, but option 2 has a better productivity rate as fewer patients are seen in option 1.<br>Noted that additional capacity will need to be considered at other EDs to enable ambulance handovers, which in turn has a cost factor. It was agreed that more work needs to be done to assess the financial position of both options, as well as mapping the impact of D2A and other system initiatives that will support cost.<br>May be some additional support services costs associated with option 2, such as radiology. |
| **Transition costs**<br>(Option 1: 0)<br>(Option 2: 0) | No variation between the models in terms of transition costs. |
| **Deliverability** | |
| **Expected time to deliver**<br>(Option 1: 0)<br>(Option 2: 1+) | An enhanced ability to recruit driven by a clear clinical strategy supports deliverability of the model. Minimal difference in short term as the staff will largely remain the same, but option 2 will be easier to retain / sustain staff in the longer term. |
| **Co-dependencies**<br>(Option 1: 1+)<br>(Option 2: 2++) | Improvements to collaborative working already in place – new models supporting improvements [particularly linked to covid pressures]<br>Partnership building blocks in place to maximise the capacity. Confirmed that the Weston locality is very integrated, which in turn bring a USP of innovation and ambition. Evaluated that the locality would support option 2 as option 1 is doesn't align to the locality aspirations.<br>Option 2 could make recruitment into primary care easier e.g., portfolio GPs enhanced by model. |

## 4) Conclusion

The consensus reached was in favour of option 2 [as can be seen in the total scores awarded] for the following reasons:

- both models require the same workforce to deliver a sustainable service due to rota requirements; option 2 retains a higher level of complexity and range of conditions presenting to Weston front door which will support retention of skills and experience and improving the potential to attract staff to work as part of a larger dedicated team
- maintaining a strong front door team with experience across a range of conditions and complexity supports greater resilience of the service
- retaining more patients in Weston reduces the potential impact on neighbouring trusts and reduces the burden on the ambulance service, ensuring more ambulances remain in North Somerset
- better value for money is achieved, as both options require the same workforce but fewer patients are seen in option 1
- an enhanced ability to recruit driven by a clear clinical strategy supports deliverability of the model

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# Appendix 3 - Healthy Weston 2 Phase 1

# Operational Policies

Date: January 2023

## Acute Monitoring Unit [AMU] and Emergency Department Observation Unit [EDOU]

**Introduction**

The model set out within the Healthy Weston 2 Outline Business Case is to enhance the existing Monitoring Unit into a 15-bed short stay [24 hours] acute admissions monitoring unit for non-frail patients, encompassing a 9 bedded unit overseen by the acute medical consultant team, and a 6 bedded short stay ward linked to the Emergency Department and overseen by the Emergency Department team. There is some flexibility in terms of bed numbers such that maximal flow can be achieved.

The AMU acts as a gateway between primary care, the Emergency Department, and the wards of the hospital. Its primary role is to provide rapid assessment, investigation and treatment for patients requiring a short stay [24 hours] in hospital. The AMU helps the Emergency Department produce a healthy turnaround for patients, helping with waiting times and avoiding admission, where appropriate.

Patients in the medical side of the AMU will be those medical patients seen and assessed in SDEC or the Emergency Department where a 24hour Length of Stay (LOS) is deemed necessary but who do not need onward inpatient care beyond this period.

Patients in the Emergency Department observation ward may include patients with a wider range of diagnoses including patients with conditions such as renal colic, who would be expected to be managed by the Emergency Department team for their entire length of stay [LOS]. Although the unit LOS should be no longer than 24 hours, Emergency Department patients should have an expected LOS of no more than 12 hours.

Any patient requiring longer than a 24 hour, or one overnight LOS should be referred to onward pathways either within Weston if appropriate or transfer to a facility within patient capability.

Patients cannot be referred directly into this unit but should come via assessment in Same Day Emergency Care or the Emergency Department to ensure all alternatives to short admission have been considered.

**Anticipated activity level (Phase 1)**

Based on the Healthy Weston 2 activity and bed model [21/22] it is anticipated Weston AMU and EDOU will treat at least16 patients per day.

**Hours of operation**
AMU - 24 hours a day, 7 days a week.

Radiology input will be available to AMU and EDOU during the following times:

| Modality | Days available | Hours available |
|---|---|---|
| MRI | Monday - Friday | 9am – 5pm with an on-call rota to 9pm and at weekends this is on-call from home only 8am - 9pm. |
| CT | Monday - Friday | 9am – 8pm<br>On call from home 8pm until 8am |
| Plain Film | 7 days a week | 8am – midnight<br>On call on-site midnight until 8am. (currently this element of on-call is being covered by CT radiographers so could be on-call from home) |
| Ultrasound | Monday - Friday | 9am – 5pm<br>Ringfenced slots provided for patients coming back the next working day for ultrasound. No cover at weekends |

**Patient identification**
Patients will be reviewed and assessed by the Emergency Department or Same Day Emergency Care senior decision maker prior to referral to AMU or EDOU.

All suitable patients must meet the AMU or EDOU inclusion criteria.

**AMU inclusion criteria**
The Acute Monitoring Unit will treat patients with a range of acute medical conditions who are anticipated to be discharged within **24 hours or less**. These conditions include:

- Gastrointestinal bleeding
- Acute asthma, chest infection and other respiratory conditions
- Acute illness
- Toxicology
- Renal colic
- Infection requiring anti-biotics
- Vulnerable adults who cannot be discharged over night
- Low risk chest pain

**EDOU inclusion criteria**
The EDOU will treat patients with a range of conditions who are anticipated to be discharged within **12 hours or less**. These conditions include:

- Mental health [e.g. self-harm, overdose and other low risk mental health presentations]
- Toxicology
- Minor head injuries
- Anaphylaxis
- Recovery from procedural sedation
- Patients awaiting OT/Physio assessment with a high likelihood of discharge

- DVT/PE - only if suitable for low risk outpatient pathway and SDEC not available
- Renal
- Patients unable to go home overnight for transport / social reasons
- Any other patient requiring observation, investigation or treatment, at the discretion of the duty Consultant

**Exclusion criteria**

- Unstable patients (NEWS>4 or >2 in one category above baseline)
- High risk Mental health patients (red on mental health matrix) or a high risk of absconding
- Violent / aggressive patients
- Patients with NO clear medical plan
- Patients who are unlikely to be discharged within 12 or 24 hours.
- Patient's requiring cubicle isolation for Infection prevention and control management

**Admissions**

The AMU and EDOBs are admissions only. Patients cannot be referred directly into this unit but should come via assessment in SDEC or the Emergency Department to ensure all alternatives to short stay admission have been considered.

Patients can be directed by a senior decision maker [ED consultant when present, middle grade overnight] to the AMU. Patients will never be transferred from a ward to the AMU.

**Care provision**

Once admitted to the AMU or EDOU patients will undergo further observation, tests, and treatment before being discharged home or to an appropriate speciality team.

The AMU care model will be delivered by a multidisciplinary team, including medical, nursing, pharmaceutical, therapeutic and diagnostic input. This integrated workforce approach will support the delivery of coordinated, safe and high-quality care for patients.

**Discharge and pathways out of AMU**

Following treatment on the AMU or EDOU, patients may be well enough to be discharged back into the community; or if requiring further inpatient medical care are transferred to the care of an appropriate speciality team at the hospital, or in a neighbouring specialist hospital.

**Workforce**

AMU

The Acute Monitoring Unit will share its acute medical workforce with the Same Day Emergency Care service. This will include 6 WTE consultants and 6 WTE middle grade doctors.

6 x AMU acute medical consultants will provide the following leadership and cover:

The requirement of 6 x AMU consultants is based on
1 x AMU consultant Mon to Fri – 9am to 5pm
1 x SDEC consultant Mon to Fri – 11am – 7pm
1 x consultant Sat to Sun 9am – 5pm

The proposed job plan is 5.5 PA DCC, 1.5 SPA, 1 PA on call, 1 PA speciality clinic, 1PA leadership and governance

The AMU Nursing workforce skill mix is as follows:

- Band 8a: 1 WTE to cover GEMS, AMU, OPAU
- Band 7: 1 WTE
- Band 6: 4.97 WTE
- Band 5: 10.15 WTE
- Band 3: 9.94 WTE
- ACP Band 8a: 2.48 WTE

The day-to-day operational management of the unit will be coordinated by the 1 WTE Band 7 Senior Sister. The unit will be staffed by 1 band 6 and 2 Band 5s 24 hours 7 days a week.

EDOU
Medical staffing is provided 24/7 by ED **UNLESS** there is no ED middle grade on overnight. In this case from 0000-0800 medical cover is the onsite on-call teams but the ED Consultant on-call remains the named consultant.

A middle grade doctor trained in emergency medicine based in the hospital overnight will oversee the EDOU and to continue to appropriately assess, manage and where appropriate discharge patients fit to go home after the Department has closed who would previously have been admitted overnight, and supported by a consultant on call for emergency medicine.

| Modality | Days available | Hours available |
|---|---|---|
| MRI | Monday - Friday | 9am – 5pm with an on-call rota to 9pm and at weekends this is on-call from home only 8am - 9pm. |
| CT | Monday - Friday | 9am – 8pm<br>On call from home 8pm until 8am |
| Plain Film | 7 days a week | 8am – midnight<br>On call on-site midnight until 8am. (currently this element of on-call is being covered by CT radiographers so could be on-call from home) |
| Ultrasound | Monday - Friday | 9am – 5pm<br>Ringfenced slots provided for patients coming back the next working day for ultrasound. No cover at weekends |

The units will also include pharmaceutical, therapeutic, and diagnostic input.

**Phasing**
Full implementation of the 15 bedded AMU will be phased and dependent on workforce recruitment [see recruitment plan].

The first phase of enhancing the AMU will be a 6 bedded Emergency Department Observation Unit [EDOU]. The EDOU is not reliant on recruitment or any significant estates investment and is anticipated to go live from winter 22.

## Same Day Emergency Care [SDEC]

**Introduction**

Same Day Emergency Care will be introduced, providing the right care, in the right place, at the right time for patients. It will benefit both patients and the healthcare system by reducing waiting times and hospital admissions, where appropriate.

SDEC is the provision of same day urgent care without an overnight inpatient admission. Under this care model, patients presenting at WGH with relevant conditions will be rapidly assessed, diagnosed, and treated without being admitted to a ward, and if clinically safe to do so, will go home the same day their care is provided.

The Weston SDEC model builds on previous improvement work in Ambulatory Emergency Care (AEC) at the hospital, with the aim of providing a consistent approach to SDEC patient pathways across UHBW Trust / and system.

The NHS Long Term Plan states:

'… every acute hospital with a type 1 A&E department should move to a comprehensive model of Same Day Emergency Care'

There are significant benefits associated with treating people through SDEC including:

- the ability for patients to be assessed, diagnosed, and start treatment on the same day, improving patient experience and reducing hospital admissions
- improve patient flow within the hospital
- avoiding unplanned and longer than necessary stays in hospital, resulting in lower risk of infections and de-conditioning for patients
- financial benefits and cost savings for the hospital

**Anticipated activity level (Phase 1)**

The 21/22 clinical model assumes that at least 33% patients who arrive at Weston ED (including frail) will be seen and treated on a SDEC pathway (total 45,853 ED attendances per year). There is an expectation that a proportion of these patients will require an admission.

SDEC activity refers to the investigation, care and treatment of patients whom admission to hospital would have been the default option in the absence of an SDEC service.

**Hours of operation**

8am – 10pm, 7 days a week.

Radiology input will be available to SDEC during the following:

| Modality | Days available | Hours available |
|---|---|---|
| MRI | Monday - Friday | 9am – 5pm with an on-call rota to 9pm and at weekends this is on-call from home only 8am - 9pm. |
| CT | Monday - Friday | 9am – 8pm<br>On call from home 8pm until 8am |
| Plain Film | 7 days a week | 8am – midnight |

| | | |
|---|---|---|
| | | On call on-site midnight until 8am. (currently this element of on-call is being covered by CT radiographers so could be on-call from home) |
| Ultrasound | Monday - Friday | 9am – 5pm<br>Ringfenced slots provided for patients coming back the next working day for ultrasound. No cover at weekends |

**Responsibility**
SDEC will Consultant lead by a mix of ED consultants, acute medics and medical consultant on call [CPOD].

**Inclusion criteria**
Suitable patients will be identified by a senior decision maker based on an expectation of same day discharge, with assessment and treatment pathways that do not include an overnight stay. Some of the patient treatment pathways may include:

- Acute headache
- Asthma
- Abscesses
- Community acquired pneumonia
- Urinary disorders
- Gastroenteritis
- Cellulitis
- Deep Vain Thrombosis [DVT]

Although in practice WGH will be a non-pathway based SDEC creating flexibility across the inclusion criteria and optimising the number of patients that are cared for by SDEC.

**Exclusion Criteria**
All exclusion criteria are at the discretion of the ED or Acute Medical Consultant.

- Patients under the age of 18
- Any patient with symptoms of diarrhoea and vomiting or with a history of diarrhoea and vomiting in the past 48 hours
- Patients with an unstable presentation
- Patients with any oxygen requirement
- Patients with an Acute Cerebral Vascular Event
- Patients with an acute mental health presentation
- Confused patients
- Patients unable to sit in a chair
- Patients clearly needing a medical admission to an inpatient area
- Patient's requiring cubicle isolation for Infection prevention and control management

**Admissions**
Relevant SDEC patients will be referred through different routes, including:

- Streamed by a senior decision maker in the Emergency Departments (ED)
- Direct referral from Primary Care

- Direct referral from paramedics
- Referral from wards to support discharge [discharge review clinic]

**Care provision**
SDEC patients will be assessed, diagnosed, and start treatment on the same day**.**

Responsibility for care for patients in SDEC lies with the relevant acute medical consultant or ED consultant.

The SDEC workforce will work closely with Primary Care and Community to offer:

- Specialist advice and guidance
- Access to same day diagnostic and assessment [e.g. DVT, headache, pulmonary embolism]

The SDEC care model will be delivered by a multidisciplinary team, including medical, nursing, pharmaceutical, therapeutic, and diagnostic input. This integrated workforce approach will support the delivery of coordinated, safe and high-quality care for patients.

The Geriatric Emergency Service will provide frailty SDEC assessment, care and treatment.

**Workforce**
Same Day Emergency Care will share its acute medical workforce with the Acute Monitoring Unit. This will include 6 WTE consultants and 6 WTE middle grade doctors.

The SDEC Nursing workforce skill mix is as follows:

- Band 7: 1 WTE
- Band 6: 2.48 WTE
- Band 5: 4.95 WTE
- Band 3: 2.48 WTE
- Band 2 Admin coordinator: 2.05 WTE

The day-to-day operational management of the unit will be coordinated by the 1 WTE Band 7 Senior Sister.

The Unit will also include pharmaceutical, therapeutic, and diagnostic input ensuring a full Mult-Disciplinary approach.

**Phasing**
Full implementation of all SDEC will be phased and dependent on workforce recruitment [see recruitment plan]. Initial SDEC pathways will be introduced as part of winter 22 plans.

Surgical SDEC will be developed and considered as part future Healthy Weston 2 plans and ongoing service improvement.

## Geriatric Emergency Medicine Service

**Introduction**

Geriatric Emergency Medicine Service is already a strong (and award-winning) clinical speciality that provides a person-centred clinical service for frail older people in an emergency at Weston General Hospital. It was developed to improve the care and outcomes of frail older adults in an acute emergency.

Moving away from the traditional Emergency Department model of care that focuses on the diagnosis and treatment of an acute presentation [an approach that fails to identify many subtler threats to an older person's health], the GEMS provides holistic, patient-centred care for acutely ill older people, with frailty and complex care needs. This means that high quality care is focused on meeting a patient's individual needs, that takes into consideration the overall health of the patient, including their physical and psychological wellbeing and their care needs.

The Comprehensive Geriatric Assessment [CGA] process, [defined as a multidisciplinary diagnostic and treatment process that identifies medical, psychosocial, and functional limitations of a frail older person to develop a coordinated plan to maximise overall health with ageing] is a key component of care at the Geriatric Emergency Service. The CGA is the gold standard of care for patient with frailty recommended by NHS England. It is an evidence-based process that can reduce length of stay, reduce dependency, and reduce mortality.

What the NHS Long Term Plan says:

*'All type 1 A&E's should provide an acute frailty service at least 70 hours a week, with the aim to complete a clinical frailty assessment within 30 minutes of arrival in the ED unit'.*

This business case seeks to expand the existing GEMS team to enable early review of 100% of frail patients arriving at Weston Emergency Department and a CGA within 30 minutes. The GEMS will provide advice and guidance to support the care of frail trauma patients who will be treated by the Emergency Department team. The hours of operation of GEMS will be extended to match the Emergency Department opening hours of 8am to 10pm, seven days a week.

**Anticipated activity level (Phase 1)**

9,609 total frail ED attendances 21/22, equating to 26 frail patients per day, although a proportion of these will be frail major and not suitable for GEMS [although GEMS in reach will be provided].

**Hours of operation**

GEMS team will operate 8am – 8pm, 7 days a week.
Mon – Fri GEMS will be consultant / senior Dr led
Wkend will be ED Consultant led alongside GEMS senior nursing team
1 consultant PA per day for Frailty SDEC

Radiology input will be available to GEMS during the following:

| Modality | Days available | Hours available |
|---|---|---|
| MRI | Monday - Friday | 9am – 5pm with an on-call rota to 9pm and at weekends this is on-call from home only 8am - 9pm. |

| | | |
|---|---|---|
| CT | Monday - Friday | 9am – 8pm<br>On call from home 8pm until 8am |
| Plain Film | 7 days a week | 8am – midnight<br>On call on-site midnight until 8am. (currently this element of on-call is being covered by CT radiographers so could be on-call from home) |
| Ultrasound | Monday - Friday | 9am – 5pm<br>Ringfenced slots provided for patients coming back the next working day for ultrasound. No cover at weekends |

**Inclusion criteria**
GEMS is a service for acutely ill older people, with frailty and complex care needs.

**Exclusion Criteria**
No frail and frail major patients

**Admissions**

Appropriate patients will be directed from the Emergency Department to GEMS.

Direct referrals to GEMS will be accepted from GPs, the Weston Frailty Coordination Hub and other Ageing Well services.

**Care provision**
Care is initiated within the main Emergency Department by medical, nursing and therapy staff with a speciality interest and skills in the care of patients with frailty. A Comprehensive Geriatric Assessment (CGA) is then completed, ideally within 30 minutes of the patient arriving.

Routinely, a CGA will be in place prior to someone needing hospital care and will be part of the proactive support offered by the community Ageing Well services. Where advanced care plans are not already in place for patients with frailty, GEMS will initiate this and will work with community and Primary Care teams that know the individual.

Following thorough CGA, diagnosis and discussion with the patient, and the administration of any initial treatment needed, GEMS can then agree on the next steps in a patients' pathway of care. This may involve discharge to community where no further care is required, referral to community teams to support the patient at home during ongoing recovery, admission to the Older People's Assessment Unit or Care of the Elderly wards. The figure below shows next steps in GEMS care pathway.


GEMS will also support Emergency Department colleagues by providing advice and support for frail patients who are being treated by Emergency Department, for example, frail trauma patients.

The GEMS team will also provide a frailty Same Day Emergency Care for appropriate patients on specific care pathways and to treat as many people as possible without hospital admission. This might include frail patients with:

- Abscesses
- Community acquired pneumonia
- Urinary disorders
- Gastroenteritis

In addition to the care described above, funding for 1 x WTE GEMS@Home consultant post will support the rapid assessment and MDT management for frail people who can be safely managed at home using a blend of remote monitoring and in-person care and treatment. This approach will allow patients to get the care they need at home safely and conveniently, rather than being in hospital.

The GEMS care model will be delivered by a multidisciplinary team, including medical, nursing, pharmaceutical, therapeutic, and diagnostic input. This integrated workforce approach will support the delivery of coordinated, safe and high-quality care for patients.

**Workforce**

The GEMS and the Emergency Department team will work together as a seamless integrated unit. The GEMS workforce will consist of 4 WTE dedicated senior decision-making doctors, plus 1 x WTE GEMS@Home consultant, who are able to provide direction to the team. This consultant and senior doctor team also works alongside the OPAU to ensure a seamless transition between the GEMS service and those requiring a short length of stay.

3 Emergency Department middle grade doctors, and junior doctors will work directly with the GEMS service.

The GEMS Nursing workforce skill mix is as follows:

- Band 8a: 1 WTE Matron who will cover GEMS, AMU and OPAU
- Band 7: 1.69 WTE
- Band 5: 4.97 WTE
- Band 3: 2.48 WTE
- ACP Band 8a: 1 WTE

The Unit will also include pharmaceutical, therapeutic, and diagnostic input ensuring a full Mult-Disciplinary approach.

**Phasing**

Full implementation of GEMS will be phased and dependent on workforce recruitment [see recruitment plan]. Phasing of some staff groups initially / plus slightly shorter hours until full workforce is in place.

**Whole system approach**

GEMS will work alongside other primary and community providers to support the 'right care, at the right time' approach and avoid people needing hospital care, where appropriate. A good example of this is the GEMS@Home pilot which is aiming to test the concept of 'Step Up' model of care in Weston. This pilot programme will enable the GEMS team to provide community providers with specialist advice and guidance to avoid admission.

## Older People's Assessment Unit

**Introduction**

There is a 'Golden Window' of opportunity during a frail patients' first three days in hospital [72 hours] to influence care plans, provide assessment and treatment and to prevent longer lengths of stay. The OPAU will target this 'golden window' of opportunity and facilitate rapid clinical assessment, investigation, and interventions to support early discharge, reducing patients' time spent in hospital.

The OPAU will provide the highest quality care for the frail older patients admitted on the medical take at Weston General Hospital. The guiding principle will be the use of 'Comprehensive Geriatric Assessment' – a multidimensional and usually interdisciplinary diagnostic process to determine a frail older person's medical conditions, mental health, functional ability, and social circumstances. The purpose is to develop and carry out a coordinated and integrated plan for treatment, rehabilitation; support and long term follow up.

Patients on the OPAU will be cared for by a multidisciplinary team including physiotherapy, occupational therapy, and in reach from social services. This should speed up their discharge from hospital and put strategies into place to try and avoid unnecessary admissions in the future. The CGA process will underpin the care that will is offered on the OPAU.

The OPAU will be a part of the frailty medical team that works across GEMS and Care of the Elderly wards, where doctors as part of an MDT workforce will be based 24/7 to manage new patients that enter the service. MDT working within GEMS and the Care of the Elderly ward is fundamental to the transformation required to older peoples' services within Weston General Hospital.

If the patient's stay is likely to be longer than 72 hours, for medical or other reasons, then their care is transferred to one of the Care of the Elderly wards as quickly as possible to maintain patient flow on OPAU.

**Anticipated activity level (Phase 1)**

Based on the Healthy Weston 2 clinical model [21/22] it is anticipated that 14 patients per day will be treated by Weston OPAU. OPAU is a 14 bedded ward.

**Hours of operation**

24 hours a day, 7 days a week

Radiology input will be available to OPAU during the following:

| Modality | Days available | Hours available |
|---|---|---|
| MRI | Monday - Friday | 9am – 5pm with an on-call rota to 9pm and at weekends this is on-call from home only 8am - 9pm. |
| CT | Monday - Friday | 9am – 8pm<br>On call from home 8pm until 8am |
| Plain Film | 7 days a week | 8am – midnight<br>On call on-site midnight until 8am. (currently this element of on-call is being covered by CT radiographers so could be on-call from home) |

| | | |
|---|---|---|
| Ultrasound | Monday - Friday | 9am – 5pm<br>Ringfenced slots provided for patients coming back the next working day for ultrasound. No cover at weekends |

**Inclusion criteria**

The Older People's Assessment Unit will treat patients with a range of acute medical conditions who are anticipated to be discharged within 72 hours or less. The inclusion criteria are:

- >75 years + frailty score ≥5
- OR <75 years if presenting with a frailty syndrome + frailty score ≥5
- Priority of bed allocation should be given to the most complex frail elderly patients who have most to gain from this model of care providing to do so will put no other patient at a disadvantage to receiving safe, quality care.

The exclusion criteria are:

- Acute stroke
- Acute GI bleed
- Acute MI
- Vascular emergencies
- Patients with cardiac chest pain who are required to have an ECG medically reviewed to ensure that a patient is appropriate for OPAU rather than AMU or Cardiology.
- Patients requiring/ or potentially requiring Non-Invasive Ventilation or insertion of/ or management of an intercostal chest drain.
- Major trauma
- <75 years (unless presenting with frailty syndrome AND CFS ≥5)
- Frailty score ≤4

**Admissions**

The OPAU is admissions only. From the Geriatric Emergency Service, patients can be directed by a senior decision maker [GEMS senior when present, ED consultant, middle grade overnight] to the OPAU. Patients will never be transferred from a ward to the OPAU.

**Care provision**

The OPAU is an integral part of the Care of the Elderly service for frail older patients who require less than 72 hours of:

- Observation
- Treatment
- Diagnostic tests
- Results of diagnostic tests

From the Geriatric Emergency Medicine Service, patients can be directed by a senior decision maker to the OPAU, where they will undergo further observation, tests, and treatment before being discharged home or to an appropriate speciality team. The patients stay in the OPAU is limited; no more than 72 hours.

This care model minimises the risk associated with longer inpatient stays such as de-conditioning and delirium by targeting the first three days of admission.

The OPAU will be guided by and support the Comprehensive Geriatric Assessment process; ensuring that care is tailored to the holistic needs of the individual.

Patients will be triaged on the ward at board round with 4 outcomes:

- Deemed short stay patients (<72hrs) and thus should remain on the OPAU with MDT input to minimise length of stay
- Identified as having complex medical/ behavioural/ social/ functional problems that are likely to lead to a medium length of stay.
- Identified as predominantly rehabilitation needs and their medical needs can be managed outside an acute hospital.
- On some occasions it may be more appropriate for the patient to transfer to another speciality ward or site because of their clinical needs (e.g., Cardiology in the Bristol Heart Institute or Respiratory High Care). This will be at the discretion of the relevant consultant team and after discussion with the receiving team.

A guiding principle of the ward is to minimise patient moves as evidence tells us that the more moves patients undertake, the more touch points there are to negatively impact on patient safety and quality of care. The patients will be triaged to other wards when this is in their interest, and they are likely to have a medium to long length of stay. Where patients can be assessed and discharged rapidly, they should remain on the ward rather than transferring to a new team.

TOPAU care will be delivered by a multidisciplinary team, including medical, nursing, pharmaceutical, therapeutic and diagnostic input. This integrated workforce approach will support the delivery of coordinated, safe and high-quality care for patients.

**Single Sex Compliance**

- UHBW policy will underpin OPAU daily practice (see UHBW Single Sex Compliance SOP)
- At all times patient dignity and privacy will be maintained.
- When a patient lacks capacity, decisions will be made in the patient's best interest by senior clinicians in discussion with the patient's family / carer where appropriate (as guided by the Mental Capacity Act and support found within the Adult Safeguarding on the Trust Connect web page).

**Workforce**

The OPAU workforce has been calculated line with UHBW OPAU Operational Policy and benchmarked against the BRI OPAU workforce model.

The OPAU workforce will consist of 3 WTE dedicated senior decision-making doctors, 1 WTE middle grade doctor and 3 WTE junior doctors who are able to provide direction to the team Monday to Friday. Weekend consultant input will be provided by the Care of the Elderly consultant workforce.

Consultant job plans will need to be competitive, and include leadership / attractive SPA, to attract geriatricians and specialist staff to Weston.

The OPAU Nursing workforce skill mix is as follows:

- Band 8a: 1 WTE Matron who will cover GEMS, AMU and OPAU
- Band 7: 1 WTE
- Band 6: 4.79 WTE

- Band 5: 10.15 WTE
- Band 3: 9.94 WTE
- ACP Band 8a: 2.48 WTE

The day-to-day operational management of the unit will be coordinated by the 1 WTE Band 7 Senior Sister. The unit will be staffed by 1 band 6 24/7, with 2 registered nurses per shift.

The Unit will also include pharmaceutical, therapeutic, and diagnostic input ensuring a full Mult-Disciplinary approach.

The approach to recruitment will be bottom up [as well as top down] and will slowly build capacity and expertise to provide specialist geriatric care. This approach will also enable the team to maximise existing expertise and experience within the current workforce.

**Phasing**
Full implementation of OPAU will be phased and dependent on bedded capacity becoming available following the release of inpatient medical beds [because of admissions avoidance created by SDEC and AMU]. It is anticipated that recruitment to OPAU will not start until Q3 23 / 24 to allow for the release of inpatient bedded capacity.

## Other enabling service improvements

**Emergency Department**
The Healthy Weston 2 Phase 1 clinical model includes an increase in Emergency Department consultants to meet the Royal College of Emergency [RCEM] guidelines on staffing for an ED with 1 WTE consultant per 3,600-4,000 attendances. Consultant cover will be 14 hours a day 7 days a week (with upper range of 16 hours). A resilient and sustainable ED workforce is critical to high quality safe care and underpins the success of the HW2 clinical model.

Care within the EDOU would be provided by the Emergency Department team, supplemented by acute medical expertise and primary care support. A core part of this service is the rapid access to diagnostics, particularly CT [heads, chests [PA], angio].

To support the introduction of EDOU staffing cover to the Emergency Department will be enhanced with a middle grade doctor trained in emergency medicine based in the hospital overnight to oversee the unit and to continue to appropriately assess, manage and where appropriate discharge patients fit to go home after the Department has closed who would previously have been admitted overnight, and supported by a consultant on call for emergency medicine.

Healthier Together

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

# Appendix 4 - Healthy Weston 2 Phase 1

# Quality Impact Assessment (QIA)

Version: 2.2
Date: January 2023

**Version Control**

| Version | Date | Author | Comments |
|---|---|---|---|
| **0.1** | 08.09.2021 | Nicole Hill | Initial draft of document |
| **0.2** | 08.10.2021 | Nicole Hill | Continuation of above |
| **0.3** | 05/01/2022 | James Cox | Formatted document |
| **0.4** | 10/02/2022 | Nicole Hill | Updated document to reflect clinical model |
| **0.5** | 14/02/2022 | Jeremy Westwood | Version submitted to BNSSG CCG Quality Committee for Review |
| **0.6** | 01/03/2022 | Jeremy Westwood / Helen Edelystyn | Incorporating feedback from CCG Quality Lead. |
| **0.7** | 07.03.22 | Jeremy Westwood / Andy Hollowood | Review and inclusion of material from HW2 clinical lead, assessing the plans against the 3 quality domains. |
| **1.0** | 09.03.21 | Jeremy Westwood | Version submitted to BNSSG CCG Quality Committee for further review |
| **1.1** | 14.03.22 | Jeremy Westwood | Incorporating suggested amends from Quality Committee – including additional detail to risk assessment section |
| **1.2** | 16.03.22 | Colin Bradbury | Review and amends incorporated |
| **1.3** | 17.03.22 | Jeremy Westwood | Final track changes included. Version submitted to clinical senate. |
| **2.0** | 07.04.22 | Jeremy Westwood | Updated clinical model plan |
| **2.1** | 26.05.22 | Jeremy Westwood | Revisions to introduction section and changes in language from consultation to engagement. OBC terminology instead of PCBC. |
| **2.2** | 23.01.23 | Fritha Voaden | Updated to align with Healthy Weston 2 Phase 1 Full Business Case |

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## 1. Introduction

Healthy Weston 2 is the concluding stage of a two-part programme developed to ensure the very best healthcare for the population of Weston, Worle and the surrounding areas.

Healthy Weston 1 was initiated with the vision for Weston General Hospital (WGH) to become a vibrant and dynamic hospital at the heart of the community - an exemplar of excellent healthcare designed specifically to respond to the needs of the local population.

The programme is already on the way to achieving this ambition through the changes implemented at Weston General Hospital as part of Healthy Weston 1 and the merger between University Hospital Bristol and Weston Area Health Trust. These have made services safer and more sustainable, particularly for urgent and emergency care, critical care, emergency surgery and acute children's services. In addition, much closer working between local GPs practices and hospital services has put more focus on providing joined-up care.

Outcomes from the first phase of the Healthy Weston programme include:

- An established and stable model of urgent and emergency care including A&E at Weston Hospital, with a sustainable workforce, running 14/7
- Improved cover of paediatric specialists in A&E so fewer children need to be transferred to Bristol
- An intensive care unit that is now fully integrated with the unit at the Bristol Royal Infirmary
- Local GP practices working together under the banner of Pier Health.
- A new Safe Haven mental health crisis service in the heart of the Weston. Operating since early 2020, Safe Haven is regularly helping between 50-80 people a week, supporting them to stay well and local rather than having to be referred to more intensive out-of-area services
- Building on new ways of working as a result of the pandemic to ensure more patients can have virtual consultations by using technology which reduces the risk of infection transmission, reduces travel times/ carbon emissions and enables the waiting list backlog to be addressed more quickly

This is welcome progress; however, it was understood that whilst Healthy Weston 1 improvements were urgent and necessary, they did not go far enough and further work in a second phase would be needed to ensure a dynamic and exciting future for health services in Weston General Hospital.

## 1.1 Healthy Weston Phase 2 Case for Change

There are four key reasons why health and care services in Weston General Hospital need to continue to change:

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

- **The current model of care is unsustainable:** Some health services at Weston General Hospital are not able to consistently meet national and local clinical quality standards because of low activity volumes and shortages of specialist staff. However, Weston General Hospital can provide enhanced services in specific areas relevant to its population, learning from the success of areas such as orthopaedics, which can thrive with the right clinical model.

- **Whole system changes are required to ensure timely access to equitable, integrated care:** The introduction of integrated care systems and the merger of Weston Area Health Trust with University Hospitals Bristol give opportunities to improve patient care across the system, increasing access and continuity of care. Organisations can collaborate to ensure that patients receive care in a setting appropriate to their needs, joining up pathways across primary care, community care and hospital care. Weston General Hospital plays an important role in the system's clinical strategy delivering key priorities such as reducing local health inequalities and accelerating elective care.

- **There is an opportunity to better use our resources:** Healthcare resources are limited across our system, with Bristol, North Somerset and South Gloucestershire region in deficit by £34m in 2019/20. The COVID-19 pandemic has put further pressure on these limited resources. Workforce, finance, and estates must be best used to provide care for our local population.

Challenges in the provision of speciality medical services have worsened and following a difficult two years responding to the consequences of the COVID-19 pandemic it is now possible to think differently about the opportunities a new improved clinical model for Weston General Hospital can offer.

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

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

## 2. Healthy Weston 2 Clinical Model

The Healthy Weston 2 Outline Business Case (OBC), agreed in June 2022, describes a series of ambitious improvement plans centred around delivering sustainable services at Weston General Hospital that are in line with national standards. A phased approach to the development of three interlinked full business cases has been agreed to cover the plans for improvement described in the Healthy Weston 2 OBC. These phases are:

- Phase 1 – Safe, high quality and sustainable urgent care
- Phase 2 – Inpatient medical care and specialist centre for care of the elderly
- Phase 3 – Surgical Centre of Excellence at Weston General Hospital

Adopting a phased approach to delivery enables an initial focus to be on those projects that are standalone and can be delivered quickly. Other elements of the programme that are sequentially dependent on one another, and in some cases requires capital funds to be effectively planned, will follow.

### 2.1 Healthy Weston 2 Phase 1

**This Quality Impact Assessment focusses on the plans set out in the Healthy Weston 2 Phase 1 Full Business Case.**

The Healthy Weston 2 Phase 1 Full Business Case describes the development of a safe, high-quality and sustainable urgent care at Weston General Hospital, that is in line with national and local standards, and that ensures local people have equity of access to the best urgent care. Senior leaders and clinicians from across Bristol, North Somerset, South Gloucestershire and Somerset have led the progression of the Phase 1 model, ensuring plans conform with system priorities and the Healthy Weston vision.

The plans have also received support from the public, who during a public engagement exercise delivered between 20 June and 14 August 2022, indicated that the majority of people thought the plans would help improve the hospital.

The scope of Healthy Weston 2 Phase 1 is the following

- Enhanced 24hr observation unit for adults providing rapid assessment and treatment [Acute Monitoring Unit]
- Improved Same Day Emergency Care [SDEC], providing the right care, in the right place at the right time
- Increased number of frail patients supported by already award-winning Geriatric Emergency Medicine Service [GEMS] meeting local need
- Creating Older People's Assessment Unit [OPAU] providing specialist rapid assessment and treatment

The Rapid Assessment Clinic for Older People (RACOP) as described in the Healthy Weston 2 OBC has been redefined as a Frailty SDEC and is included within the expansion of GEMS plans.

Phase 1 also includes the increased efficiency and improvement of existing surgical activity, which will feed into the later delivery of the Surgical Centre of Excellence as part of Phase 3 implementation.

## 3. Current Quality Assessment Overview

Health and care teams work hard to provide good quality services, but the Healthy Weston programme identified some challenges in ensuring that care at Weston General Hospital is delivered in line with national and local guidance and standards. The Clinical Standards described in Appendix 5 outlines an assessment against these standards and should be read in conjunction with the Healthy Weston Phase 1 Full Business Case and QIA.

In 2021 the CQC undertook an inspection of medical care at Weston General Hospital focusing on safety and leadership. The inspection resulted in several concerns and led them to request assurance about staffing levels. An action plan was developed that explained how the risks were to be mitigated and managed.

A review of emergency general surgery published by the South Weston Clinical Senate in 2017 found that of the fourteen acute hospitals in the region, Weston General Hospital came joint 13th in the number of standards it met. However, following the merger with University Hospitals Bristol significant improvements have been made in meeting these standards.

As one of the smallest acute hospitals in the country, Weston General Hospital has found it difficult to preserve the full range of services that a district general hospital of its type might have provided in the past. This has largely been because of its inability to recruit and retain specialist staff.

Weston General Hospital sees fewer A&E attendances each month than other local hospitals. On top of this, the A&E struggles financially, largely because it finds it difficult to recruit and retain specialist staff and therefore has high agency fees, accounting for nearly 25% of staffing costs in 2019/20.

Staffing challenges have remained, even after having been eased considerably by no longer requiring a 24hr rota. A significant proportion of A&E clinical staff are still contracted through bank or agency rather than substantively. Reviews have been conducted on the change in opening hours of the A&E, concluding that there have been no deteriorations in safety at neighbouring hospitals and no deterioration in patient safety for people cared for at Weston General Hospital.[1]

[1] SWAST Travel time audit- University Hospitals Bristol, April 2019

## 4. QIA Purpose & Development

The Health and Social Care Act 2012 sets out a clear expectation that the care system should consider relevant quality standards in planning and delivering services, as part of a general duty to secure continuous improvement in quality.

This Quality Impact Assessment (QIA) document gives an overview of the services enhancements and the quality impact associated with the Healthy Weston 2 Phase 1 clinical model.

In particular, the document reviews the three key domains of:

- Patient safety
- Clinical Outcomes
- Patient Experience

Key information the programme has considered since the implementation of Healthy Weston 1 includes:

- The Covid-19 pandemic has caused unprecedented challenges to the whole of the NHS, as it has for all public services
- Progress has been made in bringing more primary care capacity into the front door, and work has started to ensure community services can play a more active role within services of Weston Hospital
- The Safe Haven service – a new crisis support service run by mental health organisation Second Step in partnership with Avon & Wiltshire Mental Health Trust (AWP) - has made a good start under difficult circumstances as is now playing its full role in the wider service offer for mental health
- The number of patients transferring to other hospitals as a result of the Healthy Weston 1 change is stable, with well recognised and robust protocols for overnight transfers

## 5. Risk Assessment

The risks outlined in the following table are the risks that are associated with the Healthy Weston 2 Phase 1 plans, linked to the 3 quality domains. They do not consider the risks to no change at all, although there is a clear clinical consensus that there are unmitigated risks in continuing with the current model. The full programme risk register can be found in Appendix 1.

| Risk Area | Risk Score | Risk | Mitigation | Risk score post mitigation |
|---|---|---|---|---|
| **Patient Safety** | Medium | There is a risk that system pressures will limit system capacity to deliver the clinical model set out. This is particularly in relation to acute bedded capacity as well as flow through Emergency Departments | System governance process in place to manage system pressures.<br><br>Review of direct admission pathways and use of same day assessment beds.<br><br>Implementation of national and local guidance in relation to patient distancing measures. | Low |
| **Patient Safety** | Medium | There is a risk that in implementing the clinical model, sustainability of existing services may be compromised as staff recruitment and retention is impacted, leading to service failures/increased cost | Workforce Group has developed cross system practices to support recruitment and retention of a whole system workforce.<br><br>Phase 1 recruitment plan outlines strategy to have minimal impact on existing services<br><br>Comms and Engagement Group to support improved staff and stakeholder communication on progress of implementation of the plans. | Low |

| | | | | |
|---|---|---|---|---|
| **Clinical outcomes** | Medium | There is a risk that the interventions put in place at the front door don't deliver the expected improvements leading to more patients needing to be admitted than modelled | Correct workforce in place, through robust workforce and recruitment planning.<br><br>Effective leadership and oversight.<br><br>Models developed in line with national standards and based on tested clinical assumptions. | Low |
| **Patient Safety** | Low | Primary and community care will refer patients to services that are not available at Weston Hospital. | Communication to local GPs and other primary and community care providers to make clear what services are available at Weston Hospital, and the alternative and most appropriate provision available at different times of the day and night. | Low |
| **Patient Safety** | Low | There is a risk that new service models will have a destabilising effect on individual organisations within the system. | The development and evaluation of the clinical models has been made with the key stakeholders, from a system perspective. | Low |

# 6. Quality Impact Assessment

The following section assesses the quality impacts associated with the Heathy Weston 2 Phase clinical model, assessed against the three quality domains.

## 6.1 Front door urgent care services

Healthy Weston 2 Phase 1 will deliver a number of front door enhancements, as described in more detail below:

### 6.1.1 Emergency Department (ED)

The Healthy Weston 2 Phase Full Business Case outlines the plans for Weston Hospital to continue operating a consultant led, all age, Emergency Department, 8am to 10pm service, 7 days a week with full resuscitation care and facilities. Children would be conveyed to Weston Hospital in line with the opening hours of the Children's Day Assessment Unit.

**Patient Safety**

- Weston ED has been closed overnight since 2017 (temporary closure). This was confirmed following Healthy Weston 1 (2019), where the future model maintains the current opening hours and standard operating procedures for overnight access to emergency care
- Staffing within the Weston General Hospital Emergency Department has been stable since the overnight closure was confirmed
- The workforce has continued developing, and the Phase 1 recruitment plan will continue to build the ED workforce to a sustainable position, focussing on delivering high quality care that is in line with national and local standards
- Improvement in safety as a result of improving workforce position (as described in CQC report)

**Clinical Outcomes**

- Reduction in numbers of patients attending ED (although small numbers) will enable the ability to prioritise those who need emergency care
- The plans will allow the Emergency Department to recruit the required staffing levels – this will in turn improve patient care and patient outcomes

**Patient Experience**

- Patients will experience the benefits of collaborative multidisciplinary team care
- Availability of direct admission pathways (as per hospital at night) will mean patients are able to access local care where required
- The public have a good understating of the current Emergency Department and the associated opening hours

### 6.1.2 Geriatric Emergency Medicine (GEMS)

Geriatric Emergency Medicine Service is already a strong (and award-winning) clinical speciality that provides a person-centred clinical service for frail older people in an emergency at Weston General Hospital. It was developed to improve the care and outcomes of frail older adults in an acute emergency. The Phase 1 care model will expand the GEMS services to see 100% of frail patients arriving at Weston Emergency Department, providing a Comprehensive Geriatric Assessment (CGA) within 30 minutes of arrival. Direct referrals from GPs, the Weston Frailty Coordination Hub and other Aging Well services will be accepted to ensure care for older patients living with frailty is provided by this specialist team.

The GEMS team will also provide a frailty Same Day Emergency Care (formally RACOP in the Healthy Weston 2 OBC) for appropriate patients on specific care pathways. This will enable as many suitable people to be treated as possible without hospital admission.

**Patient Safety**

- Frail patients will be seen by specialist geriatric clinicians (at the front door)
- Service will be underpinned by the CGA (Acknowledged as the 'gold standard' of care) improving patient safety and clinical outcomes
- GEMS will also support Emergency Department colleagues by providing advice and support for frail patients who are being treated by Emergency Department, for example, frail trauma patients
- GEMS provide holistic assessment of patient's health needs [not just primary presentation] helping to identify, treat and prevent cause of ill-health

**Clinical Outcomes**

- Already strong service within Weston General Hospital
- Benefits associated with the specialist care of frailty patients
- Less fragmentation (for those with multiple co-morbidities)
- GEMS proven to reduce length of stay, reduce dependency and reduce mortality
- Direct referrals from GP and community colleagues will be accepted
- GEMS holistic CGA assessment will help to identify cause of ill-health and prevent future recurrence / better condition management
- Frailty SDEC provided by GEMS will reduce admissions

**Patient Experience**

- Specialist care from the start of a patient's hospital pathway
- Patients will be seen by appropriate senior clinicians first time
- GEMS emphasises treating the whole patient (comprehensive). Previously patients would've been treated for physical presentation - GEMS takes a holistic approach. In addition to a clinical assessment, GEMS looks at the patient's home environment, medication, cognition (as well as what brought them to ED)
- Enables more time to be spent with the individual and their family. This will ensure that people are given the right choices early in their care pathway
- Creation of the a more comfortable environment for patients (i.e less like ED, less chaotic)

### 6.1.3 Same Day Emergency Care (SDEC):

SDEC is the provision of same day urgent care without an overnight inpatient admission. Under this care model, patients presenting at WGH with relevant conditions will be rapidly assessed, diagnosed, and treated without being admitted to a ward, and if clinically safe to do so, will go home the same day their care is provided.

The Weston SDEC model builds on previous improvement work in Ambulatory Emergency Care (AEC) at the hospital, with the aim of providing a consistent approach to SDEC patient pathways across UHBW Trust / and system. Relevant SDEC patients will be referred through different routes, including:

- Streamed by a senior decision maker in the Emergency Department (ED)
- Direct referral from Primary Care
- Direct referral from paramedics
- Referral from wards to support discharge [discharge review clinic]

**Patient safety**

- SDEC staffed by a senior decision maker - patients to be assessed and transferred through the most appropriate pathway, mitigate against safety risks.
- Best possible care in the shortest timeframe improves patient safety

**Clinical Outcomes**

- Streamlined pathways are anticipated to improve patient outcomes.
- Improves red flagging during assessment - benefits of having senior decision making, potential serious conditions detected earlier
- Safety netting - senior clinical assessment, can articulate symptoms that may be developed if discharged home
- Improvement of investigation timeline

**Patient Experience**

- Ability to return to clinic next day if required rather than long hospital waits.
- New diagnostic and treatment practice rather than admission to ward
- More likely to be discharged home earlier in the patient pathway
- Follow-up ambulatory care and reviews could also be provided to maximise the ability the of the community and acute teams to manage peoples' care needs outside of the hospital environment

### 6.1.4 Acute Medical Unit (AMU) including ED observation unit

The Phase 1 clinical model set out in the Healthy Weston 2 Phase 1 Full Business Case is to enhance the existing Monitoring Unit into a 15-bed short stay acute admission unit for non-frail patients, providing 24-hour support. The AMU will encompass a 9 bedded unit overseen by the acute medical consultant team, and a 6 bedded short stay ward linked to the Emergency Department and overseen by the ED team. As these units will be co-located there is some flexibility in terms of bed numbers such that maximal flow can be achieved.

The AMU acts as a gateway between primary care, the Emergency Department, and the wards of the hospital. Its primary role is to provide rapid assessment, investigation and treatment for patients requiring a short stay [24 hours] in hospital. The AMU helps the Emergency Department produce a healthy turnaround for patients, helping with waiting times and avoiding admission, where appropriate.

**Patient Safety**

- More patients treated in a safe environment, by consultant review (consultant led service) - ability for patients to be transferred on if needed
- Earlier senior clinical involvement
- Reduced waiting times and admissions for patients, decreasing risks associated

**Clinical Outcomes**

- Quicker diagnosis and treatment
- Senior decision making front loaded
- Support from in reach providing specialty input as required

**Patient Experience**

- Decreased LOS
- Reduced number of times that a patient must attend a different provider (reduction in transfers)
- Reduced admissions
- Reduced waiting times
- Patients will experience the benefits of collaborative multidisciplinary team care

## 6.2 Specialist Care for Older People

The Healthy Weston 2 OBC describes the enhancements to services at WGH to develop specialist care for older people. The population local to Weston is an aging population, therefore the development of this specialism will help WGH meet local need, providing the right services to ensure the best outcomes for local people.

These developments include early interventions and specialist workforce to ensure rapid clinical assessment, investigations, and interventions to support early discharge, therefore minimising risks associated with longer inpatient stays.

This specialised offer for Older Peoples' Services will work seamlessly with community services and primary care, ensuring that the person is truly at the centre of the care offer and that inpatient hospital treatment is only utilised when all other options have been exhausted.

Under specialist care of the elderly, the Healthy Weston 2 Phase 1 will deliver the Older People's Assessment Unit (OPAU).

### 6.2.1 OPAU

There is a 'Golden Window' of opportunity during a frail patients' first three days in hospital [72 hours] to influence care plans, provide assessment and treatment and to prevent longer lengths of stay. The OPAU will target this 'golden window' of opportunity and facilitate rapid clinical assessment, investigation, and interventions to support early discharge, reducing patients' time spent in hospital.

The OPAU will provide the highest quality care for the frail older patients admitted on the medical take at Weston General Hospital. The guiding principle will be the use of Comprehensive Geriatric Assessment. The purpose is to develop and carry out a coordinated and integrated plan for treatment, rehabilitation; support and long term follow up.

Patients on the OPAU will be cared for by a multidisciplinary team including physiotherapy, occupational therapy, and in reach from social services. This should speed up their discharge from hospital and put strategies into place to try and avoid unnecessary admissions in the future. The CGA process will underpin the care that will is offered on the OPAU.

**Patient Safety**

- It is widely acknowledged that there is a 'Golden window of opportunity' in a patient's treatment. The rapid clinical assessment, investigations, and interventions to support early discharge will lead to improved patient safety
- Reduced duplication of assessment and clinical history taking
- Ability to hold risk (through CGA)
- Understanding of clinical history and needs
- Specialist geriatric staff with specialist training
- Bespoke environment reduces falls risks, confusion and harm
- Comprehensive assessment

- Medication reviews coupled with associated deprescribing
- Senior specialist decision maker at the earliest possible opportunity

**Clinical Outcomes**

- Specialist geriatric teams have been proven to improve clinical outcomes
- On site / virtual presence of community to ensure transition
- Minimising risks associated with longer inpatient stays such as deconditioning and delirium
- Availability of early supported discharge
- Shared learning between community and acute

**Patient Experience**

- An MDT will provide a seamless service from the front door to an inpatient care (continuity of care) - less of the traditional handovers of care. This is also underpinned by CGA
- Ability to meet the specific needs of the patient
- Reduced duplication of assessment and clinical history taking
- Work with the family and those that know best ('warm handover' process - personalised and integrated)
- Bespoke environment
- Care discussions can involve with family and those who know the patients best
- Reduced Length of stay
- Less risk of admission

## 7. Summary outcome of QIA

National best practice guidance has been used throughout the process for developing the Healthy Weston 2 Phase 1 clinical model. Detailed clinical evidence has been considered, drawing on national clinical standards and guidelines as set out by the relevant Royal Colleges, as well as national reports and reviews. Overall, the Phase 1 clinical model will provide high quality care in line with national and local guidelines and clinical standards.

This QIA is a continuous process to ensure the plans are assessed, and the potential consequences on quality of care are assessed with any mitigating actions are outlined. The assessment has followed due process which includes an initial desktop review, followed by thorough engagement with specialist clinicians.

The summary quality impacts assessed below, against the 3 domains, will continue to be scrutinised as the clinical model is implemented.

### 7.1 Patient safety

- The clinical model reduced admissions, waiting times and length of stay
- Bespoke environments, such as in OPAU and GEMS, reduces falls risks, confusion and harm
- Earlier senior clinical involvement will enable patients to access the right care, as early as possible in their journey.
- The workforce plan will see a range of specialist staff with specialist training in place, including specialist geriatric staff
- Thorough workforce assessments have been undertaken to ensure appropriately staffed services, with MDTs providing joined up and high-quality care across the Phase 1 service enhancements
- The clinical model will enable Weston Hospital to consistently meet national and local clinical quality standards as workforce challenges are addresses

### 7.2 Clinical Outcomes

- The clinical model will deliver interventions which are in line with best practice nationally, for example Same Day Emergency Care
- Specialist frailty services in partnership with the community will deliver improved clinical outcomes reducing the expected rate of admission in line with national guidelines (NICE QS 136, 153; NICE NG27) for those that need it the most. This will be delivered through comprehensive holistic services that treat the ‘whole patient’ rather than focussing on condition specific treatment. This also has significant patient experience benefits.
- Enhancing front door services will rapid assessment and appropriate onward care delivered in accordance with NICE guidance (NICE QS 174 - AMU).
- The plans bring the opportunity for a more specialist workforce at Weston Hospital which will in turn contribute to improved clinical outcomes
- Reduced length of stay decreased risks associated such as deconditioning and delirium

## 7.3 Patient experience

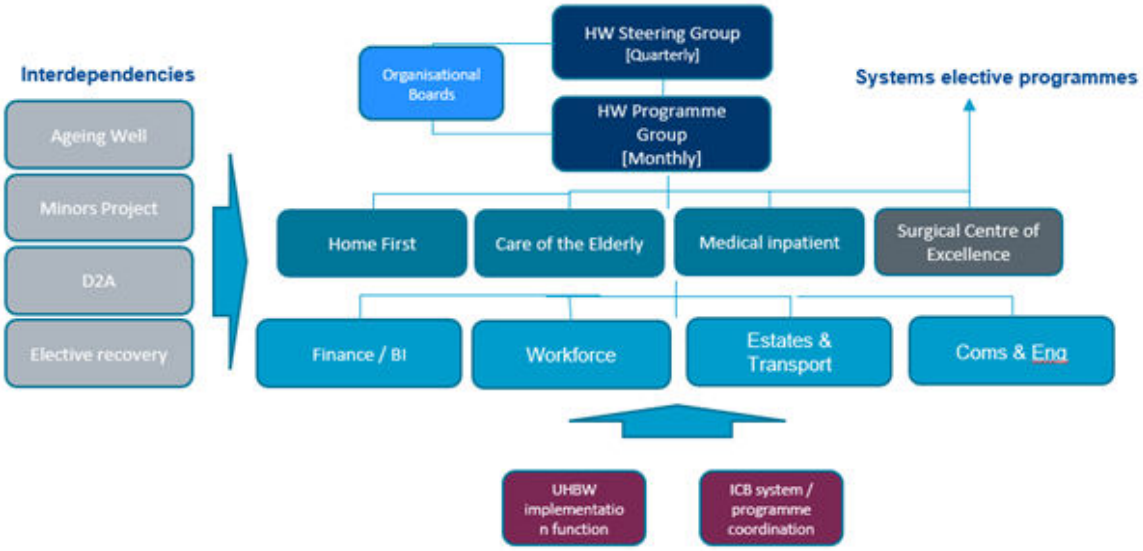
- The enhanced front door offer at WGH will ensure that the vast majority of the local population will receive high quality urgent care locally at Weston
- More people will maintain their independence due to reduced length of stay and admissions, driven by enhanced short stay provision
- Patients will receive specialist care from the start of a patient's hospital pathway
- Patients will be seen by appropriate senior clinicians first time
- Patients will experience a more comfortable environment, such as those attending OPAU and GEMS where adaptions are made to meet the need of the patients
- The Phase 1 clinical model comprises of a MDT, creating an efficient pathway of treatment and care for the patient

## 8. Governance and Quality

The Healthy Weston 2 programme sits under the BNSSG Integrated Care System, comprised of commissioning organisations and health and social care delivery partners. The assurance requirements, including quality, for the delivery of the clinical model are rigorous. To enable this and facilitate the governance and assurance process, the programme has a robust governance structure to ensure that delivery of the clinical model is assured by both system governance and the local community affected by these changes.

The figure below sets out the system governance of Healthy Weston 2. The structure provides appropriate system leadership, oversight and coordination, executive level buy-in as well as clinical leadership and patient and public involvement.

*Figure 1 - Healthy Weston 2 Governance*



Healthier Together

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

# Appendix 5 - Healthy Weston 2 Phase 1

# Meeting National Clinical Quality Standards

Version: 0.5
Date: 23.01.2023

## Meeting National Clinical Quality Standards

The Healthy Weston 2 clinical model will improve compliance of the clinical services affected with national clinical quality standards at Weston General Hospital (WGH). This has been the main focus of the Healthy Weston Clinical Design and Delivery Group (CDDG) and the workstream subgroups throughout the Healthy Weston (HW) 2 programme to date.

This appendix provides a detailed overview of the current compliance of each of the clinical services impacted against their associated national clinical quality standards with the expected compliance at full implementation of the clinical model. Whilst this document is aligned with the Healthy Weston 2 Phase 1 Full Business Case, this document captures the expected compliance at full implementation of the Healthy Weston 2 clinical model (including Phase 2 and Phase 3).

### 1. Urgent and Emergency Care

The Care Quality Commission (CQC) assesses provider organisations against 5 domains – Safe, Effective, Caring, Responsive and Well-led – to give an overall rating to 8 core services. The service ratings are combined to give an overall rating against each domain and an overall rating for the organisation. The CQC last inspected urgent and emergency services in July 2020, to follow up on concerns identified in a Section 29A Warning Notice served in December 2019 following a comprehensive inspection of the service in February 2019. The CQC June 2019 rating of urgent and emergency services at Weston Hospital is shown below:

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

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Urgent and emergency services | Inadequate →← Jun 2019 | Requires improvement →← Jun 2019 | Good →← Jun 2019 | Requires improvement ↑ Jun 2019 | Inadequate →← Jun 2019 | Inadequate →← Jun 2019 |

The July 2020 inspection focussed on assessing Weston General Hospital against the following domains – Safe, effective, responsive and well-led, all of which had been rated as inadequate or requiring improvement during the 2019 inspection. The July 2020 report describes how although some improvements had been delivered, further work is needed to continue to enhance the CQC ratings above. As this was a focussed inspection, the CQC did not provide a new rating.

The clinical model for urgent and emergency care identified in Healthy Weston 1 sought to support improvement against the CQC domains as described in Table 1. However, substantial work within Weston Hospital was still required. Healthy Weston 2 will address any outstanding requirements from the CQC action plan and build on this foundation to deliver a new model of care ensuring safe, sustainable services.

Having a strong model of care to work towards, alongside innovations happening inside the hospital and outside (the development of Aging Well community services for frailty, integrated Stroke services across BNSSG and the focus on reducing demand on ED through the BNSSG Minors Project) will enable the hospital to stabilise the Emergency Department (ED) and bring a skilled and sustainable workforce.

*Table 1: Impact of the Healthy Weston 2 clinical model to urgent and emergency care on the CQC domains*

| Domain | CQC findings (June 2019) | Impact of the Healthy Weston 1 clinical model | Expected Impact of the Healthy Weston 2 clinical model |
|---|---|---|---|
| Safe | **Inadequate**<br>• The service provided mandatory training in key skills to all staff; however, they did not make sure everyone completed it. Staff were not up to date with mandatory training and completion rates for medical staff were particularly poor. This meant we could not be assured they were familiar with safety systems and processes.<br>• Systems and processes to safeguard adults and children from abuse were not robust. Staff had | **Requires improvement**<br>• The clinical model made permanent the overnight closure of the A&E department. By transferring people who need urgent hospital care during the overnight period to hospitals that have the infrastructure to receive critically unwell patients, the risk to patient safety is reduced. This also removes the risk of unsafe staffing levels impacting patient outcomes during the overnight period and therefore reduces risk.<br>• The plans stabilise the urgent and emergency services at Weston | Good<br>• The clinical model provides a sustainable front door model in line with recommended practice and national SDEC which supports consistency of care<br>• The integration with the GEMS team ensures a greater focus on the frailty speciality and streamlines the patient pathway.<br>• The model provides enhanced patient flow both in and throughout the hospital by using SDEC, GEMS and Short Stay. |

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| | not received adequate training and did not always follow processes.<br>• Staff did not always assess and respond to patient risk and monitor their safety. Patients were not always assessed promptly on arrival in the Emergency Department, to ensure that those with serious or immediate or life-threatening illness or injury were identified and prioritised. There were frequent ambulance handover delays and patients were not always assessed within the timescale recommended by the Royal College of Emergency Medicine. Patients were not always given identification wristbands to ensure the right patient received the right treatment. Staff did not routinely assess patients for the risk of falls.<br>• The service did not have enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment. There was a shortage of registered nurses and heavy reliance on bank and agency staff. Staff reported numerous concerns about staffing levels and the associated risks. | Hospital to allow for closer collaboration and, should an organisational merger with UHB go ahead, allow the hospital to best use the resources of a merged organisation.<br>• Improved provision of specialist paediatric staff within Weston Hospital and as part of the A&E team will support improvements associated with paediatric care and ensure that the CQC “should do” recommendations are addressed. | • The model supports direct access to specialist pathways such as stroke, PCI and vascular surgery via ambulance divert which directs patients to the right place in the quickest time.<br>• The streamlined care pathways, such as Gems and SDEC result in fewer patients needing to be seen in the Emergency Department.<br>• Speciality input and hot clinics incorporated with the same-day model result in fewer admissions.<br>• Population need is at the heart of the model. Tailoring services to population need preserves local access for the vast majority of patients. In turn, care closer to home results in quicker access to acute care and less reliance on transport.<br>• The contemporary front door model is attractive to recruit to and will be an advantage in retaining staff. It also enhances the opportunity to collaborate with other ED departments. |

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| | The trust was not able to provide sufficient evidence to demonstrate that all staff were suitably skilled and up to date with mandatory and ED-specific training, including the skills required to care for sick and injured children.<br>• There were still some senior medical staff vacancies and we did not think the current senior medical staff rota was sustainable. Some junior medical staff continued to feel unsupported by senior colleagues at times, although this was improving. Some staff expressed concerns about the clinical competence of some senior medical staff.<br>• The service did not have a good safety track record and did not manage safety incidents well. Twelve serious incidents had been reported in 12 months and a never event was reported in December 2018. Many of these incidents were still under investigation or review and there were many other incident investigations outstanding. There was little evidence that incidents, including unexpected deaths and poor patient outcomes, were regularly discussed or actions and learning cascaded to prevent | | |

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| | further mistakes happening. However, staff recognised incidents and reported them appropriately. When things went wrong, the service apologised and gave patients honest information and suitable support. | | |
| Effective | **Requires improvement**<br>• Although staff could access care and treatment protocols based on national guidance and best practice, we had concerns about version control and out of date guidelines. This meant there was potential for medical staff to access out of date guidelines. Aside from participation in national Royal College of Emergency Medicine (RCEM) audits, the service did not routinely monitor compliance with national guidance or re-audit areas where national audits identified room for improvement. We could not therefore be assured that national guidance was complied with. However, during our inspection we saw good management of stroke and sepsis, which was in accordance with national guidelines.<br>• The service monitored the effectiveness of care and treatment but there was no effective system | **Requires improvement**<br>• The changes ensure that there is seven day access to paediatric expertise and support the care of this patient group.<br>• Seven day provision of a transfer team for patients requiring specialist critical care support is also provided. This ensures that patients that need specialist input are transferred swiftly to the hospital that can best meet the totality of their care needs.<br>• Closer links with the A&E clinical team at UHB have and will continue to lead to the sharing of clinical guidelines and protocols. This will ensure that clinical treatment in Weston is in line with best practice and kept up to date.<br>• The 'mixed economy' staffing model required a refresh of the multidisciplinary skill requirements and specific competency training that formalised the processes found to be lacking in previous inspections. | Good<br>• The model is designed around the population of Weston and surrounding areas meaning tailored care requirements meet the needs of local people.<br>• The model supports collaborative parallel working between emergency, medicine and surgical services which removes the 'linear' access solely via the ED<br>• The plans include daily specialist services to support the front door such as respiratory and cardiology. These services will help in making early decisions at specialty level and reduce hospital admissions.<br>• The model introduces specialist care enhanced with direct access to pathways such as PCR / Stroke, making flow more effective for patients.<br>• In this model patients are assessed in SDEC or ED and referred onward as required. The secondary transfer for patients |

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| | to report on results and limited substantial evidence to show that the service had taken action in response to poor outcomes.<br>• The service participated in national clinical audits so that it could compare its results with those of other services.<br>• The service participated in three Royal College of Emergency Medicine audits in 2016/17 and three in 2017/8. Patient outcomes were generally in line with similar services. However, no action plans had been developed in response to these audits and there were no plans to re-audit where performance required improvement. However, the service monitored the identification and management of sepsis on a monthly basis and this was improving.<br>• The service did not have effective systems to provide assurance that staff were competent for their roles. There was no oversight of nursing staff ED-specific competencies. We were not assured that poor staff performance was well managed, and staff supported to improve. Some junior doctors reported | | requiring specialist inpatient care and longer admission helps to maintain flow.<br>• An enhanced workforce will support upskilling of staff capability, derived from nursing leadership at UHBW. As a result, there will be greater oversight of teaching and training opportunities.<br>• Since the merger of UHB and WGH there has been strengthening of the guidelines and governance procedures, now with shared alignment across the UHBW.<br>• Governance reporting across a UHBW system ensures that Clinical Effectiveness is achieved, alongside National performance monitoring and GIRFT |

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| | concerns about the clinical competence of some senior doctors. Whilst senior staff told us that these concerns were taken seriously and acted upon, the trust was unable to provide evidence to demonstrate this.<br>• There was not a full range of services available seven days a week.<br>• Staff demonstrated poor understanding about how and when to assess whether a patient had the capacity to make decisions about their care and treatment. Most staff groups were not compliant with the 90% target for attendance at mandatory training in the Mental Capacity Act. | | |
| Caring | **Good**<br>• Staff cared for patients with compassion. Feedback confirmed that staff treated them well and with kindness. Staff took the time to interact with patients in a respectful, considerate and friendly manner. We observed staff introduce themselves by name and their role. The tone of voice they used was caring and compassionate and appropriate to each patient's emotional state and needs. We observed staff using | **Good**<br>• The decision surrounding the A&E opening hours gave staff within the department clarity on their expected rotas. The Healthy Weston Decision-Making Business Case recognises the commitment of the staff at Weston Hospital.<br>• Developments in the care available in the community has supported staff at the hospital to signpost patients and their relatives to new types of service provision that may support them better than hospital care can. | Good<br>• The model offers bespoke environments such as the frailty unit, which reflects the population need of Weston and surrounding areas.<br>• Healthy Weston 1 plans around paediatric care have now been implemented. There is now a more integrated and specialist offer for those with younger families, treating these patients in the most appropriate setting. |

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| | humour to engage and build a relationship with patients, as well as take their mind off their discomfort or anxiety. However, during our second visit, the Emergency Department was cold; staff had not taken steps to check on patients' comfort and offer them blankets.<br>• Staff provided emotional support to patients to minimise their distress. Staff understood the impact that a person's care, treatment or condition may have on their wellbeing and on those close to them, both emotionally and socially. We observed staff explaining procedures to patients in a way which was reassuring.<br>• Staff involved patients and those close to them in decisions about their care and treatment. All patients we spoke with told us they were aware of the treatment they were receiving and why. Relatives and carers also reported they felt involved in care and decisions, where appropriate. | | • A diverse workforce with enhanced training opportunities provides both stability and sustainability.<br>• The model results in better patient flow, both accessing care and during the pathway, providing an overall better experience for patients and their families. |
| Responsive | **Requires improvement**<br>• Facilities and premises were not wholly appropriate for the services delivered. The Emergency Department was frequently | **Requires improvement**<br>• The interdependencies of the programme supported partnership working with local health and care providers. This supported the | Good<br>• The HW2 model seeks to provide all patients equity of access to acute and specialist pathways |

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| | crowded; patients were cared for in non-clinical areas and some were accommodated overnight, without access to suitable bathroom facilities.<br>• The service had taken limited steps to support patients with complex needs and those in vulnerable circumstances. There was a limited understanding of the needs of patients with dementia and little evidence of a strategy or use of tools to support this patient group. However, staff spoke positively about the mental health liaison service, which responded promptly to support patients with mental illness.<br>• People could not always access care and treatment at the right time and in the right setting. The trust was not meeting national standards in respect of waiting times in the Emergency Department. Some patients experienced long delays and did not receive care and treatment in the right setting. At times of high demand, when there were no suitable beds available in the hospital, patients queued in the Emergency Department and were | redesign of care pathways for key groups, including the frail and elderly population and those experiencing a mental health crisis. This also supported improvements in patient outcomes and ensured that the A&E department is utilised only by those that need urgent hospital care.<br>• New developments such as implementing the digital “AskmyGP” solution in the A&E department helped ensure that patients that can be seen and treated effectively in primary care are redirected and therefore ease pressure on the A&E service.<br>• Increased presence of frailty expertise through GEMS has helped to address training and knowledge of dementia.<br>• Better community integration has improved flow and allowed more patients to be cared for promptly in the right place for their needs. | within UHBW regardless of geography.<br>• The response from feedback received in HW1 clearly demonstrated that care close to home is important. This model allows local people to continue to receive care close to home with more specialist pathways available locally.<br>• Supporting the desire to have better joined up services, enhanced community integration is implemented, specifically in the area of frailty and GEMS.<br>• The facilities are designed to meet the population demand. |

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| | sometimes accommodated overnight. | | |
| Well-led | **Inadequate**<br>• Managers did not always demonstrate they had the right skills and abilities to run a service providing high-quality sustainable care. The leadership lacked stability and cohesiveness; there had been many changes in the leadership team over a number of years and some further changes were due to take place in April 2019. The service failed to demonstrate effective management of workforce performance issues.<br>• The service did not have a formal vision for what it wanted to achieve. The service was in a state of flux. The future and shape of the Emergency Department and other 'front door' services were currently under review by the local clinical commissioning group and this was currently subject to public consultation. Staff felt uncertain about the future and did not feel well informed, despite numerous communications and opportunities to have their say.<br>• There was not a positive culture in the Emergency Department that | **Requires improvement**<br>• The changes provided clarity on the future opening hours of the A&E department. This helped stabilise the service and allowed the leadership team to focus on internal service improvement and clinical governance, which is required to improve the current CQC ratings. This also helps attract and retain staff.<br>• There are strong links to the UHB merger in this domain with a new leadership team in place from April 2020. | Good<br>• The Healthy Weston 2 plans set out a clear vision and well described model of care for the future state of the hospital.<br>• The described model of care provides clarity on the future of services at WGH giving sustainability assurance to staff and patients alike.<br>• The clear and defined vision makes WGH a stable and attractive place to work, aiding recruitment and retention.<br>• A more positive culture has been established with the new leadership and established Clinical lead. This stronger leadership, with a key focus on teaching and training, has received positive feedback from trainees.<br>• In order to streamline and improve governance and safety, WGH is now under UHBW leadership.<br>• As part of the Healthy Weston 2 communications strategy there has been dedicated engagement with UHBW staffing. This engagement includes items internal news bulletins, staff briefing sessions |

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| | supported staff. Some staff did not feel supported, respected or valued. Some junior medical staff continued to feel unsupported by some senior medical staff. This was a long-standing problem. A concerning number of staff reported being subject to, or witnessing, unpleasant and inappropriate behaviour from senior colleagues.<br>• The service did not have effective governance systems to provide assurance of quality and safety. Governance meetings were poorly attended, and minutes did not provide evidence to demonstrate that senior staff had good oversight of quality and safety. Audit was not used to drive service improvement.<br>• The trust did not have effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and the unexpected. The risk register was not used effectively to maintain oversight of and manage risks. The main forum for monitoring and managing risk was not well led.<br>• The service collected and analysed information using secure electronic systems but did not use it well to | | and a specific staff reference group initiated. |

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| | support all its activities. The service had access to different streams of information, but it did not provide leaders with a holistic view of performance. We were not assured that information was used effectively to manage risks to performance and safety.<br>• The service did not engage well with patients, staff and the public and local organisations to plan and manage appropriate services. Staff were aware of the public consultation exercise in relation to the future and shape of services at Weston General Hospital, but few had participated in any formal engagement to express their views. | | |

## 2. Medical Care (including Older People's Care)

The CQC undertook an inspection of medical care at Weston General Hospital in March 2021, focusing on the safe and well led key questions. Concerns raised during this inspection were shared in a Letter of Intent regarding potential enforcement action. An action plan was developed to address and mitigate the concerns raised which was monitored by the CQC from April 2021 for a period of 3 months to discuss the actions taken in the medical care service at Weston General Hospital.

A further inspection during June 2021 of medical care at Weston raised significant concerns about the safe care and treatment of patients receiving medical care at Weston General Hospital and the Trust was required to take urgent action to protect patients who will or may be exposed to risk of harm. The following CQC rating for medical care (including older people's care) was confirmed in November 2021:

**Figure 2: CQC rating of Weston Hospital medical care in November 2021**

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Medical care (including older people's care) | Inadequate Nov 2021 | Requires Improvement Nov 2021 | Good Nov 2021 | Requires Improvement Nov 2021 | Inadequate Nov 2021 | Inadequate Nov 2021 |

A further CQC report was then published in October 2022, showing improvements at WGH, notably against the domains of well-led and effective. The CQC rating for the October 2022 inspection can be found below:

**Figure 3: CQC rating of Weston Hospital medical care in October 2022**

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Medical care (including older people's care) | Requires Improvement ↑ Oct 2022 | Good ↑ Oct 2022 | Good → ← Oct 2022 | Requires Improvement → ← Oct 2022 | Good ↑ ↑ Oct 2022 | Requires Improvement ↑ Oct 2022 |

*Table 2: Impact of the Healthy Weston 2 clinical model to medical Care on the CQC domain*

| Standard / Domain | Compliance (CQC report – Oct 2022) | Expected impact of Healthy Weston 2 clinical model |
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| Safe | Requires improvement<br>• Staff mostly received and kept up-to-date with their mandatory training. The trust set a target of 90% of mandatory training to be completed in June 2022. At the time of the inspection Weston General Hospital had achieved 89%. Staff told us the quality and content of the training met their needs. They told us some delays in training were caused by staff shortages, and some staff completed their training outside of working hours.<br>• Safeguarding Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.<br>• Most ward areas were clean and had suitable furnishings which were visibly clean and well-maintained. However, we found some areas which did not appear clean, and the suction equipment was dusty. We found this had been rectified when we revisited the ward the following week. Cleaning records were up-to-date, displayed on all wards and demonstrated all areas were cleaned regularly. Housekeeping staff were allocated to wards we visited, and we saw good levels of cleanliness and hygiene. Housekeeping staff told us they enjoyed their role and felt supported by staff on each ward. They were made aware of any risks of cross infection and had access to personal protective equipment. Staff followed infection control principles including the use of personal protective equipment (PPE). All wards we visited had access to hand | Good<br>• To improve access and compliance, training is moving to a new system called Kallidus, with most mandatory training available online. Prior to starting, Locum staff all have their training records checked.<br>• Within the new workforce model, medical registrar staffing is improved, and medical junior posts are filled by substantive appointments.<br>• As a result of reduction in acute admissions with the new model, it is less likely that escalation areas will be used. The Waterside Suite is currently used as escalation and is unfunded, therefore also unlikely to be used in HW2 model.<br>• There is a new patient safety incident reporting process whereby feedback of learning needs to be embedded in ward / specialty governance. This directly improves safety and quality.<br>• Within the clinical model, the pharmacy workforce plan will include 7 day working and front door presence following the organisation shift to 7 day Pharmacy provision.<br>• The model supports renewal of internal professional standards including board rounds, ward rounds, time to see patients in ED, enhancement of medical records processes, electronic prescribing, and hospital at night working practices.<br>• Each environment within the clinical model will be tailored to need with specialist services as required. |

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| | sanitising gel, and we observed staff regularly washing their hands or using hand gel.<br>• The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff were trained to use them. Staff managed clinical waste well.<br>• Staff carried out daily safety checks of specialist equipment.<br>• In the surgical day care unit, patient beds were close together, which limited the privacy for patients. This proximity of each bed meant there was no room for patient lockers, or for chairs for patients or visitors to use. There were patients remaining on the unit for a week or more, which was outside of the standard operating procedure and there were no shower facilities on the unit. This meant patients needed to leave the ward to have a shower in another ward area and were reliant on staff being available to take them to another ward to shower. Patients did not have access to individual lighting by their bed.<br>• The service had reducing nursing vacancy rates. At the time of the inspection Weston General Hospital as a whole had a vacancy rate of 12.3%. Nurse vacancy rates at our inspection in January 2021 were at 28%. However, the hospital had increasing turnover rates which were at 16%, compared to 13.9% in June 2021. The service had high rates of bank and agency nurses used on the wards.<br>• The service had enough planned medical staff to keep patients safe. However, staff told us medical staffing out of hours, especially at weekends was stretched. Sickness rates for medical staff were increasing. At the time of the inspection sickness rates were 7.1% | |

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| | • Pharmacy staff visited the wards from Monday to Friday and staff knew how to access support from pharmacy outside of these hours. The trust had an effective process for disseminating medicines safety alerts and sharing learning from medicines safety incidents. | |

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| Effective | Good<br>• The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.<br>• Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.<br>• Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.<br>• Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.<br>• The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.<br>• Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.<br>• Key services were not all available seven days a week to support timely patient care.<br>• Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing | Good<br>• The plans move inpatient specialties such as cardiology, acute stroke, respiratory and gastroenterology to Bristol with continuing specialty advice and review in reach.<br>• The model enhances frailty provision at the front door and in hospital with full workforce planning. The model introduces specialist care enhanced with direct access to pathways such as PCR / Stroke, making flow more effective for patients.<br>• The model is designed around the population of Weston and surrounding areas meaning tailored care requirements meet the needs of local people.<br>• An enhanced workforce will support upskilling of staff capability, derived from nursing leadership at UHBW. As a result, there will be greater insight over teaching and training opportunities.<br>• Since the merger of UHB and WGH there has been strengthening of the guidelines and governance procedures, now with shared alignment across the UHBW.<br>• Governance reporting across a UHBW system ensures that Clinical Effectiveness is achieved, alongside National performance monitoring and GIRFT standards. |

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| | mental ill health. They used measures that limit patients' liberty correctly. | |

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| Caring | Good<br>• Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.<br>• Patients said staff treated them well and with kindness. We observed a patient due to be discharged the following day who was very grateful and clearly had developed a good relationship with those caring for them. A number of nursing and medical staff came to wish the individual well and this was an authentic and positive interaction.<br>• Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity<br>• Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.<br>• Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment. | Good<br>• With a defined and optimistic vision for the services provided at WGH, staff morale is increased. A diverse workforce with enhanced training opportunities provides both stability and sustainability.<br>• The model results in better patient flow both accessing care and during the pathway, providing an overall better experience for patients and their families. |

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| Responsive | Requires improvement<br>• The service did not always plan and provide care in a way that met the needs of local people and the communities served. It worked with others in the wider system and local organisations to plan care.<br>• The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.<br>• People could not always access the service when they needed it or receive the right care promptly. We saw the system to manage flow throughout the hospital was not completely effective. The increasing demand in the hospital outweighed the available capacity. Throughout our inspection the hospital had 100% bed occupancy with no beds available for any admissions. The hospital had problems maintaining flow from admission to discharge.<br>• It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint. | Good<br>• The model is designed around local population need, supporting community access to local medical care, for example around frailty and paediatrics.<br>• The plans seek to provide all patients equity of access to acute and specialist pathways within UHBW regardless of geography.<br>• The UHBW site team with central management responds to pressures and winter planning across both sites. The site maintain flow throughout the hospital and aid timely discharges.<br>• The plans for a bespoke environment with enhanced community integration helps to avoid prolonged inpatient stays.<br>• Robust plans and systems are in place to ensure review of patients in a timely manner. |

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| Well-led | Good<br>• Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.<br>• The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.<br>• Most staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted opportunities for career development. The service had an open culture where patients, their families and some staff could raise concerns without fear. However, we found cultural issues remained on some wards.<br>• Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.<br>• Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.<br>• The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or | Good<br>• The Healthy Weston 2 plans set out a clear vision and well described model of care for the future state of the hospital. This clear and defined vision makes WGH a stable and attractive place to work, aiding recruitment and retention.<br>• A more positive culture has been established with the new leadership and established Clinical lead. This stronger leadership, with a key focus on teaching and training, has received positive feedback from trainees.<br>• As part of the Healthy Weston 2 communications strategy there has been dedicated engagement with UHBW staffing. This engagement includes items internal news bulletins, staff briefing sessions and a specific staff reference group initiated.<br>• To ensure that staff know who their SLT/SMT are, photographs and titles have been placed around the hospital site.<br>• UHBW has site-specific management teams Site specific management teams. |

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| | notifications were consistently submitted to external organisations as required. | |

## 3. Critical Care

The commissioned standards for critical care are outlined in the for Adult Critical Care. A self-assessment against these standards was undertaken region-wide in June 2019. WAHT complied with the lowest number of standards in the region. Table 3 highlights the standards that the Critical Care Department at Weston Hospital self-assessed as “unmet” and demonstrates which of these would be met under the Healthy Weston 2 clinical model.

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

*Table 3: D05 Service Specification Standards for Adult Critical Care unmet by Weston Hospital in June 2019 and the impact of the HW2 clinical model on compliance.*

| Standard | 2019 Assessment | Impact of HW 1 clinical model on unmet standards | Baseline Assessment 2021 | Expected impact of HW 2 clinical model |
|---|---|---|---|---|
| Admission to Critical Care must be timely and meet the needs of the patient. Admission must be within 4 hours from the decision to admit (unscheduled admissions). | | | | Met |
| The decision to admit a patient to Critical Care must be made by a Consultant in Intensive Care Medicine. | Cross cover by non-intensivists Monday to Friday 1830-0800 | Met under clinical model | Cross cover by non-intensivists Monday to Friday 1830-0800 | Met |
| Care within Critical Care must be led by a Consultant in Intensive Care Medicine (as defined by the Faculty of Intensive Care Medicine). Where providers do not meet this standard consideration should be given as to how this may be achieved through involvement in their local critical care ODN to facilitate collaboration between stakeholders. | Not weekdays overnight - see 1.4 | Met under clinical model | Not weekdays overnight - see 1.4 | Met |
| Consultants must be freed from all other clinical commitments when covering Intensive Care and this must include other on-call duties. | Can be in theatre as well when on call | Met under clinical model | Can be in theatre as well when on call | Met |
| A Consultant in Intensive Care Medicine must be immediately available 24/7, be able to attend within 30 minutes. | Not weekdays overnight - see 1.4 | A consultant in either Intensive Care Medicine or Anaesthesia will be available within 30 minutes supported by an ICM consultant with remote monitoring capabilities at BRI. | | Remote Consultant monitoring is in place with a Consultant available within 45mins. Increased cover until 10pm in place on site. |
| On admission to Critical Care all patients must have a treatment plan discussed with a Consultant in Intensive Care Medicine | Not weekdays overnight - see 1.4 | Met under clinical model | Not weekdays overnight - see 1.4 | Met |
| All admissions to Critical Care must be seen and reviewed within 12 hrs by a Consultant in Intensive Care Medicine | Not weekdays overnight - see 1.4 | Met under clinical model | Not weekdays overnight - see 1.4 | Met |
| Each Critical Care Unit must have a supervisory shift clinical coordinator 24/7. | | Networked solution will provider supervisory shift clinical coordinator at BRI with oversight of Weston Hospital Critical Care Unit | | The unit is not big enough for a designated supervisory shift clinical co-ordinator at WGH. Oversight from BRI. |
| | Not needed due to size | | Not needed due to size | |
| Participation in PHE ICCIQIP | | Met under clinical model | | Met |

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| Working towards compliance with NICE Clinical Guideline 83 and Quality Standard 158 including at a minimum benchmarking data and a SMART action plan in place to achieve compliance. | | No impact as a result of the clinical model | No impact as a result of the changes | No impact as a result of the clinical model |
| Evidence of effective implementation of evidenced based practice within Intensive Care Medicine. | Not done formally | No impact as a result of the clinical model | No impact as a result of HW1 changes | Met<br>Met |
| Presence of a risk register and associated audit calendar which is regularly updated and acted upon. | | No impact as a result of the clinical model | | joint risk register reviewed at critical care executive |
| Discharge from Critical Care to ward level care must occur within 4 hours of the decision to discharge. | | No impact as a result of the clinical model | No impact as a result of the changes | No impact as a result of the clinical model |
| Access to Echocardiograph: Interdependent Services, available 24/7 | Daytime Monday to Friday | Improved under clinical model | | |
| Interventional Vascular and non-vascular Radiology: Interdependent Services, available 24/7 | | Improved under clinical model | | Met |
| Neurosurgery: Interdependent Services, available 24/7 | | Improved under clinical model | | Met |
| Vascular Surgery: Interdependent Services, available 24/7 | | Improved under clinical model | | Met |
| Nephrology: Interdependent Services, available 24/7 | | Improved under clinical model | | Met |
| Coronary Angiography: Interdependent Services, available 24/7 | | Improved under clinical model | | Met |
| Cardiothoracic Surgery: Interdependent Services, available 24/7 | | Improved under clinical model | | Met |
| Plastic Surgery: Interdependent Services, available 24/7 | | Improved under clinical model | | Met |
| Maxillo-facial Surgery: Interdependent Services, available 24/7 | | I Improved under clinical model | | Met |
| Ear, Nose and Throat Surgery: Interdependent Services, available 24/7 | | Improved under clinical model | | Met |
| Obstetrics and Gynaecology: Interdependent Services, available 24/7 | | Improved under clinical model | | Met |

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| Acute/Early Phase Rehabilitation Services: Interdependent Services, available 24/7 | | Daytime only | | |
| Additional laboratory diagnostic services: Interdependent Services, available 24/7 | | I Improved under clinical model | | |
| Local Hospital and Community Rehabilitation Services: Related Service | Monday to Friday daytime | No change | Monday to Friday daytime | |
| Specialised Rehabilitation Services: Related Service | Monday to Friday daytime | No change | Monday to Friday daytime | |
| Critical Care Follow Up: Related Service | | Met under clinical model | COVID follow up commencing | Met |
| Clinical Psychology: Related Service | | Met under clinical model | | Met |
| Spinal Cord Rehabilitation Services: Related Service | | Improved under clinical model | | Met |
| Burns Services: Related Service | | Improved under clinical model | | Met |
| Voluntary Support Services: Related Service | | Met under clinical model | | Met |
| Speciality Intensive Care Units must have their speciality specific surgical service co-located with other interdependent services e.g. vascular surgery with interventional vascular radiology, nephrology and interventional cardiology; obstetrics with general surgery. | N/A | Met under clinical model | Met under changes | Immediate transfer for emergency surgical patients outside of working hours. |
| The provider must have a designated advanced level pharmacist for critical care | Starts in June 2019 | Met under clinical model | | |
| A clinical pharmacist* performs medicines reconciliation within 24 hours of critical care admission | Weekdays only | Weekdays only | Weekdays only | |
| *(or suitable competent pharmacy technician with appropriate clinical pharmacist supervision) | | | | |
| A clinical pharmacist performs medicines reconciliation for patients discharged from critical care on the day of discharge | Weekdays only | Weekdays only | Weekdays only | |
| A clinical pharmacist performs a medicines review for each patient on a daily basis | Weekdays only | Weekdays only | Weekdays only | |
| A clinical pharmacist attends the multi professional ward round on a daily basis | Weekdays only | Weekdays only | Weekdays only | |
| Transfer from Critical Care to a ward should occur between the hours of 07.00hrs and 21.59 hrs, | | Dependant on hospital bed status | | |

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| Transfer from Critical Care to a ward should occur ideally between 0700hrs and 19.59hrs. | | Dependant on hospital bed status | Dependant on hospital bed status | |
| General Surgery for any site with surgical admissions: Interdependent Services, available 24/7 | Tertiary centre nearby | The changes provide a networked solution to BRI | networked solution to BRI | Patients requiring surgery are transferred to BRI. |
| Informatics support: Co-located Services – to be provided on the same site and to be immediately available 24/7 | Monday to Friday daytime | Met under clinical model | Monday to Friday daytime | Met |
| Medical Engineering Services: Co-located Services – to be provided on the same site and to be immediately available 24/7 | Monday to Friday daytime | Monday to Friday daytime | Monday to Friday daytime | |

## 4. Emergency General Surgery

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

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

Many of these standards overlap and 22 standards were created from the above sources by developing and combining linked standards on which the organisations providing emergency general surgery in the South West could assess themselves (see Emergency General Surgery – A review of Acute Trusts in the South West for information on the sources and the way in which the 22 standards were developed). The self-assessment was followed by a review visit by a team of local health professionals. Table 4 below outlines the compliance of WGH at the 2017 South West Clinical Senate review and the expected compliance at full implementation of the Healthy Weston 2 clinical model.

*Table 4: Compliance of Weston General Hospital at the 2017 Clinical Senate review of Emergency General Surgery and the expected compliance at full implementation of the Healthy Weston 2 clinical model.*

| | Standards for Emergency General Surgery | Compliance at 2017 review | | Compliance at full implementation of HW1 clinical model | Expected compliance at full implementation of HW2 clinical model |
|---|---|---|---|---|---|
| **No.** | **Standard** | **Week** | **Weekend** | | |
| 1 | Two consultant led ward rounds of all acute admitted patients, 7 days a week, with the timing of the ward rounds such that patients are generally seen within 14hrs from arrival. There is evidence of continuity of care. | Partially Met | Partially Met | Met for weekdays but not at the weekend under the clinical model | Met for weekdays but not at the weekend under the clinical model |
| 2 | Clearly agreed escalation policies based around an Early Warning System (EWS), are in place to deal with a deteriorating patient. Continued monitoring of the patient is carried out. If patient is not seen within 1 hour (escalation failure), the consultant is contacted. | Met | Met | Met | Met |

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| 3 | All hospitals admitting surgical emergencies to have scheduled access to diagnostic services such as plain x-ray, ultrasound, computerised tomography (CT) and pathology 24 hours a day, seven days a week to support clinical decision making: Emergency imaging reported real time. Urgent imaging reported within 12 hours. | Met | Met | Met | Met |
| 4 | All hospitals admitting surgical emergencies to have access to interventional radiology 24 hours a day, seven days a week, either on site or through a formalised network with an agreed SLA (Service Line Agreement). Critical patients - within 1 hour if IR on site, within 3 hours if networked, Non-critical patients - 12 hours. Interventional facilities are safe for emergency patients. | Not Met | Not Met | No change as a result of the clinical model - this is in place through network with NBT. | No change as a result of the clinical model - this is in place through network with NBT. |
| 5 | Rotas to be constructed to maximise continuity of care for all patients in an acute surgical environment. A single consultant is to retain responsibility for a single patient on the acute surgical unit. Subsequent transfer or discharge must be based on clinical need. There is a clear policy for handover and for transfer of care to another team or consultant, and for safe discharge. | Partially Met | Partially Met | Compliance will be improved through merger with BRI. | This has been achieved as a result of a more robust and resilient workforce. |
| 6 | A unitary document to be in place, issued at the point of entry, which is used by all healthcare professionals and all specialities throughout the emergency pathway. | Partially Met | Partially Met | Weston will adopt the BRI policy. | Shared policy with UHBW |
| 7 | All acute surgical units have provision for formalised ambulatory emergency care delivered by senior decision maker (ST3/SpR & above).<br>Ambulatory emergency care to include a dedicated hot clinic, dedicated day case pathway and dedicated care | Not Met | Not Met | Met through clinical model | Met through clinical model |

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| 8 | Access to fully staffed emergency theatre, consultant surgeon and anaesthetist within 30 minutes, 24/7 | Not Met | Not Met | This will be covered for the time that theatres are open – i.e.8:00-20.00 hours. Outside of this networked arrangements with BRI will be required. | Covered in line with theatre opening hours. |
| 9 | All patients considered 'high risk' (predicted mortality greater than or equal to 10% based on P-Possum/SORT) should be admitted to a level 2/3 area and have their operations carried out under the direct supervision (in theatre) of a consultant surgeon and consultant anaesthetist; early referral for anaesthetic assessment is made to optimise peri-operative care. | Met | Met | Met | Met |
| 10 | All emergency general surgical operations are discussed with the consultant surgeon and the discussion is documented | Met | Met | Met | Met |
| 11 | The majority of emergency general surgery to be done on planned emergency lists on the day that surgery was originally planned. The date, time and decision makers should be documented clearly in the patient's notes and any delays to emergency surgery and reasons why recorded. The WHO Safety Checklist (or local variant thereof) is used for all surgical procedures in emergency theatre. | Not Met | Not Met | Met through clinical model | Met |
| 12 | Handovers must be led by a competent senior decision maker (ST3/SpR & above) and take place at a designated time and place, twice a day. These arrangements to be in place for handover of patients at each change of responsible consultant/surgical team/shift or block of on-call days where it should be consultant led. Changes in treatment plans to be communicated to nursing staff and therapy staff ……..(cont) | Met | Met | Met | Met |

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| 13 | Patient experience data to be captured, recorded and routinely analysed and acted on. Review of data is a permanent item, on-board agenda and findings are disseminated. There has been an in-house audit within the last 5 years related to emergency surgery. | Partially Met | Partially Met | Will be met through adoption of BRI policies | Met via shared UHBW policies. |
| 14 | Hospitals admitting emergency patients have access to comprehensive (Upper/Lower) 24 hour endoscopy service, that has a formal consultant rota 24 hours a day, seven days a week covering GI bleeding. | Met | Met | Will be met via a networked arrangement with BRI overnight with onsite provision during the day | Met via network arrangements with UHBW. |
| 15 | Training is delivered in a supportive environment with appropriate, graded, consultant supervision. | Partially Met | Partially Met | Met through clinical model | Met. There has been an increase in consultant workforce which has helped to achieve this standard. |
| 16 | Sepsis bundle/pathway in emergency care. | Not Met | Not Met | This will be met through the implementation of the BRI sepsis bundle; this is a checklist that is used for all patients | Met |
| 17 | There is a policy for review of all Emergency general surgery patients by a consultant, every day, 7 days a week, whilst they remain under the care of the emergency team. | Met | Not Met | Morning consultant round will meet this. | Yes - Consultant daily ward round AM. |
| 18 | Emergency surgical services delivered via a network (e.g. vascular surgery, IR, Plastics,/Burns and Paediatrics.) have arrangements in place for image transfer, telemedicine, and agreed protocols for ambulance bypass/transfer and a formal SLA. Standards for the transfer of critically ill patients are adhered to and regularly audited. | Not Met | Not Met | Much of this is already being delivered and will be improved through new clinical model; critical care transfer team will improve compliance with transfer of critically ill patient. | Met |

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| 19 | For emergency surgical conditions not requiring immediate intervention, children do not normally wait longer than 12 hours from decision to operate to undergoing surgery. Children receive adequate hydration and symptom control during this time. Surgeons and anaesthetists taking part in an emergency rota that includes cover for emergencies in children have appropriate training and ……..(cont) | N/A | N/A | N/A | NA |
| 20 | As a minimum, a speciality trainee (ST3/SpR or above) or a trust doctor with equivalent ability (i.e., MRCS, with ATLS provider status), is available at all times within 30 minutes and is able to escalate concerns to a consultant. Juniors qualifications - i.e., experience level of team. | Not Met | Not Met | Partially met – availability of surgical support from 08:00-00:00 hours, on call consultant cover between 00:00 and 08:00 | Met with increased workforce of Consultants and appropriate level of junior doctors. |
| 21 | Do you have clear protocols for senior speciality review of all general surgical in-patients to include GI surgery (Colorectal, Upper GI, Hepato-billary), Vascular, Breast & Urology) every day, seven days a week. | Not Met | Not Met | This will be written into the implementation plans. | Met – most elective work is done as day case. |
| | | Met | Met | Met | Met |
| 22 | Do you have clear protocols, including a standard for timing, for senior medical (physician) speciality review of emergency general surgical admissions? | Not Met | Not Met | Can be met through improved joint working with medical team; resilience may remain an issue as medical positions remain highly reliant on locum cover. | Resilience enhanced with UHBW merger and recruitment of new Consultants. |

## 5. Acute Paediatrics

The Facing the Future: Standards for children in an emergency care setting were issued by the Royal College of Paediatrics and Child Health in June 2018. They were developed by the Intercollegiate Committee for Standards for Children and Young People in Emergency Care Settings to support the highest quality care for children wherever they present in the health system. These standards were not published at the time of the temporary overnight closure of the A&E department at Weston General Hospital; however they have formed an important part of the development of the Healthy Weston plans. The paediatric staffing changes, in particular, have been driven by the standards outlined below, with positive "knock-on" impacts for a high number of standards associated with process and governance of children in an urgent care environment.

Table 5 provides a detailed assessment of the compliance pre-Healthy Weston and the impact of the clinical model on compliance against the individual clinical standards. This self-assessment has been completed by a consultant in Emergency Medicine and a consultant paediatrician from Weston Area Health Trust and validated by the Healthy Weston CDDG.

*Table 5: Compliance of Weston Hospital's service model pre-Healthy Weston against the Facing the Future Standards and the expected compliance at full implementation of the Healthy Weston 2 clinical model.*

| | Standard | Compliance pre-Healthy Weston | Impact of the HW1 clinical model on compliance | Expected impact of HW2 clinical model on compliance |
|---|---|---|---|---|
| 1 | Urgent and emergency care services are planned, commissioned and delivered through clinical networks. | Partially met | Commissioning changes improve alignment of paediatric expertise to the urgent care offer | |
| 2 | The care of ICYP in integrated urgent care centres is planned and delivered using these standards to meet the needs of children. | | Standards will continue to be used | |

| | Standard | Compliance pre-Healthy Weston | Impact of the HW1 clinical model on compliance | Expected impact of HW2 clinical model on compliance |
|---|---|---|---|---|
| 3 | Staff receiving children in urgent care centres have the appropriate paediatric competence to provide immediate assessment. | All middle grade A&E doctors have training in advanced paediatric life support (APLS) | Will be improved through increased paediatric knowledge and expertise | |
| 4 | Emergency care settings are designed and provided to accommodate the needs of children and their parents/carers. | Dedicated waiting area within A&E | Children will be moved through A&E and into the Seashore Unit more swiftly under the clinical model | |
| 5 | All Emergency Departments that treat children employ a play specialist. | Not met | Role taken by the paediatric nursing staff with appropriate equipment and experience. Improved access to these paeds nursing skills by matching opening hours will help this standard. | |
| 6 | Children, young people and their parents/carers are invited to provide feedback on the service received in the urgent and emergency care setting to inform service improvement. | Currently met | Will continue to be met | |
| 7 | Children and their parents/carers must be provided, at the time of their discharge, with both verbal and written safety netting information, in a form that is accessible and that they understand. | Partially met via existing Seashore Centre opening hours | Extended hours will enable more children to go via the Seashore Centre, and the presence of more paediatric nursing in ED. Seashore Centre calls every acute admission the following day | |

| | Standard | Compliance pre-Healthy Weston | Impact of the HW1 clinical model on compliance | Expected impact of HW2 clinical model on compliance |
|---|---|---|---|---|
| 8 | Patient flow models which consider patient acuity and consultation time are used in planning capacity of the built environment. | Currently met | Will continue to be met | |
| 9 | Every Emergency Department treating children must be staffed with a PEM consultant with dedicated session time allocated to paediatrics. | Mitigated with the employment of an acute paediatrician. | Mitigated with the employment of acute paediatricians. | |
| 10 | Every Emergency Department treating children must be staffed with two registered children's nurses. | Not met | Met under new model | |
| 11 | A minimum of two children's nurses per shift in dedicated children's Emergency Departments must possess recognisable post-registration trauma and emergency training. | N/A | N/A | N/A |
| 12 | Every Emergency Department treating children must enable their staff to attend annual learning events that are specific to paediatric emergency medicine. | Being met through WATCH Training Day. Simulations and PLS course (step down from APLS) | Increase in number of paediatric trained staff available will increase within new model | |
| 13 | Every Emergency Department treating children must have a member of staff with APLS (or equivalent) training on duty at all times. | Met currently | Met currently | |
| 14 | Every Emergency Department treating children must have their qualified staff trained in infant and child basic life support (BLS). | Partially met | Met under new model | |
| 15 | PEM consultants should have adequate Supporting Professional Activities in a full time job plan in which to continue their own development and that of the trainees. | Not met | Not met but mitigated through closer working with Bristol Royal Hospital for Children | Not met but mitigated through closer working with Bristol Royal Hospital for Children |

| | Standard | Compliance pre-Healthy Weston | Impact of the HW1 clinical model on compliance | Expected impact of HW2 clinical model on compliance |
|---|---|---|---|---|
| 16 | All children who are streamed away from an emergency care setting must be assessed by a clinician with paediatric competences and experience in paediatric initial assessment within pre-agreed parameters including basic observations. | Children are not streamed away from A&E | Children will not be streamed away from A&E in new model | Children will not be streamed away from A&E in new model |
| 17 | All children attending emergency care settings are visually assessed by a doctor or nurse immediately upon arrival with clinical assessment undertaken within 15 minutes to determine priority category, supplemented by a pain score and a full record of vital signs. | Met currently | Will continue to be met | |
| 18 | A system of prioritisation for full assessment is in place if the triage waiting time exceeds 15 minutes. | Met currently | Will continue to be met | |
| 19 | Children with abnormal vital signs at initial triage assessment have their observations repeated within 60 minutes. | Under audit | Compliance will be more effective with enhanced paediatric nursing | |
| 20 | Every Emergency Department treating children has an established Early Warning System. | Met currently | Will continue to be met | |
| 21 | Policies in place for the escalation of care for critically unwell children. | Met currently | Will continue to be met | |
| 22 | The appropriate range of drugs and equipment is available for facilities receiving unwell or injured children. | Met currently | Will continue to be met | |
| 23 | Analgesia is dispensed for children with moderate and severe pain within 20 minutes of arrival to the Emergency Department and pain score is reassessed and acted upon within 60 minutes. | Not audited | Met under new clinical model | |

| | Standard | Compliance pre-Healthy Weston | Impact of the HW1 clinical model on compliance | Expected impact of HW2 clinical model on compliance |
|---|---|---|---|---|
| 24 | Registered practitioners treating children in the Emergency Department deliver health promotion and accident prevention advice that is recorded in discharge summary notes. | Not audited | Met under new clinical model | |
| 25 | Discharge summaries are sent to the child's GP and other relevant healthcare professionals within 24 hours of their attendance to the Emergency Department. | Currently met | Will continue to be met | |
| 26 | Emergency ambulatory care teams work with community services to promote and develop prevention to hospital admissions. | Currently met | Will continue to be met | |
| 27 | All staff who regularly look after children must have up to date safeguarding children training and competence in line with the RCPCH Intercollegiate Document | Not met, highlighted by CQC in June 2019 inspection | Improved through increased access to nursing staff with Level 3 Safeguarding training and consultant paediatricians who have the competencies in line with the Intercollegiate document | |
| 28 | All Emergency Departments nominate a lead consultant and a lead nurse responsible for safeguarding. | Yes for consultant from ED, nurse needs to be secured | Met under new clinical model | |
| 29 | All emergency care settings have guidelines for safeguarding children. | Currently met | Will continue to be met | |
| 30 | All staff in emergency care settings have access to safeguarding advice 24 hours a day from a paediatrician with safeguarding expertise. | Currently met | Will continue to be met | |
| 31 | Information from the Child Protection Plan is available to staff in emergency care settings. | Access via the Emergency Duty Team | Access via the Emergency Duty Team | |

| | Standard | Compliance pre-Healthy Weston | Impact of the HW1 clinical model on compliance | Expected impact of HW2 clinical model on compliance |
|---|---|---|---|---|
| 32 | Systems are in place to identify children and young people who attend frequently. | Currently met | Will continue to be met | |
| 33 | The primary care team, including GP and health visitor/school nurse and named social worker, are informed, within an agreed timescale, of each attendance. | Currently met | Will continue to be met | |
| 34 | A review of the notes is undertaken by a senior doctor or nurse when a child leaves or is removed from the department without being seen. | Currently met | Will continue to be met | |
| 35 | When treating adults, staff must recognise the potential impact of a parent's or carer's physical and mental health on the wellbeing of dependents, and take appropriate action, including when domestic abuse is suspected. | Currently met | Will continue to be met | |
| 36 | Implementation of nationally approved information sharing systems (such as the Child Protection Information Sharing (CPIS) system in England) is occurring as per contract. | Currently met | Will continue to be met | |
| 37 | Policies are in place to review cases where ICYP either leave or abscond from a department unexpectedly prior to discharge or when they do not attend for planned follow up. | Currently met | Will continue to be met | |
| 38 | ICYP at high risk of potential safeguarding presentations are reviewed by a senior (ST4+) paediatrician or PEM doctor (e.g. infants who are non-mobile presenting with injuries such as bruising, burns or fractures.) | Safeguarding systems highlighted as requiring improvement in recent CQC inspection | Will be improved through increased paediatric staffing and expertise | |

| | Standard | Compliance pre-Healthy Weston | Impact of the HW1 clinical model on compliance | Expected impact of HW2 clinical model on compliance |
|---|---|---|---|---|
| 39 | All CYP presenting to a children's ED have a developmentally appropriate assessment of their immediate emotional and mental health needs. | Not met | Will be improved through increased paediatric training and expertise | |
| 40 | A documented risk and capacity assessment should be done for all patients presenting in mental health crisis and this process should commence at triage. | Currently met | Will continue to be met | |
| 41 | Adequate and appropriate space is available for children/families in crisis and should include safe space with suitable supervision by emergency staff. | BRHC as appropriate, and Seashore Centre when open | Alignment of Seashore opening hours to ED | |
| 42 | There is access to mental health records and development of individual crisis plans for each ICYP seen and assessed in mental health crisis in the ED. | Improvements underway through Connecting Care | No change | |
| 43 | A clear system is in place with service planners to escalate care of patients who require Tier 3(+) in-patient care. | Clinical Pathway required transfer to BRHC | Clinical Pathway requires transfer to BRHC | |

| | Standard | Compliance pre-Healthy Weston | Impact of the HW1 clinical model on compliance | Expected impact of HW2 clinical model on compliance |
|---|---|---|---|---|
| 44 | Emergency clinicians with responsibility for the care of children receive training in how to assess risk and immediately manage children's mental health needs and support their family/carers. Training should include risk assessment, current legislation on parental responsibility, consent, confidentiality and mental capacity. | Not met | Compliance improved with increased expertise in paediatric care | |
| 45 | Telephone availability of paediatric mental health practitioner 24hours a day, 7 days a week, for advice and able to attend for assessment when appropriate. | Met through BRHC service provision | Met through BRHC service provision | |
| 46 | Policies are in place for the management of an acutely distressed child or young person incorporating the use of acute tranquilisation and, as a last resort, restraint for those who are acutely disturbed or at risk of harm to themselves or others. | Partially met - access to BRCH policies | Met under new clinical model | |
| 47 | When CYP require access to a mental health in-patient bed but there is a delay >4 hrs, they are looked after in a suitable paediatric facility with appropriate in-patient facilities, regular CAMHS review, trained registered mental health nurses and paediatric nursing support. | Clinical Pathway to BRHC | Clinical pathway will remain to BRHC | |

| | Standard | Compliance pre-Healthy Weston | Impact of the HW1 clinical model on compliance | Expected impact of HW2 clinical model on compliance |
|---|---|---|---|---|
| 48 | There is a clear pre-identified pathway for patients on a Section 136 order for an identified place of safety to meet their medical and mental health needs. | Currently met via BRHC | Will continue to be met | |
| 49 | Triage systems must consider the additional requirements of prioritising care for children with complex medical needs. | Currently met | Will continue to be met | |
| 50 | When treating a child with complex medical needs, the need to consider early escalation for senior review should be included in all training and induction. | Met within hours of availability of Seashore Unit | Will be improved with greater access to nurses and doctors with paediatric expertise | |
| 51 | When treating a child with complex medical needs, staff should ask to see the child's emergency care plan. | Currently met | Will continue to be met | |
| 52 | The needs of children with complex medical needs must be considered within the planning and design of the Emergency Department. | | | |
| 53 | Where electronic alerts are available these must be used to signpost to relevant information such as emergency care plans or the requirement for an early senior assessment. | Not met | No change | No change expected |
| 54 | Information about the child or young person's attendance to an emergency care setting | Partially met | | |

| | Standard | Compliance pre-Healthy Weston | Impact of the HW1 clinical model on compliance | Expected impact of HW2 clinical model on compliance |
|---|---|---|---|---|
| | should be shared with the relevant professionals involved with them, including the lead clinician. Links should also be established with local specialist nurse and community children's nursing team to ensure effective follow-up care and support. | | Increased paediatric knowledge and expertise will help achieve compliance | |
| 55 | The needs of children must be included in the strategic and operational planning and delivery of preparing and responding to major incidents. | Resilience exercises at Weston Hospital include children | Yes | |
| 56 | Children, paediatric medical staff and nursing staff must be involved routinely in appropriate incident exercises with the relevant safeguards in place. | Resilience exercises at Weston Hospital include children | Frequency could be enhanced | |
| 57 | Each region has a Paediatric Critical Care (PCC) Transport team, provided, managed and governed by its Paediatric Critical Care ODN. | Currently met | Will continue to be met | |
| 58 | The regional PICU has a dedicated, 24-hour transfer helpline, for critically ill or injured children, providing clinical support and advice, and co-ordinating paediatric retrievals and transfers. | Currently met | Will continue to be met | |
| 59 | Local facilities have appropriate staff and equipment readily available, for "time-critical" transfers. | Currently met | Will continue to be met | |
| 60 | ED staff trained in stabilisation and transfer of paediatric patients. | Partially met | Met under new model | |

| | Standard | Compliance pre-Healthy Weston | Impact of the HW1 clinical model on compliance | Expected impact of HW2 clinical model on compliance |
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| 61 | Parents and families of children transferred between hospitals are given practical help and information detailing their child's transfer destination. | Currently met | Will continue to be met | |
| 62 | All Emergency Departments caring for children have local agreed policies in place for responding to the unexpected death of a child. | Currently met | Will continue to be met | |
| 63 | Children that have died outside of the hospital setting are taken to a hospital with paediatric facilities. | Access via ED. Seashore Centre supports families locally | No change | |
| 64 | All Emergency Departments caring for children provide training to staff on how to support carers/parents in response to an unexpected death. | Not met | This can be included in staff training, rotational roles with BRHC will support. | |
| 65 | Co-operation with the Rapid Response Team and Child Death Overview panel to ensure learning is shared between agencies. | Currently met | Will continue to be met | |
| 66 | All emergency care practitioners treating children in the urgent and emergency care network have information systems that provide basic demographic and episode related information. | Currently met | Will continue to be met | |

| | Standard | Compliance pre-Healthy Weston | Impact of the HW1 clinical model on compliance | Expected impact of HW2 clinical model on compliance |
|---|---|---|---|---|
| 67 | All health organisations providing emergency care to children must collaborate with national information centres (i.e. NHS Digital) to involve and inform of the needs of patients, clinicians, managers and service planners/commissioners in developing emergency care information systems. | Currently met | Will continue to be met | |
| 68 | All Emergency Departments treating children collect performance data that is used to improve services locally and to benchmark performance nationally. | Currently met | Will continue to be met | |
| 69 | Emergency Departments treating children adhere to Emergency Care Discharge Summary Standard. | Not met | Can be met through increased paediatric support within A&E | |
| 70 | All Emergency Departments treating children have a nominated lead for paediatric emergency research with PERUKI membership. | Not met | Through networked arrangement with BRHC, but recognise that this is outside the scope of Healthy Weston plans | |

## Frailty

*Table 6: Compliance of Weston Hospital's current service model against the current recommendations and the expected compliance at full implementation of the Healthy Weston 2 clinical model*

| Recommendation | Current compliance Met / not met | Expected compliance at full implementation of HW2 clinical model |
|---|---|---|
| Hospitals with a 24 hour ED will provide an Acute Frailty service for at least 70 hours a week. | GEMS provision is currently 5/7 between 9am – 6pm Monday – Friday. | Expansion of GEMS (incl. frailty SDEC) to mirror 7 day ED opening. Direct referrals into frailty available. Same day diagnostic and imaging, seen early by MDT team, same day diagnostics. |
| Hospitals should identify patients with frailty within<br>30 minutes of their arrival and complete a clinical frailty assessment within 60 minutes of the patients arrival into the ED or SDEC unit. | Due to the small team not all patients are able to be seen within 30 mins. There are no robust mechanisms to identify all frail patients. No robust mechanisms to identify all frail patients | The bigger GEMS team means the majority of frail patients will be seen within the allotted time frame. |

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| Older people accessing any healthcare provider or services following a fall, with or without a fragility fracture should be assessed for reversible causes and subsequently referred for a falls and bone health assessment using locally agreed pathways. | In place for anyone who sees GEMS, but not all patients are reviewed by GEMS currently. | Expanding the GEMS team will enable all appropriate patients to be picked up and reviewed by GEMS. |
| The presence of one or more frailty syndromes should prompt the need for holistic assessment and comprehensive geriatric assessment (CGA) – consideration should be given as to the best place for this to be undertaken – in hospital or the community. | Due to the high volume, not all patients receive this. | All pts to have CGA in community and action plan in hospital. Enhanced information sharing across system including mental health support. There is a focus on holistic needs, prevention, and carers. |
| Agree local criteria for identifying patients who will best benefit from early CGA and processes for re-assessment | HW1 introduced frailty scoring. | Continue and adapt as the service expands. |
| An MDT capable of assessing and managing geriatric syndromes interfacing across ED, AMU and Care of the Elderly services should be available 10 hours a day 7 days a week. | GEMS is an MDT currently operating 5/7 | CGA will address this. |
| Multidisciplinary assessments should be embedded within the working of the AMU and provision is planned. | CGA takes place where capacity allows but volume means that not every patient receives this. | CGA will address this. Frailty pathway with dedicated paperwork will also benefit. |
| Ensure that staff working in the AMU can readily distinguish delirium from dementia and implement a screening tool for delirium. | Yes for some patients – pending capacity. Involvement in 'World Delirium Day'. | Yes – with more staff this will be met. Upskilling whole hospital on frailty will be part of becoming a centre of excellence |

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| All older people who self-harm should be offered a psychosocial assessment to determine ongoing risk of self-harm, and to detect and initiate management for any mental health problems. | This happens in ED. Patients are seen as very high risk due to age. | Continue and adapt as service progresses – support from existing mental health team. |
| An acute crisis in an older person with frailty should prompt a structured medication review. | Yes – part of CGA. A new GEMS pharmacist appointed as part of MDT. | Yes – continue and adapt as the service progresses. |
| AMUs should have ready access to time-critical medication commonly used by older people, such as L-Dopa. | Yes – as part of CGA. There are medication flags in patient notes to advise of time critical. | Yes – continue and adapt as the service progresses. |
| Use a tool such as ACB Calculator to assess for anticholinergic burden. | Yes – happening as part of CGA. Pharmacist will help more patients to receive this as part of medicines review. | Yes – continue and adapt as the service progresses. |
| Embed advance care planning within the working practices of frailty MDT. | Yes. RESPECT form is completed, GEMS then do more a detailed assessment and discussion. | Yes – continue and adapt as the service progresses. |
| Multi-agency management of older people leads to better outcomes, delivered in an integrated manner across interfaces between primary and secondary care, and between health and social care. | Strong links with community and social services but not operating within MDT. | Greater integration with Community, Mental Health and Social Care and voluntary sector. New post in GEMS helps to achieve this, red cross is part of GEMS team along with Sirona Integrated nursing team. |

## 6. Orthopaedic Surgery

*Table 7: Compliance of Weston Hospital's current service model against the current recommendations and the expected compliance at full implementation of the Healthy Weston 2 clinical model*

| Standard | Current Compliance | Expected impact of Healthy Weston 2 clinical model once fully implemented |
|---|---|---|
| 7 day access to routine trauma lists which are independent of general emergency theatres. **Best practice**: An additional theatre is immediately available for urgent and complex orthopaedic problems, such as open fractures and those with neurovascular compromise. | Currently dedicated trauma lists all day 3 days a week (Monday, Wednesday, Friday), half day (Tuesday, Thursday). Shared CEPOD lists with General Surgery at weekends. Provision more sporadic with COVID-related staff shortages and pre-pandemic chronic theatre staff shortage. | Met |
| Trauma patients managed within regional trauma network. Complex injuries treated in centres with appropriate volumes within the region –this does not have to be the regional centre. **Best practice**: Appropriate triage by the ambulance service to minimise secondary transfers. | Met | Met |
| Consultant led the trauma team 24/7 in all units receiving seriously injured patients. | N/A for Weston | N/A for Weston |
| If CT scanning is to be performed in patients with multiple injuries, routine use of 'top to toe' scanning is recommended in the adult trauma patient if no indication for immediate intervention exists. **Best practice**: Within 30 minutes. | N/A for Weston | N/A for Weston |
| Hip fracture care is in accordance with the British Orthopaedic Association Standards for Trauma (BOAST 1) and data is submitted to the National Hip Fracture Database. **Best practice**: Compliance with the best practice tariff for fragility hip fracture care: | Data being submitted to Hip fracture database and standards being monitored. Overall performance better than national average for most standards but not 100% always. Figures below based on NHFD website as of Jan 2022 | Met |

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| 1.Time to surgery within 36 hours from arrival in an Emergency Department, or time of diagnosis if an inpatient, to the start of anaesthesia. | Performance of 84% compared with national average 67% | Met |
| 2.Admitted under the joint care of a consultant geriatrician and a consultant orthopaedic surgeon. | No site based Consultant Orthogeriatric service so patients admitted under Orthopaedic surgeons and are reviewed by an Associate Specialist in OrthoGeriatrics Monday-Friday. | Met |
| 3.Admitted using an assessment protocol agreed by geriatric medicine, orthopaedic surgery and anaesthesia. | Protocol developed in conjunction with orthogeriatrics | Met |
| 4.Assessed by a geriatrician in the preoperative period: within 72 hours of admission. Postoperative geriatrician-directed multi-professional rehabilitation team. | Prompt orthogeriatric assessment in 93% of patients (national average 88%). Lead is however at middle grade level with Consultant support, not consultant led. | Met |
| 5.Fracture prevention assessments (falls and bone health). | 98% performance compared with national average of 92.8% | Met |
| Pelvic and acetabular fracture care in accordance with BOAST. **Best practice:** Regional protocols for initial emergency management. | N/A for Weston | N/A for Weston |
| On identification of patients with a fracture of the pelvis or acetabulum in a non-specialist centre, referral is made within 24 hours. **Best practice**: Within an established trauma network, patients suspected of having sustained these injuries will be transported direct to the regional centre. | Referred across to Bristol (regional pelvic unit) | Met |
| Severe open lower limb fractures care is in accordance with BOAST aiming to achieve timely, specialist surgery rather than emergency surgery by less experienced teams. **Best practice:** Specialist orthoplastic care within a trauma network. | N/A for Weston | N/A for Weston |
| Centres that cannot provide combined plastic and orthopaedic care for severe open tibial fractures have protocols in place for early transfer to an appropriate specialist centre. | Green- transferred to MTC | Met |

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| All surgical providers should have a defined facility that exclusively accepts appropriate orthopaedic patients. This should be distinct from other clinical areas either within an acute site or at a separate geographic location. | Work in progress to define a ringfenced area as specified but still very much in its infancy (COVID effects) | Met |
| a. Ensure that all appropriate orthopaedic patients have access to these facilities throughout the year. | Partially met | Met |
| b. Enable effective administration and regular audit of the ring-fenced pathway. | Partially met | Met |
| c. Ensure that individual rooms are available to accommodate all patients with infection including implant infections. | Partially met | Met |
| If this facility is situated in an acute clinical area, separation must be maintained by configuration of estate and resources to ensure that all components, including staff, are used exclusively for ring-fenced patient care. | Partially met | Met |
| Before breaking ring-fenced policy, immediate review of available capacity should be undertaken by the Duty Consultant Orthopaedic Surgeon and Duty Matron. The decision to breach should be sanctioned by the Duty Executive Officer. | Partially met | Met |
| If the ring-fenced capability is breached, all planned cases must be cancelled until the integrity of the facility is re-established, whilst supporting the safe management of patients. | Partially met | Met |
| Outpatient Fracture management standards - assessed by Orthopaedic consultant within 72hrs. | Virtual fracture clinic has facilitated this. | Met |
| Patients with haemarthrosis, following an acute knee injury, should be assessed by a clinician proficient in assessment of knee injuries. This should be in form of an Acute Knee injury clinic led either by a surgeon, a physiotherapist or a suitably trained doctor or allied professional. | Efforts to set up acute knee clinic have stalled due to effects of pandemic. However, the initiation of the VFC has helped triaging of potential acute knee injuries and streamlining into a knee specialists fracture clinic. | Met |

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| The prime indication for ACL reconstruction is symptomatic instability. The decision for early surgical reconstruction vis a vis trial of nonoperative treatment should be individual to each patient. | Met | Met |
| All patients being considered for surgery should be offered prehabilitation to recover knee movement and quadriceps strength. | Currently partially met, previously met but availability of physiotherapy services has been denuded by pandemic effects. The launch of the MyMobility App will help facilitate prehab and monitoring of patients awaiting Arthroplasty - this is being progressed and should be live within 1-2 months. | |
| ACL surgery: An examination under anaesthetic must be performed to take into account the degree of anteroposterior and rotational laxity as well as any other associated injuries and documented. | Met | Met |
| ACL surgery: The procedure should be performed on a Day Case basis, for majority of patients. The surgery should be performed by or under supervision of a surgeon with special interest in soft tissue knee reconstruction. | Met | Met |
| Support shared decision making by discussing treatment options with people offered primary elective hip, knee or shoulder replacement and their families or carers (as appropriate). | Met | Met |
| Offer people having primary elective hip or knee replacement a choice of:<br>regional anaesthesia in combination with local infiltration analgesia (LIA) or<br>general anaesthesia in combination with LIA. | Met | Met |
| Consider a nerve block that does not impair motor function as an alternative to LIA in either of the options above, provided it does not delay surgery significantly. | Met | |

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| Give people having hip or knee replacement advice on preoperative rehabilitation. Include advice on exercises to do before and after surgery that will aid recovery maximising functional independence and quality of life before and after surgery. | Met | Met |
| Use ultra-clean air ventilation in operating theatres for primary hip, knee or shoulder elective joint replacement. | Met | Met |
| Use 2 intraoperative 'stop moments', 1 before implantation and 1 before wound closure, to check all implant details and ensure compatibility of each component. | Met | Met |
| Consider intraoperative real-time data entry before implantation using a system that provides an alert of mismatched implant components, such as the National Joint Registry database. | Not met | Met |
| Offer resurfacing of the patella to people having primary elective total knee replacement. | Met | Met |
| A physiotherapist or occupational therapist should offer rehabilitation, on the day of surgery if possible and no more than 24 hours after surgery, to people who have had a primary elective hip, knee or shoulder replacement. | Partially met | Met |

## 7. Surgical SDEC

*Table 8: The below table sets out the recommended standards that the Surgical SDEC at Weston General Hospital aspires to achieve with the progression and development of the service.*

| Recommendation | Future state after HW2 clinical model implemented |
|---|---|
| The working patterns of senior clinicians support early clinical review, decision-making, treatment, rapid access to diagnostic services and surgical intervention. | Job planning supports this with AM for review and PM for theatre. |
| Services should be open for surgical referral (direct or indirect) for a minimum of 12 hours per day during peak demand e.g: 8 am to 8 pm. | Services reflect theatre opening times. |
| Surgical SDEC should be a designated and ring-fenced area protected from in-patient admissions or from being 'bedded'. | This is an aspiration for the service as it develops. |
| Utilisation outside of the intended use should be recorded and presented regularly during Annual Reports and Care Quality Commission assessments. | This is an aspiration for the service as it develops. |
| Should be co-located close to or within the acute surgical area of the hospital but should be discernibly different in terms of physical space and workforce. | Will be either in front door footprint or 2nd floor close to theatres |
| Referral guidance should be in place to help colleagues from across healthcare to have direct access to sSDEC. This should be communicated and reviewed regularly to increase learning and system maturity to avoid inappropriate referrals. | There is a Standard Operating Procedure (SOP) to support this. |
| Referrals should be process driven rather than protocol driven to ensure that patients can be referred directly to the sSDEC rapidly and efficiently. | This is an aspiration for the service as it develops. |
| Access to rapid diagnostics, emergency theatre and day surgery recovery areas should be a minimum standard to facilitate rapid discharge. | Diagnostic capacity enhancements planned |
| Strict infection prevention and control measures should be in place to minimise the risk of nosocomial infection. | Prevention and control measures are in place. |
| Acute frailty units and teams support the timely delivery of comprehensive geriatric assessment for frail older people in urgent care settings and they may enhance the capability to manage such patients on a same day basis. | Enhancements to GEMS and the frailty offering provide a specialist service for these patients which meets requirements. |
| Where a surgical SDEC (sSDEC) unit is designated this should not be used for in-patient care with exception of times of escalation and there is no other bed capacity in the hospital. When this occurs, there should be a mandatory reporting structure in place to record each time sSDEC is used to accommodate overnight admissions. | This is an aspiration for the service as it develops. |

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| sSDEC services must be open for a minimum of 12 hours per day, 7 days per week. It is anticipated that as experience with sSDEC grows, opening hours will extend, depending on staffing and diagnostic capacity. | Will require additional staffing resource - middle grade, consultant and nursing to be developed. |
| The physical infrastructure should have a mix of trollies and recliner chairs, have a comfortable and open waiting area and some space for privacy. | Will be part of space planning |
| There should be capacity for 'hot clinic' provision for appropriate patients who can be directly referred and a procedure room or area for minor operations to be carried out under local anaesthetic or recovery areas for patients who have had short general anaesthetics and uncomplicated procedures. | Will be part of physical space planning |
| Referrals should be designed in such a way that patients can be streamed rapidly and efficiently to the service. | The Bristol Royal Infirmary (BRI) has a focus on making referrals more direct. This process to be adopted by WGH. |
| Expert clinical decision makers should be dedicated to receiving referrals to ensure that patients are transferred to the correct area for initial surgical assessment. | Yes - this is met across UHBW. |
| There should be a dedicated point of contact for all referrals (usually a senior nurse or doctor) who is able to accept and triage referrals to manage both patient assessment and patient flow throughout the day. | Dedicated on call registrar freed of theatre commitments - job planning and additional workforce. |
| There should be dedicated administrative support and nursing staff to ensure sufficient capacity to assess, triage and maintain patient flow. | To form part of workforce plan |
| A dedicated medical workforce is ideal, although, it is recognised that this may not be possible for many providers. As such, an on-call emergency surgical team should have a permanent presence to allow rapid assessment and management with regular consultant reviews. | This is achieved in line with theatre opening hours. |
| Clinical leads from surgery, radiology and pathology work closely together to provide diagnostic support to all SDEC services with access to rapid and timely diagnostics which are crucial to the effective functioning of a surgical SDEC unit. | There is ongoing work across UHBW to achieve this. |
| Ultrasonography provision throughout the day. This is most commonly ultrasound scans of the abdomen and/or pelvis. SDEC services can choose to implement booked appointments (usually in the mornings) or have an on-site SDEC ultrasonographer. The key requirement is that patients do not wait several hours for imaging alone. | To form part of diagnostic workforce plan |
| Dedicated diagnostic provision for SDEC patients is crucial to ensure short waiting times and positive patient experience. | Yes - this is met across UHBW. |

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| Endoscopy requirements for a sSDEC includes the provision of ERCP, diagnostic and therapeutic endoscopy and diagnostic flexible sigmoidoscopy or colonoscopy. However. Patients who are appropriate for urgent outpatient investigations (such as small volume rectal bleeding) should not be managed within sSDEC. | Yes - this is met across UHBW. |
| Adequate theatre capacity is vital for effective sSDEC services. In line with NCEPOD guidance, each unit should have access to a dedicated emergency operating theatre with dedicated surgical and anaesthetic staff. | This is achieved in line with theatre opening hours. |
| sSDEC services should have access to pre-operative beds or trolleys to allow patients to be sent for quickly and without delay and should have access to adequate recovery facilities to enable rapid discharge where appropriate after surgery. | Yes - this is met across UHBW. |
| Every patient who is treated and discharged through a sSDEC service should have a named consultant and have consultant accountability for decision-making. | Yes - this is met across UHBW. |
| All patients who pass through the sSDEC services should have a formal discharge letter or other appropriate documentation which details the working diagnosis, treatment received and follow-up plans. | Yes - this is met across UHBW. |
| Patients discharged from sSDEC should have criteria for re-admission within a determined period of time and methods for contacting the unit after discharge. sSDEC service provision should have a concurrent surgical 'hot' clinic within which patients may be followed up. | sSDEC SOP will cover this |
| Patients managed within a 'Virtual Ward' setting should have regular documentation of remote reviews and should be assessed 'in person' prior to formal discharge from the SDEC service. | This is an aspiration for the service as it develops. |
| Efficient theatres with minimal delays between cases are vital to allow a high-functioning surgical SDEC unit. Consideration should be given to establishing regular theatre planning meetings between surgeons, anaesthetists and theatre staff to minimise delays between cases. | Theatre planning meetings already in place. Theatre efficiency project underway to improve flow and throughput. |
| Referrals from ED should have appropriate blood tests sent prior to referral though results are not always necessary prior to transfer to sSDEC. | Yes - this is met across UHBW. |

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# Appendix 6 – Healthy Weston 2 Phase 1

# Benefits Realisation Plan

Date: January 2023

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# Benefits Realisation Plan – Healthy Weston 2 Phase 1

| Desired Benefit | Stakeholders impacted | Enablers required to realise benefit | Outcomes displayed if benefit is realised | Measure | Who is responsible | Target date |
|---|---|---|---|---|---|---|
| **Reduced length of stay (LOS) in hospital [10%]** | Patients, their families & carers<br><br>Weston General Hospital staff | • Short stay provision at Weston General Hospital enhanced for all adult care<br>• Enhanced care of the elderly services implemented | • More people accessing services where national standards are met, and specialised care delivered<br>• More people maintain their independence<br>• Fewer delays are experienced for treatment<br>• Reduced risk to frail older patients of conditions related to longer LOS e.g. delirium, pressure sores and deconditioning | 10% decrease in LOS for emergency care at WGH and neighbouring sites<br><br>No. bed days utilised<br><br>90-day readmission rates | UHBW / Weston Business Unit | From April 2023 |
| **Workforce is more sustainable** | UHBW staff | Successful implementation of new workforce models | • Fewer vacant posts<br>• Improved retention and recruitment rates<br>• Improved staff experience<br>• Reduced cost of contracting with agency staff<br>• Increased % of substantive staff employed<br>• Improved network working with other hospitals<br>• More opportunities and progression available to staff<br>• Enhanced access to training and development for staff | % Agency use [Less than 10% medics]<br><br>% Staff with joint working job plans / contracts<br><br>Vacancy rate [Less than 5%]<br><br>Staff survey results | UHBW HR / Workforce Division | From April 2023 |
| **Improved ED performance** | Patients accessing Urgent and Emergency Care | Enhanced Urgent and Emergency care offer at WGH | • 10% improvement in time to be assessed, treated and discharged<br>• Improved patient flow | ED total time in department (10% improvement in under 4 hours) | UHBW / Weston Business Unit | From April 2023 |

| | | | | | | |
|---|---|---|---|---|---|---|
| | Weston General Hospital ED staff | | • Improved patient experience<br>• Reduced risk to frail older patients of conditions related to longer LOS e.g. delirium, pressure sores and deconditioning<br>• 20% of ED attendance through SDEC by 2024<br>• Reduction in ambulance diverts<br>• 14 additional people seen treated and discharged each day | ED time to initial assessment (% under 15 mins)<br>ED time to start of treatment (% under 60 minutes)<br>Number of ED 12-hour trolley waits<br>Ambulance handover times / time lost to handover delays | | |
| **Improved outcomes for patients receiving Urgent and Emergency Care** | Patients accessing Urgent and Emergency Care, their families & carers<br><br>Local health and care providers | Implementation of Healthy Weston 2 changes to Urgent and Emergency Care, short stay models, same day emergency care (SDEC, GEMS, AMU, OPAU) | • Improvements in the quality and responsiveness of care<br>• Decreased length of stay for emergency care at Weston compared to baseline<br>• Increased bed availability<br>• Reduced risk to frail older patients of conditions related to longer LOS e.g. delirium, pressure sores and deconditioning<br>• Fewer deaths because of improvements in time to be seen [60 fewer deaths per year]<br>• Reduction in number of safety datix raised relating to overcrowding | Outcome measures / PROMS<br>Emergency re-admission rates<br>Hospital mortality indicators<br>Friends and Family test results (ED) | UHBW / Weston Business Unit | From April 2023 |
| **Improved system flow** | System health and care providers and staff | Increased interventions at the front door at WGH | • Improvements in the efficiency of services<br>• Decreased length of stay for patients<br>• Increased bed availability at WGH | % of general and acute beds occupied | UHBW / Weston Business Unit | From April 2023 |

| | | | | | | |
|---|---|---|---|---|---|---|
| | Patients accessing services across the system | | • Improvements in the quality and responsiveness of care<br>• Reduction in ambulance diverts | % of beds occupied by no criteria to reside patients | | |
| **Hospital care maintained locally** | All those living in the Weston General Hospital catchment area, or are accessing services at the Hospital | • Urgent and Emergency Care, Care of the Elderly, care for children and young people and a range of planned care services are provided on the Weston General Hospital site | • People living locally to Weston General Hospital are able to receive the majority of their care locally<br>• Improved access for local visitors / family<br>• Reduced travel for the system | ED attendance at Weston and neighbouring sites with Weston postcodes | UHBW / Weston Business Unit | From April 2023 |
| **Improved patient experience** | Patients accessing Urgent and Emergency Care, Front door services and Care of the Elderly services | Enhancements to Urgent and Emergency Care, Front door services and Care of the Elderly | • Improvements in the quality and responsiveness of care<br>• Improvements to the reputation of the hospital<br>• Clinical outcomes and patient safety enhanced | Friends and family test results<br>Number of patient complaints received<br>Number of falls reported<br>Number of serious incidents reported | UHBW / Weston Business Unit | From April 2023 |
| **Increased care at home** | Patients receiving care at home, their families & carers<br><br>Weston General Hospital staff<br><br>Local health and care providers | • Development of community services for older people<br>• Implementation of frailty model<br>• Application of short stay models to ensure that long hospital stays are avoided unless absolutely necessary | • Hospital services are utilised only by those that need acute care, reducing demand on staff in-hospital<br>• 10% reduction of length of stay for patients<br>• Increased hospital bed availability in acute care<br>People are supported to be independent | LOS for emergency care at Weston care home hub measures | Aging well programme | From April 2023 |

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# Appendix 7 - Healthy Weston 2 Phase 1

# Equality Impact Assessment (EIA)

Version: 1.0
Date: January 2023

**Version Control**

| Version | Date | Author | Comments |
|---|---|---|---|
| **0.1** | 08.09.2021 | Nicole Hill | Initial draft of document |
| **0.2** | 29.09.2021 | Nicole Hill | Draft continued including Covid impact and updates following conversation with Partnerships and Engagement Manager |
| **0.3** | 06.10.2021 | James Cox | Inserted footnotes for referencing. |
| **0.4** | 05/01/2021 | James Cox | Formatted document |
| **0.5** | 10/02/2022 | Nicole Hill | Updated following Clinical Model development |
| **0.6** | 11/02/2022 | Sharon Woma | Approval and sign off |
| **0.7** | 06/04/2022 | Nicole Hill | Updated to incorporate Sharon Woma's comments for next iteration and further developments on the model. |
| **0.8** | 26.05.2022 | Helen Edelstyn | Updated model content in-line with the Outline Business Case |
| **0.9** | 27.05.2022 | Jeremy Westwood | Formatting amends |
| **1.0** | 23.01.2023 | Fritha Voaden | Updated to align with Healthy Weston 2 Phase 1 Full Business Case |

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## 1. Introduction

Healthy Weston 2 is the concluding stage of a two-part programme developed to ensure the very best healthcare for the population of Weston, Worle and the surrounding areas. Healthy Weston 1 was initiated with the vision for Weston General Hospital (WGH) to become a vibrant and dynamic hospital at the heart of the community - an exemplar of excellent healthcare designed specifically to respond to the needs of the local population.

The system is already on the way to achieving this ambition through the changes implemented at Weston General Hospital as part of Healthy Weston 1 and the merger between University Hospital Bristol and Weston Area Health Trust. These have made services safer and more sustainable, particularly for urgent and emergency care, critical care, emergency surgery and acute children's services. In addition, much closer working between local GPs practices and hospital services has put more focus on providing joined-up care.

Outcomes from the first phase of the Healthy Weston programme include:

- An established and stable model of urgent and emergency care including A&E at Weston Hospital, with a sustainable workforce, running 14/7 and serving on average 137 people every day
- Improved cover of paediatric specialists in A&E so fewer children need to be transferred to Bristol
- An intensive care unit that is now fully integrated with the unit at the Bristol Royal Infirmary
- Local GP practices working together under the banner of Pier Health.
- A new Safe Haven mental health crisis service in the heart of the Weston. Operating since early 2020, Safe Haven is regularly helping between 50-80 people a week, supporting them to stay well and local rather than having to be referred to more intensive out-of-area services
- Building on new ways of working as a result of the pandemic to ensure more patients can have virtual consultations by using technology which reduces the risk of infection transmission, reduces travel times/ carbon emissions and enables the waiting list backlog to be addressed more quickly.

This is welcome progress; however, it was understood that whilst Healthy Weston 1 improvements were urgent and necessary, they did not go far enough and further work in a second phase would be needed to ensure a dynamic and exciting future for health services in Weston General Hospital and to address the case for change.

## 2. Case for Change

There are four key reasons why health and care services in Weston General Hospital need to continue to change:

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

**The current model of care is unsustainable:** Some health services at Weston General Hospital are not able to consistently meet national and local clinical quality standards because of low activity volumes and shortages of specialist staff. However, Weston General Hospital can provide enhanced services in specific areas relevant to its population, learning from the success of areas such as orthopaedics, which can thrive with the right clinical model.

**Whole system changes are required to ensure timely access to equitable, integrated care:** The introduction of integrated care systems and the merger of Weston Area Health Trust with University Hospitals Bristol give opportunities to improve patient care across the system, increasing access and continuity of care. Organisations can collaborate to ensure that patients receive care in a setting appropriate to their needs, joining up pathways across primary care, community care and hospital care. Weston General Hospital plays an important role in the system's clinical strategy delivering key priorities such as reducing local health inequalities and accelerating elective care.

**There is an opportunity to better use our resources:** Healthcare resources are limited across our system, with Bristol, North Somerset and South Gloucestershire region in deficit by £34m in 2019/20. The COVID-19 pandemic has put further pressure on these limited resources. Workforce, finance, and estates must be best used to provide care for our local population.

Challenges in the provision of speciality medical services have worsened and following a difficult two years responding to the consequences of the COVID-19 pandemic it is now possible to think differently about the opportunities a new improved clinical model for Weston General Hospital can offer.

## 3. The Clinical Model

**Developing the clinical model**
A structured, clinically led process has been used throughout the Healthy Weston Programme to develop the new clinical model. The Decision Making Business Case for Healthy Weston 1 (published in 2019) set out a potential long-term model for Weston which it undertook to revisit and progress within this second phase of the work. Local clinicians, working in partnership with staff and patient representatives, have refined and developed the plans, considering the impact of the pandemic and the benefits of the merger with University Hospitals Bristol.

The consensus from the Healthy Weston Programme is that doing nothing carries the greatest risk for both Weston General Hospital and the wider system as it brings with it the possibility of continuing unplanned changes that have the potential to destabilise the system and affect patient care. A Review Panel from the South West Clinical Senate agreed that 'do nothing' is not an option', stating that there is significant and robust clinical evidence that it is neither sustainable nor safe to continue services as they are.

Feedback collated from stakeholders has been used to develop the criteria by which options for improvement were assessed. The criteria used to evaluate potential options, which are directly linked to the reasons for change and the themes from engagement activities, were:

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

The conclusion of this work is a series of exciting improvements to clinical model at WGH, which are centred around delivering sustainable services at the Hospital that are in line with national standards. These plans have been supported by clinicians from across the Bristol, North Somerset, South Gloucestershire (BNSSG) and Somerset system and shaped by patient, public and staff representation.

The Healthy Weston 2 Outline Business Case (OBC), agreed in June 2022, describes the ambitious improvement plans. A phased approach to the development of 3 interlinked full business cases has been agreed to cover the plans. These phases are:

- Phase 1 – Safe, high quality and sustainable urgent care
- Phase 2 – Inpatient medical care and specialist centre for care of the elderly
- Phase 3 – Surgical Centre of Excellence at Weston General Hospital

Adopting a phased approach to delivery enables an initial focus to be on those projects that are standalone and can be delivered quickly. Other elements of the programme that are sequentially dependent on one another, and in some cases requires capital funds to be effectively planned, will follow.

## 3.1 Healthy Weston 2 Phase 1

This Equality Impact Assessment focusses on the changes set out in the Healthy Weston 2 Phase 1 Full Business Case.

Phase 1 leads the development of a safe, high-quality and sustainable urgent care at Weston General Hospital, that is in line with national and local standards, and that ensures local people have equity of access to the best urgent care. Senior leaders and clinicians from across Bristol, North Somerset, South Gloucestershire and Somerset have led the progression of the Phase 1 model, ensuring plans conform with system priorities and the Healthy Weston vision.

The plans have also received support from the public, who during a public engagement exercise delivered between 20 June and 14 August 2022, indicated that the majority of people thought the plans would help improve the hospital.

The scope of Healthy Weston 2 Phase 1 is the following

- Enhanced 24hr observation unit for adults providing rapid assessment and treatment [Acute Monitoring Unit]
- Improved Same Day Emergency Care [SDEC], providing the right care, in the right place at the right time
- Increased number of frail patients supported by already award-winning Geriatric Emergency Medicine Service [GEMS] meeting local need
- Creating Older People's Assessment Unit [OPAU] providing specialist rapid assessment and treatment

The Rapid Assessment Clinic for Older People (RACOP) as described in the Healthy Weston 2 Outline Business Case has been redefined as a Frailty SDEC and is included within the expansion of GEMS plans.

Phase 1 also includes the increased efficiency and improvement of existing surgical activity, which will feed into the later delivery of the Surgical Centre of Excellence as part of Phase 3 implementation.

The Phase 1 service improvements will bring about a range of system benefits, including increased quality and responsiveness of care, reduced length of stay, improved patient outcomes, improved system flow, reduced staff vacancies, and improved staff retention. Clinicians and health service leaders agree that the new clinical model will be more accessible and better able to support the changing needs of the local population.

**Programme phasing and business case development**
The scope of the 3 interlinked full business cases, as described in the Healthy Weston 2 OBC, are set out in the table below.

*Table 1 – Healthy Weston 2 business case, scope and phasing*

| Workstream | Scope | Delivery phase |
|---|---|---|
| **Home First** | Same Day Emergency Care (SDEC) | Phase 1 |
| | Geriatric Emergency Medicine Service (GEMS) including Frailty SDEC | Phase 1 |
| | Acute Monitoring Unit (AMU) | Phase 1 |
| **Care of the Elderly** | Older Persons Assessment Unit (OPAU) | Phase 1 |
| | Care of the Elderly Wards (CoE Wards) | Phase 2 |
| **Inpatient Medical Care** | Transfer of inpatient beds | Phase 2 |
| **Surgical Centre of Excellence** | Efficiency and Improvement | Phase 1 |
| | New development modular theatres | Phase 3 |
| | Refurbishment and growth | Phase 3 |

Phase 2 is sequentially dependent on Phase 1 with the focus being on the development of the Care of the Elderly (CoE) Wards and the transfer of inpatient beds (8 patients a day). Phase 3 leads the development of the Surgical Centre of Excellence and is sequentially dependent on the capacity created in Phase 1 and 2, as well as a system wide approach to elective care.

The clinical model builds on the existing approach taken by hospitals across Bristol, North Somerset and South Gloucestershire that already work closely together on a networked basis to provide specialist services for conditions such as major trauma, stroke, and serious heart attacks. Under existing arrangements, patients with these conditions do not necessarily get treated in their nearest hospital but are instead seen by the specialist team in the relevant lead hospital.

## 4 EIA Purpose and Development

This Equality Impact Assessment (EIA) gives an insight into the local population and their health needs, and what we have learnt through our engagement so far. The document assesses potential equality impacts of the plans, so that the programme is informed about the likely consequences of the clinical model, can seek to avoid, reduce or mitigate potential adverse impacts through consideration of alternative options and can take informed and transparent decision-making.

The equality act 2010, makes it unlawful to directly or indirectly discriminate against people with protected characteristics, we have considered within this document the impact of any changes to services on these 9 protected characteristics.

## 5 The COVID-19 Impact

This document acknowledges that the COVID-19 outbreak has affected, and continues to affect, people and their communities differently. For some groups, the impact will be more severe than that experienced by the general population as a whole and, as a result, there is the potential of worsening health inequalities.

The Public Health England report 'Disparities in the risk and outcomes of COVID-19'[1] identifies the following groups as being disproportionately impacted – males, those aged 80 or older, those living in more deprived areas and those from Black, Asian, and Minority Ethnic (BAME) communities. The PHE report highlights further challenges including language barriers, cultural differences, the link to comorbidities, socio-economic factors (housing, employment, education etc.).

This EIA further considers the COVID-19 impact associated with each of the 9 protected characteristics, as well as further aspects where the planned changes to Weston General Hospital may impact the BNSSG and Somerset population.

## 6. Public Sector Equality Duty

The main Public Sector Equality Duties 2011, set out in section 149(1) of the Equality Act 2010 ("the Act") applies in three ways:

- it applies to "public authorities" including the National Health Service in respect of all of their functions, unless the authority is specified in respect of only certain functions;

[1] Disparities in the risk and outcomes from COVID-19 – Public Health England – Accessed : https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/908434/Disparities_in_the_risk_and_outcomes_of_COVID_August_2020_update.pdf

- where a public authority is specified in Schedule 19 of the Equality Act 2010 in respect of only certain functions, the Duty applies to the authority in respect of only those functions;
- where persons are not public authorities but exercise public functions, the Duty applies in respect of the exercise of those functions.

In addition to the importance of considering the equality impact of any changes, relating to the 9 protected characteristics of the Equality Act 2010, NHS organisations must, in the exercise of its functions, **have due regard to the need to**:

(a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act, but not age, so far as relating to persons who have not attained the age of 18, or marriage and civil partnership.

(b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it; in particular, to the need to:

- remove or minimise disadvantages suffered by persons who share a relevant protected characteristic that are connected to that characteristic;
- take steps to meet the needs of persons who share a relevant protected characteristic that are different from the needs of persons who do not share it;
- encourage persons who share a relevant protected characteristic to participate in public life or in any other activity in which participation by such persons is disproportionately low.

(c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it. In the context of this limb, public authorities need to: tackle prejudice, and promote understanding between person who share a relevant protected characteristic and persons that do not share it.

These are known as the three sections of the “general duty”. In addition to the “general duty”, NHS organisations also need to evidence compliance against the specific equality duty, and under this section of legislation, NHS organisations are required to:

(a) Set specific, measurable equality objectives;

(b) Analyse the effect of our policies and practises on equality and consider how they further the equality aims;

(c) Publish sufficient information to demonstrate that we have complied with the general duty on an annual basis. This compliance is in respect of the effect of their services and employment on the protected characteristics: Age, Disability, Gender Reassignment, Race, Religion or Belief, Sex, Sexual Orientation, Pregnancy & Maternity and Marriage and Civil Partnership.

The following section builds upon this 'due regard' in additional equality areas that may be affected by Healthy Weston 2 plans

*Table 2 - Equality areas affected by Healthy Weston 2 service improvements*

| **Protected Characteristic** | **Analysis+ / N / -** | **Impact Assessment Summary** | **Healthy Weston 2 Phase 1 mitigation** | **Wider programme mitigations (incl. Phase 2 and Phase 3)** |
|---|---|---|---|---|
| Age | + | Ageing population within North Somerset<br><br>High number of care homes in North Somerset particularly Weston area<br><br>Potential communication barriers for patients with dementia [dementia is associated with an ageing population]<br><br>The ability to travel may prove more challenging with older age, particularly increased reliance on public transport<br><br>Potential reliance on carers or family members for transport | Continue to provide and Emergency Department 14 hours a day (8am to 10pm) seven days a week, exactly as now<br><br>Phase 1 will enhance the urgent care offer at Weston General Hospital (WGH). This includes expanding the GEMS offer and introducing the OPAU service, **specialising in elderly urgent care**. These developments will allow rapid assessment and treatment, improve outcomes, reduce admissions and reduce the amount of time people need to spend in hospital, **across all age groups.**<br><br>During the public engagement period (June - August 2022), the programme worked closely with partners, to ensure contact and inclusion of the local age-related groups to better inform the | Expand the care of the elderly services to create **a centre of excellence for older people**. This particularly reflects the local need as the population characteristics Weston Hospital has the highest average inpatient age of any general hospital in the country<br><br>Travel time analysis to consider impact of changes – review of patient transport services, signposting visitors to help with travel and transport if eligible, meeting with local transport providers and local authorities to discuss bus routes and timetables, making sure people who are transferred can come back to WGH after they finish their specialist care, so they can finish their inpatient stay closer to home if possible.<br><br>Continue to provide outpatient appointments and diagnostic tests for |

| | | | | |
|---|---|---|---|---|
| | | People who have work or school commitments Monday - Friday may have difficulty attending appointments during the hours of 8am-5pm | improvement plans and inform the communications approach. The feedback gathered was analysed by age cohort, to indicate any significant differences in the views from different age groups. The outcomes from this report have informed the programmes approach to implementation and communication. | a wide range of specialties at Weston General Hospital<br><br>Ageing Well programme to focus on the needs of the older population within North Somerset - new community models created for local older population<br><br>Enhanced digital access to avoid the need to travel to site.<br><br>The Healthy Weston 1 programme saw the extension of opening hours at the Seashore Centre for urgent children's service, matching the opening hours as ED. |
| Disability | - | For those with physical impairments potential obstacles can include travel and access.<br><br>Along with the ability to travel, the desire to travel may also be less for those with a disability.<br><br>Poor mental health can impact the desire and ability to attend and | Consideration will be given to the physical equipment available such as ramps, hearing loops as part of the development of implementation plans.<br><br>The plans ensure that the majority of care is delivered locally.<br><br>During the public engagement period (June - August 2022), the programme worked closely with partners, to ensure contact and inclusion of the local disability | Travel time analysis to consider impact of changes – review of patient transport services, signposting visitors to help with travel and transport if eligible, meeting with local transport providers and local authorities to discuss bus routes and timetables, making sure people who are transferred can come back to WGH after they finish their specialist care, so they can finish their inpatient stay closer to home if possible. |

| | | | | |
|---|---|---|---|---|
| | | keep appointments. Depression is the most prevalent diagnosis – 75% of the population with mental health. 26% have SAD diagnoses (stress, anxiety and low to moderate depression).<br><br>Potential reliance on carers or family for those who need additional assistance<br><br>For people with a sensory impairment communication can often be a barrier, along with travel and access. It is recognised that some individuals may have a condition which causes more than one sensory impairment, and this can add to the challenges associated with accessing health care.<br><br>It is acknowledged that individuals may have | groups to better inform the improvement plans and inform the communications approach. Any significant differences in the views from those with a disability or long-term condition were pulled out in the analysis and reporting. The outcomes from this report have informed the programmes approach to implementation and communication. | Assistance with appointments.<br><br>Flexible hours to fit in with local transport services, carer availability, home before dark etc.<br><br>Specific adaptations to enable effective communication and engagement to be taken.<br><br>Consideration should be given to the physical equipment available such as ramps, hearing loops as part of the development of implementation plans for Phase 2 and Phase 3.<br><br>Enhanced digital access to avoid the need to travel to site, with considerations around accessibility. |

| | | | | |
|---|---|---|---|---|
| | | more than one of these conditions. | | |
| Gender Reassignment | N | Providers need to apply NHSE Delivering Same-sex Accommodation Guidance and local policy to manage male or female specific acute bed provision, balancing the needs of transgender patients and any other patient.<br><br>Awareness in care homes | Training and education will be provided, embedding equality and diversity through the implementation of the service improvements, alongside ensuring staff are confident in discussing transgender issues.<br><br>The principles of UHBW E&D Guide on Transgender people to be adopted by all staff working at Weston general Hospital. | Training for those working in care homes will be included in part of the 'Care Home Diversity Training Package'.<br><br>UHBW Diversity and Inclusion Strategy '20-'25 includes 2 x patient and diversity inclusion groups, and a specific LGBT forum. UHBW governance ensures progress is made against strategic inclusion objectives. |
| Marriage and civil partnership | N | It is expected that changes will have a limited impact on people based on their marital or civil partnership status. | Although not limited to marriage and civil partnerships, there needs to be an awareness of the challenges of travelling to visit a spouse in hospital. The Phase 1 service improvements will reduce admissions and length of stay, decreasing the requirements for spouses to travel. | Travel time analysis to consider impact of changes, including a review of patient transport services and enhanced digital access to avoid the need to travel to site. |
| Pregnancy / maternity | N | Travel to be considered, particularly for those with existing childcare needs | Local access to services in the community to be considered as part of Phase 1 planning | Travel time analysis to consider impact of changes, including a review of patient transport services and |

| | | | | |
|---|---|---|---|---|
| | | Importance of local community access. | | enhanced digital access to avoid the need to travel to site. |
| Race/Ethnicity | N | Evidence suggests that COVID-19 may have a disproportionate impact on people from Black, Asian and minority ethnic (BAME) groups.<br><br>National evidence highlights that staff attitudes towards Black and Minority Ethnic groups can affect the quality of care delivered (Goddard 2008)<br><br>The HW2 programme is mindful of the potential for individuals within this category to also fit within another protected characteristic category. | Each organisation will ensure their staff are trained in equality, diversity and inclusion and patients have access to interpreters where required.<br><br>Services to be tailored to individual needs.<br><br>During the public engagement period (June - August 2022), the programme worked closely with partners, to ensure contact and inclusion of race/ethnicity groups to better inform the improvement plans and inform the communications approach. Any significant differences in the views from different ethnic groups were pulled out in the analysis and reporting. The outcomes from this report have informed the programmes approach to implementation and communication. | Specific adaptations to enable effective communication and engagement to be taken if required, e.g., translated materials and interpreters. |
| Religion | N | People with different religious beliefs access healthcare in different ways. | Each organisation will ensure their staff are trained in equality, diversity | Specific adaptations to enable effective communication and engagement to be taken if required, |

| | | | | |
|---|---|---|---|---|
| | | Important that we understand access points in the context of any service change.<br><br>Important that people feel able to approach and attend services within the community | and inclusion and patients have access to interpreters where required.<br><br>Services to be tailored to individual needs. | e.g. translated materials and interpreters. |
| Sex | N | It is expected that changes will have a limited impact on people based on their sex | | |
| Sexual Orientation | N | Awareness of the challenges people face with regards to their sexual orientation, particularly with regards to Care of the Elderly | Each organisation will ensure their staff are trained in equality, diversity and inclusion. | Gender and sexual orientation sensitivity in care settings to be considered.<br><br>Training for care homes will be included in part of the 'Care Home Diversity Training Package' |

## 6.1 Inequality

The main contributing factors to disability/poor health Nationally are:

- Musculoskeletal disease
- Cardiovascular disease (CVD) and stroke
- Respiratory diseases including COPD
- Depression and mental health problems
- Cancers and particularly lung cancer
- Alcohol and drug misuse

*Figure 1 - Deprivation rates within Weston-super-Mare*

| Area | Count | Value |
|---|---|---|
| **England** | 7,036,442 | 12.9 |
| North Somerset | 21,105 | 10.1 |
| Weston-super-Mare South | 3,549 | 32.9 |
| Weston-super-Mare Central | 2,435 | 24.7 |
| Weston-super-Mare Hillside | 1,407 | 16.0 |
| Weston-super-Mare Milton | 1,330 | 13.8 |
| Weston-super-Mare Winterstoke | 941 | 12.3 |
| Weston-super-Mare Mid Worle | 538 | 12.2 |
| Weston-super-Mare South Worle | 1,080 | 11.1 |
| Congresbury & Puxton | 368 | 10.3 |
| Weston-super-Mare Kewstoke | 629 | 9.8 |

*Figure 2 - Unemployment rates in Weston-super-Mare*

| Area | Count | Value |
|---|---|---|
| **England** | 981,880 | 2.8* |
| North Somerset | 2,572 | 2.1* |
| Weston-super-Mare Central | 420 | 7.3* |
| Weston-super-Mare South | 382 | 6.4* |
| Weston-super-Mare Hillside | 209 | 3.9* |
| Weston-super-Mare Uphill | 127 | 2.8* |
| Weston-super-Mare Milton | 153 | 2.7* |
| Weston-super-Mare Mid Worle | 58 | 2.5* |

As shown above[2], North Somerset, specifically Weston Central, has one of the worst deprivation scores in England. The percentage of working age people claiming out of work benefit is also extremely high within Weston-super-Mare.

COVID-19 has presented challenges for a number of people financially. The health and wellbeing of people in deprivation are negatively impacted by the wider determinants of health including housing, employment, education, access to social networks and lifestyles. It should also be noted that people with more limited financial means may use more public transport. The impact of the rising cost of living also needs consideration, with lower income families being most at risk of facing negative impacts on their health and wellbeing[3].

[2] Local Health - Data - PHE

[3] The cost of living crisis is a health emergency too | Comment | Health Service Journal (hsj.co.uk)

## 6.2 Travel analysis

Overall, the Healthy Weston 2 plans mean that people will travel less. Weston General Hospital will provide thousands more planned operations each year, so fewer people will need to travel to other hospitals for surgery, or for outpatient appointments before and afterwards, or to visit people having surgery in another hospital.

The plans for Healthy Weston 2 Phase 1 focus on enhancing urgent care services at Weston General Hospital, resulting in minimal impact on travel.

There are three groups of people who may have to travel further under Phase 2 and Phase 3 plans:

- People who need longer medical inpatient care for specific conditions like lung and stomach problems (estimated at about eight people per day) (Phase 2)
- People coming from around Bristol for planned operations at Weston General Hospital (Phase 3)
- People visiting either of these two groups (Phase 2 and Phase 3)

Further analysis on travel will be required as part of the planning and evaluation process for Phase 2 and Phase 3, to ensure equity of access to health care services across BNSSG and Somerset. It is particularly relevant to consider the impact of additional travel on those living in areas of economic deprivation, where the cost-of-living crisis and access to public transport may impact the ability to travel.

The Healthy Weston programme are already taking a number of actions to reduce the impact, including:

- Reducing the number of people who need to be admitted to hospital by strengthening our community service and same day emergency care
- Providing a patient transport service to neighbouring hospitals for those who need to transfer
- Signposting visitors to help with travel and transport to hospital if they are eligible
- Considering ways to help people stay in touch if people cannot visit. For example, providing laptops or tablets to help people in hospital speak with loved ones on video
- Meeting with transport providers and local authorities to discuss bus routes and timetables
- Making sure that people who are transferred to other hospitals can come back to Weston General Hospital after their specialist care, so they can finish their inpatient stay closer to home if possible.

During the public engagement period (June – August 2022), three quarters of respondents indicated that they understood the rationale behind transferring patients to neighbouring sites for specialist care, however some concerns were raised around the physical, emotional and financial impact of additional travel. Respondents were

also asked what could be done to support those who would be transferred and their families. Answers included providing free or subsidised shuttle buses running between hospital sites (38% of those who commented), providing access to technology for patients to contact loved ones (35%) and providing access to laundry services, toiletries and other amenities if people have no visitors to bring things (10%). This feedback has been used to inform the plans for Healthy Weston 2, and the programme will continue to engage with the public, staff and wider stakeholders around the impact of travel as it progresses.

### 6.3 Carers

As the population ages and medical therapies advance, more individuals are living in the community with complex health conditions. These individuals, as well as their clinicians, often assume their family members and friends will be capable of, and willing to, provide the caregiving work necessary to continue living at home. There is an ethical problem in this assumption that unpaid community care will be provided by family or friends. From engagement work recently undertake by BNSSG Integrated Care Board (ICB) for the Stroke Reconfiguration Programme, it has been highlighted that family members are often the primary source of support for older adults with chronic illness and disability.

The proportion of the population who are carers in North Somerset is 11.1%, slightly higher than the national average of 10.3%. To recognise the significant impact associated with unpaid community care, the programme has worked and will continue to work closely with partners to ensure carers can have the opportunity to have their say. This was exemplified during the public engagement period ran between June and August 2022, where a targeted approach was adopted linking closely with local carers groups and support organisations across BNSSG and Somerset to facilitate conversations.

# 7. Population and demographics

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

## 7.1 Local Population

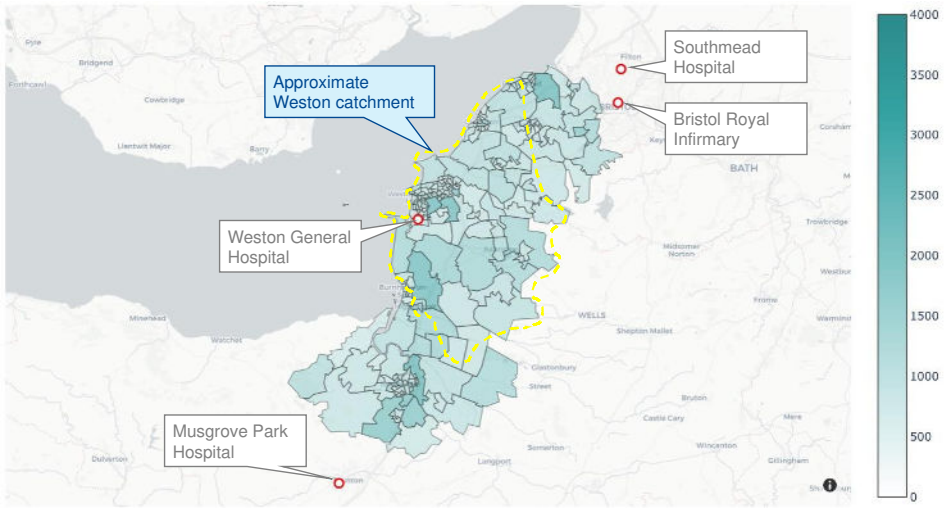
The population of the Weston and Worle area is in the region of 110,000, but the Healthy Weston programme includes the wider population served by Weston General Hospital, including the surrounding villages and population in Somerset who are referred to and use Weston General Hospital services.

Based on 2019/20 activity, the population served by Weston General Hospital is just over 120,000, as determined by the inpatient activity from the surrounding post-codes. This is shown in Figure 4 below.

*Figure 3 - Catchment geography of Weston General Hospital*

**Weston General Hospital has a coastal catchment in the South West of England, surrounded by three larger acute sites**

**Weston General Hospital catchment and surrounding acute sites**
Colouring reflects LSOA populations




Source: Office for National Statistics population data

The population is on average older than the England national average, with 25% of people predicted to be over 65 years of age by 2026. In North Somerset, 25,000 residents are aged over 75 (about 10%), of which around 7,500 are aged over 85.

Significant new build housing developments are planned in Weston, many of which will be for younger families. This has implications for the type and number of local services needed including primary care and children's services. Additional new build developments are also expected near Nailsea, Yatton and Portishead and between Long Ashton and Bristol. Although residents in those areas typically receive acute care from hospitals in Bristol; if Weston were to extend its reach as a Centre of Excellence this would be supportive to the Bristol Hospitals.

## 7.2 Health inequalities

The health status of people in Weston Town is poor compared to other parts of North Somerset and the other Integrated Care System (ICS) locality areas, as shown in Table 3 below. While life expectancy in North Somerset is broadly in line with the England average, it varies by area, with Weston-super-Mare Central Ward having the lowest life expectancy (69.3 years for males and 76.6 years for females). Conversely, Clevedon Yeo has the highest life expectancy for both males and females at about 85.2 years and 93.1 years respectively.

*Table 3 - Healthy life expectancy at birth (ONS)*

| | Male | Female |
|---|---|---|
| **England** | 79.8 | 83.4 |
| **South West region** | 80.4 | 84.1 |
| **North Somerset** | 80.7 | 84.6 |
| **Weston Central Ward** | 69.3 | 76.6 |
| **Clevedon Yeo** | 85.2 | 93.1 |

*Source: Office for National Statistics Life expectancy estimates*

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

Obesity and binge drinking are particularly prevalent around Winterstoke Road and South Worle. Weston has a higher number of people living with mental health issues, learning disabilities and those struggling with drug and alcohol addiction than other areas in North Somerset. These people tend to have much poorer physical health and lower life expectancy. These populations tend to be registered with GPs in central Weston, where prevalence for smoking and obesity are over twice the ICS average.

North Somerset is also estimated to have more than 150 homeless people on any given night, including 59 children[4]. This figure includes those who are in temporary accommodation and those sleeping rough. People experiencing homelessness suffer worse mental and physical health than the general population and are more likely to experience barriers to accessing healthcare.

In summary, the overall catchment population for Weston General Hospital is varied. Focus will be required on both the elderly frail and the more deprived areas of the

[4] Shelter - The housing and homelessness charity

population, ensuring that unplanned acute admissions are avoided where possible and patients do not stay in hospital longer than required.

## 7.3 Long-term health conditions

Up to 73% of those registered with Weston Town GP surgeries report having a long-term health condition, compared to 51% in Worle and 57% in the North Somerset area. Individuals with long term conditions are more likely to attend A&E and require ongoing care.

The long term impact of the COVID-19 pandemic is unclear, but early experimental ONS research suggests 13.7% of those infected with COVID-19 suffer from Long COVID symptoms, primarily fatigue, for 12 weeks after infections. These symptoms can worsen other long term conditions and require additional care provision for the local population.

To address the increase of people living with long term conditions, and to keep people healthier and living well for longer by managing these conditions there is a need to change our services and improve the levels of integration of care across primary, community and hospital care. Services must be provided matched to their demands and take a proactive care approach that empowers people to stay healthier and well.

## 7.4 Age

Age is one of the most critical factors in planning the healthcare for Weston, Worle and the surrounding areas. The population served by *Weston General Hospital* is older than the England average and within the North Somerset area, 20% of people are expected to be over the age of 70 by 2025[5]. In addition, over half of the total population increase between 2018 and 2025 will be in the 70+ group.

The 65+ population of North Somerset (as outlined below) is proportionally greater than other areas in the region and therefore increased consideration must be given to ensure appropriate mitigations to address this demand on services such as frailty and care of the elderly.

*Table 4 - Population of Bristol, North Somerset and South Gloucestershire*

| Group description | Bristol population (2021 Census) | North Somerset population (2021 Census) | South Glos population (2021 Census) |
|---|---|---|---|
| Aged 0-15 | 17.53% | 17.6% | 18.28% |

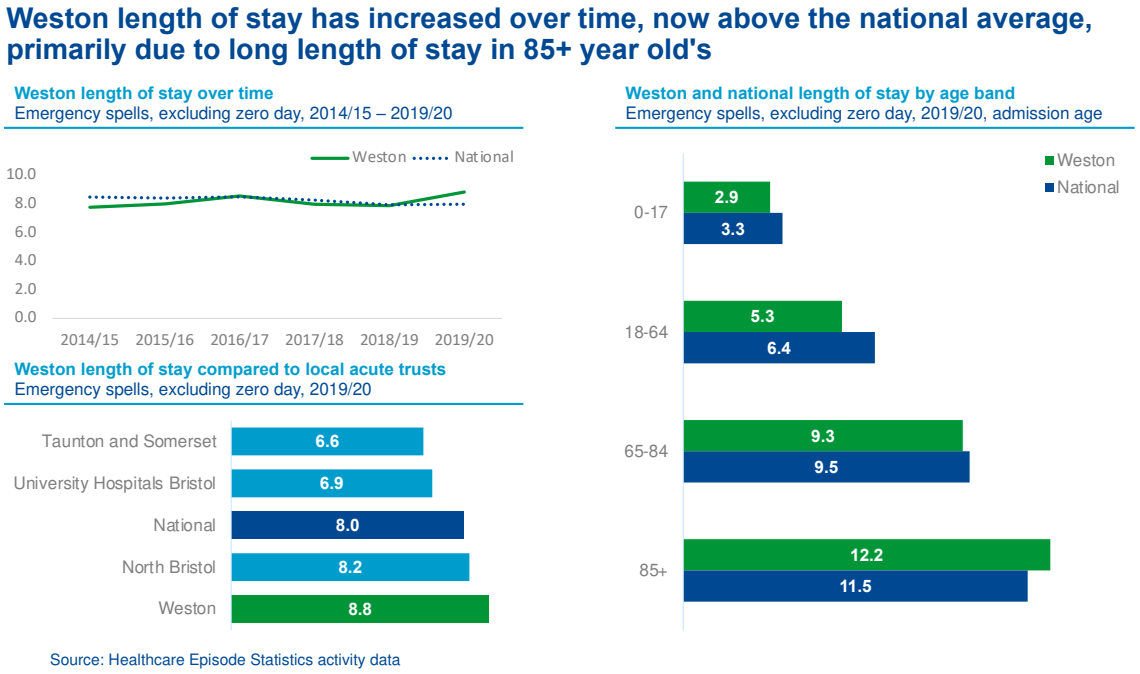
[5] North Somerset JSNA – Disease Prevalence Models Accessed: https://www.n-somerset.gov.uk/sites/default/files/2020-02/disease%20prevalence%20models.pdf

| | | | |
|---|---|---|---|
| Aged 16-64 | 69.64% | 58.45% | 63.04% |
| Aged 65+ (85+) | 12.87% | 23.95% | 18.65% |

With a significant increase in the projected frail and elderly populations in the future, the system must change the way services are delivered to better meet their health and care needs.

As with in other parts of the country, over 85-year-olds in Weston, Worle and surrounding areas are more likely to attend A&E and be admitted to hospital than other age groups. Those aged over 65 years makeup 23% of the Weston General Hospital catchment population but accounted for 34% of all A&E attendances at Weston General Hospital in 2019/20. The over 65 population currently accounts for 61% of all acute admissions and 83% of hospital emergency beds, with an associated proportion of older people having a longer length of stay at Weston General Hospital than local peers and the national average and this has increased since the overnight closure of A&E in 2017 healthcare spend and workforce requirement. Figure 5 shows the Weston General Hospital elective and emergency care bed days.

*Figure 4 - Hospital spells and bed days for Weston elective and emergency care*




Unplanned and emergency admissions can be detrimental for older people. Frail older people experience 5% muscle wastage for every day spent in a hospital bed, meaning they can find it difficult to return to their previous level of independence. Thresholds for admission are often lower than medically necessary and lengths of stay are longer than they need to be, resulting in poorer outcomes.

COVID-19 has a significant effect on the older population. Among people already diagnosed with COVID-19, people who were 80 or older were seventy times more likely to die than those under 40. Coupled with this, COVID-19 diagnosis rates increased with age for both males and females.[1]

Older people may have multiple heath and care needs, they might not speak English or limited English and live alone or in care homes or environments where they are at greater risk. This group might find it difficult to cope with change and adhere to COVID-19 restrictions due to poor memory or lack of understanding.

COVID-19 has meant more services are readily accessible online. Whereas this may be beneficial for some, for others there may be an adverse effect on those who are older do not use digital technology. AgeUK has identified a digital divide in later life, only 33% of adults over 75 use digital technology[36].

NHS England's RightCare toolkit states that the poorest care is often received by those least likely to make complaints, exercise choice or have family to speak up for them, such as people living with frailty

Although we have an older profile population, the needs of the young population in the area must also be reflected in the planning and provision of high-quality care. A&E attendances in under-5s are particularly high in the south of the WGH catchment area, and new housing developments are likely to attract a growing number of young families.

## 7.5 Gender

The gender distribution across the area is broadly in line with the regional picture.

*Table 5 - Gender distribution of Bristol, North Somerset and South Gloucestershire*

| Group description | | Bristol population (2011 Census) | North Somerset population (2011 Census) | South Glos population (2011 Census) |
|---|---|---|---|---|
| Sex | All population, all ages | 49.8% male | 49% male | 49.5% male |

[6] Age UK – Later life in a digital world – Accessed: https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/reports-and-briefings/active-communities/later_life_in_a_digital_world.pdf

| | | | | |
|---|---|---|---|---|
| | | 50.2% female | 51% female | 50.5% female |

In England, average life expectancy has been relatively static for women at 64.1 years, whereas men have seen a small but steady increase from 63 to 63.4 years. Life expectancy in the region is 66.3 years for women and 66 years for men.

## 7.6 Ethnicity

The population of North Somerset is less ethnically diverse than England and Wales as a whole, with 97% of people living in North Somerset classifying themselves as belonging to a white ethnic group (including White Irish and Other White ethnic groups). Of those classified as a Black or Minority Ethnic (BME) group, 44% were Asian and 37% were mixed race (Census, 2011).

There is variation in the percentage of the population from a BME group by ward within North Somerset. Population numbers by ward range from 8% in Weston-super-Mare central to 1% in Clevedon Walton.

## 7.7 Disability

Of the total population in North Somerset, 8.6% (17,335) have a disability that limits their day-to-day activities a lot and 10.6% (21,405) have a disability that affects their day-to-day activities a little. (Census, 2011).

In North Somerset the number of adults with a learning disability known to their General Practitioner was 809 (2011-12), creating a value of 4.77 (95% CI 4.45 to 5.11) per 1,000 population (Learning Disabilities Profile, 2013). In 2011, ONS estimated that there were 1,582 children in North Somerset aged between 0 and 4 years old with a long-standing illness or disability. 4,923 children in North Somerset have special needs, of which 486 have statements and 4,437 do not (School Census, 2014).

Nationally the number of adults with learning disabilities is increasing and is predicted to increase by 1% each year for the next 15 years. Mental and physical health problems are more common amongst people with learning disabilities, yet they are less likely to receive regular primary care health checks and access routine screening than the general population,[7]

People with learning difficulties may not cope well with change and the disruption might cause long-term negative impact to their emotional wellbeing and mental health. It is important to recognise the sensitivities of change and to ensure that the service improvements are communicated in an inclusive and supportive manner.

## 7.8 Religion and Belief

[4] The Lancet - Health care and mental health challenges for transgender individuals during the COVID-19 pandemic, May 20 – Accessed : https://www.thelancet.com/journals/landia/article/PIIS2213-8587%2820%2930182-0/fulltext

The religious make up of North Somerset is 61.0% Christian, 29.5% No religion, 0.4% Muslim, 0.3% Buddhist, 0.2% Hindu, 0.1% Jewish, 0.1% Agnostic. This compares with the national levels of 59.4% Christianity, 24.7% No religion, 5% Muslim, 1.5% Hinduism, 0.8% Sikhism. There are faith networks operating throughout the county, in particular around Weston-super-Mare.

It is recognised that people who practice other faiths could be vulnerable to religious discrimination. Muslims can be particularly vulnerable to religious discrimination; research conducted by the Joseph Rowntree Foundation in 2008 found that nearly a third of British Muslims had experienced religious discrimination.

## 7.9 Sexual Orientation

Sexual Identity in the UK 2015 report (ONS) stated that 1.7% of people in the general population identified themselves as lesbian, gay or bisexual. In the 2011 census data for North Somerset, 6% of people identified as lesbian, gay or bisexual, notably higher than the national average.

We must consider gender sensitivity in care settings, particularly where people struggle with the ability to communicate. From our previous consultation with the North Somerset LGBT+ group, we know that there is a need for better training and awareness in care homes and when dealing with the elderly population.

It is important for organisations commissioning and providing health and social care to be aware of the existence and needs of 'hidden' lesbian, gay and bisexual people who are older, from black and minority ethnic or working class backgrounds.

## 7.10 Gender Reassignment

Gender reassignment refers to people who have either undergone, intend to undergo or are currently undergoing gender reassignment (the medical and surgical treatment to alter their body) and also individuals who do not intend to undergo surgery but wish to live as a different gender than their gender at birth. These people self-identify as transgender or trans.

Transgender people face health inequalities and have poor health outcomes when compared to the non-transgender population. According to The Lancet Journal[4] inequalities faced by transgender individuals in societal aspects and policy making based on binary gender norms could increase the risk of illness and mortality during the COVID-19 pandemic.

During 2017-18 Healthwatch Bristol worked with the Diversity Trust and other partners to identify health inequalities, and discrimination, experienced by Trans and Non-Binary people and communities across the South West.[8]

The project worked with over 200 Trans and Non-Binary people, aged from 16 to 80. Headline figures / findings noted that:

[8] Kerr MP, Richards D, Glover G (1996) Primary care for people with a learning disability - a Group Practice survey. Journal of Applied Research in Intellectual Disability

- 60% of participants have felt discriminated against because of their gender identity
- 30% of participants felt discriminated against in the health care system

It is known that transgender people can sometimes experience challenges accessing healthcare services. Pending the outcome of a national review relating to this particular issue, we will consider any learning points in designing an inclusive service across BNSSG.

There are risks associated with defined male or female specific acute bed provision and the programme needs to be mindful of the impact of this in regard to any plans made.

Monitoring the impact of any service improvements on this characteristic will continue throughout the entire process. Training and education of all staff on equality and diversity and embedding equality and diversity through the implementation of service change alongside ensuring staff confidence in discussing transgender issues.

### 7.11 Pregnancy and Maternity

The birth rate is expected to decline 0.2% p.a. until 2025 in North Somerset. In North Somerset and the catchment area of Weston General Hospital there are a number of planned housing developments that will attract families with young children to the area. Access to nearby healthcare will remain of importance to this group and will be factored into the design, taking into account travel and childcare needs.

## 8. Overview of engagement

Healthy Weston 2 builds on the extensive engagement that has taken place over the last four years, with more than 5,000 local people having influenced plans to date. From the outset, the programme has sought the views of clinicians at University Hospitals Bristol and Weston (UHBW), Sirona, South Western Ambulance Service NHS Foundation Trust, Somerset Foundation Trust, North Bristol Trust, North Somerset Community Hospital, Brisdoc, Avon and Wiltshire Mental Health Partnership and GP practices across the area. In addition, engagement with a range of frontline staff; patient, carer and public representatives; the voluntary sector; local councillors, Members of Parliament and national bodies has taken place.

The Healthy Weston 2 Outline Business Case describes the engagement carried out to refine the Healthy Weston 2 vision, evaluation criteria and options. This included a public survey delivered in March 2022, where nearly 900 shared their views. The survey highlighted that the vast majority of people agreed that services at the Hospital need to change.

In April 2022, the North Somerset HOSP deemed that Healthy Weston 2 is a programme of continuous improvement, not a substantial variation to services. This meant that there was no legal requirement for formal public consultation prior to considering implementation. However, the Healthy Weston programme led an eight-week period of public engagement between June and August 2022, to gather the views of local people and organisations to help refine plans and to inform how we let people know about the changes.

### 8.1 Results from public engagement period

Between 20th June and 14th August 2022, the Healthy Weston Programme asked members of the public, staff, people who might be particularly affected and those who had not been involved before to help plan practical next steps for Healthy Weston 2. A total of 890 people shared their views, with most people indicating that they thought the plans would help improve the hospital. Table 6 below summarises the demographic characteristics of respondents.

*Table 6 – Demographic characteristics of people providing feedback, where know*

| Characteristics | Percentage of respondents |
|---|---|
| Over 65 years | 33% |
| Ethnic Minority Groups | 10% |
| Parent of a child under 18 years | 14% |
| Disabled person or person with a long-term condition | 27% |
| Member of the LGBTQ+ community | 4% |
| NHS Employee | 25% |

The key findings included:

- Of 376 responding to a survey question, three quarters thought the plans would improve Weston General Hospital (73%)

- Two thirds of people living in Weston, Worle and surrounding villages thought the plans would improve the hospital (68%). Even more people from other parts of North Somerset (87%), Bristol (83%) and South Gloucestershire (90%) thought this.
- People were equally positive no matter what their age, gender or ethnicity; whether or not they had a long-term health condition or disability and whether they were NHS staff or members of the public.

While there was positive feedback about the plans, people also shared their views on the extra travel that could affect up-to eight patients per day. They commented on the physical, emotional, and financial challenges that further journeys could bring, not just on the patients but for loved ones and carers too. People said that technology, such as video call equipment, could help to overcome this, but also shared thoughts on improving transport links.

People also said that more could be done around communicating the plans, with one in four people not clear on what was being proposed and many saying that more needs to be done to enhance the reputation and trust in Weston General Hospital.

The full summary of what we heard during the engagement period can be found in the engagement themes report in Appendix 8.

The Healthy Weston programme, and decision-making groups within the programme governance infrastructure, have and will continue to consider the outputs from all strands of engagement activity carried out as part of Healthy Weston 2. The programme will also continue to feedback publicly how the engagement outputs have been used to inform decision making, alongside outlining the programmes next steps through a continuous iterative communications and engagement approach.

## 8.2 Seldom Heard Communities and Health Inequality Groups

A proactive communications and engagement approach has been taken by the Healthy Weston 2 programme with seldom heard communities and health inequality groups. This has ensured members of these communities are able to effectively understand and feedback on the plans, to ensure their voices are represented in the shaping of future services at Weston General Hospital. This builds on the success of this approach during Healthy Weston 1.

The programme is working closely with local authorities and Voluntary and Community Sector Enterprise (VCSE) organisations to make sure that once again we effectively communicate with these communities, including:

- Older people, including those in care homes
- Ethnic minority communities
- Homeless populations
- People experiencing substance misuse issues
- Those with a long-term condition or disability
- People with learning disabilities

- LGBT+ communities
- People affected by mental ill health.
- Carers

During the public engagement period (June – August 2022), the programme adopted a targeted communication and engagement approach, to better enable those from underserved communities and health inequality groups the opportunity to have their say. The following are examples of adaptations made by the programme as part of the approach to communication and engagement activities:

- Offering adapted materials such as easy-read guides for people with learning difficulties, large print for those with sight problems and translated materials for those where English is not their first language
- Offering additional activity within community settings such as nursing homes and Gypsy, Roma and Traveller sites to avoid any obstacles with travel
- Attendance at meetings such as 'The Deaf Café' with pre-arranged interpreters and translators to target those people who find verbal communication a challenge
- Working closely with trusted individuals and community leaders to share messaging and promote engagement opportunities
- Offering a range of feedback mechanisms including telephone, email and written feedback, as well as face to face
- Linking closely with VCSE groups and local authorities to ensure opportunities were appropriately advertised and groups invited
- Considering location, time and date of any face-to-face activity, to best enable access and attendance from those from seldom heard and health inequality groups

This targeted approach to communications and engagement will continue to be adopted as the programme develops, building on the trusted relationships established through earlier phases of engagement. The importance of clear and accessible communications has been highlighted throughout previous engagement, and the programme will ensure that all future communications will continue to be offered in accessible formats upon request. This includes British Sign language, Easy Read and multi-language translations. During the public engagement period, the public were asked about the best way to share messaging about the plans, including with targeted groups. Suggestions included sharing messaging in public venues, holding drop-in sessions at sites such as hospitals and general practice, working through others such as retirement villages and care homes, and visiting community groups, care homes and other targeted groups. This feedback has been taken on board by the Healthy Weston programme and has been incorporated into the plans for informing and involving seldom heard and health inequalities groups through Phase 1 implementation.

It is imperative that as the programme continues, it builds and takes learnings from the engagement achieved to date with different communities, and considers any specific themes identified in the feedback from different cohorts. The programme will also take learnings from other public engagement activity taking place, using insights gathered on how best to engage with communities in a way that is accessible for

them. For example, the BNSSG Mass Vaccinations Programme has highlighted the importance of working with community leaders and trusted individuals when engaging with specific seldom heard and health inequalities groups. This approach has been adopted by the Healthy Weston 2 programme, linking with key community stakeholders to share messages with their communities, to build trust and understanding.

The Healthy Weston 2 Phase 1 implementation communications and engagement plans are iterative documents, which will be built upon as community conversations, feedback and learnings are taken on board throughout the delivery of the Phase 1 service improvements. The Healthy Weston programme remains dedicated to providing accessible and equal opportunities to communications and engagement, considering what we know about the local populations needs and applying an adaptable, accessible and robust approach to engaging with different communities.

## 8.3 Engagement with clinicians and staff

Integrated working led by and with clinicians is at the heart of the Healthy Weston 2 programme and the development and operationalisation of the clinical model for Weston General Hospital. Clinicians play a core role in the leadership, governance, and oversight of Healthy Weston 2 Phase 1 Full Business Case. Clinical leaders from BNSSG ICB and UHBW chair design and decision-making meetings and subgroups, they contribute to the design and evaluation of new pathways and plans, and work in partnership with clinicians from across BNSSG and beyond, including for example with South West Ambulance Services NHS Foundation Trust and Somerset NHS Foundation Trust.

This engagement with clinicians has ensured clinical expertise is at the heart of Healthy Weston 2 Phase 1 service improvement plans.

There has been a regular flow of information, briefings, and updates for all staff in UHBW and other partner organisations, including primary and community care colleagues, throughout the Healthy Weston programme, which will continue as the programme progresses. The public engagement period also ensured a range of staff specific activities were ran, with the opportunity to ask questions and give feedback on the plans to inform decision making. Staff provided similar feedback to the public in the feedback that they shared during the public engagement period, and shared some specific concerns including around infrastructure, capacity, funding and workforce.

## 8.4 The role of the Patient and Public Reference Group (PPRG) and Staff Reference Group (SRG)

Working closely with Healthwatch, the Healthy Weston Patient Participation Reference Group was initiated in February 2022, with the membership encompassing a broad range of characteristics, including representation of parents, carers and ethnic minority groups. These sessions were independently facilitated by Healthwatch, meeting four times.

The Staff Reference Group was also initiated in February 2022, with the sessions facilitated by the UHBW Communications leads. The group was made up of a range of roles and specialities. The sessions followed the same structure as the PPRG, with the sessions based on the following:

**Meeting 1 - Population need**
Reviewing what's important in health and care today for the people of Weston – sharing learnings and outcomes from Healthy Weston 1 and checking in on any changes which have taken place in the months since this initial phase of work (especially around the pandemic), which need to be considered as we go forward.

**Meeting 2 – Vision**
Our vision for the future – sharing our vision for the future of Weston General Hospital and its context in the wider health and care system. Listening and understanding the views of both staff and patients related to this vision and what it means to them today.

**Meeting 3 - Evaluation criteria**
Reviewing the evaluation criteria – explaining how options for models of care have been developed and exploring how the appraisal process has taken place.

**Meeting 4 – Public engagement period**
Reviewing the approach to public engagement, with a focus on targeted communication and engagement approaches to those who would be particularly impacted by the plans, and those who had had less involvement in engagement activity to date. The outcomes of this session helped to inform the public engagement communications and engagement approach and plan.

The full summary of the PPRG and SRG sessions can be found in the Healthy Weston 2 OBC. It is planned that the SRG will continue to meet as Healthy Weston 2 Phase 1 implementation begins, to inform staff of the changes and to gather feedback on specific elements of the delivery of the clinical model.

### 8.6 Wider communications and engagement

An 'early socialisation' approach to communications is being implemented providing staff, stakeholders (including MPs and councillors) and the public with a consistent core narrative about Healthy Weston 2. Existing channels and opportunities are being utilised to share information widely, for example through intranets and websites, newsletters and bulletins, social media channels and conventional media, as well as through existing meetings, forums, networks, and interest groups.

Feedback mechanisms have been and will continue to be put in place through Phase 1 implementation, including staff meetings, discussion, correspondence and meetings with Health Overview and Scrutiny members and other elected members

such as MPs, and outreach work; to ensure we are capturing a wide range of views from a wide range of people.

Staff at UHBW, particularly those working at Weston General Hospital and specifically those across the trust most likely to be impacted by any proposed changes, have had a regular opportunity to be involved and engaged in discussion. There has also been a regular flow of information delivered by the trust as the programme has progressed.

Engagement has also been extended to GPs and primary, community care and mental health teams in Weston and the surrounding area to ensure their views have been fully considered, and that they continue to be informed as Phase 1 changes are implemented.

## 9. Next steps

This is an iterative document, further work to understand the impact of any proposed changes will continue to develop with the Healthy Weston 2 Programme.

Further versions of the EIA will be drafted, drawing upon all learning, knowledge and lived experience from our full engagement process. This assessment will present equality impact risks and mitigations associated with the final model that is being recommended.

The impacts identified so far will be further considered as part of the contextualised engagement process going forward where the engagement approach and methods must reflect the needs of our diverse populations. Any findings identified through programme engagement activities will be added to existing themes identified and used to inform the decision-making process going forward.

The programme will continue to actively engage with protected groups and incorporate this into engagement plans going forward.

## 10. Relevance to the Public Sector Equality Duty

There is a general duty which requires the system to have due regard to the need to:
**Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Equality Act 2010?**
*Does this proposal address risk in relation to any particular characteristics? (Yes)*

- It is acknowledged that each equality group has been impact assessed, where differential experience or impact is noted mitigation or objective justification has been made.

**Advance equality of opportunity between people who share a protected characteristic and those who do not?**
*Will this proposal facilitate equality of opportunity in relation to particular characteristics? (Yes)*

- Project proposes to improve access to equality groups who might experience negative differential impact; mitigations have been put in place including further engagement or objective justification provided.

**Foster good relations between people who share a protected characteristic and those who do not**
*Will this proposal foster good relations between people who share a protected characteristic and those who do not? (Yes)*

- Education and engagement have been used to foster good relations between one group and another, and between the patient/population and providers.

**Is a FULL Equality Impact Assessment required?**
Yes – to be undertaken at a later date.

**EIA Impact Assessment Approver(s)**

| | |
|---|---|
| **Full Name:** | **Sharon Woma** |
| **Comments from Equality Lead:** | **Version 0.7 approved. Noting mitigations, if there are any actions arising, please ensure they are recorded in a log.** |
| **Date Approved:** | **25.04.22** |

Healthier Together

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

HEALTHY WESTON

NHS

# Turning plans for Weston General Hospital into reality

## What we heard between June and August 2022

September 2022

# Key messages


## What we did

Healthier Together is a partnership of organisations improving health and social care across Bristol, North Somerset and South Gloucestershire.

Our 'Healthy Weston Phase 2' programme is developing Weston General Hospital into a thriving hospital at the heart of the community. On top of routine ongoing service development, our Phase 2 plans focus particularly on three areas:

- becoming a centre of surgical excellence so thousands more planned operations for adults of all ages can be carried out at Weston General Hospital
- becoming a centre of excellence for older people's care so the Hospital provides more specialised care for older people, in addition to services for people of all ages
- helping more people go home from hospital quickly after an accident or emergency

Senior doctors, nurses and other health and care professionals are leading the planning. More than 5,000 members of the public, patients, carers, staff, community organisations and others have helped to shape the plans over the past five years.

Between 20 June and 14 August 2022 we asked members of the public, staff, people who might be particularly affected and those who had not been involved before to help us plan practical next steps. We promoted opportunities to get involved by:

- **advertising** using newspaper articles, webpages, social media, pop-up stands at hospitals, videos, existing meetings, and the staff intranet and newsletters
- **directly inviting** community groups and partner organisations, members of the Healthier Together Citizens' Panel, hospital staff and people on our mailing lists
- **working with others**, such as placing leaflets, posters and website links in health and care organisations, and attending existing meetings of community groups and staff

**We heard from 890 people.** They were from different areas, age groups and roles:

- three quarters were members of the public, community groups or other groups (75%) and one quarter were NHS staff (25%)
- two thirds lived in Weston, Worle and villages (44%) or other parts of North Somerset (19%). The rest were mainly from Bristol (17%) and South Gloucestershire (11%)
- two thirds were women (69%). About 1 in 10 were from minority ethnic groups (9%). One third were aged under 50 years (30%), one third 50 to 65 years (36%) and one third older than 65 (34%). One quarter had a disability or long-term health issue (27%)

In total, there were 657 'responses', such as survey forms and meeting notes. 96% were from individual people. 4% of responses were notes from meetings, which included multiple people.

# What we heard

## Overall impression of the plans

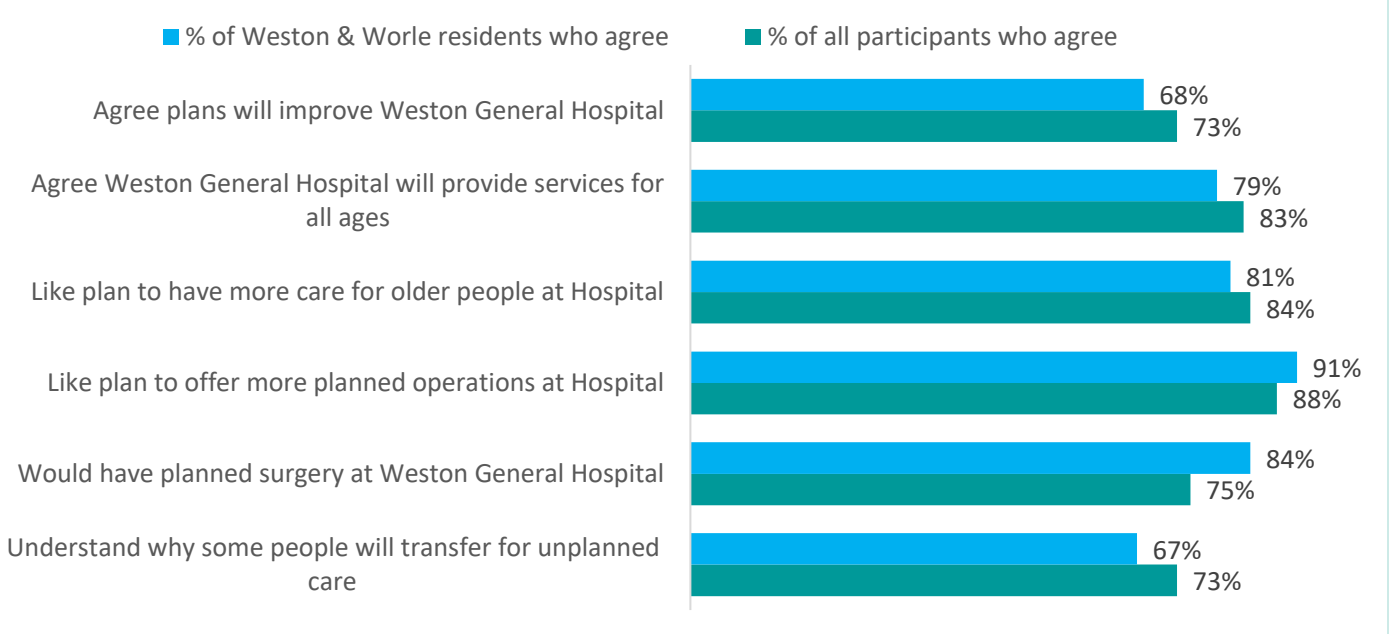
People providing feedback were usually positive about plans for Weston General Hospital overall:

- Of 376 people responding to a survey question, **three quarters thought the plans would improve Weston General Hospital** (73%).
- Two thirds of people living in Weston, Worle and surrounding villages thought the plans would improve the Hospital (68%). Even more people from other parts of North Somerset (87%), Bristol (83%) and South Gloucestershire (90%) thought this.
- People were equally positive no matter what their age, gender or ethnicity; whether or not they had a long-term condition or disability and whether they were NHS staff or members of the public.

The main area of concern with the plans was that some patients, loved ones and staff would need to travel to another hospital. People were concerned about the impact of travel on people's wellbeing and quality of life, the environment, costs for families, and the availability of ambulances and patient transport. They said that we should consider the impact on loved ones and visitors, in addition to patients themselves. They suggested that the NHS should work with local authorities, transport companies and voluntary and community groups to identify solutions.

People said that it would be important to have enough time, staff and funding to put the plans into action. They also wanted us to focus on joined up care to prevent hospital admission and support care after discharge.

Figure 1: Overall feedback about Healthy Weston Phase 2 plans




Note: proportions are based on the number of responses that commented on a specific topic. The numbers ranged from 397 to 527. Most were survey responses. 'All responses' also include Weston, Worle and surrounding villages.

## Sharing information about the plans

At meetings and in surveys and emails, people said that it was important to raise awareness in the community about what was planned and why. The most common ways that people thought we should communicate about next steps were:

- **general promotion** and media campaigns using local tv, radio and newspapers (45% of responses that commented about this), social media campaigns (44%) and placing leaflets and posters in local venues (29%)

- **direct communication** such as posting leaflets to every letterbox (18%) and emailing and texting everyone that the health service holds contact details for (15%)

- **working through others**, such as placing items in the newsletters of local authorities, retirement villages and community groups (11%) and communicating with health and care staff so they can share messages with patients (6%)

Most people said that we were describing the plans clearly. The main things that people suggested that we could provide additional or clearer information about were:

- more clarity about **which services** will be available at Weston General Hospital and who they will be for, such as whether maternity and children's services will be provided (32% of the 129 responses that suggested extra information)

- the **quality and safety** of care provided at Weston General Hospital, including good news stories to counteract past negative press (21%)

- more **specifics** about the plans, such as defining what we consider 'older' or 'frail' people (7%), what a centre of excellence is (5%), and more details about how patient transport will work (5%)

## Supporting people of all ages

One of our plans is for Weston General Hospital to become a centre of excellence in caring for older, frail people who are less likely to bounce back after being unwell. This is in addition to continuing to provide a range of services for people of all ages.

When we talked about this in the past, some people thought that this meant that Weston General Hospital would focus mainly on older people and not care for the whole population. Healthier Together has changed the way that we describe the plans to make it clearer that Weston General Hospital will continue to support all ages.

- In the 396 surveys and meetings that commented about this, **8 out of 10 of responses understood that Weston General Hospital will continue to provide care for people of all ages** (83%).

- 8 out of 10 said they were pleased with plans for additional support for frail and older people at Weston General Hospital (84%).

- 8 out of 10 responses from Weston, Worle and surrounding villages liked the idea of offering more care for older people, though this was less than the proportion from other areas. This is probably because some people from Weston, Worle and surrounding villages were concerned that care would mainly be for older people, not available for all ages.

## Planned surgery

Healthier Together wants to increase the number and type of planned operations at Weston General Hospital and give people from a wider area the chance to have their surgery here.

- In 527 surveys and meetings that commented about this, **9 out of 10 were positive about offering more planned surgery at Weston General Hospital (88%)**.

- **Three quarters of people surveyed said they would be happy to have planned surgery at Weston General Hospital** (75%). People living in Weston, Worle and surrounding villages (84%) and other parts of North Somerset (85%) were more positive about this than people living in Bristol (49%) or South Gloucestershire (64%).

People thought that we could do practical things to encourage people to choose Weston General Hospital for planned surgery, including:

- a widespread **promotional campaign** to build up awareness of the quality and safety of the Hospital and enhance its reputation (48% of those who commented about this)

- publicising **shorter waiting times** for planned operations (41%)

The main things that people thought would get in the way of people choosing to have planned surgery at Weston General Hospital were:

- the **time and distance travelling** to and from the hospital for patients, especially following surgery (60% of responses that commented on this)

- **lack of confidence** in Weston General Hospital's reputation based on press reports and/or poor past experience (34%)

- difficulty, cost and inconvenience of **travel for loved ones** who want to visit (28%)

## Specialist care after an emergency

We plan that Weston General Hospital will help people get home quicker after accidents, emergencies or other unplanned care, with special units for assessing and treating people promptly. People experiencing stroke, serious heart attack and major trauma already go straight to another hospital with specialist services. Ambulances will take everyone else to Weston General Hospital to be assessed and get immediate care, as usual.

Older people who are frail and need to be admitted will stay at Weston General Hospital, the same as now. Adults of any age who need emergency surgery will have their operation at Weston General Hospital. They will stay for as long as they need to recover, exactly like now. A dedicated patient transport team will take anyone else who needs a longer stay in hospital to a neighbouring hospital providing the specialist care they need.

413 people commented about this. **Three quarters understood why we want to do this (73%)**. 6 out of 10 people living in Weston, Worle and surrounding villages said they understood the reasons for this plan compared to over 8 out of 10 people from other areas.

In surveys and meetings, people said we could support people who are transferred by:

- providing a free or subsidised **shuttle between hospital sites** that visitors and patients can use (38% of responses that commented) and direct **public transport routes** (13%)
- giving people **access to technology** to contact loved ones when in hospital and help to use it if needed (35%)
- providing access to laundry services, newspapers and **toiletries** if people have no visitors to bring things. This may include having volunteers or the League of Friends visiting wards to provide books, papers and conversation (10%)

## Feedback from NHS staff

221 NHS staff provided feedback by email, survey or taking part in meetings at Weston General Hospital and Bristol Royal Infirmary. NHS staff were just as likely as members of the public to be positive about the plans overall, like the plans to offer more planned surgery and care for frail and older people at Weston General Hospital and understand the reasons why we are considering changes to unplanned specialist medical care.

People did not give much feedback about parts of the plan that they thought would particularly impact on NHS staff. Some suggested that it was important to communicate clearly and quickly with staff about how the plans might affect them, clarify arrangements for working across hospitals and recognise the need to build up staff morale.

## Next steps

The key things that we learnt from this period of engagement were:

- There was **a lot of positivity** about the plans for Weston General Hospital. People think we are on the right track to redevelop and sustain a thriving local hospital. There is more we could do to communicate clearly as one quarter of responses were not clear about some of the plans. People wanted to be involved and wanted us to **extend how we communicate**.
- People's main concerns were about how to put the plans into practice, including ways to help people with travel, make sure care stayed joined up, address staff shortages and get funding. People were particularly concerned about the physical, emotional and financial impact of **additional travel** for those transferred to another hospital for unplanned care and their loved ones. They thought that older people, children and those reliant on public transport may be particularly affected. People proposed having a free shuttle service between hospitals and campaigning for improved public transport.
- People want us to consider the **impacts for loved ones** and carers in detail.
- There is work to do to **build up the reputation** of and trust in Weston General Hospital amongst the public and staff. People suggested that an extensive promotional campaign might showcase the Hospital facilities and teams.

Healthier Together will use people's ideas when refining plans and communicating next steps.

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# Acknowledgements


Healthier Together would like to thank everyone who shared their ideas about how to help Weston General Hospital keep developing. Healthier Together is continuing to refine the plans based on what we heard from people during this engagement period and ongoing work led by senior doctors, nurses and other professionals.


This summary of themes in people's feedback was prepared for us by an independent organisation, outside the NHS, called The Evidence Centre. **The report uses the term 'we' to mean the Healthier Together Integrated Care System** because it summarises what we did and what we heard.

We have used the wording and format of the report exactly as provided by the independent team because it is based on the words of the people and groups who took part. The report summarises people's opinions, not 'facts'. The opinions expressed in this report do not necessarily reflect the views of Healthier Together or any other organisation.

# 1. What we did

## What is this document about?

Healthier Together is a partnership of organisations in Bristol, North Somerset and South Gloucestershire. We are tackling the issues that matter most in health and social care and finding ways to continue providing safe, high-quality care for generations to come.

Our Healthy Weston programme is developing Weston General Hospital into a thriving hospital delivering the care that local people need most often. Senior doctors, nurses and other health and care professionals have led the plans for a long-term future for Weston General Hospital. The plans have been informed by meetings, conversations, interviews and surveys with members of the public, patients and their loved ones, staff, community organisations and many other groups.

Healthier Together is refining the plans, ready to start making them a reality from 2023 if the organisations responsible decide to proceed. Between 20 June and 14 August 2022 we engaged with members of the public, patients, hospital staff and community organisations to get more ideas about how to communicate the plans widely and other practical next steps.

This document summarises themes from people's feedback. An independent team from outside the NHS drew together the themes for us.

# What are we planning?

Box 1 summarises the 'Healthy Weston Phase 2' plans for Weston General Hospital. This is the text Healthier Together used on our website and in a leaflet during this engagement period.

Box 1: Healthy Weston 2 plans

"On top of routine, ongoing service development at the Hospital, there is a particular focus on three areas. The Hospital will:

- become a centre of surgical excellence. This means thousands more planned operations for adults of all ages will be carried out at Weston General Hospital
- become a centre of excellence for older people's care. This means the hospital will provide more specialised care for older people, as well as a wide range of services for people of all ages
- help more people go home quickly after going to hospital in an emergency. The hospital will have a dedicated unit for assessing and treating people quickly

Weston General Hospital will continue to provide A&E services from 8am to 10pm, exactly the same as for the last five years.

Other services at Weston General Hospital will continue to be provided and improved the same as now for people of all ages. This includes outpatient appointments, maternity care, children's services, cancer care, tests and x-rays, intensive care, emergency surgery and stroke rehabilitation."

# What did we want to learn?

More than 5,000 members of the public, patients and carers, staff and members of community groups and other organisations have provided feedback that shaped the Healthy Weston programme over the past five years.

Healthier Together wanted to continue involving and listening to people as we finalise the plans for the next phase and start to put them into action. We facilitated an 8-week engagement period to help strengthen what we do next.[1]

We focused on getting practical suggestions about next steps. We did not aim to get feedback about specific proposals, promote the plans to large numbers of people or be 'representative' of everyone in local communities. The Healthy Weston programme has already done those things in previous stages of developing the plans.

We particularly wanted to listen to:

- anyone interested in sharing practical ways to address issues that people had already told us needed more work
- people and groups that we had not heard a lot from before
- groups that may be most affected by the plans, such as vulnerable older people, those with disabilities and loved ones of people admitted to hospital including carers and parents

The key questions that Healthier Together wanted to address during this engagement period were:

1. What is the best way of **sharing information** about the next steps for Weston General Hospital?
2. Do people understand that services will remain available for people of all ages at Weston General Hospital? Are people happy with or concerned about developing more **services for frail and older people** at the Hospital?
3. Are people happy with or concerned about the possibility of having more **planned surgery** available at Weston General Hospital? What could we do to encourage people from a wide area to see the Hospital as a positive place to have planned surgery?
4. What could we do to help reduce ay negative impacts for people who **transfer to another hospital** for ongoing care after an accident or emergency?
5. Do **Hospital Trust staff** have any specific concerns and any suggestions to address those concerns?

1 The North Somerset Health Overview and Scrutiny Panel decided that there is no legal requirement to formally consult the public before deciding whether to proceed with the plans for Weston General Hospital because the proposed changes are not a substantial variation to services.

# How did we engage with people?

## How did we promote opportunities to take part?

**We shared information with more than 30,000 people** during the engagement period. We advertised opportunities to get involved using these approaches:

### Advertising

- sharing **122 messages on social media** to up to 10,000 people per time, with 2,361 engagements with the material (includes Hospital trust social media). Healthwatch also shared social media messages, reaching about 1,100 people
- contributing to **11 newspaper articles**, press releases and radio shows
- distributing over **1,000 leaflets** and posters, including via partners
- including articles in newsletters and online alerts sent to **14,000 staff** of Bristol and Weston University Hospitals Trust, which runs Weston General Hospital. 245 staff viewed Healthy Weston articles online

### Online information

- providing information on our website and the websites of partner organisations, including a leaflet with a summary of our plans, a simplified 'easy read' version, videos (**4 videos** viewed a total of 2,156 times), frequently asked questions and other information. **1,371 people** visited this section of the Healthier Together website during the engagement period and 598 people downloaded our leaflet
- providing a survey for the public and staff on our website

### Meetings

- hosting **2 pop-up stands** at hospitals in Weston and Bristol where we talked to people, gave out copies of our leaflet and encouraged people to complete the online survey
- hosting or attending **30 face-to-face and online meetings** and drop in sessions for the public, staff and community groups. At some of these meetings we provided information about our plans and encouraged people to provide feedback using our survey. At other meetings we asked for feedback and used small group discussions to hear people's ideas. If people provided feedback we counted the meeting as a 'response'

### Directly contacting people

- emailing **89 organisations** such as parish councils and telephoning 17 community groups and other stakeholders to set up meetings
- working with **Healthwatch** to contact Patient and Public Involvement Groups and voluntary and community sector groups
- emailing information and a survey to members of the **Healthier Together Citizens' Panel**, which is a group of local people who volunteered to provide ongoing feedback to help shape health and social care. The Panel has been selected to have characteristics representative of those living across our area. This Panel is regularly asked for feedback about different topics. We sent one survey to members of the panel who lived in North Somerset asking about all our plans. We sent another survey to people who lived in Bristol or South Gloucestershire, asking mainly about having more planned surgery available at Weston General Hospital and how to communicate about our plans

## How could people take part?

We invited people to provide feedback in any of these ways:

- at meetings we organised for members of the public and staff
- at meetings we attended with an organisation or community group
- in writing, by email or post
- by completing a survey online or on paper
- by telephoning us
- by posting a comment on our social media

## How did we look at the themes?

Members of the Healthier Together team listened to and read all the feedback to help us refine the plans. We discussed the feedback in our teams and with hospital staff and patient and public reference groups that are helping to develop the plans.

In addition, an independent organisation outside the NHS read all the feedback and drew out the main themes.

The independent team gave every comment that people made a numerical code. This meant they could count how often people made each point. The independent team calculated percentages to help compare between different topics.[2] They also compared whether different types of people thought the same or not.[3]

2 Throughout this report, we sometimes provide the percentage of 'responses', not people. A response is one set of meeting notes, one survey or one letter/email. This means one response does not necessarily equal one person because multiple people took part in meetings. We used this approach because it was not possible to say how many people at a meeting supported a particular comment.

3 In this report, whenever we say there was a 'difference' between what various groups said, this means there is a statistically significant difference at the 95% level of confidence ($p<0.05$). This means that the independent team used statistical tests to check whether we can be confident that the difference is real rather than something that might have happened by chance.

# Who shared their ideas?

## How many people took part?

In total, we heard from **890 people** during this engagement period.[4] This was more than our target of at least 370 people.

## How did people take part?

People took part by:

- attending online or in-person meetings or providing comments at a pop-up stand (260 people, 29% of people taking part)
- filling in a survey online or on paper (614 people, 69%)
- writing a letter, emailing or telephoning (16 people, 2%)

Figure 2: Proportion of people using various feedback methods (n = 890)

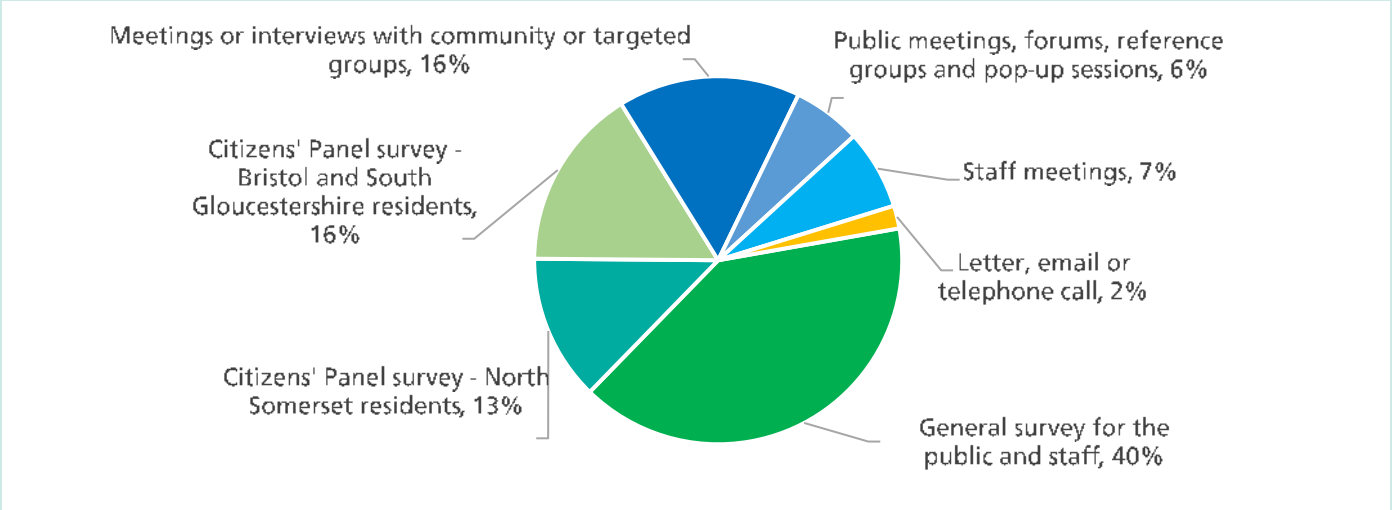



Table 1: Number of people who took part in various ways

| Feedback method | Number of responses (% of responses) | Total number of people represented (% of people) |
|---|---|---|
| Online survey | 349 (53%) | 349 (39%) |
| Hard copy survey | 8 (1%) | 8 (1%) |
| Citizens' Panel survey | 257 (39%) | 257 (29%) |
| Notes from meetings or interviews with community or targeted groups | 10 (2%) | 139 (16%) |
| Notes from public meetings, forums and reference groups | 4 (1%) | 46 (5%) |
| Comments from pop-up sessions | 9 (1%) | 9 (1%) |
| Notes from staff meetings | 5 (1%) | 66 (7%) |
| Letter, email or telephone call | 15 (2%) | 16 (2%) |
| Total | 657 | 890 |

4 People could contribute in more than one way such as attending a meeting and filling in a survey. This means the 'number of people' counts people who took part multiple times more than once.

## Who took part?

Table 2 shows the characteristics of people who provided feedback using a survey, email or letter, where known. A range of people shared their ideas, but the majority were White women aged 50 or older living in the Weston area or other parts of North Somerset:

- 7 out of 10 individual responses were from people **aged 50 or older** (70%)
- 7 out of 10 were **women** (69%)
- 4 out of 10 were people living in **Weston, Worle** and surrounding villages (44%)
- 9 out of 10 were from **White British people** (91%) and 1 out of 10 from minority ethnic groups. In addition, we also attended outreach meetings with representatives from minority ethnic groups
- One quarter were people **working in the NHS** (25%). We did not ask whether people were unpaid carers but we offered to meet with carers groups
- One quarter were people with a **long-term condition or disability** (27%). Our Equality Impact Assessment identified this as a group we should particularly seek feedback from

Table 2: Demographic characteristics of people providing feedback, where known

| Characteristics | Number | Proportion |
|---|---|---|
| **Geographic area** (n = 621) | | |
| Weston, Worle and surrounding villages | 286 | 44% |
| Other parts of North Somerset | 125 | 19% |
| Bristol | 113 | 17% |
| South Gloucestershire | 71 | 11% |
| Somerset | 20 | 3% |
| Other | 6 | 1% |
| **Age** (n = 596) | | |
| Under 30 years | 37 | 6% |
| 30 to 49 years | 143 | 24% |
| 50 to 64 years | 217 | 36% |
| 65+ years | 199 | 34% |
| **Gender** (n = 588) | | |
| Female | 405 | 69% |
| Male | 179 | 30% |
| Other / prefer to self-describe | 4 | 1% |
| **Ethnicity** (n = 592) | | |
| Asian or Asian British | 10 | 2% |
| Black or Black British | 9 | 2% |
| White British | 541 | 91% |
| Other White | 16 | 3% |
| Other / prefer to self-describe | 16 | 3% |
| **Participant type** (n = 622) | | |
| Member of the public | 451 | 74% |
| Someone who works in the NHS | 155 | 25% |
| Responding on behalf of organisation or community group | 6 | 1% |
| **Other characteristics** (n = 638 total individual responses) | | |
| Long-term physical or mental health condition or disability | 175 | 27% |
| Parent of a child aged under 18 years | 91 | 14% |
| Self or partner pregnant | 3 | <1% |
| Member of the LGBTQ+ community | 24 | 4% |

Note: 'n' is the number of responses that provided information about a specific characteristic. Percentages are calculated from this number. The numbers do not include most of the 260 people attending meetings or taking part in pop-up discussions, as we did not usually know their characteristics.

# 2. What we heard

## What did people think of the plans overall?

### What did we want to learn?

We wanted to give people an opportunity to say what they thought of the vision for Weston General Hospital overall. This was not a formal public consultation, but we wanted to get a sense of whether people feel the plans are moving in the right direction. We have already asked people what they think of specific plans in earlier phases of engagement.

### How many people provided feedback about this?

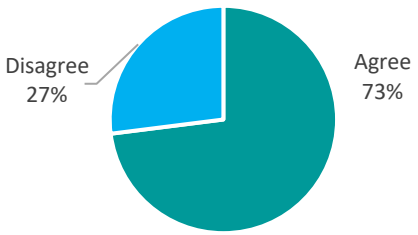
376 people answered a survey question about whether they thought the plans would improve Weston General Hospital (57% of all responses). People also discussed their overall impression of the plans in meetings, pop-up sessions and emails.

### Did people think the plans were worthwhile?

The people we engaged with were positive overall about the plans for Weston General Hospital.

- The survey asked people whether they agreed or disagreed that "the plans will improve Weston General Hospital." Of the 376 responses, **73% agreed and 27% disagreed**. In meetings and pop-up stand discussions people were also positive about the overall vision for developing Weston General Hospital. Some felt that the plans would improve capacity at the Hospital and help to sustain it. Some commented that they would like to see the plans in place as soon as possible.

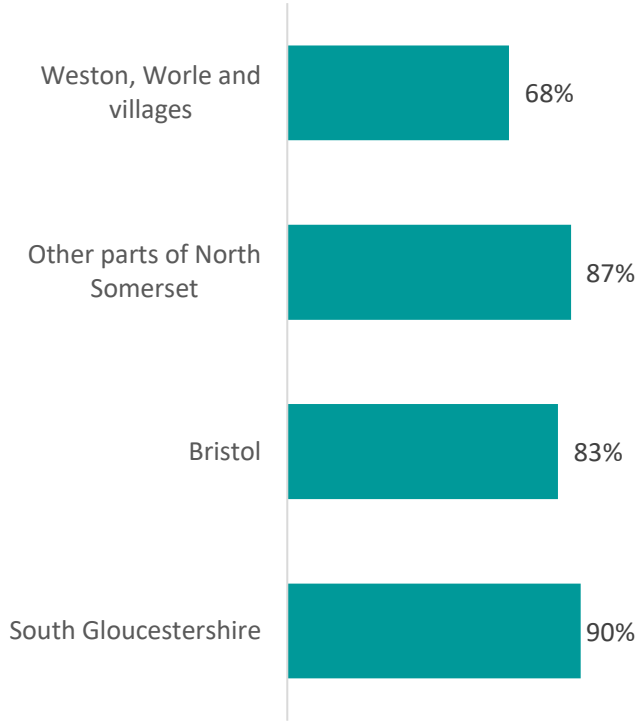
Figure 3: Plans will improve Weston General Hosptal




- People were positive about the plans no matter what their age, gender or ethnicity, whether or not they had a long-term condition or disability and whether they were a member of the public or NHS staff.

- There was a difference in people's views depending where they lived. Two thirds of people living in Weston, Worle and surrounding villages thought the plans would improve the Hospital (68%) compared with over 8 out of 10 from other areas (Figure 4).

## Figure 4: % who thought plans would improve Weston General Hospital




Note: There were too few responses from Somerset and other areas to compare.


*"If these proposals were put in place, this would be brilliant. How much confidence is there that it will all come to pass? Is there funding? The service proposals sound good for older people (such as the participants in this group). Like the idea of the same day emergency service with no waiting around for investigations and possibility of returning home with support if needed on the same day."* (Community group meeting)

*"I really like the sound of it. It sounds like you're really thinking about the people that live in Weston and what they actually need, rather than what the Hospital wants to show off. That's the bit that makes the difference."* (NHS staff, via pop-in session)

*"I really am hopeful that Weston General Hospital gets at least some of its identity back. Staff have felt quite disconnected and that seems to be quite prevalent at the moment. [There is] hope for the future of Weston General Hospital. It would be lovely to see staff more settled and confident in their own hospital."* (NHS staff, via email)

*"Always good to know that planned improvements are underway. The overriding story coming through is the increasing backlog of demand for medical procedures. A positive newsfeed on how Weston General Hospital is proactively working to combat this would help to promote its plans."* (Bristol resident, via Citizens' Panel)

*"I feel it's about time that we are using all hospitals to benefit people who need procedures with waiting times. I have only heard negative things about Weston Hospital. It's great to hear something positive."* (South Gloucestershire resident, via Citizens' Panel)

## Areas to consider further

One quarter of all responses (24%) raised concerns about the overall scope of the plans, saying that they would like to continue all services largely as is at Weston General Hospital or expand services to better meet the needs of the growing population.

These responses sometimes stated that the opening hours of the A&E Department should be extended. In Phase 2 of the Heathy Weston programme we are not proposing any changes to the A&E Department opening hours that have been in place for the past five years. Healthier Together was not seeking feedback about this during this engagement period as the NHS has already made decisions about this.

Other reasons that responses did not think that the plans would have a positive impact on the Hospital focused on whether the plans would be feasible to implement and the perceived potential negative impact of specific elements of the plans. We describe these in the sections on the following pages.

*"For those without their own means of transport a difficult journey by public transport. For those with their own vehicles this will result in additional journeys, many of which will involve using polluting vehicles, so from an environmental perspective this is a deeply flawed policy. This at a time when we're being called upon to make fewer car journeys by North Somerset Council."* (Weston and Worle area resident, via email)

*"There are some worries about the plans. Is there a plan to reinstate A&E overnight? How much more expensive is locum cover than standard salaries for medical and nursing staff?"* (Community group meeting)

*"The problem is with people not getting care packages and the waiting list for domiciliary care in particular. It is no good putting in these services without addressing the issues in social care. Need to work together with Local Authorities for this to happen and have better funding at a national level."* (Community group meeting)

Whether or not they were positive about the plans overall, most responses suggested things that we could do to strengthen the approach and work in a joined up way. Suggestions included:

- focusing more on **transport and parking**, such as liaising with transport providers to campaign for direct public transport links between hospitals (26% of the 657 responses mentioned this)
- the need to proactively promote and build the **reputation** of Weston General Hospital (20%)
- undertaking detailed work on **staff morale**, retention and wellbeing to make sure that the plans could be implemented and sustained, and also providing a staff transport service between hospital sites (10%)
- more **integrated planning**. Some responses said that the plans rely on integrated work with social care, transport and other services to help people leave hospital quickly. They worried that these ways of working were not in place, would take time to embed and were not resourced as part of the plans. Some responses said that the plans did not go far enough to make sure Weston General Hospital could be sustained. They wanted to see more preventive, population health and follow on care elements built into the longer-term plan. They said this might include increasing rehabilitation and outpatient care at Weston General Hospital in order to reduce admissions; strengthening access to primary care; and making sure that there was good follow on care at home after discharge (10%)

Responses suggested the same concerns or suggestions for further work whether or not they were positive about the plans overall.

*"The current public perceptions of Weston General Hospital do not seem very positive. Lots of wide ranging, positive public information would be very helpful. Seeing it as an integral and important part of the local health authority provision would also be a positive move."* (Weston and Worle area resident, via email)

*"There might be some upset surrounding the plans so there needs to be a campaign to highlight the benefits as much as possible and build up the reputation. Facebook groups and community groups could be used to hold events outlining the plans as well as council run events. Maybe avoid news services that always seem to put a negative spin on everything. The community needs to be on board with the changes so reassurance about the services that will be lost must be a priority."* (North Somerset resident, via Citizens' Panel)

# What did people say about communicating?

## What did we want to learn?

We wanted to understand the best ways of sharing information about what is happening at Weston General Hospital and who we should engage with. We plan to put Healthy Weston Phase 2 into action in stages for many years and want to make sure that we keep members of the public, staff, community groups and others involved and up to date.

## How many people provided feedback about this?

511 responses (representing 619 people) provided feedback about this.

## What did people say about ways to share information?

Responses were positive about continuing to communicate and engage with the public and staff (19%). One in ten responses (10%) said, without prompting, that they had not heard of the Heathy Weston Phase 2 plans before. This included staff at Weston General Hospital and others working in the NHS as well as members of the public. This does not mean everyone else had heard of the programme.

In our survey, we asked "How should we let people know about plans for Weston General Hospital? We are eager to hear new ways to share information and any groups we should contact." People made comments about potential ways to communicate about plans in meetings and emails as well. 511 responses commented on this.

A small number of responses suggested people that we should particularly target to engage with further. Suggested groups were:

- older people and community groups supporting them, such Age Concern
- people with mental health issues
- those living in deprived areas and families with limited income
- people in other areas such as those living in Somerset who use Musgrove Park Hospital in Taunton
- people with specific health issues and needs such as those with visual or hearing impairments and other disabilities
- minority ethnic groups
- groups supporting maternity care

10 or fewer responses mentioned each group.

*"In addition to the groups you have already contacted, you should contact those with mental health problems and groups which support these individuals, people in Somerset such as pop up events in Taunton Hospital."* (Patient group meeting)

Common suggestions for sharing information were a widespread promotional campaign and directly sending material to all residents and patients:

### General promotion

- local tv, newspaper and radio **campaigns** e.g. Weston Mercury (45% of the 511 responses that provided feedback about communication)

- **social media and websites** such as community Facebook groups and the Next Door app (44%)

- placing leaflets, posters or other information on lampposts, billboards, bus stops, train and bus slide shows and **in public venues** like libraries, children's centres, supermarkets, GP clinics, pharmacies, hospitals. This could include a website address and email and telephone number for further information (29%)

- keeping Healthier Together's **Healthy Weston webpages** up to date and including relevant information and links to these pages on the council and hospital websites (6%)

### Direct communication

- **posting leaflets** through all (North Somerset) letterboxes, and perhaps considering doing this as a newsletter once or twice per year to keep people up to date (18%)

- **emailing and texting** everyone that health services hold an email address or mobile phone number for with a website address or summary information. This includes the Hospital Trust membership (15%)

- **visiting** community groups, older people's groups, care homes, neighbourhood watch groups and other targeted groups (7%)

- online and in person **meetings** and drop in sessions, hosted at hospitals and general practices, for example (7%)

- inserting a leaflet into **letters already being** sent to patients by GPs, hospitals, those receiving repeat prescriptions and those on waiting lists (5%)

- placing information on the **staff intranet** at health and care organisations (2%)

### Working through others

- placing an item in the **newsletters and briefings of other organisations** such as local authorities, retirement villages and care homes, schools, clubs for older people and groups such as the Women's Institute, (11%)

- meetings and emails for **NHS and care staff** such as GP staff, hospital staff, care homes and schools so they have clear messages to promote to patients and the public. This might include asking all GPs and other referrers to mention Weston General Hospital as an option when referring people for surgery or potential surgical investigations (6%)

*"I assume that many service users are probably of retirement age or working from home and therefore probably watch tv or listen to radio, so news items using these forms of communication would be useful. Leaflets/notes placed in repeat prescription packages would be useful too as they might make things clearer/ easier to understand."* (Weston and Worle area resident, via email)

*"A brief quarterly newsletter outlining progress towards goals and any new information for patients. Make it 2 sides of A4 and include a couple of pictures. This could be sent to most patients via email, and to others by post. I think this would be the only way to reach all patients. To reduce postage, newsletters could be left in doctors' surgeries, day care centres, libraries, and passed to any clubs which cater for specific medical or chronic ailments."* (South Gloucestershire resident, via survey)

*"This is a good news story and should be shared by every possible means to get the message across to the maximum numbers of households. It would be best if this was done as a campaign or a project so that it gathers its own momentum first and then reminders issued periodically. Hopefully this will give a sense of direction to the Weston Healthcare professionals and aid recruitment of the right specialists too."* (Weston resident, via Citizens' Panel)

*"Have a display at the Hospital entrance and in all waiting areas and the restaurant. Use the Weston Mercury and North Somerset Times. Use the village agents, billboards, library displays, GP surgeries, scout groups, sports centres, council offices, supermarket display areas, Job Centres, bus display areas. Health and care staff could also drop off leaflets at the homes."* (North Somerset resident, via Citizens' Panel)

*"You could go to places where lots of people go like doctors' surgeries. You could advertise on the screens that they have there. Use North Somerset Life as that goes to every household in North Somerset. You would get more people to engage if you were more honest about the downside of the proposals."* (Public meeting)

*"What we have learned (at public meeting) is clear: loads of aspects will stay the same. The perception in Weston is that things would change, but the change is minimal. People need to hear how things are improving. Use any positive case studies. Counsellors are really good for explaining messages. Make it clear that changes won't affect A&E."* (Public meeting)

*"Local tv, stands in shopping centre/pier, good graphics, easy to read posters. Make people feel proud and well informed about their hospital. Invite people to join and contribute to online communities like Facebook, Twitter and Instagram and # appeal."* (South Gloucestershire resident, via Citizens' Panel)

## What did people want more information about?

Most responses that commented about communication thought that Healthier Together was describing the plans for Weston General Hospital in a clear way. 129 responses suggested extra information they would like or ways we could help people understand better. Suggestions included:

### Information about care for all ages

- stating whether or not **maternity and children's services** will be available at Weston General Hospital, including services for younger people with long term conditions and disabilities (32% of the 129 responses that suggested additional information)
- continuing to emphasise that **most services will stay as they** are and explicitly saying that services are used by all ages (10%)
- defining **what is meant by older people / frail older people** and whether these people will all stay at Weston for the duration of their admission, no matter how long they need to stay (7%)
- saying if/**why** plans for transferring to another hospital are based on age rather than level of fitness (e.g. frail younger people) (3%)

### Information about planned surgery

- defining what a **centre of excellence** is, how the Hospital will become such a centre and what the benefits of this are (this applies to both older people's care and planned surgery) (5%)
- stating **why** Healthier Together wants to increase planned surgery at Weston General Hospital e.g. lack of capacity at other hospitals (5%)
- emphasising that people have a **choice** for their place of surgery and how they can exercise that choice if it is not offered to them by their GP or other referrers (3%)
- providing more information about where **funding** is coming from and when since we have said that improvements to surgery depend on funding (3%)
- being clear that adults of **all ages** (16+ years) will be able to have planned surgery at Weston General Hospital and stating which operations will be available (3%)

### Information about care after an accident or emergency

- providing more details about **patient transport**, such as whether this will include monitoring people's condition whilst travelling and whether there are enough ambulances or other vehicles (5%)
- stating **which hospitals** people will be transferred to if they need ongoing care (3%)
- explaining **how** the plans will help people to go home quicker and get emergency care on same day without recruiting more staff (1%)

### Other elements

- showing that Weston General Hospital is **safe and good quality**, especially given past negative press. This may include patient stories about experience of care (21%)
- stating whether outpatient services such as for people with **cancer** will be available for all specialities at Weston General Hospital or will mostly be in Bristol (7%)
- providing more details about the practicalities such as difficulties with **staff** recruitment, how staff from the Bristol Royal Infirmary may need to travel to work in Weston and how the management structure will work, such as whether services provided in Weston will be managed from Bristol (6%)
- including **videos** and photos showing the Hospital and maps of where it is (4%)
- **repeating** messages frequently, as it takes time to build awareness (4%)

*"Be more explicit about the consequences of not changing without being too alarmist. Explain what it might mean, stop being so mealy mouthed about patients being transferred. If your health is jeopardised surely you will need to be treated where your outcomes will be the best."* (North Somerset resident, via Citizens' Panel)

*"Explain how you will attract staff. Are the clinicians contractually obliged and expected to be based either in Bristol or Weston as the demand for services requires? Are there plans to create Weston as more of a teaching hospital?"* (North Somerset resident, via Citizens' Panel)

*"It doesn't explain what building work is envisaged at Weston but plainly some will be needed. Is this something that will be explained in more detail in Phase 3? is some of the Diagnostic Centres money potentially available via Government going to be part of the funding for the upgrade? None of this will happen without the money so it might be good to understand how long the upgrade stage is likely to take and starting from when."* (Weston and Worle area resident, via Citizens' Panel)

*"The model suggests only 40 extra beds are needed (19 BRI, 9 NBT, 12 Taunton) across all medical specialities. From my perspective this is a long way off. Does the recent divert experience suggest we can accommodate elsewhere the >>40 that it will be as well as those diverted over the last 2 weeks?"* (NHS staff, by email)

*"People want to know how Weston General Hospital is spending its money and how it is getting better. They aren't being told of the benefits of Healthy Weston Phase 1. They have the image of a hospital that is dying. That has changed. This needs to be made clear."* (Public meeting)

*"Today was clear but people who have not been here aren't clear… I have heard that A&E is going to close all together. You need to leaflet through people's doors to help change people's minds."* (Public meeting)

*"When you consider the amount of traffic on the M5 in the summer months a journey to Bristol or Taunton becomes even more of a hassle. So some people will be transferred elsewhere even though there is the resource to carry out the treatment in Weston? It must be available as the criteria is not the condition (as with stroke, heart attack etc). If you can treat an 80 year old in Weston why not a 40 year old with the same condition? What about borderline cases – will it depend on bed availability in Weston (or the receiving hospital)?"* (Weston and Worle area resident, by email)

*"What does a dedicated patient transport team mean in practice? For some patients I'd imagine an ambulance would be required to monitor their condition. This will mean ambulances that could be used for emergency work being unavailable for some time – especially with the reported delays in admissions at many hospitals. What is the anticipated cost of these dedicated vehicles, surely the money could be better spent on improving services at Weston?"* (Weston and Worle area resident, by email)

# What did people say about care for all ages?

## What did we want to learn?

We wanted to know whether people are clear that services will remain available for people of all ages at Weston General Hospital. We also wanted to understand whether people are pleased or concerned about the plans for providing more specialised care for older / frail people at the Hospital.

## How many people provided feedback?

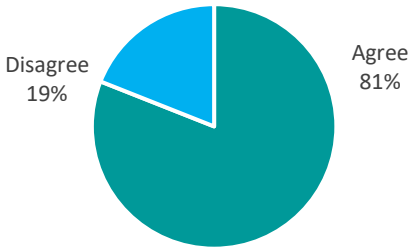
388 responses (451 people) provided feedback about this.

## Did people think messages were clear?

In previous periods of engagement some people expressed concern that the plans might mean that Weston General Hospital would mainly cater for older people. Since then our team has revised the way it describes planned changes, emphasising that most services for people of all ages will be available exactly as they are now. There will be some extra services for people older than 75 years.

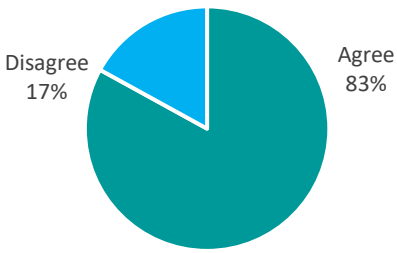
- A survey question asked "Most services at Weston General Hospital will continue as they are now, with services for all ages including maternity, children's services and adults' services. If you have read or listened to our plans, are we clear there will be services for all ages at Weston General Hospital? Yes/No". People also commented on this in meetings and emails. Of the 388 responses, 81% thought that the plans were clear about services for all ages and 19% thought the plans were not clear about this (Figure 5).

Figure 5: Plans are clear about services for all ages




- Another survey question asked whether people agreed or disagreed that "Weston General Hospital will include services for people of all ages." 83% of the 396 responses agreed and 17% disagreed (Figure 6).

Figure 6: Hospital will include services for all ages




- Women and men, NHS staff and members of the public, people from all different ethnic groups and those with and without long-term conditions or disabilities all had a similar level of understanding of the plan to continue offering care for all ages.

- There was a difference depending on people's age and where they lived. People older than 65 years were most likely to say they were clear about care being available for all ages. About one in five people under 65 did not realise this (Figure 7).

- Responses from Weston, Worle and surrounding villages were less likely than others to realise that the Hospital will continue to provide care for all ages. 1 in 5 people from Weston were not clear about this compared to about 1 in 10 from other areas (Figure 8).

Figure 7: % of age groups who thought Hospital will include services for all ages

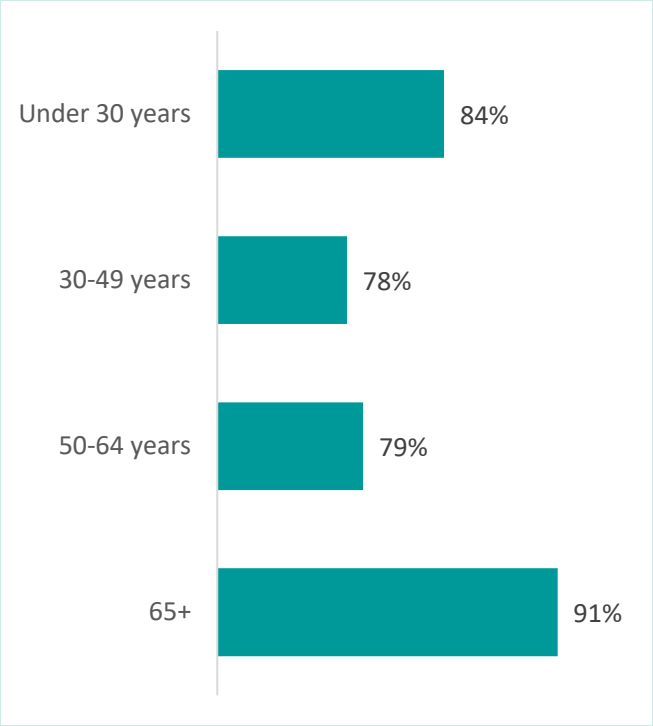
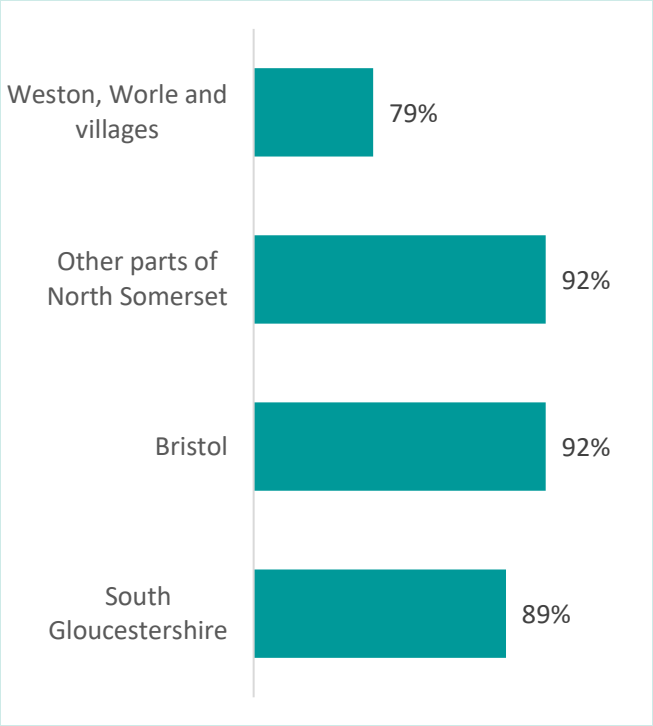



Figure 8: % from areas who thought Hospital will include services for all ages




Note: There were too few responses from Somerset and other areas to compare.

We described the things that people wanted more clarity about in terms of care for all ages in a previous section. The most common queries were about whether or not maternity and children's services will be available at Weston General Hospital, including services for young people with long-term conditions and disabilities.

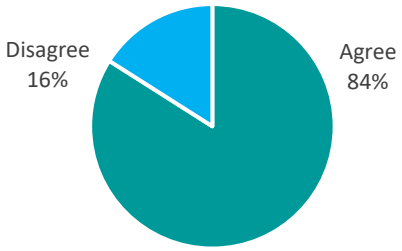
We used the term 'centre of excellence' in our Healthy Weston Phase 2 plans to describe becoming known for providing the very best care for frail and older people, including adding teams with lots of experience in this. Some responses suggested that the term 'centre of excellence' was unclear. This term might inadvertently also give the impression that the whole hospital will focus on older people's care.

*"Need to be promoting a whole hospital. Need to use simple language. Centre of excellence language not clear / not suited to all demographics: needs a definition. Show as continuation of general hospital but with improvements. Less about age groups, more about serving the community. Staff didn't know what was going on before."*
(Public meeting)

# Did people support providing more care for older people?

Another survey question asked whether people "like the plan to have more care for older people at Weston General Hospital." **84% of the 396 responses agreed** and 16% disagreed.

Figure 9: Like plan to have more care for older people




- Women and men, NHS staff and members of the public, people from all different ethnic groups and those with and without long-term conditions or disabilities all had a similar level of understanding of the plan to continue offering care for all ages.
- There was a difference depending on people's age and where they lived. People older than 65 years were most likely to say they liked the plan to have more care for older people at Weston General Hospital. Those younger than 65 still mainly supported this approach, though in lesser numbers (Figure 10).
- 8 out of 10 responses from Weston, Worle and surrounding villages liked the idea of offering more care for older people, though this was less than the proportion from other areas (Figure 11). This may be linked to the lower proportion from Weston and Worle realising that most care would continue to be available for people of all ages at the Hospital, as described on the previous pages.

Figure 10: % of age groups who liked the plan to provide more care for older people

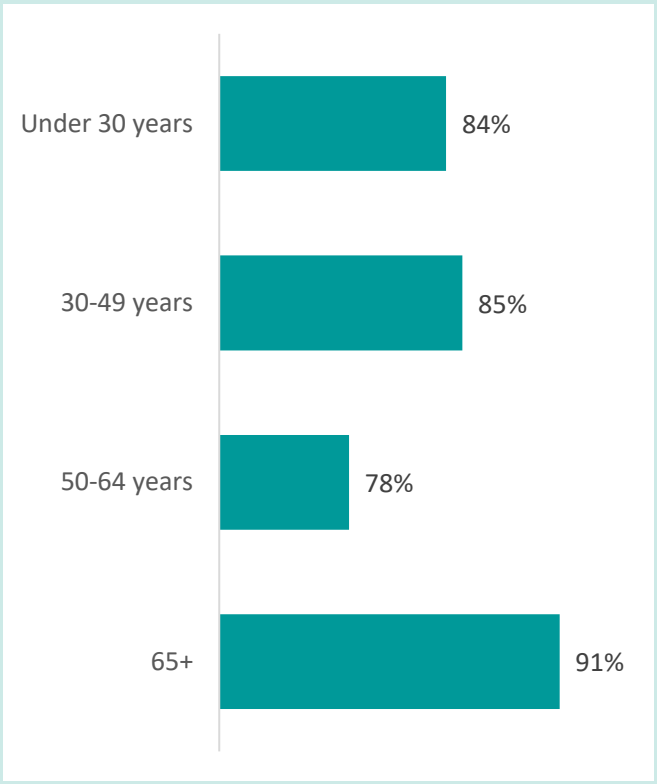
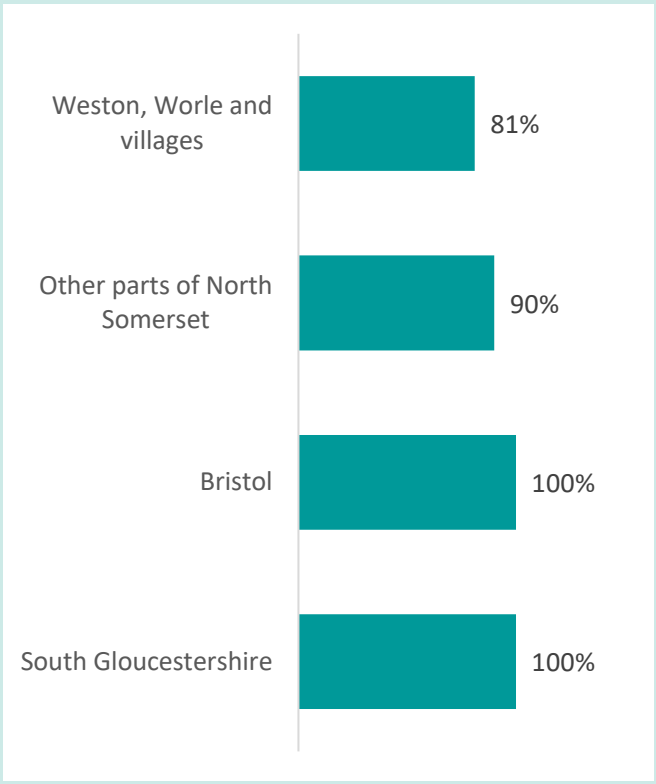



Figure 11: % from areas who like the plan to provide more care for older people




Note: There were too few responses from Somerset and other areas to compare.

# What did people say about planned surgery?

## What did we want to learn?

We wanted to know whether people were pleased or concerned about having more planned surgery available at Weston General Hospital. We also wanted to understand what would encourage or discourage people from choosing to have planned surgery at the Hospital.

## How many people provided feedback?

527 responses (representing 527 people) provided feedback.

## Did people support providing more planned surgery?

A survey question asked whether people "like the plan to offer more planned operations at Weston General Hospital". **88% of the 527 responses agreed** and 12% disagreed.

- Women and men, people from different age and ethnic groups, NHS staff and members of the public, and those with and without long-term conditions or disabilities were all similarly positive about offering more planned operations at Weston General Hospital.
- There was a difference depending on where people lived. Those living in Bristol generally supported this plan, but were less likely to do so than those from other areas (Figure 13).

Figure 12: Like plan to have more planned operations

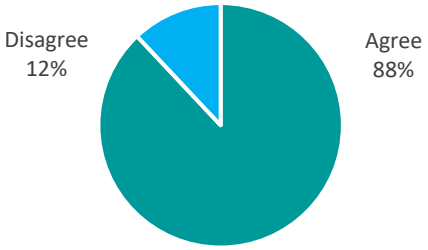


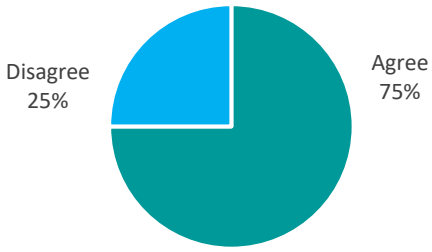

Figure 13: % from areas who like the plan to provide more planned surgery at Weston


Note: There were too few responses from Somerset and other areas to compare.

## Would people have planned surgery at Weston General Hospital?

Another survey question asked whether people would be "happy to have planned surgery at Weston General Hospital". **75% of the 527 responses agreed** and 25% disagreed.

Figure 14: Would have planned surgery at Weston

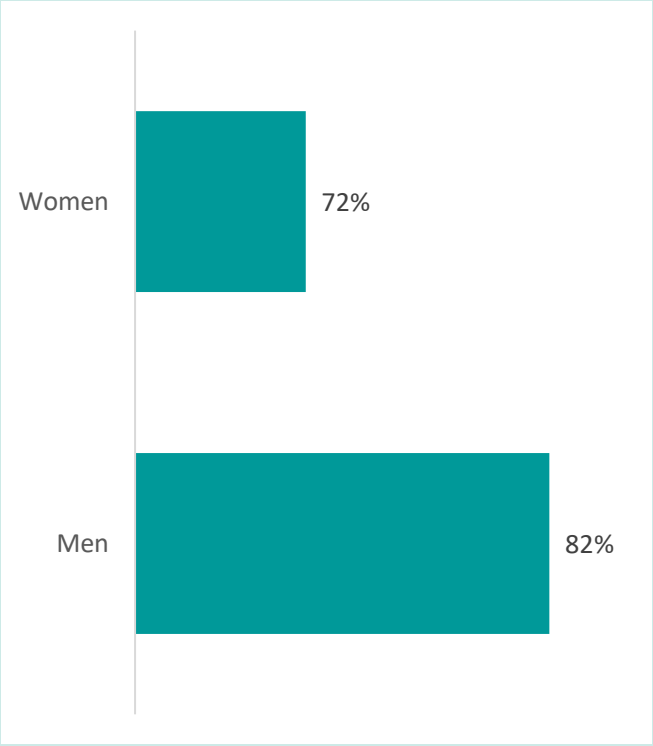



- People from different age and ethnic groups, NHS staff and members of the public, and those with and without long-term conditions or disabilities were all equally likely to say that they would be happy to have planned surgery at Weston General Hospital.

- The preferences of men and women differed. Women were less likely to say that they would be happy to have planned surgery at Weston General Hospital (Figure 15). This trend remained after accounting for where people lived and their other demographic characteristics. Nothing in people's comments explained why women were less likely to be happy with this as men and women both provided similar reasons for liking or not liking the plan.

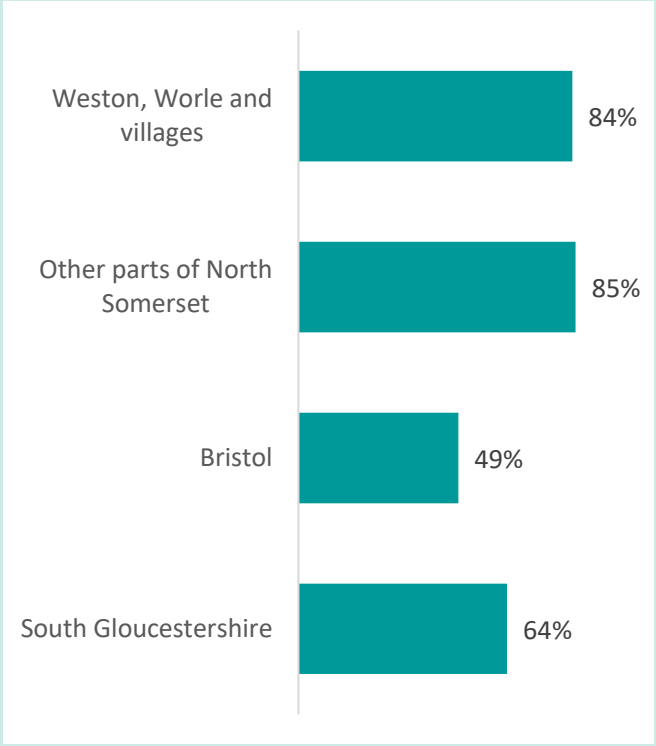
- The views of people living in different areas varied. Those in the Weston and Worle area and people living in other parts of North Somerset were more likely to say they would be happy to have planned surgery at Weston General Hospital, largely due to being closer to home. Less than half of people living in Bristol said they would choose to have surgery at Weston General Hospital (Figure 16).

Figure 15: % of women and men who would have planned surgery at Weston




Note: There were too few responses from people who self-identified to compare.

Figure 16: % from areas who would have planned surgery at Weston




Note: There were too few responses from Somerset and other areas to compare.

To understand what might attract people living further away to choose planned surgery at Weston General Hospital, we asked members of our **Citizens' Panel living in Bristol and South Gloucestershire** why they "would or would not be happy to have a planned operation at Weston General Hospital?" There were 123 responses.

Those who said they would be happy to have planned surgery at Weston General Hospital said that this was because they:

- would be able to **have surgery more quickly** compared to the waiting lists at other hospitals (24% of 123 responses that made one or more comments)
- felt **able to travel** because they were physically able, had a vehicle and were close enough (8%)
- would have more **choice** (7%)
- were **familiar** and happy enough with the hospital's ability to provide minor procedures, such as having visited or had appointments there before (6%)
- wanted to help **reduce pressure** on other hospitals and reduce waiting lists elsewhere for others (4%)
- had **friends or family** in the area who could visit to provide support (2%)
- thought that **parking** was better (2%)

Barriers for people living outside the immediate area having a planned operation at Weston General Hospital included:

- logistical difficulties in the **time and distance travelling** to and from hospital, especially as some people cannot travel easily after surgery (60%)
- **lack of confidence** in Weston General Hospital's reputation based on press reports and/or poor past experience of self or loved ones (34%)
- difficulty, cost and inconvenience of **travel for loved ones** who want to visit (28%)
- there are other hospital options closer to home that people would prefer (15%)
- **lack of continuity** if follow on care is needed and concerns about safety if people need to transfer for care following complications (9%)
- not knowing anything about the hospital or where it is (2%)

*"I use public transport in and around Bristol, but getting to Weston from central Bristol would be difficult. If this was for surgery as well, being able to go back home would be a worry. In addition, Weston's reputation leaves an awful lot to be desired. Patients would need to know that emergency care would be available if anything went wrong."* (Bristol resident, via Citizens' Panel)

We asked everyone who answered a survey or who took part in a meeting "What could we do to encourage people to have a planned operation at Weston General Hospital? e.g. advertising shorter waiting times". 413 responses made one or more comments about this. Things that people said would encourage them to have planned surgery at Weston General Hospital were:

### Confidence and continuity

- building up the **reputation** and awareness of the Hospital. People suggested a promotional campaign to emphasise that Weston General Hospital has good quality experienced staff, equipment that can be trusted and a nice environment. Many perceived that the Hospital has a poor reputation. They suggested publishing data about the waiting times and outcomes of surgery compared with other hospitals. They also suggested including photos so people can see how the Hospital looks (48% of responses that commented about this)

- promoting **safety and continuity of care**, such as reassuring that people would not be transferred elsewhere in the event of postoperative complications and emphasising that people could have outpatient appointments with their Weston surgeon before and afterwards close to their own home (12%)

- giving people the name of the **staff** who will do operations so they check their experience and emphasising that these staff might be the same as working in other locations (11%)

### Timing

- emphasising **shorter waiting times** and how this will help to clear NHS backlogs. This may include regularly publishing up to date waiting times and comparing with other options (41%)

- saying that people will have **more choice** and flexibility over their surgery date and that cancellations will be kept to a minimum (4%)

- emphasising that people may be able to **return home quicker** (2%)

### Transport

- having a **shuttle** to and from hospital / between hospitals for patients and visitors (e.g. a shuttle that runs two to four times a day) (7%)

- free and readily available **parking** (7%)

- better **public transport** i.e. direct routes, more frequent and cheaper services (5%)

- giving people information about how to get to the hospital (maps and travel times) (2%)

### Other factors

- emphasising that people have a **choice** about where to have surgery (7%)

- **getting GPs on board** so they think the Hospital provides good care and make referrals (5%)

- emphasising that there will be **good access for visitors**, such free or cheap parking, longer visiting hours and access to technology and apps such as FaceTime and WhatsApp so people can keep in touch with loved ones (4%)

*"I think shorter waiting times would be a compelling reason for many! Also clarifying that the standard of care and related services (e.g. physio, scanners, other medical services and aftercare) would be as good. I say this as friends in Weston just had a baby and said that maternity services were very limited. It casts doubt on whether the other facilities are as far reaching as in bigger Bristol hospitals. Provide free parking - especially if people are having to spend petrol on driving to Weston - it's a serious consideration with petrol prices like they are currently. If some sort of public transport discount could be offered that might encourage some people."* (Bristol resident, via Citizens' Panel)

*In my experience working in a hospital, most people would far rather wait a long time than travel for care. Is there any evidence this model would work, enabling capacity at Weston to be fully used without creating big disparities with the Bristol site? A small proportion of patients will travel but most would rather wait to have even urgent procedures locally. The hospital would also need to improve its reputation if you want people outside of Weston to travel there. It would need to be able to demonstrate how it offers safe, modern care of the same standard as the Bristol hospitals. Putting on bespoke public transport from Bristol - some sort of shuttle bus for patients - might help as getting to Weston on public transport is not as easy as it could be, especially if you've starved for an operation/are going home after undergoing surgery. Free car parking is always popular and would probably be a big enough incentive for some."* (NHS staff, via survey)

*"You need to rebuild reputation and give the public confidence in the quality of surgeons and care that they will receive. You should publish quality and outcomes data and let people know the quality of care that they will be getting. GP recommendation is key here and the first question I would ask my GP is would you send your friends or family there… You need to be more open and transparent about the downsides of the proposals."* (Public meeting)

*"Provide information that gives confidence in the hospital staffing as well as reassurance on what would need to happen if things escalated. Can Weston cope with problems in surgery where additional equipment/specialist staff might be required? A possible transfer if something were to go wrong might put people off."* (Weston resident, via survey)

*"Need travel / transport for families to visit if they are elderly and have no car."* (Weston and Worle area resident, via easy read survey)

*"Stress the advantages of going to Weston e.g. shorter waiting lists and specialist staff. Also ensure that you have schemes in place to counteract the disadvantages e.g. If coming from a distance 1) could the operation time be later in the morning so the patients don't have to get up at a ridiculously early hour to travel and 2) offer free parking. Hold more public engagement events in the areas that you hope to attract people from NOT just in Weston."* (South Gloucestershire resident, via Citizens' Panel)

# What did people say about transferring to another hospital?

## What did we want to learn?

We plan that Weston General Hospital will help people get home quicker after accidents, emergencies or other unplanned care, with special units for assessing and treating people promptly. Older people who are frail and need inpatient care will stay at Weston General Hospital, the same as now. Adults of any age who need emergency surgery will have their operation at Weston General Hospital. They will stay for as long as they need to recover, exactly like now. A dedicated patient transport team will take anyone else who needs a longer stay in hospital to a neighbouring hospital providing the specialist care they need. We wanted to know what the biggest impacts might be for those transferring to another hospital, how we might support them and who might be most affected.

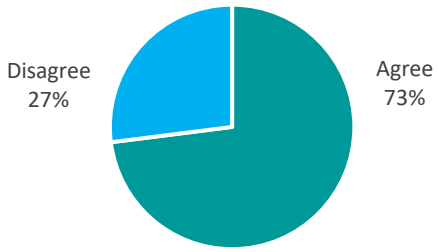
## How many people provided feedback?

414 responses (representing 414 people) provided feedback about this.

## Did people understand the reasons?

Our survey asked people whether they understood "why some people taken to Weston in an emergency would transfer if they needed to stay in hospital longer than 24 hours." Out of 413 responses, 73% understood and 27% did not. This does not mean people supported the plan, just that they understood the reasons we propose this.

Figure 17: Understand why some people will transfer




- Men and women, people of different age and ethnic groups, people with and without a long-term condition or disability and NHS staff and members of the public all had similar feedback.
- 6 out of 10 people living in Weston, Worle and surrounding villages said they understood the reasons for this plan compared to over 8 out of 10 people from other areas (Figure 18).

Figure 18: % who understood why some people may transfer


People who said they did not understand the plan, regardless of where they were from, often said that they disagreed with the rationale or did not understand the criteria to decide who would transfer.

*"I do not agree with moving people to hospitals further away based on age. It is discriminatory and is not based on fitness and will disadvantage the poorer and most vulnerable. Lots of young people live in Weston. It is also not very environmentally friendly, for a Trust that has committed to green policies to be encouraging large numbers of people to travel between Bristol and Weston all the time."* (Bristol resident, via survey)

## How did people think we could support those affected?

Our survey asked "Some of our plans mean that people will travel to another hospital for their care, like people who choose to come to Weston for surgery or people transferred to another hospital. What practical things could health services do to help if people and visitors are at a hospital away from home?" 336 responses provided one or more comments about this.

Common suggestions about practical support were:

### Transport

- free or subsidised **shuttle between hospital sites** that visitors and patients can use (38% of responses that provided one or more comments about this)
- direct **public transport routes** rather than needing to take multiple buses; lower fares; and providing patients and families with information about public transport (13%)
- hospitals helping people get home after discharge. This may include working with **volunteer groups** to provide lifts (8%)
- assisting with transport **costs for visitors** in hardship, through an application system (8%)
- free or cheaper **parking** (13%)

### Communication

- giving people **access to technology** to contact loved ones if they need it e.g. loan service for video call equipment for those who do not have tablets or mobile devices with them and IT support for family members e.g. a telephone number to call to help people set up video calls at home (35%)
- improving **Wi-Fi access** and technical support to help people use it (13%)
- better **communication** between wards and family so people how their loved one is (6%)
- providing a **direct dial number** to the ward and cordless telephones that can be taken to patients who do not have mobile phones with them (5%)
- explaining the reason for the transfer and **providing information** such as the potential length of stay and what will happen when transferring; parking, public transport at other hospital (2%)
- making sure **extra support** is available for those who need it e.g. translators, sign language (1%)

### Facilities

- providing access to laundry services, newspapers and **toiletries** if people have no visitors to bring things. This may include having **volunteers** / League of Friends visiting wards to provide books, papers and conversation (10%)
- longer **visiting hours** since people may have to travel a long way to visit (5%)
- support for loved ones such as signposting to subsidised or **inexpensive accommodation** where relatives can stay, providing family rooms/meeting area for visitors to see patients outside wards and **catering** facilities for visitors who have travelled (6%)

During the engagement period members of the Healthier Together team met with transport providers to consider next steps. For example, at one meeting we discussed an additional bus stop at Weston General Hospital. We talked about planning routes to fit with times that the public and staff may need to access the hospital.

*"Regarding families having difficulty visiting patients who have been transferred out of area, could there be a hub within the hospital for remote access? Perhaps a room with pods and laptops (secured to tables/desks) with basic access to Teams or similar platform. It may need to be staffed. Sessions could be booked with someone liaising with the wards for suitable times."* (Staff member, via email)

*"Arrange transport, have more flexible visiting hours, wifi for technology, provide free TV for patients who do not have access to modern technology. League of Friends to do rounds of wards as they used to with library books and magazines/papers, snacks/drinks/toiletries for patients to purchase if not able to get to shop in hospital or family are not able to get in to visit due to distance."* (Bristol resident, via survey)

*"People need organised transport and it would be good if attention was paid to giving patients access to communications. For instance, when my mother was recently in hospital she became too confused to be able to use her own mobile phone so the only way to talk to her was by phoning the ward phone and the nurse taking the phone into the ward. The staff were too busy to do this."* (North Somerset resident, via Citizens' Panel)

*"Volunteer drivers. Community transport schemes. A dedicated shuttle bus. If transported somewhere, patients would need to be assisted in transporting back. Care homes have transport available so there could be collaboration here. Provide greener ways of transport, electric car charging points, more bicycle spots."* (Public meeting)

*"Travelling to Southmead from Weston by public transport is particularly difficult for both patients and visitors. The trip into the bus station and out to Southmead can easily take over 3 hours each way. Taxi fares are out of the reach of the majority. Friends and family are not always available, particularly for those who have moved into the area and do not have a strong support network. The idea of a dedicated hospital bus service is an excellent one. For example, the X1 bus between Weston and Bristol bus station could easily be re-routed though the Long Ashton park and ride which has frequent bus links directly to Southmead, potentially cutting a travel by bus time by 50% while adding little time to the journey into Bristol. Confidence in the new proposals will for many hinge on the availability of transport. The proposals make it clear that a dedicated transport service will be available to take patients from Weston to remote hospitals. It does not make clear whether these patients would have transport to return home if discharge was from the remote hospital."* (Weston and Worle area resident, via email)

*"Living in a retirement development we are aware of the worries many older people have concerning admission to hospital. There is a real fear amongst frail, elderly people that they will be treated and then expected to make their own way home. There is also much worry that if an extended admission is required their family and friends will be unable to visit because of transport difficulties. Not everyone drives or is confident to drive into a new area. It would be helpful if there was some clarity about transfer back home after an emergency admission to a remote hospital."* (Weston and Worle area resident, via email)

## Who might be most affected?

We asked "If you think some groups may be more affected than others by being in a hospital away from home, please tell us who and why." 268 responses provided one or more comments about this.

Groups that people thought might be **particularly affected** if transferred were:

- elderly people (62% of 268 responses that commented)
- people with a physical disability, learning disability or mental ill health (30%)
- children and young people who need their families for support 23%)
- people who do not drive or have access to a vehicle (23%)
- people with less income / high deprivation (16%)
- people with dependents / children (11%)
- family members / carers / visitors (9%)
- single people, including single parents (6%)
- people who do not have access to or struggle to use technology (5%)
- people who do not speak English well (2%)
- staff who need to work across hospital sites (2%)

People thought that planned changes might affect these groups more because they may have less support available to them or be more in need of support, including for their mental wellbeing and for practical reasons.

*"Older people get lonely a lot quicker, sometimes get overwhelmed and may want company 24/7. Any young child would be sad and possibly uncomfortable with going away from family as it could be overwhelming and scary for them. Teenagers can get quite emotional and overwhelmed. Will want contact and support most of the time."*
(Weston and Worle area resident, via Citizens' Panel)

*"One of the highest levels of deprivation outside of London is in North Somerset. People within this demographic won't have access to a car to travel and will face financial difficulties with visiting loved ones or even getting home when discharged. Public transport routes from Bristol are not simple or convenient or affordable for many people."*
(Weston and Worle area resident, via survey)

*"People with poor mental health may be affected; people who struggle to use computers / video chat or don't have access to devices; people who are unprepared for admission (when I was in hospital elsewhere charity provided hospital goodie bags with toiletries, puzzle/activity books and snacks)."*
(Weston and Worle area resident, via survey)

# What did NHS staff say?

## What did we want to learn?

We wanted to understand whether NHS staff had any specific concerns about the plans. We also wanted ideas about ways to address those concerns.

## How many people provided feedback about this?

160 responses (representing 221 people) were from NHS staff. This included emails, responses to our survey from people who said they worked in the NHS[5] and meetings facilitated by University Hospitals Bristol and Weston NHS Foundation Trust (UHBW), which runs Weston General Hospital.

## What did staff think?

In our survey, NHS staff provided similar feedback as members of the public. NHS staff were just as likely as members of the public to think the plans would improve Weston General Hospital, support plans to increase planned surgery and care for frail people and say that they understood the reasons why some people may transfer to another hospital for unplanned care.

Amongst staff that raised concerns, the themes were similar to comments in other responses:

- concern about the availability of **infrastructure** to put the plans into action, such as patient transport and the impact on the ambulance service
- concern about the impact of more (patient, staff and visitor) travel on the **environment**
- concern about whether other hospitals would have the **capacity** to cope with patients transferring, and worry that it was an unrealistic aim to change the number of unplanned care beds from 247 to 164 at Weston General Hospital
- concern about the **criteria** for transferring people to another hospital after an emergency. Some felt that decisions might be made largely based on people's age and they thought this may be discriminatory
- being realistic about the **time** it would take to implement plans and improve ways of working at the Hospital. They wanted to see clear and realistic timelines when planning next steps
- recognising that some of the plans are dependent on additional **funding**, which may not be available

5 These may not all have been people working at the Trust running Weston General Hospital.

We asked whether the plans may have any specific impacts for the workforce or whether there was anything we should consider from a workforce perspective during five meetings with staff from hospitals in Weston and Bristol run by University Hospitals Bristol and Weston NHS Foundation Trust. We also drew out any comments about this in surveys.

Very few responses considered potential impacts for the workforce. Those that did said that we should:

- consider the implications of the plans for specific departments or staff groups such as haematology and oncology, fracture liaison and orthogeriatric support, palliative care, paediatrics, endoscopy, and medical students (7 responses)
- clearly communicate with staff quickly about what the impacts will be for them (2 responses)
- consider the impact of travel on staff that may be asked to work across hospitals in both Weston and Bristol (2 responses)
- consider how to cover interdependencies in medical care, such as how to make sure there were enough appropriate staff to address any complications during in inpatient treatment (2 responses)
- be clear about management structures when changing services and the extent to which services at Weston General Hospital will have autonomy (2 responses)

In meetings and emails staff suggested that the following groups should be involved workforce planning to help put the plans into action:

- attending existing meetings of teams across Bristol and Weston, particularly staff who work across both sites and emergency care (4 responses)
- departments such as haematology and oncology (2 responses), staff delivering care for older people (1 response), palliative care (2 responses), therapy (1 response)
- clinical coding (1 response)
- patient representatives, including people with learning disability and autism (1 response)

# 3. What happens next

Healthier Together is continuing to refine the plans for Weston General Hospital.

Towards the end of 2022, Bristol, North Somerset and South Gloucestershire Integrated Care Board will consider the plans. The Integrated Care Board is the organisation that is legally responsible for planning next steps.

If approved, we will begin putting the plans into action from 2023.

We will use people's feedback from this engagement period to shape a communications plan with key messages and approaches to let a wide range of people know what is happening. We will also think about how we can work with partners and explore whether it would be feasible and valuable to include some of the suggestions.

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# Appendix 9 - Healthy Weston 2 Phase 1

# New and Advanced Role Definitions

Date: January 2023

## New and Advanced Role Definitions

Health Education England (HEE), in association with its multi-disciplinary partners, has developed a definition of Advanced Clinical Practice:

- Advanced clinical practice is delivered by experienced, registered health and care practitioners. It is a level of practice characterised by a high degree of autonomy and complex decision making. This is underpinned by a master's level award or equivalent that encompasses the four pillars of clinical practice, leadership and management, education and research, with demonstration of core capabilities and area specific clinical competence.

- Advanced clinical practice embodies the ability to manage clinical care in partnership with individuals, families and carers. It includes the analysis and synthesis of complex problems across a range of settings, enabling innovative solutions to enhance people's experience and improve outcomes.

- The ACP definition has been developed to provide clarity for employers, service leads, education providers and healthcare professionals, as well as potential ACPs practising at an advanced level. This is the first time a common multi-professional definition has been developed which can be applied across professional boundaries and clinical settings. The definition serves to support a consistent title and recognises the increasing use of such roles in England.

- In addition to the ACP role a wide breadth of roles have emerged whereby their scope of practice has been extended and they work at an advanced level in order that they can practice at a higher level of clinical practice and can therefore be used in different ways and be able to undertake duties that might have been carried out by other more senior professionals such as medical staff. Examples of these are Advanced critical care practitioners, Nurse practitioners, Emergency Nurse Practitioners and Non - Medical Consultants.

- A range of new roles have also been developed in response to the ongoing workforce challenge the NHS faces and the struggle to fill more traditional nursing, medical and AHP roles. A new role is defined as; 'Health and care roles designed to meet a defined workforce requirement, warranting new job title; the likely ingredients including additionality to the workforce, a formal education and training requirement (whether vocational or academic), an agreed scope within the established Career Framework, and national recognition (although not necessarily regulatory) by clinical governing bodies.'

- This term includes roles such as the Nurse Associate, Physician Associate and Medical Support Workers.

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# Appendix 10 - Healthy Weston 2 Phase 1

# Finance Summary

Date: January 2023

| | | 2021/22 Baseline Subset | | | ED (In Part) / GEMS / SDEC / AMU (15 Beds) | | OPAU 14 bedded Unit | | Other Posts - Future State | | HW2 Ph1 Impact | 2023/24 | | | 2024/25 | | | 2025/26 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Staff Type / Grade | Funded WTE | In Post WTE | Actual Cost 2021/22 | WTE | £ | WTE | £ | WTE | £ | WTE | WTE | Total Cost | Impact / Cost | WTE | Total 2024/25 | Impact / Cost | WTE | Total 2024/25 | Impact / Cost |
| **Pay** | | | | | | | | | | | | | | | | | | | | |
| **Medical Staff** | | | | | | | | | | | | | | | | | | | | |
| **ED Medical Staff** | Consultant | 9.00 | 1.75 | 297,537 | 3.75 | 484,587 | | | | | 2.00 | 3.75 | 355,364 | 57,827 | 6.62 | 590,873 | 293,336 | 6.62 | 855,457 | 557,920 |
| | Locum consultant | | 5.38 | 714,775 | 5.38 | 714,775 | | | | | 0.00 | 5.38 | 714,775 | 0 | 5.38 | 714,775 | 0 | 5.38 | 714,775 | 0 |
| | Agency consultant | | 2.87 | 908,921 | 2.87 | 908,921 | | | | | 0.00 | 2.87 | 908,921 | 0 | 0.00 | 568,076 | (340,846) | 0.00 | 0 | (908,921) |
| **Subtotal consultants** | | 9.00 | 10.00 | 1,921,234 | 12.00 | 2,108,283 | 0.00 | 0 | 0.00 | 0 | 2.00 | 12.00 | 1,979,060 | 57,827 | 12.00 | 1,873,724 | (47,510) | 12.00 | 1,570,233 | (351,001) |
| | Middle grades | 12.00 | 8.03 | 539,023 | 10.46 | 883,578 | | | | | 2.43 | 10.46 | 793,263 | 254,241 | 10.46 | 1,080,117 | 541,094 | 10.46 | 1,137,417 | 598,394 |
| | Locum Middle grades | | 4.54 | 427,773 | 4.54 | 427,773 | | | | | 0.00 | 4.54 | 424,083 | (3,690) | 4.54 | 208,547 | (219,226) | 4.54 | 0 | (427,773) |
| **Subtotal middle grades** | | 12.00 | 12.57 | 966,796 | 15.00 | 1,311,351 | 0.00 | 0 | 0.00 | 0 | 2.43 | 15.00 | 1,217,346 | 250,550 | 15.00 | 1,288,664 | 321,868 | 15.00 | 1,137,417 | 170,621 |
| | Junior Doctors | 5.00 | 6.24 | 436,448 | 10.00 | 754,196 | | | | | 3.76 | 10.00 | 754,196 | 317,748 | 12.00 | 905,035 | 468,587 | 12.00 | 905,035 | 468,587 |
| | Agency Junior Doctors | | 5.76 | 969,158 | 2.00 | 280,675 | | | | | -3.76 | 2.00 | 280,675 | (688,483) | 0.00 | 0 | (969,158) | 0.00 | 0 | (969,158) |
| **Subtotal junior doctors** | | 5.00 | 12.00 | 1,405,606 | 12.00 | 1,034,871 | 0.00 | 0 | 0.00 | 0 | 0.00 | 12.00 | 1,034,871 | (370,735) | 12.00 | 905,035 | (500,571) | 12.00 | 905,035 | (500,571) |
| | Physician Associate (Band 7) | | 0.00 | 0 | 3.00 | 173,436 | | | | | 3.00 | 3.00 | 57,812 | 57,812 | 3.00 | 173,436 | 173,436 | 3.00 | 173,436 | 173,436 |
| **Subtotal ED Medical Staff** | | 26.00 | 34.57 | 4,293,636 | 42.00 | 4,627,942 | 0.00 | 0 | 0.00 | 0 | 7.43 | 42.00 | 4,289,090 | (4,547) | 42.00 | 4,240,859 | (52,777) | 42.00 | 3,786,121 | (507,516) |
| **GEMS / Frailty Service Medical Staff** | Consultant | 0 | 0.00 | 0 | 2.00 | 258,446 | | | 0.00 | 0 | 2.00 | 2.00 | 150,760 | 150,760 | 2.00 | 258,446 | 258,446 | 2.00 | 258,446 | 258,446 |
| | Associate Specialists | 2.00 | 1.13 | 163,414 | 2.00 | 206,144 | | | 0.00 | 0 | 0.87 | 2.00 | 177,657 | 14,243 | 2.00 | 206,144 | 42,730 | 2.00 | 206,144 | 42,730 |
| **Subtotal GEMS Medical Staff** | | 2.00 | 1.13 | 163,414 | 4.00 | 464,590 | 0.00 | 0 | 0.00 | 0 | 2.87 | 4.00 | 328,418 | 165,004 | 4.00 | 464,590 | 301,176 | 4.00 | 464,590 | 301,176 |
| **AMU/SEDEC Medical Staff** | Consultant | | 1.00 | 200,488 | 3.00 | 387,670 | | | | | 2.00 | 3.00 | 247,678 | 47,190 | 5.00 | 624,579 | 424,091 | 5.00 | 915,331 | 714,843 |
| | Locum Consultant | | 1.00 | 129,223 | 1.00 | 129,223 | | | | | 0.00 | 1.00 | 129,223 | 0 | 1.00 | 129,223 | 0 | 1.00 | 129,223 | 0 |
| | Agency Consultant | | 2.00 | 578,822 | 2.00 | 568,268 | | | | | 0.00 | 2.00 | 568,268 | (10,554) | 0.00 | 378,845 | (199,977) | 0.00 | 0 | (578,822) |
| **Subtotal consultants** | | 0.00 | 4.00 | 908,533 | 6.00 | 1,085,160 | 0.00 | 0 | 0.00 | 0 | 2.00 | 6.00 | 945,169 | 36,636 | 6.00 | 1,132,647 | 224,114 | 6.00 | 1,044,554 | 136,021 |
| | Specialty Doctor | 1.00 | 0.00 | 0 | | | | | | | 0.00 | | | | | | | | | |
| | St 3 To 8 | 3.00 | 3.00 | 203,110 | 5.00 | 422,361 | | | | | 2.00 | 5.00 | 288,613 | 85,503 | 6.00 | 506,833 | 303,722 | 6.00 | 506,833 | 303,722 |
| | Locum Middle Grades | | 0.05 | 56,484 | | | | | | | -0.05 | | 0 | (56,484) | | 0 | (56,484) | | 0 | (56,484) |
| | Agency Middle Grades | | 1.00 | 184,496 | 1.00 | 184,496 | | | | | 0.00 | 1.00 | 184,496 | 0 | 0.00 | 0 | (184,496) | 0.00 | 0 | (184,496) |
| | Other | | 0.00 | 0 | | | | | | | 0.00 | | 0 | 0 | | 0 | 0 | | 0 | 0 |
| **Subtotal middle grades** | | 4.00 | 4.05 | 444,090 | 6.00 | 606,857 | 0.00 | 0 | 0.00 | 0 | 1.95 | 6.00 | 473,109 | 29,019 | 6.00 | 506,833 | 62,743 | 6.00 | 506,833 | 62,743 |
| | Junior Doctors | | 0.00 | 61,259 | | | | | | 0 | 0.00 | | 0 | (61,259) | | 0 | (61,259) | | 0 | (61,259) |
| | Physician Associate (Band 7) | 1.69 | 1.60 | 100,964 | | | | | 1.69 | 100,964 | 0.09 | 1.69 | 100,964 | () | 1.69 | 100,964 | () | 1.69 | 100,964 | () |
| **Subtotal AMU/SEDEC Medical Staff** | | 5.69 | 9.65 | 1,514,846 | 12.00 | 1,692,017 | 0.00 | 0 | 1.69 | 100,964 | 4.04 | 13.69 | 1,519,242 | 4,396 | 13.69 | 1,740,444 | 225,598 | 13.69 | 1,652,350 | 137,505 |
| **Older Persons Assessmer** | Consultant | | 0.00 | 0 | | | 2.75 | 355,535 | | | 2.75 | 1.75 | 43,074 | 43,074 | 2.75 | 269,272 | 269,272 | 2.75 | 355,535 | 355,535 |
| | St 3 To 8 | 1.00 | 1.00 | 64,662 | | | 1.00 | 64,662 | | | 0.00 | 1.00 | 64,662 | 0 | 1.00 | 64,662 | 0 | 1.00 | 64,662 | 0 |
| | Mid point between FY2 and STA2 | 3.00 | 3.00 | 184,522 | | | 3.00 | 184,522 | | | 0.00 | 3.00 | 184,522 | 0 | 3.00 | 184,522 | 0 | 3.00 | 184,522 | 0 |
| **Subtotal OPAU Medical Staff** | | 4.00 | 4.00 | 249,184 | 0.00 | 0 | 6.75 | 604,719 | 0.00 | 0 | 2.75 | 5.75 | 292,258 | 43,074 | 6.75 | 518,456 | 269,272 | 6.75 | 604,719 | 355,535 |
| **Radiology Medical Staff** | Consultant and Specialty Doctor | 0.69 | 0.69 | 98,058 | 2.93 | 379,236 | | | | | 2.24 | 1.69 | 138,168 | 40,110 | 2.93 | 272,003 | 173,945 | 2.93 | 379,236 | 281,179 |
| **Subtotal Medical Staff** | | 38.38 | 50.04 | 6,319,138 | 60.93 | 7,163,786 | 6.75 | 604,719 | 1.69 | 100,964 | 19.34 | 67.13 | 6,567,175 | 248,037 | 69.37 | 7,236,352 | 917,214 | 69.37 | 6,887,017 | 567,878 |

| | | 2021/22 Baseline Subset | | | ED (In Part) / GEMS / SDEC / AMU (15 Beds) | | OPAU 14 bedded Unit | | Other Posts - Future State | | HW2 Ph1 Impact | 2023/24 | | | 2024/25 | | | 2025/26 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Staff Type / Grade | Funded WTE | In Post WTE | Actual Cost 2021/22 | WTE | £ | WTE | £ | WTE | £ | WTE | WTE | Total Cost | Impact / Cost | WTE | Total 2024/25 | Impact / Cost | WTE | Total 2024/25 | Impact / Cost |
| **Nursing Staff** | | | | | | | | | | | | | | | | | | | | |
| **GEMS / Frailty Service** | Nurse Band 2 | | 0.00 | 0 | 0.00 | 0 | | | | | 0.00 | 0.00 | 0 | 0 | | 0 | 0 | | 0 | 0 |
| | Nurse Band 3 | | 0.00 | 0 | 2.48 | 83,053 | | | | | 2.48 | 2.48 | 38,088 | 38,088 | 2.48 | 83,063 | 83,063 | 2.48 | 83,063 | 83,063 |
| | Nurse Band 5 | 1.00 | 1.00 | 28,048 | 4.97 | 205,262 | | | | | 3.97 | 4.97 | 80,427 | 52,379 | 4.97 | 205,262 | 177,214 | 4.97 | 205,262 | 177,214 |
| | Band 6 PEF | | 0.00 | 0 | 1.00 | 44,671 | | | | | 1.00 | 1.00 | 26,058 | 26,058 | 1.00 | 44,671 | 44,671 | 1.00 | 44,671 | 44,671 |
| | Nurse Band 7 | 1.00 | 1.00 | 11,501 | 1.69 | 106,214 | | | | | 0.69 | 1.69 | 88,145 | 76,644 | 1.69 | 106,214 | 94,713 | 1.69 | 106,214 | 94,713 |
| | Nurse Band 8a (Matron) | 1.00 | 1.00 | 51,426 | 1.00 | 62,065 | | | | | 0.00 | 1.00 | 62,065 | 10,639 | 1.00 | 62,065 | 10,639 | 1.00 | 62,065 | 10,639 |
| | Nurse - Bank and Overtime | | 0.00 | 211 | 0.00 | 0 | | | | | 0.00 | 0.00 | 0 | (211) | 0.00 | 0 | (211) | 0.00 | 0 | (211) |
| | Advanced Care Practioners (ACPs) | 1.00 | 1.00 | 59,206 | 1.00 | 62,065 | | | | | 0.00 | 1.00 | 62,065 | 2,860 | 1.00 | 62,065 | 2,860 | 1.00 | 62,065 | 2,860 |
| **Subtotal GEMS/Frailty Service** | | **4.00** | **4.00** | **160,381** | **12.14** | **683,330** | **0.00** | **0** | **0.00** | **0** | **8.14** | **12.14** | **356,828** | **206,436** | **12.14** | **683,330** | **412,939** | **12.14** | **683,330** | **412,939** |
| **Same Day Emergency Care (SDEC)** | Agency Nursing & Midwifery | | 0.00 | 1,046 | | | | | | | 0.00 | 0.00 | 0 | (1,046) | 0.00 | 0 | (1,046) | 0.00 | 0 | (1,046) |
| | A&C Coordinator Band 2 | | 0.87 | 22,047 | 2.05 | 64,608 | | | | | 1.18 | 2.05 | 49,113 | 27,066 | 2.05 | 64,608 | 42,561 | 2.05 | 64,608 | 42,561 |
| | Nurse Band 2 | | 0.00 | 329 | 0.00 | 0 | | | | | 0.00 | 0.00 | 0 | (329) | 0.00 | 0 | (329) | 0.00 | 0 | (329) |
| | Nurse Band 3 | | 0.00 | 0 | 2.48 | 86,780 | | | | | 2.48 | 2.48 | 33,476 | 33,476 | 2.48 | 86,780 | 86,780 | 2.48 | 86,780 | 86,780 |
| | Nurse Band 4 | 2.17 | 1.96 | 67,208 | 0.00 | 0 | | | | | -1.96 | 0.00 | 0 | (67,208) | 0.00 | 0 | (67,208) | 0.00 | 0 | (67,208) |
| | Nurse Band 5 | 2.47 | 1.47 | 63,212 | 4.95 | 208,351 | | | | | 3.48 | 4.95 | 105,849 | 42,437 | 4.95 | 208,351 | 145,139 | 4.95 | 208,351 | 145,139 |
| | Nurse Band 6 | 0.81 | 0.81 | 39,133 | 2.48 | 130,436 | | | | | 1.67 | 2.48 | 85,029 | 45,896 | 2.48 | 130,436 | 91,303 | 2.48 | 130,436 | 91,303 |
| | Nurse Band 7 | | 0.00 | 0 | 1.00 | 55,329 | | | | | 1.00 | 1.00 | 18,443 | 18,443 | 1.00 | 55,329 | 55,329 | 1.00 | 55,329 | 55,329 |
| | Nurse - Bank and Overtime | | 0.47 | 19,140 | | | | | | | -0.47 | 0.00 | 0 | (19,140) | 0.00 | 0 | (19,140) | 0.00 | 0 | (19,140) |
| **Subtotal Same Day Emergency Care (SDEC)** | | **5.45** | **5.58** | **212,116** | **12.96** | **645,504** | **0.00** | **0** | **0.00** | **0** | **7.38** | **12.96** | **291,709** | **79,584** | **12.96** | **645,504** | **333,389** | **12.96** | **645,504** | **333,389** |
| **Acute Medical Assessment Unit (AMU)** | Agency Nursing | | 0.38 | 131,858 | | | | | | | -0.38 | 0.00 | 0 | (131,858) | 0.00 | 0 | (131,858) | 0.00 | 0 | (131,858) |
| | A&C Band 2 | 3.00 | 1.43 | 42,903 | 2.05 | 64,608 | | | | | 0.62 | 2.05 | 68,488 | 13,583 | 2.05 | 64,608 | 21,706 | 2.05 | 64,608 | 21,706 |
| | Nurse Band 2 | 11.68 | 8.29 | 257,067 | | | | | | | -8.29 | 0.00 | 0 | (257,067) | 0.00 | 0 | (257,067) | 0.00 | 0 | (257,067) |
| | Nurse Band 3 | | 1.00 | 14,088 | 9.94 | 370,971 | | | | | 8.94 | 9.94 | 348,734 | 334,646 | 9.94 | 370,971 | 358,883 | 9.94 | 370,971 | 358,883 |
| | Nurse Band 4 | | 2.00 | 23,483 | | | | | | | -2.00 | 0.00 | 0 | (23,483) | 0.00 | 0 | (23,483) | 0.00 | 0 | (23,483) |
| | Nurse Band 5 | 12.64 | 8.83 | 388,075 | 10.15 | 461,365 | | | | | 1.32 | 10.15 | 436,385 | 48,290 | 10.15 | 461,386 | 73,290 | 10.15 | 461,386 | 73,290 |
| | Nurse Band 6 | 2.60 | 4.80 | 236,400 | 4.97 | 276,881 | | | | | 0.17 | 4.97 | 270,687 | 34,187 | 4.97 | 276,881 | 40,481 | 4.97 | 276,881 | 40,481 |
| | Nurse Band 7 | 1.00 | 1.00 | 49,829 | 1.00 | 55,329 | | | | | 0.00 | 1.00 | 55,329 | 5,500 | 1.00 | 55,329 | 5,500 | 1.00 | 55,329 | 5,500 |
| | Nurse Band 8a - ACPs | | 0.00 | 0 | 2.48 | 172,615 | | | | | 2.48 | 2.48 | 67,538 | 67,538 | 2.48 | 172,616 | 172,616 | 2.48 | 172,616 | 172,616 |
| | Nurse Band 8a (Matron) | 0.00 | 0.00 | 0 | 0.00 | 0 | | | | | 0.00 | 0.00 | 0 | 0 | 0.00 | 0 | 0 | 0.00 | 0 | 0 |
| | Nurse - Bank and Overtime | 0.72 | 4.79 | 224,345 | | | | | | | -4.79 | 0.00 | 0 | (224,345) | 0.00 | 0 | (224,345) | 0.00 | 0 | (224,345) |
| **Subtotal Acute Monitoring Unit (AMU)** | | **31.84** | **32.52** | **1,388,048** | **30.58** | **1,401,788** | **0.00** | **0** | **0.00** | **0** | **-1.93** | **30.58** | **1,226,000** | **(143,048)** | **30.58** | **1,401,788** | **33,721** | **30.58** | **1,401,788** | **33,721** |
| **Older Persons Assessment Unit (OPAU)** | Agency Nursing & Midwifery | | 1.29 | 213,446 | | | | | 1.29 | 213,446 | 0.00 | 1.29 | 213,448 | 0 | 1.29 | 213,448 | 0 | 1.29 | 213,448 | 0 |
| | A&C Band 2 | 0.00 | 1.71 | 41,744 | | | 2.05 | 64,608 | | | 0.34 | 2.05 | 57,484 | 16,721 | 2.05 | 64,608 | 22,886 | 2.05 | 64,608 | 22,886 |
| | Nurse Band 2 | 17.58 | 17.10 | 540,832 | | | | | 7.16 | 169,861 | -9.94 | 7.16 | 169,861 | (370,971) | 7.16 | 169,861 | (370,971) | 7.16 | 169,861 | (370,971) |
| | Nurse Band 3 | | 0.00 | 0 | | | 9.94 | 370,971 | 0.00 | 0 | 9.94 | 9.94 | 370,971 | 370,971 | 9.94 | 370,971 | 370,971 | 9.94 | 370,971 | 370,971 |
| | Nurse Band 4 | | 2.00 | 57,511 | | | 0.00 | 0 | 2.00 | 57,511 | 0.00 | 2.00 | 57,511 | 0 | 2.00 | 57,511 | 0 | 2.00 | 57,511 | 0 |
| | Nurse Band 5 | 20.07 | 14.20 | 452,269 | | | 9.94 | 461,365 | 4.26 | (9,096) | 0.00 | 14.20 | 452,269 | 0 | 14.20 | 452,269 | 0 | 14.20 | 452,269 | 0 |
| | Nurse Band 6 | 2.60 | 4.53 | 181,171 | | | 5.18 | 276,881 | -0.65 | (95,710) | 0.00 | 4.53 | 181,171 | 0 | 4.53 | 181,171 | 0 | 4.53 | 181,171 | 0 |
| | Nurse Band 7 | 1.00 | 0.92 | 55,084 | | | 1.00 | 55,329 | 0.00 | 0 | 0.08 | 1.00 | 55,329 | 245 | 1.00 | 55,329 | 245 | 1.00 | 55,329 | 245 |
| | Nurse Band 8a - ACPs | 0.00 | 0.00 | 711 | | | 2.48 | 172,615 | 0.00 | 0 | 2.48 | 2.48 | 67,538 | 68,827 | 2.48 | 172,616 | 171,904 | 2.48 | 172,616 | 171,904 |
| | Nurse Band 8a (Matron) | 0.00 | 0.00 | 0 | | | 0.00 | 0 | 0.00 | 0 | 0.00 | 0.00 | 0 | 0 | 0.00 | 0 | 0 | 0.00 | 0 | 0 |
| | Nurse - Bank and Overtime | 1.06 | 4.94 | 273,751 | | | | | 4.94 | 273,751 | 0.00 | 4.94 | 273,751 | 0 | 4.94 | 273,761 | 0 | 4.94 | 273,761 | 0 |
| **Subtotal Older Persons Assessment Unit (OPAU)** | | **42.31** | **48.89** | **1,816,518** | **0.00** | **0** | **30.58** | **1,401,788** | **19.00** | **608,782** | **2.90** | **48.58** | **1,889,311** | **72,793** | **48.58** | **2,011,531** | **195,013** | **48.58** | **2,011,531** | **195,013** |
| **Subtotal Nursing Staff** | | **83.40** | **88.79** | **3,647,072** | **55.68** | **2,510,603** | **30.58** | **1,401,788** | **19.00** | **608,782** | **18.48** | **106.28** | **3,762,845** | **215,773** | **106.28** | **4,622,134** | **976,062** | **106.28** | **4,622,134** | **976,062** |

| | | 2021/22 Baseline Subset | | | ED (In Part) / GEMS / SDEC / AMU (15 Beds) | | OPAU 14 bedded Unit | | Other Posts - Future State | | HW2 Ph1 Impact | 2023/24 | | | 2024/25 | | | 2025/26 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Staff Type / Grade | Funded WTE | In Post WTE | Actual Cost 2021/22 | WTE | £ | WTE | £ | WTE | £ | WTE | WTE | Total Cost | Impact / Cost | WTE | Total 2024/25 | Impact / Cost | WTE | Total 2024/25 | Impact / Cost |
| Pharmacy Staff | Band 6 - Frailty and ED Lead Pharmacy Techn | 0.00 | 0.00 | 0 | 1.00 | 44,671 | | | | | 1.00 | 1.00 | 26,058 | 26,058 | 1.00 | 44,671 | 44,671 | 1.00 | 44,671 | 44,671 |
| | Band 7 - Specialist frailty and ED pharmacist | 0.00 | 0.00 | 0 | 1.00 | 55,328 | | | | | 1.00 | 1.00 | 4,611 | 4,611 | 1.00 | 55,328 | 55,328 | 1.00 | 55,328 | 55,328 |
| | Band 8a - Lead frailty and ED Pharm | 1.00 | 1.00 | 62,065 | 1.00 | 62,065 | | | | | 0.00 | 1.00 | 62,065 | 0 | 1.00 | 62,065 | 0 | 1.00 | 62,065 | 0 |
| | Band 8b - Care of Elderly Pharmacist | 0.00 | 0.00 | 0 | 1.00 | 72,347 | | | | | 1.00 | 1.00 | 24,116 | 24,116 | 1.00 | 72,347 | 72,347 | 1.00 | 72,347 | 72,347 |
| Subtotal Pharmacy | | 1.00 | 1.00 | 62,065 | 4.00 | 234,410 | 0.00 | 0 | 0.00 | 0 | 3.00 | 4.00 | 116,849 | 54,784 | 4.00 | 234,410 | 172,345 | 4.00 | 234,410 | 172,345 |
| Occupational (OT) / Physiotherapy (PT) Staff | Occupational Therapist Band 5 | 0.00 | 0.00 | 0 | 1.00 | 38,037 | | | 0.00 | 0 | 1.00 | 1.00 | 22,188 | 22,188 | 1.00 | 38,037 | 38,037 | 1.00 | 38,037 | 38,037 |
| | Occupational Therapist Band 6 | 0.00 | 0.00 | 0 | 1.00 | 46,682 | 1.20 | 56,018 | 0.00 | 0 | 2.20 | 2.20 | 59,909 | 59,909 | 2.20 | 102,700 | 102,700 | 2.20 | 102,700 | 102,700 |
| | Occupational Therapist Band 7 | 0.00 | 0.00 | 0 | 1.00 | 57,812 | | | 0.00 | 0 | 1.00 | 1.00 | 33,724 | 33,724 | 1.00 | 57,812 | 57,812 | 1.00 | 57,812 | 57,812 |
| | Physiotherapist Band 4 | 0.00 | 0.00 | 0 | | | 0.80 | 27,291 | 0.00 | 0 | 0.80 | 0.80 | 15,919 | 15,919 | 0.80 | 27,291 | 27,291 | 0.80 | 27,291 | 27,291 |
| | Physiotherapist Band 5 | 0.00 | 0.00 | 0 | 1.00 | 38,037 | 1.00 | 38,037 | 0.00 | 0 | 2.00 | 2.00 | 44,377 | 44,377 | 2.00 | 76,074 | 76,074 | 2.00 | 76,074 | 76,074 |
| | Physiotherapist Band 6 | 0.00 | 0.00 | 0 | 2.00 | 93,364 | 1.50 | 70,023 | 0.00 | 0 | 3.50 | 3.50 | 95,309 | 95,309 | 3.50 | 163,387 | 163,387 | 3.50 | 163,387 | 163,387 |
| | Physiotherapist Band 7 | 0.00 | 0.00 | 0 | 1.00 | 57,812 | 0.50 | 28,906 | 0.00 | 0 | 1.50 | 1.50 | 50,585 | 50,585 | 1.50 | 86,718 | 86,718 | 1.50 | 86,718 | 86,718 |
| | Physiotherapist Band 8a | 0.00 | 0.00 | 0 | 0.22 | 14,123 | 0.10 | 6,420 | 0.00 | 0 | 0.32 | 0.32 | 20,542 | 20,542 | 0.32 | 20,542 | 20,542 | 0.32 | 20,542 | 20,542 |
| | Physiotherapist Band 8b | 0.00 | 0.00 | 0 | 0.12 | 8,682 | 0.08 | 5,788 | 0.00 | 0 | 0.20 | 0.20 | 14,469 | 14,469 | 0.20 | 14,469 | 14,469 | 0.20 | 14,469 | 14,469 |
| Subtotal Occupational Therapy and Physiotherapy | | 0.00 | 0.00 | 0 | 7.34 | 354,548 | 5.18 | 232,482 | 0.00 | 0 | 12.52 | 12.52 | 357,023 | 357,023 | 12.52 | 587,031 | 587,031 | 12.52 | 587,031 | 587,031 |
| Dietetics / Speech & Language Therapy (SLT) Staff | Dietician Band 4 Assistant | | 0.00 | 0 | 0.44 | 15,010 | | | 0.00 | 0 | 0.44 | 0.44 | 8,756 | 8,756 | 0.44 | 15,010 | 15,010 | 0.44 | 15,010 | 15,010 |
| | Dietician Band 6 | | 0.00 | 0 | 0.80 | 37,346 | 0.64 | 29,876 | 0.00 | 0 | 1.44 | 1.44 | 39,213 | 39,213 | 1.44 | 67,222 | 67,222 | 1.44 | 67,222 | 67,222 |
| | Dietician Band 7 - Team Lead | | 0.00 | 0 | 0.80 | 46,250 | | | 0.00 | 0 | 0.80 | 0.80 | 26,979 | 26,979 | 0.80 | 46,250 | 46,250 | 0.80 | 46,250 | 46,250 |
| | Dietician Band 8a - Pathway Lead | | 0.00 | 0 | 0.20 | 12,839 | | | 0.00 | 0 | 0.20 | 0.20 | 7,489 | 7,489 | 0.20 | 12,839 | 12,839 | 0.20 | 12,839 | 12,839 |
| | Speech Therapist Band 4 Assistant | | 0.00 | 0 | 0.44 | 15,010 | | | 0.00 | 0 | 0.44 | 0.44 | 8,756 | 8,756 | 0.44 | 15,010 | 15,010 | 0.44 | 15,010 | 15,010 |
| | Speech Therapist Band 6 | | 0.00 | 0 | 0.80 | 37,346 | 0.64 | 29,876 | 0.00 | 0 | 1.44 | 1.44 | 39,213 | 39,213 | 1.44 | 67,222 | 67,222 | 1.44 | 67,222 | 67,222 |
| | Dietician Band 7 - Team Lead | | 0.00 | 0 | 0.80 | 46,250 | | | 0.00 | 0 | 0.80 | 0.80 | 26,979 | 26,979 | 0.80 | 46,250 | 46,250 | 0.80 | 46,250 | 46,250 |
| | Dietician Band 8a - Pathway Lead | | 0.00 | 0 | 0.20 | 12,839 | | | 0.00 | 0 | 0.20 | 0.20 | 7,489 | 7,489 | 0.20 | 12,839 | 12,839 | 0.20 | 12,839 | 12,839 |
| Subtotal - Dietetics / Speech & Language Therapy (SLT) Staff | | 0.00 | 0.00 | 0 | 4.48 | 222,888 | 1.28 | 59,753 | 0.00 | 0 | 5.76 | 5.76 | 164,874 | 164,874 | 5.76 | 282,641 | 282,641 | 5.76 | 282,641 | 282,641 |
| Diagnostic Staff | Plain film imaging radiographers- Band 5 | 0.56 | 0.56 | 28,318 | 3.94 | 175,776 | | | | | 3.38 | 3.94 | 112,946 | 84,628 | 3.94 | 175,776 | 147,458 | 3.94 | 175,776 | 147,458 |
| | CT&MRI Radiographers - Band 6 | 1.55 | 1.55 | 75,563 | 10.99 | 543,748 | | | | | 9.44 | 10.99 | 365,675 | 290,112 | 10.99 | 543,748 | 468,185 | 10.99 | 543,748 | 468,185 |
| | Ultrasongraphers - Band 7 | 0.12 | 0.12 | 7,435 | 0.12 | 7,435 | | | | | 0.00 | 0.12 | 7,435 | 0 | 0.12 | 7,435 | 0 | 0.12 | 7,435 | 0 |
| | Healthcare support workers - Band 3 | 0.83 | 0.83 | 26,621 | 5.43 | 190,277 | | | | | 4.60 | 5.43 | 101,916 | 75,295 | 5.43 | 190,277 | 163,656 | 5.43 | 190,277 | 163,656 |
| | Reception staff - Band 3 | 0.06 | 0.06 | 1,872 | 1.55 | 57,499 | | | | | 1.49 | 1.55 | 34,409 | 32,537 | 1.55 | 57,499 | 55,627 | 1.55 | 57,499 | 55,627 |
| Subtotal Diagnostic Staff | | 3.11 | 3.11 | 139,809 | 22.02 | 974,735 | 0.00 | 0 | 0.00 | 0 | 18.91 | 22.02 | 622,381 | 482,571 | 22.02 | 974,735 | 834,926 | 22.02 | 974,735 | 834,926 |
| Subtotal Pharmacy, Therapies and Diagnostics Staff | | 4.11 | 4.11 | 201,874 | 37.84 | 1,786,582 | 6.46 | 292,235 | 0.00 | 0 | 40.19 | 44.30 | 1,261,126 | 1,059,252 | 44.30 | 2,078,817 | 1,876,943 | 44.30 | 2,078,817 | 1,876,943 |
| Total Pay | | 125.89 | 142.94 | 10,068,085 | 154.47 | 11,460,971 | 43.80 | 2,298,723 | 20.69 | 710,726 | 76.02 | 216.72 | 11,591,147 | 1,523,062 | 218.96 | 13,837,304 | 3,769,219 | 218.96 | 13,487,968 | 3,419,884 |

| | 2021/22 Baseline Subset | | | ED (In Part) / GEMS / SDEC / AMU (15 Beds) | | OPAU 14 bedded Unit | | Other Posts - Future State | | HW2 Ph1 Impact | 2023/24 | | | 2024/25 | | | 2025/26 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Staff Type / Grade | Funded WTE | In Post WTE | Actual Cost 2021/22 | WTE | £ | WTE | £ | WTE | £ | WTE | WTE | Total Cost | Impact / Cost | WTE | Total 2024/25 | Impact / Cost | WTE | Total 2024/25 | Impact / Cost |
| **Non Pay** | | | | | | | | | | | | | | | | | | | |
| **Nonpay** | | | | | | | | | | | | | | | | | | | |
| Clinical Supplies & Services | | | 115,118 | | 167,669 | | | | | | | 167,669 | 52,551 | | 167,669 | 52,551 | | 167,669 | 52,551 |
| Drugs and Blood Expenditure | | | 246,116 | | 295,092 | | | | | | | 295,092 | 48,976 | | 295,092 | 48,976 | | 295,092 | 48,976 |
| Establishment Expenses | | | 1,798 | | 5,579 | | | | | | | 5,579 | 3,781 | | 5,579 | 3,781 | | 5,579 | 3,781 |
| General Supplies & Services | | | 19,863 | | 23,747 | | | | | | | 23,747 | 3,885 | | 23,747 | 3,885 | | 23,747 | 3,885 |
| Other Expenditure | | | 16,355 | | 44,761 | | | | | | | 44,761 | 28,407 | | 44,761 | 28,407 | | 44,761 | 28,407 |
| Premises And Fixed Plant | | | 9,627 | | 16,688 | | | | | | | 16,688 | 7,061 | | 16,688 | 7,061 | | 16,688 | 7,061 |
| | | | | | | | | | | | | 0 | 0 | | 0 | 0 | | 0 | 0 |
| D&T Outsourcing Costs | | | 0 | | 214,500 | | | | | | | 214,500 | 214,500 | | 214,500 | 214,500 | | 214,500 | 214,500 |
| **Subtotal Nonpay** | | | 408,878 | | 768,037 | | | | | | | 768,037 | 359,159 | | 768,037 | 359,159 | | 768,037 | 359,159 |
| Facilities management costs | | | | | | | | | | | | | | | | | | | |
| Soft FM Costs | | | 25,160 | | 28,660 | | | | | | | 28,660 | 3,500 | | 28,660 | 3,500 | | 28,660 | 3,500 |
| Hard FM Costs | | | | | | | | | | | | 0 | 0 | | 0 | 0 | | 0 | 0 |
| Capital Charges | | | | | 15,426 | | | | | | | 19,505 | 19,505 | | 19,505 | 19,505 | | 19,505 | 19,505 |
| **Total Cost HW2 Ph1** | 125.89 | 142.94 | 10,502,122 | 154.47 | 12,273,094 | 43.80 | 2,298,723 | 20.69 | 710,726 | 76.02 | 216.72 | 12,407,349 | 1,905,227 | 218.96 | 14,653,506 | 4,151,384 | 218.96 | 14,304,170 | 3,802,048 |
| **Non Recurring Costs** | | | | | | | | | | | | | | | | | | | |
| Project Management Costs | | | | | | | | | | | | 73,445 | 73,445 | | 0 | 0 | | | 0 |
| Recruitment Costs | | | | | | | | | | | | 542,949 | 542,949 | | 392,949 | 392,949 | | | 0 |
| **Subtotal non recurring costs** | | | | | | | | | | | | 616,394 | 616,394 | | 392,949 | 392,949 | | 0 | 0 |
| **Estimated Ph1 benefits of Front Door Enhancements** | | | | | | | | | | | | | | | | | | | |
| Phase 1 benefits of front door investments due to reduced bed escalation costs | | | | | | | | | | | | 0 | 0 | | (289,776) | (289,776) | | (1,159,103) | (1,159,103) |
| **Total Net Impact cost / (saving)** | 125.89 | 142.94 | 10,502,122 | 154.47 | 12,273,094 | 43.80 | 2,298,723 | 20.69 | 710,726 | 76.02 | 216.72 | 13,023,743 | 2,521,621 | 218.96 | 14,756,679 | 4,254,557 | 218.96 | 13,145,067 | 2,642,945 |

Healthier Together

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

# Appendix 11 - Healthy Weston 2 Phase 1

# Implementation Plan

Date: January 2023

# Healthy Weston 2 Phase 1 Implementation Plan

This implementation plan outlines the delivery arrangements for the Healthy Weston 2 Phase 1 service enhancements:

1. Same Day Emergency Care (SDEC)
2. Expansion of Geriatric Emergency Medicine Service (GEMS)
3. Acute Monitoring Unit (AMU)
4. Older People's Assessment Unit (OPAU)

Whilst SDEC and OPAU are provided on the University Hospitals Bristol and Weston NHS Foundation Trust's (UHBW) Bristol site, they will be new services at Weston General Hospital. GEMS and AMU (currently known as Medical Assessment Unit MAU) are existing services at Weston General Hospital, with plans to expand and enhance the existing models of care.

Implementation of the service enhancements will commence from April 2023, following system approval of, and investment in the Phase 1 Full Business Case, and the successful implementation of the Phase 1 pilots through winter plan investment. Implementation will start with the phased delivery of the front door enhancements (GEMS, SDEC and AMU), with OPAU delivery following once sufficient bed capacity has been released, around January 2024.

The strategic timeline, including the required governance for implementation of the Phase 1 clinical model, is presented below. The timeline also highlights that the Phase 1 clinical model will be fully implemented by April 2024, with recruitment to fill existing vacancies with substantive posts ongoing until March 2025.

*Table 1 – Healthy Weston 2 Phase 1 strategic timeline*

| | **22/23** | **23/24** | | | | **24/25** | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 |
| System Governance and sign off - Phase 1 Full Business Case | | | | | | | | | |
| Inclusion of transitional investment in 22/23 operational planning | | | | | | | | | |
| ED, AMU, SDEC & GEMS workforce recruitment to future model | Medical recruitment to commence from Jan 2023 (subject to approval) | Nursing, Therapies, Pharmacy & Diagnostic recruitment to commence | | | Majority of workforce recruited by Q4 23/24 | | | Future workforce recruitment complete | |
| Phased implementation of front door enhancements - AMU, SDEC, GEMS | | | | | | | | | |
| OPAU recruitment | | | | | | | | | |
| OPAU implementation | | | | | | | | | |
| Recruitment to existing vacancies | | | | | | | | | |

The following operational milestones and enablers are identified in table 2 below:

*Table 2 – Operational milestones and enablers*

| Plan/service area | Indicative timeline for implementation | Date |
|---|---|---|
| **Expansion of Geriatric Emergency Medicine Service (GEMS)** | - Recruitment process commences for new medical roles | Jan 2023 |
| | - Recruitment process commences for new therapies, nursing, diagnostics, and pharmacy roles | April 2023 |
| | - Commence alignment of operating policies and planning for workforce integration | Feb 2023 |
| | - Preparation for changes to workforce rotas | March 2023 |
| | - Admission pathways established and implemented | April 2023 |
| | - New service model commences (go live) | April 2023 |
| | - New service model fully operationalised | April 2024 |
| **Delivery of Same Day Emergency Care (SDEC)** | - Recruitment process commences for new medical roles | Jan 2023 |
| | - Recruitment process commences for new therapies, nursing, diagnostics, and pharmacy roles | April 2023 |
| | - Minor estates alterations to create office space | April 2023 |
| | - Commence alignment of operating policies and planning for workforce integration | Feb 2023 |
| | - Preparation for changes workforce rotas and establishment of new workforce | March 2023 |
| | - Admission pathways established and implemented | April 2023 |
| | - New Service Model commences (go live) | April 2023 |
| | - New service model fully operationalised | April 2024 |
| **Delivery of the Acute Monitoring Unit (AMU)** | - Recruitment process commences for new roles | Jan 2023 |
| | - Recruitment process commences for new therapies, nursing, diagnostics, and pharmacy roles | April 2023 |
| | - Commence alignment of operating policies and planning for workforce integration | Feb 2023 |
| | - Preparation for changes to workforce rotas | March 2023 |
| | - Admission pathways established and implemented | April 2023 |
| | - New service model commences (go live) | April 2023 |
| | - New service model fully operationalised | April 2024 |
| **Delivery of the Older People's Assessment Unit (OPAU)** | - Recruitment process commences for new roles | July 2023 |
| | - Commence alignment of operating policies and planning for workforce integration | Nov 2023 |
| | - Preparation for changes to workforce rotas | Dec 2023 |
| | - Admission pathways established and implemented | Dec 2023 |
| | - Estates arrangements in Sandford ward established | Dec 2023 |
| | - New service model commences (go live) | Jan 2024 |
| | - New service model fully operationalised | April 2024 |
| **Emergency Department (ED)** | - Recruitment process commences for new medical roles | Jan 2023 |
| | - Recruitment process commences for new therapies, nursing, diagnostics, and pharmacy roles | April 2023 |
| | - Commence alignment of operating policies and planning for workforce integration | Feb 2023 |
| | - Preparation for changes to workforce rotas | March 2023 |
| | - New service model commences (go live) | April 2023 |
| **Recruitment of substantive workforce to replace agency and bank roles** | - Recruitment process commences to fill existing vacancies | April 2023 |
| | - Full substantive workforce achieved | April 2025 |

| | | |
|---|---|---|
| **Outcomes and Benefits** | - Increase of 2 non-frail patients a day seen and discharged through SDEC pathways<br>- Increase of 1 frail patient per day seen and discharged through GEMS SDEC pathways<br>- Increase of 10 patients per admitted and treated through Short Stay Units<br>- Net release of 27 inpatient beds<br>- Cost savings through reduced bank and agency staff commence | April 2024<br><br>April 2024<br><br>April 2024<br><br>From Oct 2024<br>Phased from April 2023 |

## Recruitment

The Healthy Weston 2 Phase 1 recruitment plan outlines the key work-streams to create a strategy and comprehensive action plan for the recruitment to the Phase 1 clinical model and the reduction of the underlying vacancy position at Weston. The plan recommends that recruitment for medical roles should commence in January 2023, subject to authorisation to recruit to posts.

The majority of the recruitment to the additional posts in the future model will take place over the initial 12 months of the project (2023/2024). The focus will be on recruiting substantively to the new posts, whilst maintaining the existing temporary workforce until these posts are filled. This approach will ensure that the focus is on getting the service enhancements up and running as quickly as possible. During this period, it will be accepted that there is an ongoing cost of agency fill. See table 3 below (recruitment plan to future model).

In the following year (2024/2025) the recruitment efforts will be on addressing the underlying vacancy position currently covered by bank and agency staff, and the vacancies created as a result of the internal promotions in year 1. The conversion of the temporary arrangements into substantive posts will result in a cost saving. This will only apply to medical posts as the other staff groups will recruit substantively to the additional HW2 posts in the first year. See table 4 (recruitment to existing vacancies)

## *Table 3 – Recruitment plan to future model*

| | | | | Staff in post - 2023/2024 | | | | 2024/2025 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | RAG | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 |
| **Front Door Services** | | | | | | | | | | | |
| **Staff** | **Band** | **WTE** | | | | | | | | | |
| **Medical Staff** | | | | | | | | | | | |
| **ED** | | | | | | | | | | | |
| Consultant | Consultant | 2 | A | | 1 | | 1 | | | | |
| Middle Grade | ST3+ | 2.43 | A | | 1 | 1 | 0.43 | | | | |
| Physician Associate | Band 7 | 3 | A | | 1 | 1 | 1 | | | | |
| **Frailty Service (GEMS) including cover for Frailty SDEC** | | | | | | | | | | | |
| Consultant | Consultant | 2 | A | 1 | | 1 | | | | | |
| Specialist Grade Doctors | Specialist grade | 0.87 | A | | | 0.87 | | | | | |
| **Ambulatory Emergency Care (AEC) / AMU** | | | | | | | | | | | |
| Consultant | Consultant | 2 | A | | 1 | | 1 | | | | |
| Middle Grade | ST3+ | 2 | A | | | 1 | 1 | | | | |
| **Pharmacy** | | | | | | | | | | | |
| Pharmacy Technician | Band 6 | 1 | A | | 1 | | | | | | |
| Pharmacist (development role B6/7) | Band 7 | 1 | A | | | | 1 | | | | |
| Consultant Pharmacist | Band 8b | 1 | A | | | 1 | | | | | |
| **Radiology** | | | | | | | | | | | |
| Consultants | Consultant | 2.24 | A | | | 1 | | | | 1.24 | |
| Admin & Clerical | Band 3 | 1.49 | A | 1 | 0.49 | | | | | | |
| Radiographic Assistants | Band 3 | 4.6 | A | 2 | 2.6 | | | | | | |
| Radiographer | Band 5 | 3.38 | A | | 2 | 1.38 | | | | | |
| MRI/CT Radiographer | Band 6 | 9.44 | A | | | | 9.44 | | | | |
| Radiographer (Backfilling for Band 6 MRI/CT internal promotions) | Band 5 | 9.44 | A | | | | | | 9.44 | | |
| **Therapies** | | | | | | | | | | | |
| Occupational Therapist | Band 5 | 1 | A | | 1 | | | | | | |
| Occupational Therapist | Band 6 | 1 | A | | 1 | | | | | | |
| Occupational Therapist | Band 7 | 1 | A | | 1 | | | | | | |
| Physiotherapist | Band 5 | 1 | A | | 1 | | | | | | |
| Physiotherapist | Band 6 | 2 | A | | 2 | | | | | | |
| Physiotherapist | Band 7 | 1 | A | | 1 | | | | | | |
| Physiotherapist | Band 8a | 0.22 | A | 0.22 | | | | | | | |
| Physiotherapist | Band 8b | 0.12 | A | 0.12 | | | | | | | |
| Dietician Assistant | Band 4 | 0.44 | A | | | 0.44 | | | | | |
| Dietitian | Band 6 | 0.8 | A | | 0.8 | | | | | | |
| Dietitian Team Lead | Band 7 | 0.8 | A | | 0.8 | | | | | | |
| Dietitian Pathway Lead | Band 8a | 0.2 | A | | 0.2 | | | | | | |
| SLT Assistant | Band 4 | 0.44 | A | | | 0.44 | | | | | |
| SLT | Band 6 | 0.8 | A | | 0.8 | | | | | | |
| SLT Team Lead | Band 7 | 0.8 | A | | 0.8 | | | | | | |
| SLT Pathway Lead | Band 8a | 0.2 | A | | 0.2 | | | | | | |
| **Nursing** | | | | | | | | | | | |
| **Frailty Service (GEMS)** | | | | | | | | | | | |
| HCSW (Unregistered) | Band 3 | 2.48 | A | | 1 | 1.48 | | | | | |
| Registered Nurse | Band 5 | 3.97 | A | | 2 | 1 | 0.97 | | | | |
| PEF | Band 6 | 1 | A | | 1 | | | | | | |
| Registered Nurse | Band 7 | 0.69 | A | | 0.69 | | | | | | |
| **Medical Assessment Unit (AMU)** | | | | | | | | | | | |
| Admin & Clerical | Band | 0.62 | A | | 0.62 | | | | | | |
| HCSW (Unregistered) | Band 3 | 0.65 | A | | | | 0.65 | | | | |
| Registered Nurse | Band 5 | 1.32 | A | | 1 | 0.32 | | | | | |
| Registered Nurse | Band 6 | 0.17 | A | | | 0.17 | | | | | |
| ACP / ANP | Band 8a | 2.48 | A | | | 2.48 | | | | | |
| **Ambulatory Emergency Care (SDEC)** | | | | | | | | | | | |
| Admin & Clerical | Band 2 | 1.18 | A | | 1.18 | | | | | | |
| HCSW (Unregistered) | Band 3 | 2.48 | A | | 1 | 1 | 0.48 | | | | |
| Registered Nurse | Band 5 | 3.48 | A | | 1 | 1.48 | 1 | | | | |
| Registered Nurse | Band 6 | 1.67 | A | | 1 | 0.67 | | | | | |
| Registered Nurse | Band 7 | 1 | A | | | 1 | | | | | |
| **14 beds OPAU Q3 2023/2024** | | | | | | | | | | | |
| **Staff** | **Band** | **WTE** | | | | | | | | | |
| **OPAU Medical Staff** | | | | | | | | | | | |
| Consultant | Consultant | 2.75 | A | | | 1 | | 1 | | 0.75 | |
| **Nursing** | | | | | | | | | | | |
| Admin & Clerical | Band 2 | 0.34 | A | | | 0.34 | | | | | |
| Registered Nurse | Band 7 | 0.08 | A | | | 0.08 | | | | | |
| ACP / ANP | Band 8a | 2.48 | A | | | 2.48 | | | | | |
| **Therapies** | | | | | | | | | | | |
| Occupational Therapist | band 6 | 1.2 | A | | | 1.2 | | | | | |
| Therapy Technician | Band 4 | 0.8 | A | | | 0.8 | | | | | |
| Physiotherapist | Band 5 | 1 | A | | | 1 | | | | | |
| Physiotherapist | Band 6 | 1.5 | A | | | 1.5 | | | | | |
| Physiotherapist | Band 7 | 0.5 | A | | | 0.5 | | | | | |
| Physiotherapist | Band 8a | 0.1 | A | | | 0.1 | | | | | |
| Physiotherapist | Band 8b | 0.08 | A | | | 0.08 | | | | | |
| Dietitian | Band 6 | 0.64 | A | | | | 0.64 | | | | |
| SLT | Band 6 | 0.64 | A | | | | 0.64 | | | | |

*Table 4 - Recruitment to existing vacancies*

| | | | | Staff in post - 2023/2024 | | | | 2024/2025 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | RAG | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 |
| **EXISTING VACANCIES** | | | | | | | | | | | |
| **Staff** | **Band** | **WTE** | | | | | | | | | |
| **Medical Staff** | | | | | | | | | | | |
| **ED** | | | | | | | | | | | |
| Consultant | Consultant | 2 | R | | | | | | 1 | | 1 |
| Middle Grade | ST3+ | 2.47 | R | | | | 0.47 | 1 | | 1 | |
| Junior Doctors | ST1/2 | 2 | R | 1 | | 1 | | | | | |
| **General Medicine** | | | | | | | | | | | |
| Consultant | Consultant | 2 | R | | | | | | 1 | | 1 |
| Middle Grade | ST3+ | 3 | R | 1 | | | | 1 | | 1 | |

## Communications and Engagement

If the clinical model is approved, ongoing work will be required to continue to inform staff, the public and wider stakeholders about the service improvements. The importance of regular, clear, and accessible communications came through strongly in the public engagement period (June – August 2022), where respondents shared ideas around how they would best like to receive information, and the type of information they would like to receive. The outcomes of the public engagement period have been used to inform the implementation communications plan, and forms part of an ongoing exercise of stakeholder communications and engagement.

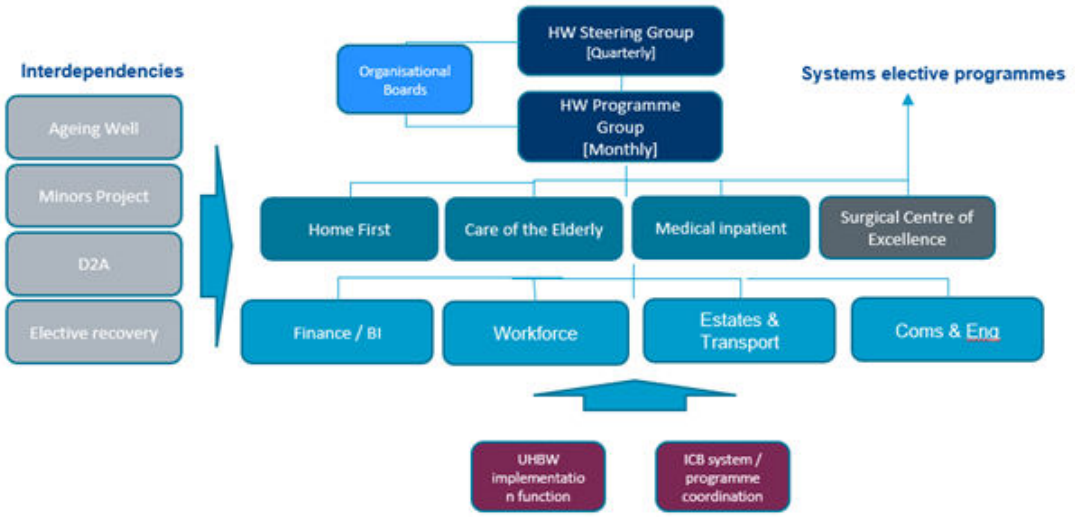
A dedicated plan to inform and involve staff through Phase 1 implementation, particularly those who will be affected by the plans, will be designed by UHBW communications leads. This builds on the dedicated programme of staff activity to date, including staff drop-in sessions, programme updates at team meetings, communications through the staff intranet and newsletter, and printed materials distributed around the Hospital site. The staff communications and engagement plans will be closely linked to the implementation plan, correlated with key milestones and delivery dates to ensure staff are aware of any changes in advance and have the opportunity to share any feedback. This will facilitate a smooth transition period for those working at Weston General Hospital and ensure good morale, ultimately supporting positive staff satisfaction and retention levels.

## Implementation Governance

The Phase 1 Full Business Case is due to go through system governance early 2023. If approved, responsibility of the delivery of Phase 1 will lie with University Hospitals Bristol and Weston NHS Foundation Trust (UHBW), with BNSSG ICB providing ongoing system and programme coordination.

The programme governance structure will remain as before, as outlined in the diagram below.

*Diagram 1 – Programme governance structure*




## Implementation Risks

There are a number of risks associated with the implementation of Healthy Weston 2 Phase 1 clinical model. Many of these are captured and monitored within the Programme risk register (Appendix 1), which is overseen and regularly updated by the Healthy Weston Programme Group. Key implementation risks have been identified below:

*Table 5 – Implementation risks*

| Implementation Risk | Mitigation |
|---|---|
| **Workforce -** There is a risk that the workforce model is not deliverable, due to national shortages, resulting in delays to implementation and bed benefit and savings release | 1) Consideration of Workforce included in implementation work<br>2) Ongoing work between Workforce and Finance sub-groups to refine and test the activity and workforce modelling<br>3) Workforce group developing considered workforce recruitment and retention plans - that are fit with other system initiatives |
| **Finance - Reliance on Discharge to Assess (D2A) -** There is a risk that the programme is reliant on the system approved Discharge to Assessment Business Case being implemented and delivered by all partners in accordance with the Business Case, to release the bed capacity to accommodate the non-elective bed transfer to the BRI and Southmead Hospitals. | 1) Discharge to Assess operational delivery must be tracked and understood in the System via the D2A Project Board and reported into the HW Finance & BI Group.<br>2) Discharge to Assess operational delivery programme pending. |
| **Finance – revenue investment -** There is a risk that the non-recurrent revenue investment required in the phase 1 Full Business Case is not sourced, resulting in the implementation of the model stalling, leading to ongoing exposure to risk of unsustainable clinical services needing to be suspended at short notice | 1) Work ongoing with BNSSG system to identify opportunities for non-recurring revenue investment in HW2 Phase 1 Full Business Case<br>2) Develop a benefits realisation plan that will help identify when invest to save benefits will be realised |
| **Bed modelling –** There is a risk related to the capacity and demand modelling, which is based on 2021/22 activity flow and high-level assumptions. | 1) Model to undergo granular testing through audits and winter funded pilots |

## Benefits

The Healthy Weston 2 Phase 1 benefits are based on both outputs from the Healthy Weston activity and bed model, and national and local expectations. A full benefits management approach has been established to ensure the Phase 1 benefits are quantified, realised and reviewed. This includes the regular testing of the benefits, and assumptions behind the Healthy Weston activity and bed model, as the plans are implemented. Key operational milestones will define the points at which specific elements of the benefits realisation plan are expected to be achieved. Through established data sharing pathways, key measures will be collected and monitored over time, enabling the programme to continually review the impact of the clinical model, and assess the achievement of expected benefits.

## Considerations

In preparation for Phase 1 implementation and to help reduce winter pressures, the first step in the Phase 1 enhancements have been introduced and funded on a short-term basis through winter funding. This includes SDEC pathways, enhancement to the Acute Monitoring Unit and the introduction of ED Observation beds. These early Phase 1 improvements offer early insight into implementation and benefits realisation.

Healthier Together

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

# Appendix 12 - Healthy Weston 2 Phase 1

# Sustainability Impact Assessment

Version: 1.2
Date: January 2023

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## 1. Purpose

As part of major service improvement, it is particularly important to consider the sustainability impact of the clinical model being put forward. This is to ensure that where identified, mitigating actions are put in place to limit any potential negative impacts on sustainability, whist also promoting positive sustainable opportunities.

Climate change poses a major threat to people's health as well as the planet. The environment is changing, that change is accelerating, and this has direct and immediate consequences for patients, the public and the NHS.

Climate change has been declared as 'the greatest threat to global health' (Lancet, 2017) which will have serious implications for health, wellbeing, livelihoods, and the structure of organised society. Failure to act quickly will heighten existing national health challenges, place further financial strain on the NHS, and worsen health inequalities within the UK and internationally.

In delivering services for the public, the NHS and Local Authorities generate carbon emissions and air pollution that are harmful to health. There is a moral duty to the BNSSG population to assess and minimise these impacts.

This document particularly considers the sustainability impact of the Healthy Weston 2 Phase 1 plans put forward in line with the wider ICS sustainability ambitions.

The process of assessment will remain iterative, and the document will be updated as further information becomes available.

## 2. Healthy Weston 2 Clinical Model

The Healthy Weston 2 Outline Business Case (OBC) describes a model that will put Weston General Hospital on a sustainable footing ensuring that it is robust, resilient, and fit for the future.

The exciting and innovative opportunity, presented in the OBC, represents the second and concluding chapter in the Healthy Weston Programme, and aims to establish Weston General Hospital as a thriving hospital in the heart of the community, delivering the care local people need most often.

It maximises the transformational benefits of the merger between University Hospital Bristol and Weston Area Health Trust to continue to develop high quality health care that meets the health needs of the local population and secures the future of Weston General Hospital in the long term.

The model is guided by the principle that the community is the default setting of care. The Healthy Weston Programme is as focused on improving peoples' overall health and wellbeing as their in-hospital care. To this end, the plans drive further integration with local community and primary care services.

The Healthy Weston 2 Outline Business Case (OBC), agreed in June 2022, describes the ambitious improvement plans. A phased approach to the development of 3 interlinked full business cases has been agreed to cover the plans. These phases are:

- Phase 1 – Safe, high quality and sustainable urgent care
- Phase 2 – Inpatient medical care and specialist centre for care of the elderly
- Phase 3 – Surgical Centre of Excellence at Weston General Hospital

## 2.1 Healthy Weston 2 Phase 1

Healthy Weston 2 Phase 1 leads the development of a safe, high-quality and sustainable urgent care at Weston General Hospital, that is in line with national and local standards, and that ensures local people have equity of access to the best urgent care. Senior leaders and clinicians from across Bristol, North Somerset, South Gloucestershire and Somerset have led the progression of the Phase 1 model, ensuring plans conform with system priorities and the Healthy Weston vision.

The plans have also received support from the public, who during a public engagement exercise delivered between 20 June and 14 August 2022, indicated that the majority of people thought the plans would help improve the hospital.

The scope of Healthy Weston 2 Phase 1 is the following

- Enhanced 24hr observation unit for adults providing rapid assessment and treatment [Acute Monitoring Unit]
- Improved Same Day Emergency Care [SDEC], providing the right care, in the right place at the right time
- Increased number of frail patients supported by already award-winning Geriatric Emergency Medicine Service [GEMS} meeting local need
- Creating Older People's Assessment Unit [OPAU] providing specialist rapid assessment and treatment

The Rapid Assessment Clinic for Older People (RACOP) as described in the Healthy Weston 2 Outline Business Case has been redefined as a Frailty SDEC and is included within the expansion of GEMS plans.

Phase 1 also includes the increased efficiency and improvement of existing surgical activity, which will feed into the later delivery of the Surgical Centre of Excellence as part of Phase 3 implementation.

Clinicians and health service leaders agree that the new clinical model will be more accessible and better able to support the changing needs of the local population.

## 3. Sustainability Impact Assessment summary

The case for change and the benefits of the Healthy Weston 2 Phase 1 plan are fully described in the Phase 1 Full Business Case. It is important to ensure that the plans also consider the impact on the environment and identify possible mitigations. The table below summarises the impact assessment, against the BNSSG Green Plan aims, and lists the associated mitigations. Further detail is reviewed within Section 5.

Whilst this Sustainability Impact Assessment is focusses on Healthy Weston 2 Phase 1, recognition of the impacts that the sequential and interlinked Phase 2 and Phase 3 Business Cases will have are captured below. This document is intended to be interactive, with further details on the latter two phases being added as further details become available.

| Green Plan | **Analysis + / N / -** | **Phase 1 Impact Assessment Summary** | **Phase 1 Suggested Mitigation / actions** | **Phase 2 & Phase 3 Impact Assessment Summary** | **Phase 2 & Phase 3 Suggested Mitigation / actions** |
|---|---|---|---|---|---|
| **Improve the environment**<br><br>(Improve the overall environmental impact and sustainability of services, such as air pollution, travel and transport impact and biodiversity) | N | Phase 1 will have minimal effect on travel and transport.<br><br>The Phase 1 estates requirements are minimal, however consideration to be taken where changes are required. | Improve the environmental sustainability of care pathways, and better integrate healthcare services to improve efficiency.<br><br>**Estates**<br>Estate modernisation – in line with new building regulations that are more sustainable (this is linked to building efficiencies such as improved insulation. This also presents opportunities for renewable sources of heat.<br><br>Estate rationalisation and maximising use avoids unnecessary new building with the significant embodied carbon impacts.<br><br>Focussing on refurbishment or replacement of inefficient building | **Elective Care**<br>People that would previously have had to travel into the centre of Bristol, to Southmead or to Taunton to receive their treatment will be offered care at Weston General Hospital through the development of a surgical centre of excellence.<br><br>It is expected that there will be a significant number of journeys saved per year, particularly when reviewing the number of preoperative assessment and outpatient visits required, per elective procedure.<br><br>**Non Elective / Emergency Care** | Work with local councils and travel leads regarding mitigations associated with additional secondary transfer journeys, particularly public transport links.<br><br>Improve the environmental sustainability of Phase 2 and Phase 3 care pathways, and better integrate healthcare services to improve efficiency.<br><br>**Estates**<br>Estate modernisation – in line with new building regulations that are more sustainable (this is linked to building efficiencies |

| | | | | | |
|---|---|---|---|---|---|
| | | | stock reduces carbon impacts of operational use.<br><br>Implementation of sustainability guidelines for the associated estate reconfiguration to drive resource efficiency through the Estates Strategy<br>and standard specification.<br><br>Build upon the UHBW biodiversity and greenspace strategy that encompass the challenges and opportunities<br>across the Weston General Hospital (WGH) estate. | The plans ensure that services people most often need are available locally, for the Weston catchment and across BNSSG. However, modelling of the non elective (emergency care) impact associated with the plans highlights an increase in patient journeys above baseline.<br><br>This increase in patient journeys is as a result of:<br>- some patients being diverted to neighbouring hospitals by ambulance<br>- some patients being taken to Weston General Hospital ED and then transferred to another hospital following assessment, or<br>- some patients being admitted to Weston General Hospital for a short stay and then requiring transfer to another hospital<br><br>The Programme is working with BI and modelling colleagues to determine the exact impact of journeys associated with the planned changes to elective and non elective care. This will be updated when available | such as improved insulation. This also presents opportunities for renewable sources of heat.<br><br>Estate rationalisation and maximising use avoids unnecessary new building with the significant embodied carbon impacts.<br><br>Focussing on refurbishment or replacement of inefficient building stock reduces carbon impacts of operational use.<br><br>Implementation of sustainability guidelines for the associated estate reconfiguration to drive resource efficiency through the Estates Strategy<br>and standard specification.<br><br>Build upon the UHBW biodiversity and greenspace strategy that encompass the challenges and opportunities<br>across the WGH estate. |

| | | | | | |
|---|---|---|---|---|---|
| **Net zero carbon** | + | The plans will significantly enhance the urgent care offer at Weston General Hospital, including enhanced provision of same day emergency care (SDEC) and short stay admissions. This will result in a significant reduction in bed days and reduced total number of admissions.<br><br>An average inpatient bed day is 63.7 kgCO2e/ bed day | Ensure delivery of urgent care enhancements including SDEC, AMU and GEMS to minimise the carbon impact of a patient's pathway.<br><br>Identify carbon hotspots such as medical equipment and pharmaceuticals and ensure that action plans identify and mitigate environmental impacts.<br><br>Embrace and implement new and existing digital technologies in urgent care<br>to reduce the environmental impact of care,<br>prevent ill health and manage long-term<br>health conditions. | | Continue to work with partners and stakeholders to identify and deliver solutions that reduce the number of hospital visits and deliver the provision of treatment closer to home.<br><br>Identify carbon hotspots such as medical equipment and pharmaceuticals and ensure that action plans identify and mitigate environmental impacts.<br><br>Explore new and existing digital technology as par of the planning for Phase 2 and Phase 3. |
| **Generate a BNSSG-wide movement** | + | Engagement with a wide range of stakeholders to develop a sustainable model of care<br><br>Significant opportunity as part of the public engagement process to ask the public about what sustainability means to them and what mitigations can be put in place to offset any potential negative impacts. | Build in sustainability as part of the ongoing engagement activities to develop mitigations / further actions<br><br>Implementation of actions for staff<br>- Increase access to the Trust's cycle-scheme, car sharing, park & ride and discounted bus fares.<br>- Annual staff travel survey to improve engagement with staff and capture data on staff commuting. | | |

## 4. UHBW strategy

UHBW have an ambitious sustainability strategy that aims to end their contribution to the climate and biodiversity emergencies. They aim to be leaders in delivering improved patient outcomes that decouple the significant impact that healthcare has on the environment.

As one of the largest organisations in the area, they recognise the significant positive contribution that they can make to the local economy, society and the environment.

It looks to address all aspects of their environmental impact from the carbon produced from their buildings, clinical activities, purchases made and staff and patient travel as well as improving air quality and the natural environment.

In doing so they are aiming to:

- Be carbon neutral by 2030
- Send zero waste to landfill by 2025
- Achieve an excellent rating on the Clean Air Hospital Framework by 2025
- Maximise the quality and benefits of our green spaces
- Support and empower staff to make sustainable choices

The Sustainable Development Strategy is supported by several action plans. These focused plans outline the approach and specific actions that will be taken to achieve the headline targets. These include site specific actions on biodiversity, climate change adaptation and decarbonising building energy use.

The strategy also supports the ICS Green Plan and a full copy of it can be found here: 00929_uhb_sustainability_report_web.pdf (uhbristol.nhs.uk)

# 5. Integrated Care System (ICS) Green plan

The Integrated Care System has a 'Green Plan' which aligns to the sustainability vision, set out as one of the seven broader ICS strategic aims.

> "We will act as leading institutions to drive sustainable health and care by improving our environment, achieving net zero carbon by 2030; improving the quality of the natural environment; driving efficiency of resource use."

Operating sustainably is at the core of how the system plans to meet the ICS aims and objectives.

The ICS Green plan sets out three high level key outcomes, to:

- **Aim 1 - Improve the environment**
- **Aim 2 - Net zero carbon**
- **Aim 3 - Generate a BNSSG-wide movement**

The document considers the Healthy Weston Phase 2 plans in turn, against these three outcomes, to provide an overall impact assessment.

## 5.1 ICS Aim 1 - Improve the environment

### 5.1.1 Context

The ICS plan sets out the ambition to improve the overall environmental impact and sustainability of services, especially the damaging local impacts of air pollution. The following section analyses the travel and transport impact, with particular reference to CO2 as well as biodiversity.

### 5.1.2 Travel & transport (carbon impact)

The Healthy Weston 2 Phase 1 model enhances the urgent care offer at Weston General Hospital, helping local communities to access specialist urgent care, reducing admissions and reducing length of stay. This model will have minimal impact on travel and transport, although it is expected that reduced admissions and shorter lengths of stay will decrease the travel requirements of those visiting patients receiving urgent care.

**Phase 2 and Phase 3**
It is recognised that Phase 2 and Phase 3 of the programme will have significantly more impact on travel and transport, and further detailed work will be undertaken to understand and plan how the programme can best mitigate any impact this may have. The plans put forward seek to utilise capacity released from inefficient emergency care to develop a centre of surgical excellence; this proposes to increase, for example the amount of general and orthopaedic and sub-speciality day case surgery at Weston General Hospital. This will ensure that many additional people can receive their care locally. People that would previously have had to travel into the centre of Bristol, to Southmead or to Taunton to receive their treatment will be offered care at Weston General Hospital through the development of a surgical centre of excellence.

Equally people from the wider BNSSG population will have the opportunity to have surgery or planned procedures at the Weston surgical centre of excellence and may require a longer journey. However, continuing the development in provision of outpatient and pre-operative care it is envisaged that pre-and post-operative care will be provided remotely or as close to home as possible.

The programme is working with BI and modelling colleagues to determine the exact reduction of journeys associated with the proposed changes to elective care and will be updated when available.

The benefits associated with creating a local surgical centre of excellence is in part offset with the non elective impact of the plans. Changes to the front door model and associated speciality changes describes an increase in patient journeys per year. It is difficult to calculate the exact distances of these journeys, are they are dependent on where people live. As a proxy, the 2019 travel analysis identified the following key figures:

- It will take on average between 13 and 19 additional minutes of blue light travel time to transfer to a neighbouring hospital.
- It will take on average an additional 17 minutes at peak time and an additional 14 minutes at off peak time to travel to a neighbouring hospital by private car.
- Travel to a neighbouring hospital by public transport will take an average of an additional 18 minutes at peak and 41 minutes at off-peak times.

The programme will seek to calculate the net carbon impact of the change in journeys by ambulance and public/private conveyances as the journeys, which will be calculated as further modelling is undertaken and the outputs of public engagement enable further detailed modelling.

The impact of the vision for planned care and the development of a surgical centre of excellence on journeys and change from baseline will be subject to assessment as the vision is underpinned by further detailed planning.

### 5.1.3 Estate efficiency

The Healthy Weston 2 Phase 1 plans outline minimal estates requirements, however where estates changes are required, careful planning to use available estates most efficiently and effectively has been applied, linking with the UHBW Sustainability Strategy.

The Phase 1 estates requirements includes developing Sandford Ward into a 14 bedded OPAU, and a minor change in AEC to create an office area for SDEC. Working closely with UHBW Estates team, plans have been outlined to maximise the use of these areas, which will have a net carbon benefit associated. Estate rationalisation and maximising use avoids unnecessary new building with the significant embodied carbon impacts. Focussing on refurbishment or replacement of inefficient building stock reduces carbon impacts of operational use.

**Phase 2 and Phase 3**
The Healthy Weston 2 clinical model puts forward a vision of an enhanced elective care offer through a Centre of Surgical Excellence for the wider region. Capital investment in potential modular build expansion and redevelopment of existing estate is proposed to support this vision as described in the Healthy Weston 2 OBC Finance chapter.

In accordance with the UHBW Sustainability Strategy, the programme will continue to seek to reduce the environmental impact of building works during design, refurbishment, construction, operation and decommissioning stages, embedding sustainability and efficiency using smart design and emerging technologies across the improvement works, including refurbishment and new build.

The programme will abide by sustainability guidelines and in developing future capital business cases embed sustainability impact assessment as a core component.

### 5.1.4 Biodiversity (WGH biodiversity action plan)

The Weston General Hospital (WGH) Biodiversity Action Plan (BAP) provides an over-arching framework for habitat and species conservation within the WGH Estate. Importantly, it also recognises the benefits of wildlife to WGH patients, staff, contractors and visitors and helps to identify ways to better promote, and engage people in, biodiversity conservation in a healthcare environment.

The WGH BAP is aimed at all those groups and individuals who are either working to protect and enhance biodiversity across the Estate, or who may impact on it in some way.

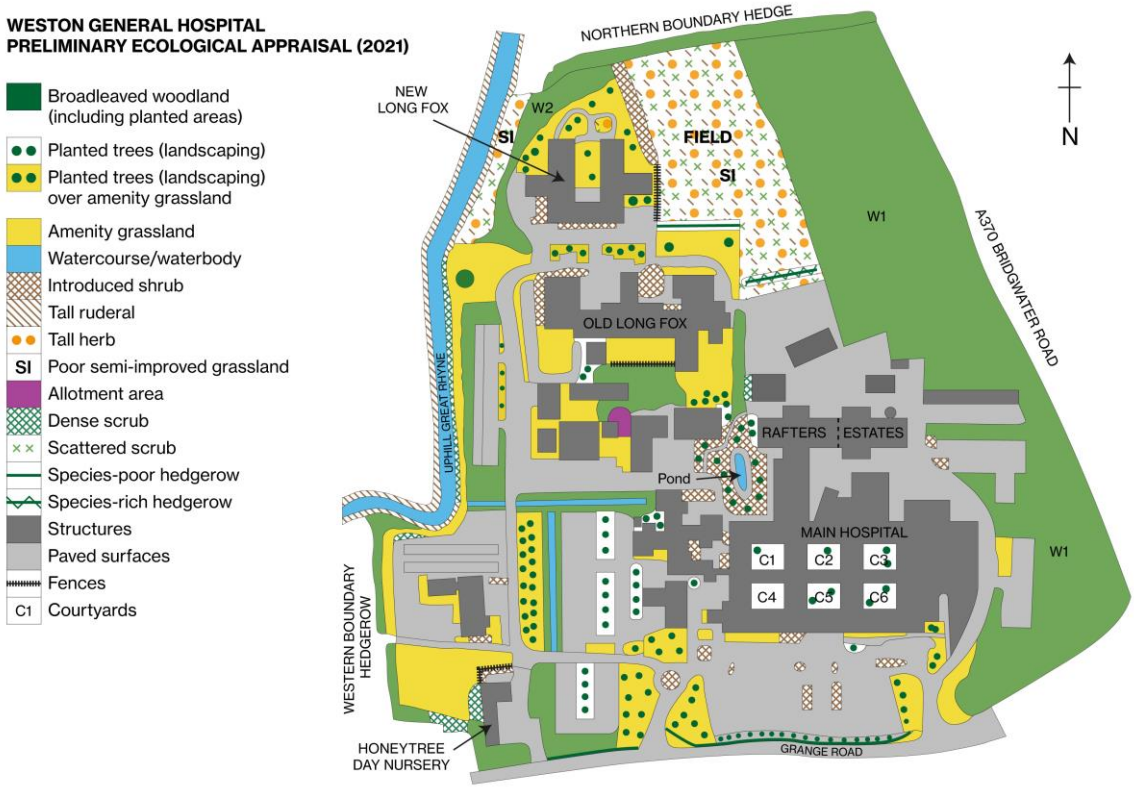
Weston General Hospital is situated on the southern edge of the Weston-super-Mare urban area. The urban environment presents a challenge for biodiversity. Like any other ecosystem, however, urban areas are made up of biological and physical components that interact with one another.

The biodiversity action plan describes six main areas of focus and development as described below:

- Invertebrate garden
- Living roof
- Woodland enhancement
- Ditches and Rhynes enhancement
- Retention of areas of unmanaged land
- Parkland development

Figure 1 below describes the ecological appraisal completed in 2021.

**Figure 1 - Ecological Appraisal**




It is not anticipated that any changes in estate use at WGH as a result of the Phase 1 plans will impact on the projects as set out in the BAP. It is important that estate leads do continue to consider the biodiversity impact as the plans progress through to Phase 2 and Phase 3. The woodland areas on the eastern fringe need to be retained as the strategic gap identified by North Somerset County Council which limits the scale of potential development in this area.

## 5.2 ICS Aim 2 - Specifically target carbon

### 5.2.1 Context

The ICS plan sets out the urgency to address the carbon footprint and plans to reduce the impact of services on the environment by achieving net zero carbon across all emissions scopes by 2030.

Though there is an estimate of the NHS's carbon footprint overall, the carbon impact of quality improvement projects is not usually routinely measured. In order for the NHS to reduce its greenhouse gas emissions to net zero by 2050, carbon needs to become an additional currency alongside money, understood by all working in the health system.

A carbon footprint is the sum of greenhouse gas (GHG) emissions attributable to a given process. Six different types of gases are commonly included; as each has a different global warming potential, the quantities are expressed in "carbon dioxide equivalents" (CO2e).

### 5.2.2 Carbon as part of Length of Stay

The Centre for Sustainable Healthcare (SUSQI) describes the carbon impact of bed days. This is broken down into 'high intensity' and 'low intensity' to give the kgCO2e

An average inpatient bed day is 63.7 kgCO2e/ bed day. The Healthy Weston 2 Phase 1 clinical model describe a reduction in the number of bed days and admissions at WGH as a result of the enhanced urgent care offer, with an associated reduction in carbon.

**Phase 2 and Phase 3**
The plans outline a reduction in the number of bed days at WGH, with an associated reduction in carbon, an associated increase at other hospitals for patients transferred will be netted against this reduction for the System as a whole. This increase will be contained below the baseline assessment, and the efficiency in Lengths of Stay at receiving hospitals will be a benefit to the System carbon footprint.

### 5.2.3 Digital Technology

The BNSSG Digital Strategy has been developed to enable the benefits of technology to drive forward our vision for healthcare. It sets out three core objectives, to design a digitally enhanced ICS, develop digitally empowered citizens' and deliver digitally enabled care. These objectives are a core part of the Healthy Weston programme and will support implementation of the Healthy Weston 2 clinical model at Weston General Hospital.

There are a number of environmental benefits that can be realised, as a result of implementing digital advancements as part of the future model. The high level benefits are summarised in the table below:

*Table 2 – High level benefit of digital advancements*

| Digital Technology | Benefit |
|---|---|
| **Telemedicine** | Reduced need for travel by consultants or other clinicians between sites |

| | |
|---|---|
| | Reduced patient and visitor travel to hospital. Enabling care to be delivered at home reduces occupancy in carbon intensive hospital |
| **Application of digital technology to create a networked solution for critical care** | Enable a networked solution for critical care which will allow the service to operate across three sites (critical care in the BRI, cardiac critical care in the Bristol Heart Institute and the critical care unit in Weston General Hospital) |
| **Artificial Intelligence (AI) for diagnosis/decision making support: potential to ensure only the right patients are transferred** | Less inappropriate/unnecessary patient transfers |
| **Transfer process transformation** | Reduced paper-based systems |
| **All UHBW staff reporting on same IT system** | Reduced duplication, potential for reduced travel between sites (multiplied by many staff) as all access IT system remotely so notes can be done from anywhere |
| **Interdependencies** | |
| **Improving Local Services: Virtual Ward / Hospital at Home** | Across BNSSG remote monitoring solutions are being rapidly stood up to support the safe management of higher acuity patient care in the community. This will support people to be looked after in their homes with the support of an integrated clinical team monitoring their clinical condition remotely. |

### 5.2.4 Models of care & Carbon impact

Different models of care have an associated carbon impact. For example, improving end-of-life care by providing it in lower carbon intensity settings at home and out of acute care, working more closely with hospices and social care agencies would therefore improve not only quality of end of life but also financial and environmental sustainability.

The programme plans to review and monitor the carbon impact of the Phase 1 clinical model, taking learning to apply to future work and sharing outcomes with partners and other systems where appropriate.

## 5.3 ICS Aim 3 - Generate a BNSSG-wide movement

### 5.3.1 Context

The ICS plan describes that our sustainability behaviours, actions and innovations as anchor institutions will support a cultural change amongst local citizens and businesses resulting in wider improvements in air quality, biodiversity, and the quality of the natural environment.

### 5.3.2 Behavioural changes at key life events (academic nudge theory)

Healthcare has a major opportunity to influence public perception of the importance of environmental sustainability. Making a clear public commitment to environmental sustainability as a guiding principle in healthcare design, purchasing policy, and in the design of care pathways sends a very clear message to employees, patients and visitors that the NHS considers climate change a real threat, and one that we can all do something about. Many hospitals now offer smoking cessation support to staff: the service is now being encouraged to take active steps to reduce obesity amongst its staff. Obesity itself carries a significant carbon footprint due to the higher food requirements of obese people and the increased fuel costs of transporting a heavier population before considering the increased carbon impacts of treating obesity related health impacts. There is strong evidence that experiencing either a change in health or a partner's change in health and its consequences can change people's diets and physical activity behaviours to healthier and more sustainable lifestyles, particularly among older adults.

Medicines make up 25% of the NHS carbon footprint. Medication reviews, shared decision-making, social prescribing and other ways to reduce overprescribing depend critically on people being confident to challenge and be more involved in decisions about their care. Giving patients and their carers better information about their care and medicines they are taking, or being advised to take, enables informed choices which have been found to often be lower carbon choices.

### 5.3.3 Staff Impact

There is an increasing awareness amongst staff of their individual sustainability impact. UHBW, as part of their strategy, are aiming to increase access to the Trust's cycle-scheme, car sharing, park & ride and discounted bus fares. An annual travel survey is undertaken to determine changes in how staff travel to work and collate feedback. Data is analysed using the HOTT (Health Outcomes Travel Tool) to see which interventions will have the best effect in making progress. This in turn is likely to contribute to the wider ICS aim, developing a BNSSG wide movement.

# 6. Conclusion and next steps

The following actions are recommended as a result of this impact assessment document:

- Continual review of available technology to minimise unnecessary travel as well as systems integration to minimise use of paper
- Continue to review how new models of care, have different carbon impacts
- Maintain regular updates in relation to local environmental polices to ensure the plans meet the latest requirements
- Continue to communicate and engage with staff and the public around sustainability

- Build on developed channels of communication with Trust sustainability leads to ensure a system approach to the environmental impact of the plans
- Develop a further lived experience travel working group to further explore the impacts and mitigations of the Phase 2 and Phase 3 plans

## Version Control

| Date | Version | Author | Revisions |
|---|---|---|---|
| **March 2022** | V0.1 | Jeremy Westwood | First draft – linking with ICS Green Plan lead and UHBW sustainability leads |
| **20/04/2022** | V0.2 | Sian Barry | Inclusion of summary impact assessment table & document review |
| **27/04/2022** | V0.3 | Jeremy Westwood | Review by HW2 Programme Manager. Review by UHBW sustainability leads – comments incorporated |
| **28/04/2022** | V1.0 | Jeremy Westwood | Version circulated to HW2 SRO's for review ahead of submission to Healthy Weston Steering Group |
| **26/05/2022** | V1.1 | Jeremy Westwood | Minor formatting amends |
| **17/01/2022** | V1.2 | Fritha Voaden | Updated to align with Healthy Weston 2 Phase 1 Full Business Case |

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

# Appendix 13 - Healthy Weston 2 Phase 1

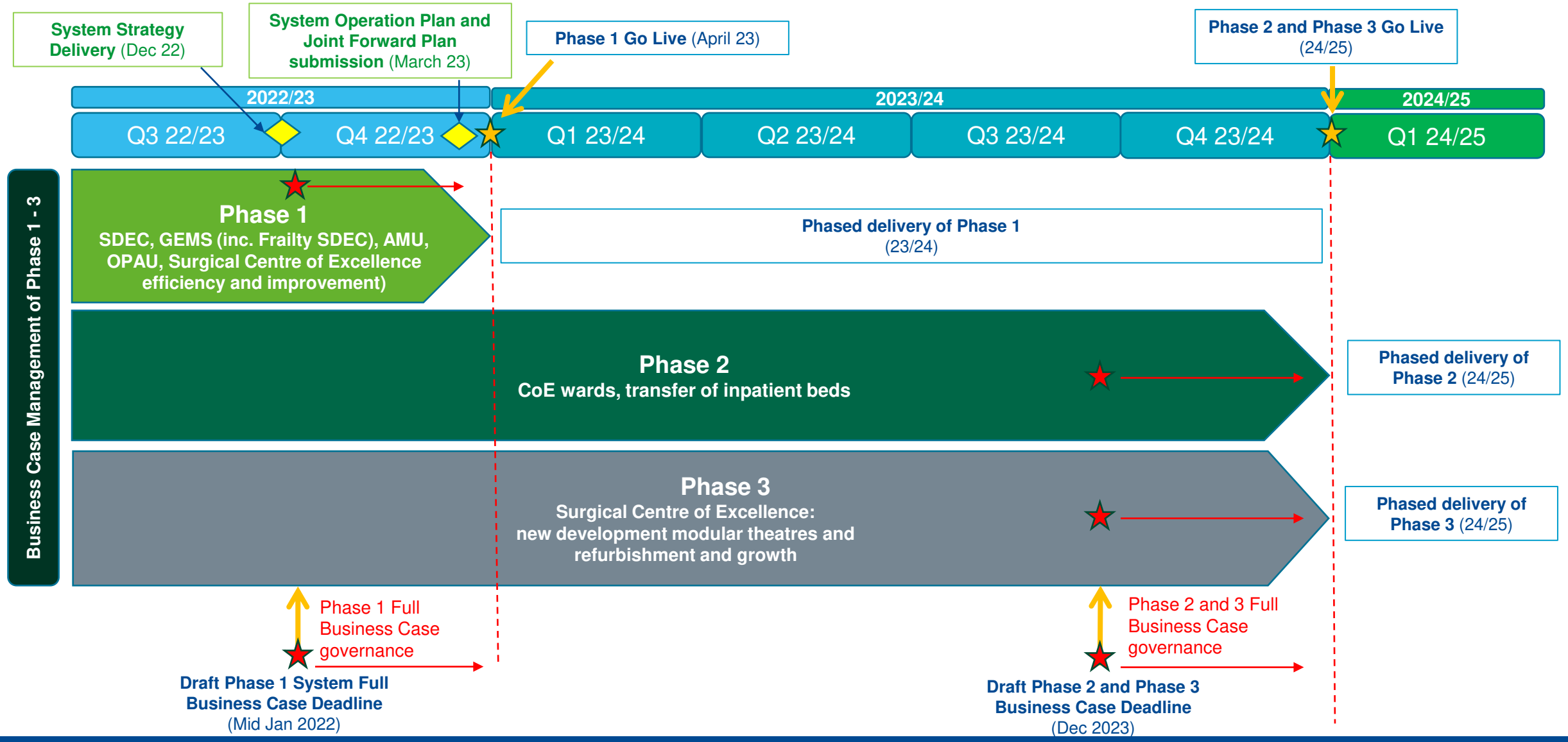
# Project Plan

**January 2023**

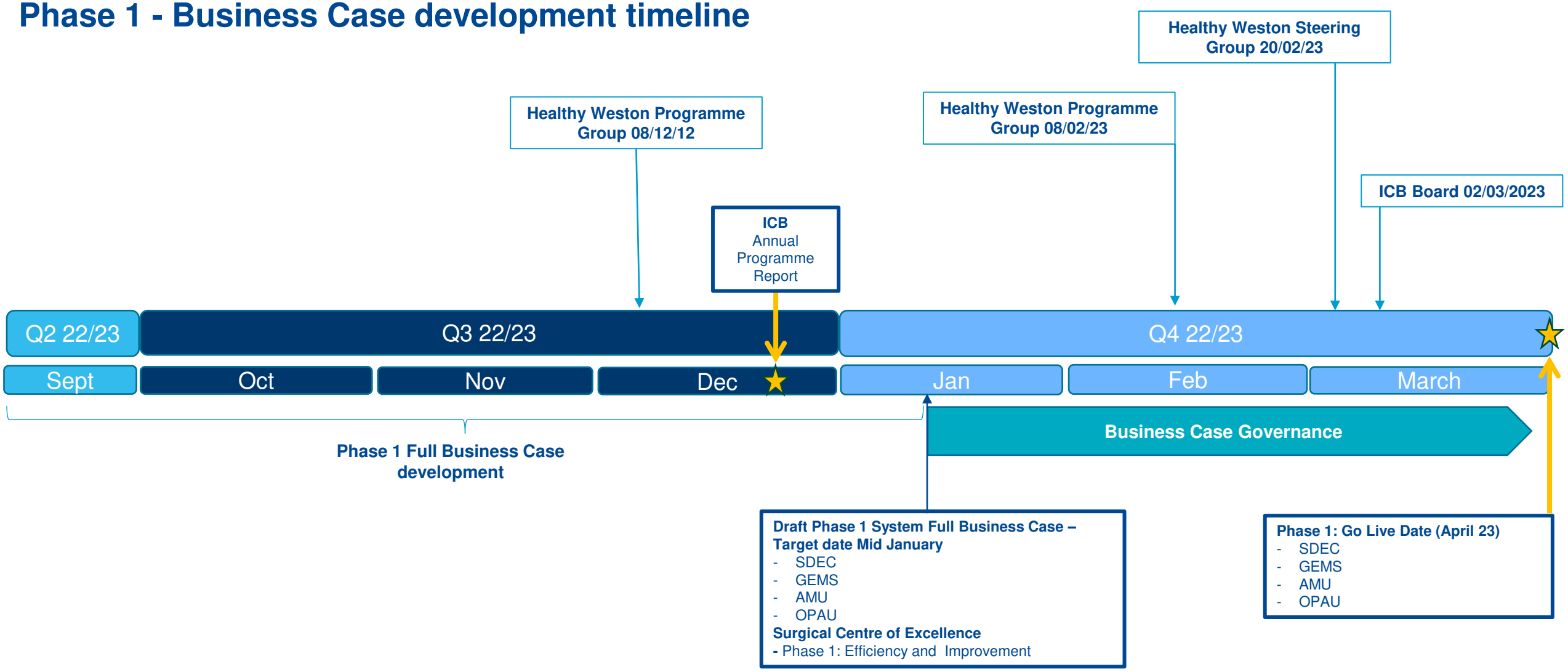
# Healthy Weston 2 workstreams, scope and phasing

| Workstream | Scope | Delivery Phasing |
|---|---|---|
| **Home First** | Same Day Emergency Care (SDEC) | Phase 1 |
| | Geriatric Emergency Medicine Service (GEMS)<br>Includes Frailty SDEC | Phase 1 |
| | Acute Monitoring Unit (AMU) | Phase 1 |
| **Care of the Elderly** | Older Persons Assessment Unit (OPAU) | Phase 1 |
| | Care of the Elderly Wards (CoE Wards) | Phase 2 |
| **Inpatient Medical Care** | Transfer of inpatient beds | Phase 2 |
| **Surgical Centre of Excellence** | Efficiency and Improvement | Phase 1 |
| | New development modular theatres | Phase 3 |
| | Refurbishment and growth | Phase 3 |

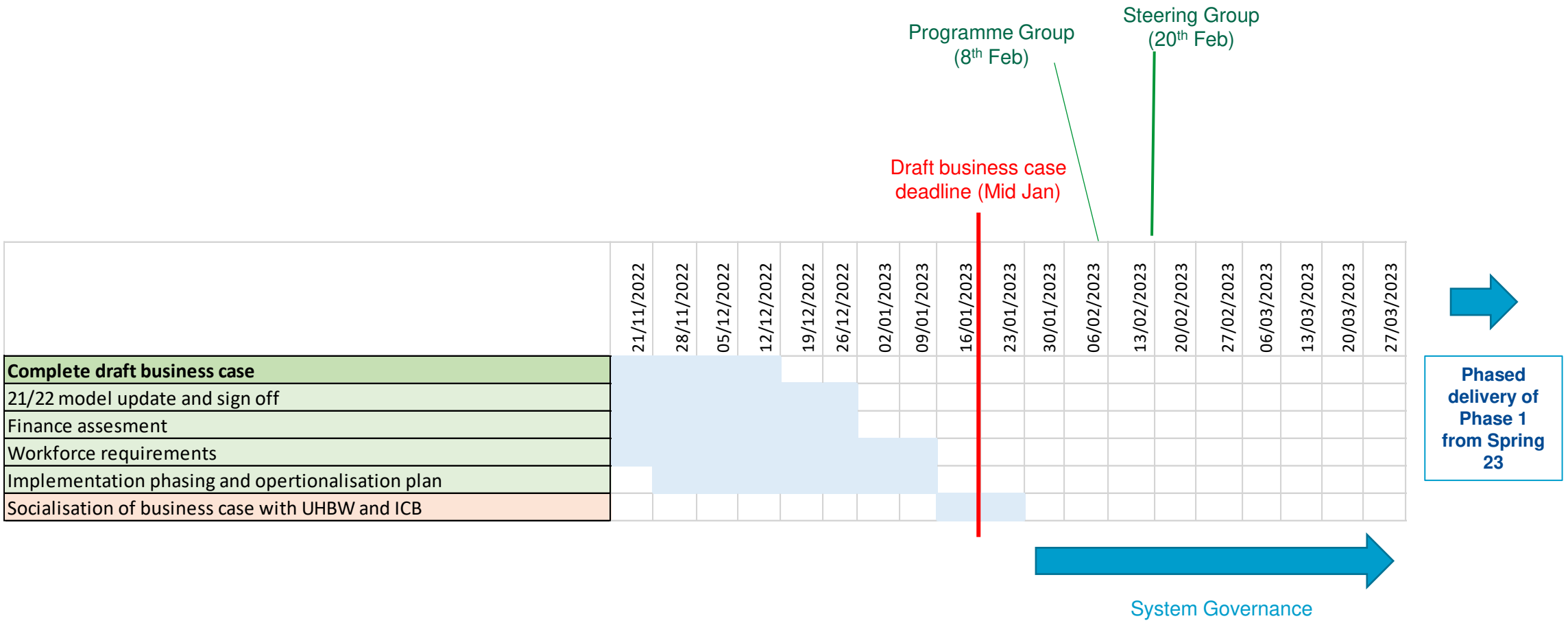
# Healthy Weston 2 – programme timeline



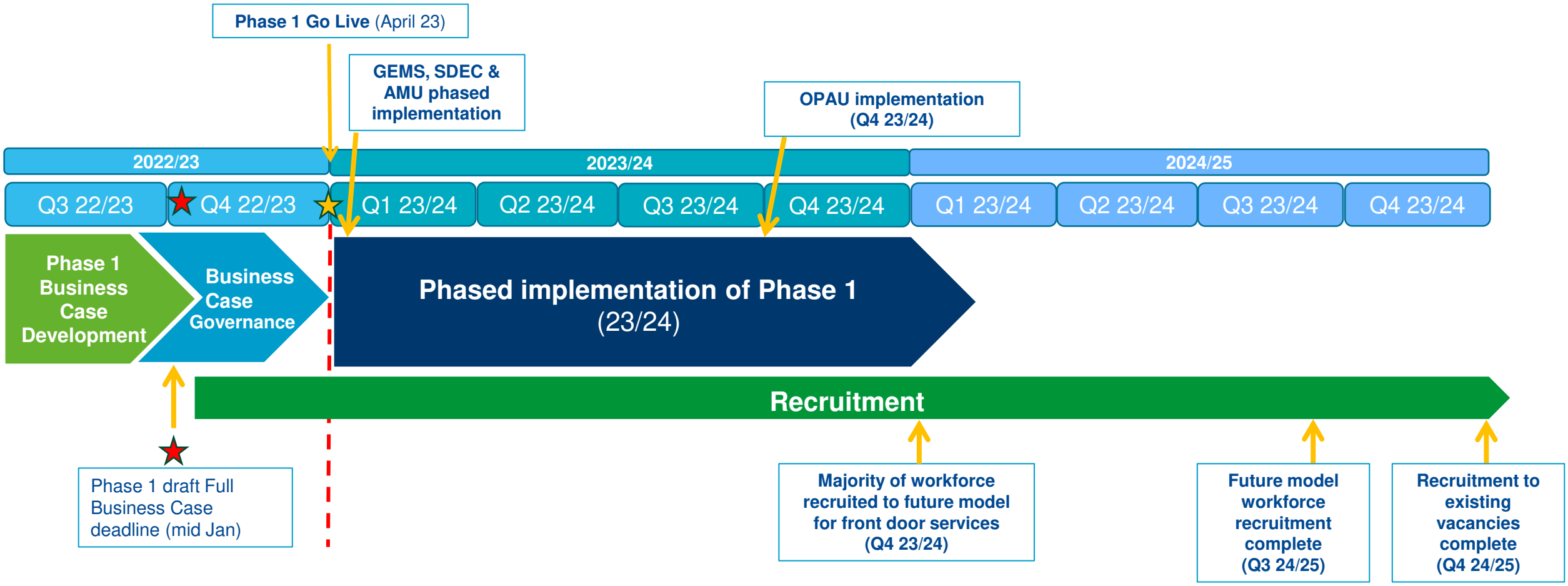
# Phase 1 - Business Case development timeline



# Current critical path for Phase 1 Business Case



# Phase 1 high level implementation timeline



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# Appendix 14 - Healthy Weston 2 Phase 1

# Data Protection Impact Assessment (DPIA)

Version: 0.3
Date: January 2023

## 1. Introduction

Healthy Weston 2 is the second stage of a two-part programme developed to ensure the very best healthcare for the population of Weston, Worle and the surrounding areas. Healthy Weston 1 was initiated with the vision for Weston General Hospital (WGH) to become a vibrant and dynamic hospital at the heart of the community - an exemplar of excellent healthcare designed specifically to respond to the needs of the local population. Healthy Weston 2 builds on this, and the transformational change because of the Weston Area Health Trust (WAHT) and University Hospitals Bristol NHS Foundation Trust (UHB) merger, to secure a dynamic future for health services in Weston, from community frailty to outstanding hospital care.

In October 2018 the Healthy Weston programme published 'Healthy Weston: why our local services need to change' which summarised the four main challenges at the time, and driving the need for change within Weston General Hospital.

- **Health needs are changing:** Our population is growing and getting older, people are living with more long-term conditions and there are significant inequalities in health.
- **Variations in care and in access to primary and community care:** There are differences in the way care is currently provided, with some patients finding it harder than others to get the right care.
- **Meeting national clinical quality standards:** Some services at Weston General Hospital don't see enough of certain cases to meet national quality standards and there is a shortage of specialist staff.
- **Getting value for money:** We have a duty to spend every pound for the greatest public benefit. We must live within our financial means and make sure we use our available resources most effectively to meet local needs.

Healthy Weston 2 builds upon this work in Healthy Weston 1, recognising the additional local challenges that have arose due to the COVID-19 global pandemic and the new opportunities coming from the merge between Weston Area Health Trust and University Hospitals Bristol.

## 2. DPIA Development

Article 35 of the General Data Protection Regulation 2016 (GDPR) requires that a Data Protection Impact Assessment (DPIA) is undertaken where there are 'high risks to the rights and freedoms of natural persons resulting from the processing of their personal data'.

The use of Privacy Impact Assessments has become common practice in the NHS to achieve compliance with the NHS Digital Information Governance Toolkit (now the Data Security and Protection toolkit) and DPIAs build on that practice. The GDPR identifies a number of situations where the processing could be considered high risk and where a DPIA is a legal requirement.

The DPIA has been developed to ensure that data protection and privacy are built into the programme and future new ways of working.

This version of the DPIA covers the Healthy Weston 2 Phase 1 part of the programme.

It is expected that a further iteration of the DPIA will be developed as the programme progresses.

# 3. Description of data, data flows and retention period

## 3.1 Description of data

The BNSSG Healthy Weston 2 programme is currently developing the Healthy Weston 2 Phase 1 Full Business Case (FBC), with a view to implementing the new clinical model from April 2023.

At no time during the phase will any patient identifiable data be held by the programme.

The data that will be held by the programme is as follows:

### Project Management:

- Terms of reference (TOR) for working groups and Programme Governance groups
- Agendas for meetings
- Action notes from meetings
- Minutes from meetings
- Risk and issues log for the programme
- Project plans
- Communication strategy and plan
- Highlight reports

### Programme Governance:

- Healthy Weston 2 Phase 1 Full Business Case and appendices including:
  - Quality Impact Assessment (QIA)
  - Equality Impact Assessment (EIA)
  - Data Protection Impact Assessment (DPIA)
  - Operational Policies

### Engagement documentation (including from the public engagement period (June – August 2022):

- Engagement documentation e.g. leaflets
- Engagement online / paper-based surveys
- Staff engagement documentation
- Public engagement documentation
- Letters
- Emails
- Feedback (non-patient identifiable data)

## 3.2 Data Flows

### 3.2.1 Project Management

Project management documentation will be issued by the programme office by way of email from NHS email accounts. All email accounts are controlled by user name and password protection. The recipients will predominantly have NHS email accounts.

The Project Management documentation will contain project team members' names and job titles and be stored on the ICB's network and the programme MS Teams and NHS Futures shared storage area.

The NHS Futures and MS Teams shared storage area is subject to a national DPIA / information Governance arrangements.

The ICB's network access is controlled through Line Managers authorising access to certain areas of the network based on employees needs to access the folders.

The above data will be stored on the ICB's network, MS Teams shared storage area and NHS Futures for the lifetime of the programme and any challenge period. The data will then be archived in line with the ICB's data retention policy.

## 3.3 Programme Governance

The Phase 1 FBC document and appendices will not contain any patient or staff member identifiable information other than the authors and appointed personnel. Summary data will be included as well as anonymised quotes from stakeholders.

The Phase 1 FBC has supporting appendices in the form of a QIA and EIA. Various non patient identifiable data sets have been collated across a ICB and Commissioning Support Unit (CSU) business intelligence network to create the assessment. The aim of the reports are to understand the current services and assess the consequences of any change whilst maximising the positive impacts and minimising negative impacts of the proposed change. The majority of the information provided is considered as 'in the public domain'.

### 3.3.1 Programme Documentation Storage

The draft and final versions of the Phase 1 FBC will be stored on the ICB's network and the NHS Futures platform.

The document has been shared to the programme team and stakeholders using NHS mail and supporting NHS Futures links.

NHS Futures is a secure NHS platform, with managed authorisation access to specific aspects of the platform. Permission can be granted and reviewed by the project and programme managers.

Programme documents will remain stored on the ICB's network area for the lifetime of the programme and any challenge period. The data will then be archived in line with the ICB's data retention policy.

## 3.4 Engagement Documentation

All emails relating to engagement will be administered through the Healthy Weston email account and the ICB Engagement Team's generic email account. Access to these accounts is through Line Manager authorisation and user name and password protection. Should a letter be received then this is scanned, and the hard copy shredded. The letter is then held on the Patient Engagement team 'S' drive together with any response. The letter is stored in accordance with the team's retention schedule.

### 2.5 Lawful basis for processing personal data under GDPR/DPA 2018 (NHS Digital guidance)

NHS digital guidance has been consulted

**For processing Personal Data:**
GDPR 6(1)(e) – the processing is necessary for the performance of a task carried out in the exercise of official authority vested in the controller by the NHS Act 2006.

**For processing Special Category Data (e.g. health):**
No special categories of personal data will be processed.

## 4 Stakeholder engagement - data protection and privacy risks

The Healthy Weston programme sits under the Healthier Together Integrated Care System, comprised of commissioning organisations and health and social care delivery partners, so there is whole-system ownership of the process used to develop the plans, and all risks relating to the plans are shared.

The assurance and governance requirements for service improvements of this scale are rigorous. To enable this and facilitate the governance and assurance process, the programme has a robust governance structure to ensure that the clinical models are co-designed and assured by both HT system governance and people with lived experience of services.

The BNSSG Healthy Weston Programme is overseen by the Healthy Weston Steering Group where a centralised risk register is managed to identify and mitigate risks associated with the programme. Any data protection and privacy risks are highlighted to the board.

## 5 Data Protection - Summary Risks

The following data protection risks have been identified:

| | Risk | Mitigation |
|---|---|---|
| **Risk 1** | Unauthorised access to lists of individuals names and job titles and email addresses contained on ToR's, action log, minutes etc. | Secure file structure and use of NHS mail. Access to the documents will be available to those with a ICB user account. For documents on the NHS Futures platform, access will be centrally managed and granted by the programme management team. |
| **Risk 2** | Unauthorised access to surveys completed through the survey / engagement systems via hacking the site or accessing the summary reports generated by the system | Strict access control, password protection. Access to the survey / engagement online systems will be limited to the Engagement Team this will be controlled through user name and password protected accounts. |
| **Risk 3** | Unauthorised access to 'hard copy' surveys completed from public engagement period. | Hard copy surveys will be stored by members of the ICB's Insight and Engagement team and only made available to Programme Team members on request with a business need for the hard copy forms. |

| | | |
|---|---|---|
| | | Development and implementation of IG processes including confidential waste management |
| **Risk 4** | Paper copy completed surveys or hand delivered letters are delivered to the wrong ICB department | Clear centralised location for submission, as described on all engagement material. |
| **Risk 5** | Access to commercially sensitive data such as financial information and analysis | Secure file structure and use of NHS mail. Organisations to follow internal agreed governance processes for commercially sensitive information. |