

REPORT TO SHA 20 OCTOBER 2005 APPENDICES

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*Working together on the Bristol Health Services Plan
Building better health services*



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APPENDIX ONE:
MODEL OF CARE:
FULL REPORT

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Working together on the Bristol Health Services Plan

Building better health services

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Bristol Health Services Plan

Model of Care

October 2005

The Bristol Health Services Plan Clinical Redesign Group

This model of care has been developed by the Bristol Health Services Plan Clinical Redesign Group. The group comprises senior clinical staff from all Bristol Health Services Plan (BHSP) organisations and the Strategic Health Authority. It is chaired by the Chief Executive of Bristol North Primary Care Trust and reports directly to the BHSP Programme Board.

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1 Introduction

The Bristol Health Services Plan (BHSP)¹ is a major reconfiguration programme designed to transform, modernise and improve acute and community-based health services in Bristol, North Somerset and South Gloucestershire (BNSSG), over the next ten years. Underpinning the BHSP is a model of care that sets out the basis and rationale for these changes. This document describes this model of care.

1.1 The Bristol Health Services Plan

The plan consists of a series of integrated developments in tertiary, secondary, intermediate, community, primary and self-care. Through the redesign of many current services, the BHSP will deliver patient-focused services that will:

- improve clinical outcomes
- enhance the patient experience
- increase the efficiency of services.

The services will be locally accessible, integrated, modern and sustainable. They will be developed and supported by all partners within the local health community, including independent providers, and they will take into account the potential of these independent providers. Central to these developments is the need to provide and deliver additional choice for patients, as well as modern and flexible healthcare that can adapt to changing needs.

The BHSP will ensure a strategic shift towards primary and community services. This shift will enable substantial numbers of people to be treated in local primary care and community settings, rather than in the major hospitals.

Critical to the success of this shift is the ability of the whole system to:

- increase productivity, including the removal of unnecessary duplication of treatment and investigation between all providers of services
- reduce the rate of increase of referrals to specialist acute/emergency hospitals from primary care
- develop effective links with the independent sector (IS) and social services, and prioritise partnership working across all organisations.

1.2 Development of the model of care

In this document we consider care from three different perspectives: the main areas of healthcare, the main streams of patients and the main teams and systems required to provide services. We also consider the impact of the changes in services on the workforce.

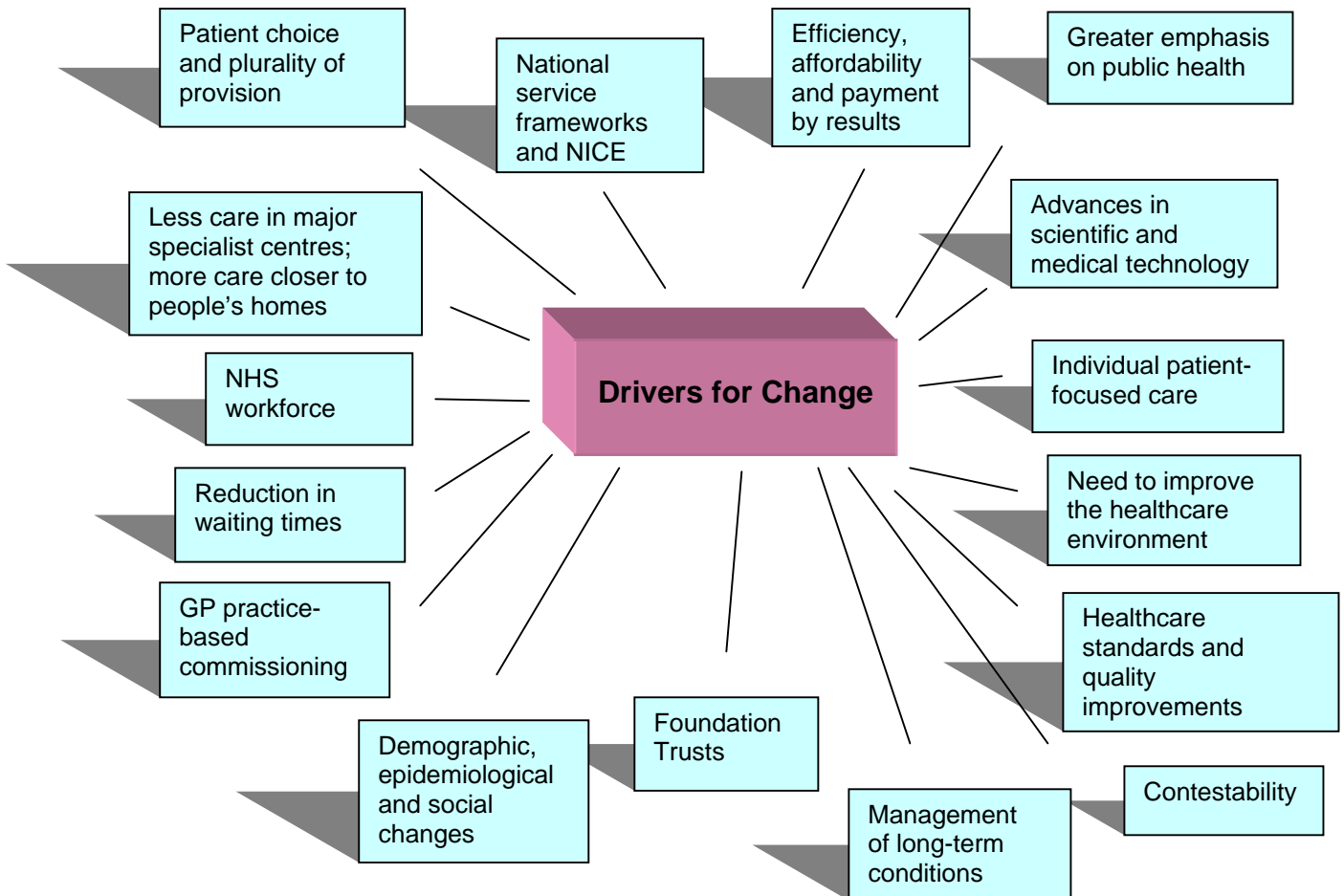
Developing this model will create the coherence needed, as a greater number of providers enter the market. It will ensure that plurality and competition create an integrated, not a fragmented, service. It will provide a framework within which all future services, regardless of who provides them, can develop and thrive.

¹ see Bristol Health Services Plan website at www.avon.nhs.uk/bhsp

2 The New NHS Landscape

This model of care has been developed in the context of a healthcare environment that is undergoing rapid change. A range of factors are changing the way in which healthcare will be delivered in the future.

Figure 1: Drivers for Change



2.1 The Impact of 'Choice'

In particular, the national policy, as outlined in *Creating a Patient-Led NHS*,² is changing the system to create more choice, more personalised care, and greater empowerment of people to enable them to improve their own health. Key themes include:

- choice for patients of when and where they are treated
- better services offered to maintain health, not just to treat sickness
- 'joined up' services, which provide integrated care for patients.

The impact of 'choice' across all areas of services will mean some changes to traditional patient flows. The quality, accessibility, and availability of providers of services within BNSSG may mean there will be increased use of alternative providers outside the NHS sector. This advent of new and alternative providers into the network will also change the provision of the traditional NHS sector.

² DH 2005 *Creating a Patient-led NHS - Delivering the NHS Improvement Plan* see www.dh.gov.uk

3 Developing the Model of Care

The major drive for this model of care is the need for improved patient care, better health and greater choice for the BNSSG population. Care systems will operate around the needs of the patient and their families, and carers.

The model will form the foundation of future patient care pathways, organisation, service and workforce design, new ways of working, health community configuration, the assessment of overall affordability, and a framework for trust and primary care trust (PCT) business cases and implementation plans.

3.1 Objectives

The overall objectives are to:

- provide care **closer to the patient's home** where clinically appropriate.
- provide effective local health services by **harmonising primary care, social care, and local hospital services**, to prevent inefficiencies, gaps in provision, delays and duplication of effort.
- develop **specialist services and networks for a wider group** of patients within the NHS; provide high quality and faster access to specialist opinion, with care provided closer to home, where appropriate.
- provide a **vibrant learning and education culture** that benefits clinical services.
- improve the **efficiency, productivity and value for money** of services.
- enable local services to **respond to national initiatives** such as 'patient choice' and *Creating a Patient-led NHS*, plurality of provision, and contestable services.
- provide a model of care that is **robust and able to both withstand and inform organisational change** e.g. PCT reconfiguration and Foundation status of trusts.

3.2 Principles

The BHSP model of care is characterised by a number of key principles.

Public health

We will maximise the potential large gains highlighted in *The Wanless Report*³ by focusing on the promotion of good health and the prevention of illness, as well as supporting the public to make healthier and more informed choices.

Self-care

This is highlighted in the *NHS Plan*,⁴ and is one of the key building blocks for a patient-centred health service. Research shows that increasing the support for self-care can improve outcomes and increase patient satisfaction.

³ Wanless D 2002 Securing our future health: taking a long term view. Public Enquiry Unit TSO

⁴ DH 2000 The NHS Plan: a plan for investment, a plan for reform TSO at www.dh.gov.uk

Enhancement of primary care

The role of primary care, as the principle orchestrator of patient care, will be enhanced and developed, so that it manages a greater proportion of the patient's care, as well as their overall journey through the health system.

Joined up hospital and community services

Better outcomes can be achieved by joining up hospital, community and social care services more effectively. This will be facilitated by the use of technology, including the National Care Record Service.

Concentration of acute services

More rapid and effective decision-making, avoidance of duplication and increase in quality, flexibility and speed of throughput can be achieved by a concentration of acute and specialist resources and expertise, in a smaller number of places.

Patient empowerment

Patients and carers will be supported and encouraged to make informed decisions regarding their health/condition, and will be full partners in the development and delivery of care plans.

Rapid access and rapid throughput

Patients will receive treatment as soon as they are clinically ready and will not be waiting in queues for a diagnosis, or treatment. Immediate expert assessment will be provided for patients with acute problems, when required.

Harmonisation of approach

Equity of access for patients will be achieved by using a more systematic approach across the community, including the adoption of joint protocols by community providers and social services.

Case management

Patients in all parts of the health system will have their care coordinated by staff who will be responsible for them. There will be an integration of assessment and planning processes for patients.

Flexibility

The model responds to *Creating a Patient-led NHS*, by creating clinical systems and working partnerships within which a range of treatment and care options can be provided. Services will have the ability to flex and change in response to changes in technology, service approach, clinical process, local needs and national drivers. This will dictate a more generic approach to the provision of beds, theatres and diagnostics.

Governance

Shared governance arrangements will support the model of care, with an emphasis on enabling patients to move smoothly between services, regardless of organisation. There will be mechanisms in place to ensure clear lines of responsibility and accountability for care across organisations.

Increased efficiency

Simplifying care pathways will enable us to reduce inefficiencies in the whole system, by avoidance of unnecessary duplication and/or fragmentation of services.

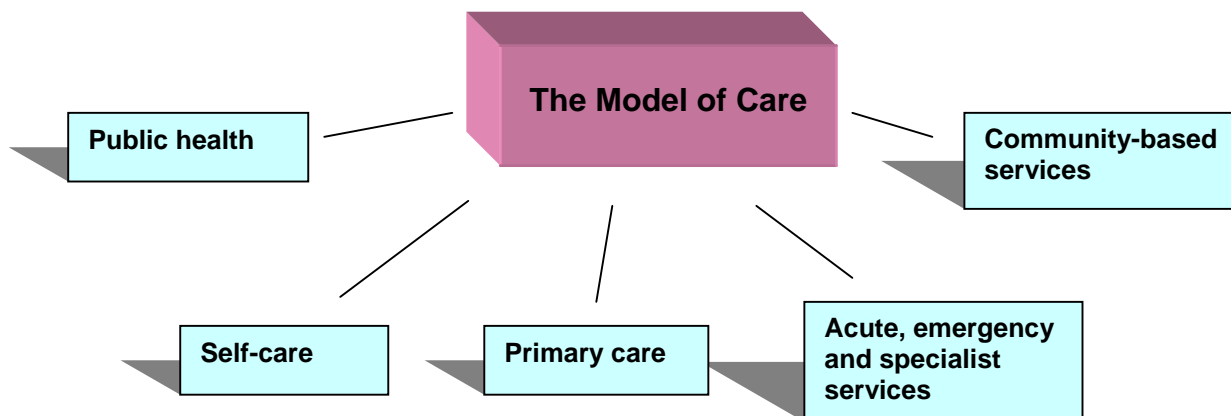
Plurality and contestability

The model will provide a coherent framework within which future services can develop, and ensure that plurality and competition create an integrated, not a fragmented, service.

4 The Main Areas of Healthcare

The BHSP model of care covers five main areas of healthcare.

Figure 2: Areas of healthcare covered by the model of care



4.1 Public Health

Public health initiatives aim to:

- tackle health inequalities
- reduce the number of people who smoke
- reduce obesity and improve diet and nutrition
- increase physical exercise
- reduce harm and encourage sensible drinking
- improve sexual health
- improve mental health and well-being.

In addition, the following areas will be addressed.

Community health development

We will emphasise community health development work, to ensure the most deprived of our local communities have the information, support and infrastructure to be able to benefit as much from health improvement and health service activity, as other communities.

Quality cancer care

We will ensure quality cancer care across the full range of the patient pathway, and ensure the delivery of national cancer screening programmes to the highest standards.

Coronary heart disease

We will ensure care across the full range of coronary heart disease and diabetes disease expression, and with a particular emphasis on preventive activity. This will include stopping smoking, maintaining a sensible diet and weight, and taking adequate exercise.

Diabetic retinopathy

We will implement the national screening programme for diabetic retinopathy.

Children and young people

We will work to improve the health of children and young people through partnership activity, and through supporting the integration of services. Specific tasks include reducing the rising levels of obesity, increasing breast-feeding rates, the better management of education/behavioural disorders and reducing teenage pregnancy rates.

4.2 Self-Care

Our increased support for self-care will improve health outcomes, increase patient satisfaction and help in deploying the biggest collaborative resource available to the NHS and social care – patients and the public. Our key self-care initiatives include:

- *'The Expert Patient'* programme⁵
- chronic disease management in primary care
- secondary prevention, including exercise, weight and smoking cessation
- enhanced preventive services for heart and lung diseases.

New specialist expertise and skills are required to support these programmes, and addressing how these skills are obtained and developed is an important part of our workforce assessment.

4.3 Primary Healthcare

Primary healthcare will remain a fundamental and central building block of community-based care, and the coordinating point for integrated primary healthcare teams.

The model of care will enable primary care to support the patient, maintain the patient's independence and reach rapid and accurate diagnoses. Admission to inpatient services will be avoided and care will be provided closer to the patient's home, wherever this is possible and clinically appropriate.

Primary healthcare will provide:

- first contact and assessment of patients, diagnosis, care, treatment and referral
- 'whole of life' care for patients, including continuing care, rehabilitation, long-term conditions management, and terminal care

⁵ see www.expertpatient.nhs.uk

-
- provision of extended and enhanced care for all sections of the population
 - diagnostic services including mobile facilities, where appropriate.

Practice based commissioning

*Commissioning a Patient-led NHS*⁶ indicates that there will be 100 per cent coverage of practice-based commissioning by December 2006. Whilst the impact of this will need to be more fully assessed in a local context, it can be assumed that, subject to the availability of 'choice' of provision, it will enable GPs and their teams to innovate and transform patient pathways.

This change will also impact on hospital-based services. There will be a greater focus on controlling demand and remodelling pathways e.g. follow-up and continuing care from the acute sector specialists, enhanced case management, and new pathways in the management of long term conditions and chronic disease, which will impact on unplanned admissions.

Support for GPs

GPs will be supported to enable them to care for more patients (where appropriate), without the need to refer to specialist hospital care. Examples of support include:

- improving levels of skill within/between practices
- supporting GP decision making with better guidelines
- making specialist advice much more easily available by incorporating this function into consultant and other specialist job plans
- using new technologies e.g. tele-medicine and transfer of radiology images.

4.4 Community-Based Services

A network of community-based healthcare services will be expanded and developed, to increase the range and volume of services provided closer to people's homes. These will incorporate a number of the services currently provided from acute hospital sites, reducing the need for many patients to travel. There will be close links with social care services.

Community-based healthcare facilities will include a range of services appropriate to the population and consistent with the principles of the model of care. This will include a mix of services from the following:

- high volume and low complexity outpatient services
- elective minor surgery (local anaesthetic)
- minor injury/illness services
- diagnostics (e.g. routine x-ray, ultrasound, endoscopies)
- maternity outpatient services
- rehabilitation support

⁶ Department of Health 2005 *Commissioning a Patient-led NHS* see www.dh.gov.uk

- intermediate care
- therapy services
- children's and long-term conditions clinics
- some inpatient beds such as for intermediate care and rehabilitation.

Most services will not be provided from every location and work is in progress to agree the optimal location of community-based services to ensure:

- patient safety
- clinical efficiency and effectiveness
- ease of access
- effective capacity planning
- the distribution of specialist skills and equipment.

Community hospitals and healthcare centres will provide a focus for healthcare provision in each locality. These centres will relate closely to primary care centres and GP surgeries. Co-location of services, such as minor injuries and primary care out-of-hours services will be beneficial. They will require access to GPs, nurses, midwives, therapists and specialists with a range of skills. Clinician work plans will reinforce vertical integration of the clinical teams. Many staff will be peripatetic and will work in different settings and across organisational boundaries. The emphasis will be on seamless care achieved by appropriate integration of the clinical team, regardless of employer or base.

The expansion of local community health services will also complement wider action on regeneration, enhance public health, contribute to the reduction of inequalities, and provide improved access for those with long-term conditions.

4.5 Acute, Emergency and Specialist Services

The function of the emergency/acute services in BNSSG will be to provide major Accident and Emergency (A&E) services, complex elective work and low volume, highly complex and multi-specialty outpatient work, supported by relevant diagnostics and clinical support services.

The provision of these services will lead to better health outcomes, more efficiency and the prevention of crises. They will concentrate on solving problems promptly and returning people to their homes as quickly as possible. This will be through close liaison between hospital and community services, active case management and accelerated recovery programmes, e.g. fast tracking elective surgical patients through the acute phase of their care.

By 2013, BNSSG will be served by three centres of emergency/acute and specialist care:

- Bristol Royal Infirmary, Bristol Children's Hospital and the rest of the central Bristol complex
 - The new North Bristol/S Gloucestershire acute/emergency hospital at Southmead
-

-
- Weston General Hospital.

Services will be rationalised to avoid the duplication and fragmentation of services across the three centres. This will enable the development and concentration of specialist skills, expertise and equipment in the fewest number of settings, allowing for critical mass, sub-specialisation, economies of scale and access to improved services. Providers will work within the guidelines set out by the national service frameworks (NSFs) and *Improving Outcomes Guidance*.⁷

It is recognised that this will lead to centralisation of some services on single sites. Work has started on the plans to centralise and rationalise breast services, adult ear, nose and throat (ENT) and children's inpatient services. Further work will be undertaken to identify the long term location and co-location of other acute, specialist and – in the case of the two major Bristol hospitals - tertiary services, at each relevant acute hospital centre.

There will also be:

- **planned elective care separated from emergency care** to avoid disruption to elective inpatient cases and allow a wider range of providers
- **major expansion in designated day case surgery** and investigation. This will be housed in purpose-built accommodation capable of handling high volume workload and facilitating a high standard of safe service. Options for provision include the independent sector.
- innovative approaches developed to **resolve problems of out-of-hours shift rota provision**, resulting from implementation of the *European Working Directive*. This may include identifying core skills required across specialties in the emergency/acute hospital at night, and introducing more city-wide rotas in some specialties in Bristol.
- **efficient emergency departments within high quality environments** and designed to meet the requirements of the guidelines of the Bristol Association of Accident and Emergency Medicine and Faculty of Accident and Emergency Medicine.⁸ This will necessitate a review of the model of service in emergency departments including provision of trauma services.
- the **ongoing rationalisation and streamlining of major acute centres** which will enable resources to be released to invest in the provision of primary care and community-based services.

4.6 Tertiary Services

Bristol's acute Hospitals will continue as the major providers of tertiary services for the South West and parts of Wales. Areas of highly specialist expertise will, as now

⁷ National service frameworks at www.dh.gov.uk and *Improving Outcomes Guidance* at www.nice.org.uk

⁸ see www.emergencymed.org.uk/FAEM and www.ubht.nhs.uk/ed

be provided to a larger regional area with some provision at a national and international level.

The work covers both elective and emergency care and is frequently resource intensive. Services are complex and, apart from a few high volume and elective procedures, are unlikely to be undertaken in the independent sector. There is an assumption that maturation of 'payment by results' will ensure costs are not cross-subsidised by the locally commissioned secondary services. However, the biggest service demand is from areas of high population and, therefore, the greatest numbers of patients will continue to be from Bristol and the surrounding community.

Access targets will need to be met. Service development will account for the appropriate adjacencies of specialties, especially where there is a commitment to both adult and paediatric care. Split working patterns will be kept to a minimum. The provider trusts will work collaboratively delivering timely care without interference to secondary provision.

Bristol will continue to support research and strategies to allow rapid transfer from laboratory bench to clinical application. This is most likely to occur in key tertiary services e.g. oncology, neurosciences, renal and cardiac, where staff will to be provided with both the right environment and strong links to universities in order to deliver. Key to the aim is development of modern clinical research facilities and the Bristol will position itself to take full advantage of reforms in NHS research funding.

4.7 Mental Health

Avon and Wiltshire Mental Health Partnership provide mental health services. The service model is set out in *Modernising Mental Health Services in Avon*⁹ in which the key principles are:

- consistency with the National Service Framework for Mental Health i.e. improving mental health services for adults of working age and for older people.
- services to focus on developing community-based services.
- general services for adults and older people to be provided as locally as possible.
- specialist services also to be provided as locally as possible, using 'whole community' solutions, where appropriate, for these high cost and low volume services.

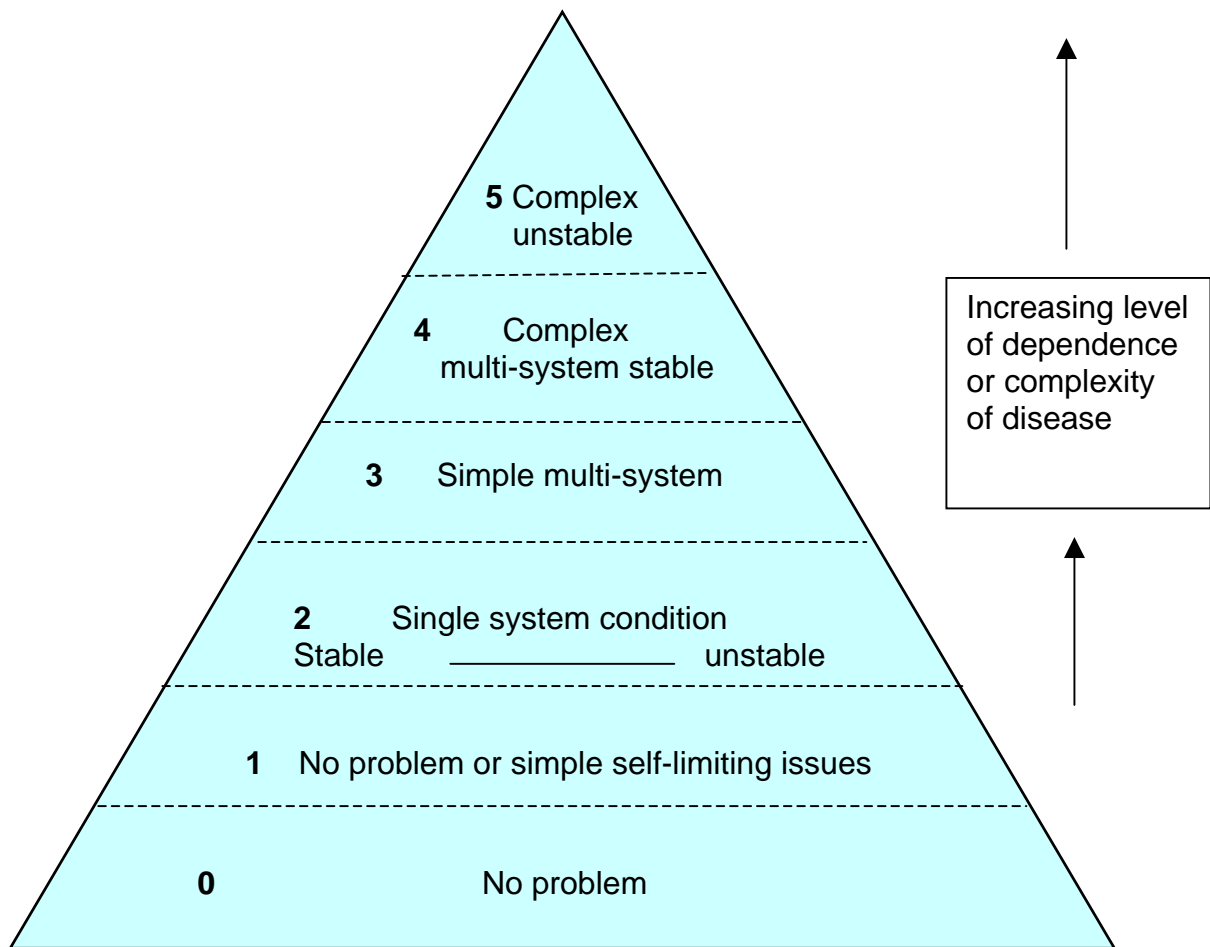
⁹ see www.awp.nhs.uk

5 Main Streams of Patients

To develop the model of care, patients who use services have been categorised into main streams. This categorisation is used in the document to show how these flows of patients interact with the various elements of the health system.

The main categories of patients are illustrated in the diagram below and examples given in the subsequent table.

Figure 3: Population Triangle of Health and Social Need



The triangle represents the whole population. When an individual is located in the higher levels, this represents high need and high complexity of need. This does not necessarily represent greater demand on hospital services, but greater need of complex health, social and voluntary sector input.

The examples in the table overleaf illustrate where individuals may be placed and how they may move between levels.

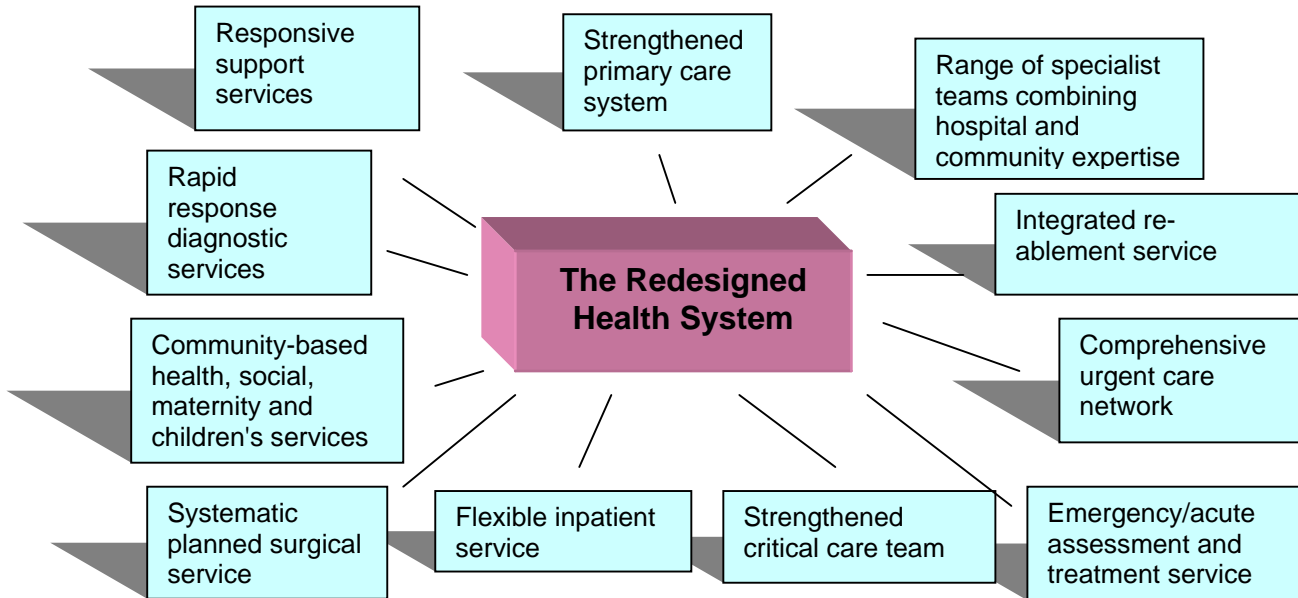
Figure 4: Population Triangle examples

	Overall category	Description	Example
0	No problem	Person at risk of problem, but with no current use of services.	Young smoker.
1	...or simple self limiting issues	Simple self-limiting illness that leads patient into single system problem, but then returns to full health.	Acute appendicitis or simple chest infection (simple system condition until returns to full health).
2a/ 2b	Single system condition – stable or unstable	2a Single system problem. Need for long term supervision or acute complex short term input. 2b Single system problem that develops into a complex and/or multi-system problem.	2a) Diabetes mellitus or myocardial infarction in the past. 2b) Diabetic patient develops myocardial infarction, renal failure and acute heart failure (complex unstable), recovers from acute episode but continues with more complex needs (simple multi-system).
3	Simple multi-system conditions	Simple multi-system problem, high level of dependence and support needs. Surgery complex because of risks of infection and respiratory compromise but post surgery and rehabilitation is able to return to higher level of function.	Patient with chronic obstructive pulmonary disease (COPD) and osteoarthritis of hip.
4	Complex multi-system stable	Complex multi-system stable This situation can easily break down with changes in social situation or by acute infection leading to a complex unstable situation. Good communication of both health and social care networks are vital in these situations.	COPD, diabetes with dementia or mental health problems.
5	Complex unstable	Complex multi-system, possibly including social, patient requiring intensive multi-disciplinary/agency input. Usually a transient phase but requires rapid response to condition in all cases.	Patient with a medical or social crisis requiring immediate resolution, such as by providing intensive support in a domiciliary placement, admission to acute hospital, or care home.

6 Main Teams and Systems

The redesigned health system in BNSSG consists of a number of teams and systems.

Figure 5: The redesigned health system



6.1 A Strengthened Primary Care System

Primary care will be a fundamental part of all the care systems and will be the main orchestrator of care for most patients. GPs, in their role as practice-based commissioners, will play a significant role in determining effective and efficient pathways of care for their patients. They will be supported in taking a greater role than currently, in the diagnosis and treatment of patients in community settings.

The main features of the new strengthened primary care infrastructure will be:

- orchestration of care to **coordinate patient care** and treatment
- **agreement and implementation of protocols** and best practice standards
- full **access to diagnostic facilities**, where investigation in the community is appropriate
- **improved access to specialist opinions**, diagnostics, intermediate care and support from specialist and hospital care
- shared care with **cooperative working** between hospital and primary care teams
- improved **communication infrastructure**, including e-mail access to opinions and electronic test results
- enhanced **development and training opportunities** including development of 'Practitioners with a Special Interest' (PwSI) roles

- appropriate **hospital support**, to enable the care of long term conditions in primary care
- **empowerment of patients**, including access to information and education, expert patient programmes, and direct access to services.

6.2 Integrated Re-ablement System

This 'integrated re-ablement system' will combine community hospital nursing teams, therapy teams, social care teams and home and practice-based services, to provide 'joined up' assessment, planning and delivery of care.

The team will overlap with, and have strong working relationships with, primary health and social care services. This will increase the capacity of local services to maintain the independence of people with a range of health and social care problems. The service will have a range of beds in community hospitals that will be used to rehabilitate patients.

The service will have three main elements:

- an integrated community-based assessment and case management team, combining social and healthcare skills
- a front door reception and assessment function that will assess and prepare plans for patients arriving at the emergency/acute assessment service
- a community hospital bed management team with a close relationship with the community based support service and other teams.

Key features of this service will be:

- case management of patients coupled with clear care planning.
- a focus on building cohesive, well-led, multidisciplinary teams.
- a clinically appropriate pull-through system orchestrated by the team with the emphasis on pulling people back towards home once they have attended/been admitted to hospital.
- community hospital beds run by the team with easy access to other services and close connection with the acute service.
- an arm of the team based by the front door of the hospital to redirect patients or to start care and recovery plans immediately from the point of admission.

6.3 Networked Specialist Teams combining hospital and community expertise

The local population will be served by a series of specialist teams with a strong community focus. They will provide a seamless and integrated service for patients, from prevention and health promotion through to intensive care and support. These teams will support the delivery of primary care services when specialist support is required, and will improve the capacity of local services to manage populations of patients with specific conditions, and maintain them at home where possible. This will include outpatient, inpatient and community services.

Key features of these teams will be:

- combine primary care and hospital expertise to provide a single, full spectrum service for a patient population/specialty area e.g. respiratory services to include consultants, physiotherapists, administrative staff, nurses, GPs with special interests (GPSI) and 'expert patients'.
- systemisation of these team activities, so that a continuous service can be provided to patients in acute and community settings e.g. one consultant being in charge of acute duties, whilst another covers consultations and advice with primary care, whilst another is on leave.
- a shared governance approach to individual patient care.
- self management by the teams with the responsibility for delivery of services and adherence to targets (with incentives to deliver) and the ability to control the care planning and treatment of patients from first point of contact with services.
- rapid access to specialist expertise opinion with on-going care provided closer to the patient's home.
- multi-disciplinary team approach making best use of all the members of the team.
- a clinically appropriate pull-through system orchestrated by the team, with the emphasis on pulling people back towards home once they have attended/been admitted to hospital.
- no-wait services without backlogs and with protocol led access for all members of the multi-disciplinary team.
- easy and informal access to specialists through e-mail etc.
- empowered patients with enhanced advice and support.
- protocols to govern patient pathways, with full agreement from specialist teams and primary care teams.
- adoption of case managers (nurses or therapists) to give patients under chronic care management direct access to support.

6.4 A Comprehensive Urgent Care Network

This primary care led system, which is closely linked to the Emergency and Acute Assessment and Treatment Service, will be accessed by patients on a 24-hour basis by telephone (through the practice, NHS Direct, or 999), or through presentation at a minor injuries unit or Walk-in Centre, either in a community setting, or on the main acute hospital site. A triage process will lead to assessment and treatment either at home, in an ambulance (for example by an emergency care practitioner), at a GP practice, or in the minor injuries unit/walk in centre. In the case of minor illness or injury (including, for example, simple fractures), once treated, the patient will return home. If triage highlights a major illness or injury then there will be direct access to the Emergency/Acute Assessment and Treatment Service.

This service will incorporate out-of-hours GP teams and a network of facilities based in community centres. The service will provide training opportunities for

junior medical and other health staff and will construct these training programmes in tandem with the emergency/acute team.

On the hospital site, this service will give the main hospital a primary care 'front door', providing the opportunity to re-route patients attending the main hospital into community services, and to provide access into the main primary care system.

6.5 An Emergency/Acute Assessment and Treatment Service

This service will include the A&E and acute assessment teams, and will provide a rapid decision-making and treatment service for patients with major illness or injuries. The team will have a primary focus of re-routing patients back to the community through rapid access to assessment, diagnosis and treatment and preventing inpatient admissions unless absolutely necessary. It will have a strong working relationship with the comprehensive urgent care network described above.

It is anticipated that patients will not self-refer to the service, but will access it after triage, either through the ambulance service, the practice, or the Walk-in Centres/minor injuries units in the community, or on the hospital site. The development of this team will give the specialist medical teams and the primary care team, facilities where their patients can be assessed and treated, in dedicated areas run by dedicated staff.

The main features of the new service will be:

- a 'see and treat' principle
- a multi-disciplinary approach
- integrated working between emergency departments and acute assessment teams
- concentration on processing patients and preventing admission into IP beds
- ability to hold patients until a clear decision is made
- principle that this service initiates the hospital based care pathway
- assessment and stabilisation of children prior to transfer.

6.6 A Strengthened Critical Care Team

This team will have a central core of high intensity services that will support the other teams. The team will run a central area, as well as providing outreach advice and support to other teams.

There will be three main groups of patients accommodated in the service:

- level 3 patients (ventilated and/or in multi-organ failure)
- level 2 physiologically unstable patients
- level 2 physiologically stable, but high-risk patients that need monitoring. Risk may be due to both the nature of surgery, and/or to patient co-morbidity.

The main principles of the new service are:

-
- harmonisation of critical care services, including improved provision for the detection and early treatment of critically ill ward patients, across all specialties and diagnoses.
 - networks of critical care provision - the new service will work in harmony with services at UBHT and other nearby hospitals, and has a responsibility to provide its share of sector-wide level 3 bed requirements. Inbound transfers due to external requirements for level 3 beds to support other trusts, will form a small but significant route of entry to the hospital.
 - flexible, highly trained workforce - the service will rely on a pool of staff with elements of multi-skilling to enable the service to be resilient to change and to be able to absorb peaks and flows in demand.
 - leadership - the service will have a team of intensivists that will take responsibility for the overall clinical management of the unit. The intensivists will work closely with the emergency and acute specialists and with surgeons and physicians who have patients on the unit.

6.7 A Flexible Inpatient Service

This service will be run as a single aggregated service that is capable of moving patients quickly, safely and efficiently through the system, and that has maximum flexibility. This service will be organised into units and clusters, which recognise specialty adjacencies, so that services are appropriately grouped together. The boundaries between these areas of specialism will, however, be fluid.

The key features of the service are:

- a bed and theatre slot pre-booked for the patient
- patients admitted to an inpatient bed for an elective procedure (except patients requiring complex pre-operative treatment or stabilisation) will be allocated a bed after the procedure has taken place
- patients admitted to an inpatient bed as an emergency will have been stabilised and will have had initial diagnostics before admission to the inpatient facility.

Clinical teams will not own beds except in the case of specialist services, which are dependent on key adjacencies, equipment and facilities.

6.8 A Systematic Planned Surgical Service

There will be whole-system planned care services that will provide one-stop, assessment and treatment for the majority of elective work. These services will include:

- rapid access services for minor and intermediate elective work with associated diagnostics
- whole-system complex surgery services based on systematic pre-planning and accelerated recovery techniques.

Key characteristics will be:

- pooling of referrals into broad streams of work for the purpose of assessment, booking and treatment
- rapid access to assessment and booking of treatments
- a one-stop process for minor electives, where appropriate i.e. diagnosis followed by immediate treatment
- health and social care pre-operative assessment in primary care, with consenting and final confirmation of appropriateness for surgery undertaken in the acute setting
- systematic case-management of major electives, including timely pre-assessment (mainly community based), check-back on all results pre-admission, and management of follow-up pathways
- admission on the day of surgery except for those patients requiring complex pre-operative treatment or stabilisation
- organisation of reception and arrival, same-day in the majority of cases, through a theatre holding area.
- responsiveness to technological advancements and maximisation of day case treatments and minimally invasive procedures, wherever clinically appropriate
- fast-track recovery processes in a dedicated unit with co-ordination of anaesthetic techniques and assertive recovery support, to ensure minimum time in hospital
- enhanced home support pre and post admission from the surgical teams to supplement general primary care support.

6.9 Rapid Response Diagnostic Services

The key characteristics of these services will be:

- networks of provision across the locality structured to reflect economies of scale and local access. These networks will be developed in more detail as the service is designed and will need to be able to reflect patient choice.
- access by patient need rather than requesting clinician or patient location.
- rapid access and reporting, matching capacity to demand.
- digital imaging coupled with electronic ordering and access to reports.
- spread of expertise to allow widening of process bottlenecks.
- access to specialist advice on investigation to support appropriate use by primary care.
- maximum use of tele-medicine and latest technologies to allow decision-making at distance.

6.10 Responsive Support Services

The new system will be backed up by a range of responsive support services making the best use of modern technology and approaches.

There will be some general themes in the development including:

- technology advancement including '*Connecting for Health*' will continue, enabling rapid change and improved efficiency
- process improvement, including the use of technology, will continue and add real value to the clinical processes.

6.11 Community-based health, social, maternity and children's services

Key features are:

- redesigned, locality-based, pathway-led services from secondary care, to support primary care services
- commissioning in line with NSF/*Change for Children*
- a single inpatient site for children's services
- discussion about the future for maternity/neonatal services, both in the community and in hospital.

7 Workforce

The new clinical system has significant implications for the workforce.

7.1 Agenda for Change

The NHS workforce throughout the country will undergo considerable development in the years ahead, through *Agenda for Change*.¹⁰ Our challenge will be to ensure that there is mutual strength gained by integrating these developments, with changes required to support the model of care.

The key issue is how the recruitment, retention and development of staff needs to be adjusted, to ensure that the agreed models of care can be delivered. Key features include:

- staff development
- sustaining the expected changes
- full utilisation of *Agenda for Change* as a catalyst for redesigning roles within a competency framework.

We should expect significant role redesign and skill mix with a radical review of which roles deliver specific aspects of care. We need to consider:

- IT systems
- improved processes
- strategic outsourcing of services within the context of a plurality of providers
- the development of specialty teams working across organisational boundaries. More groups of staff will become 'peripatetic', following the patient through the whole care pathway.

7.2 Main Themes

These are the key issues that arise from the model of care that will impact on the workforce.

- Primary care will become the main coordinator of care.
- There will be a plurality of providers within primary and community settings.
- The break-up of traditional functional departments into new services will need the re-adjustment of some professional boundaries e.g. relationships between acute/medical; assessment and A&E.
- The integration of working between primary and secondary care sectors will lead to new role definitions e.g. role of GP and/or specialist practitioners in minor injuries/illness and some outpatient services.
- There will be an increased emphasis on competence-based and cross-organisational team-working, as opposed to hierarchical and organisational systems.

¹⁰ see www.dh.gov.uk

-
- A focus on active rehabilitation and fast-track recovery will reinforce the role of therapists and nurses with rehabilitation skills.
 - The creation of fairly generic departments and teams will lead to a degree of multi-skilling.
 - The development of the bed-cluster within the North Bristol/S Gloucestershire acute hospital, rather than the specialty-specific ward, will require greater flexibility.
 - Inpatient acuity in the three emergency/acute hospitals will increase as a result of the expansion of day surgery/investigation, and the strategic shift towards primary and community services, which will treat many of the less complex conditions.
 - A more fluid interface between specialists and GPs will require a more flexible and qualified administration team.
 - Increasing emphasis on 'do-now' diagnostics, will require a diagnostic team that identifies with the patient processes as a whole, as opposed to the processes within the department. There is an issue around incentivisation and alignment with overall organisational goals.
 - There will be increased integration between health and social care and the advent of practice-based commissioning.

8 Impact of Affordability

As the rate of increase in NHS investment reduces and competition in NHS service provision increases, healthcare organisations in Bristol, North Somerset and South Gloucestershire will need to operate ever-more efficiently.

The advent of payment-by-results, patient choice, practice-based commissioning, pressure to secure income whilst driving down costs, and increased use of the independent sector, could have a significant effect on the model of care.

Whilst the current model of care is based on broad assumptions concerning these changes, the Clinical Redesign Group will need to take more detailed account of these policies, as the national and local implementation programmes proceed.

9 Further Development of the Model of Care

The model of care is a working model that will evolve and develop in the light of changes to the local and national NHS policy context, demographic changes, advancements in technology, and changes in service practice. It will also be shaped by periodic and systematic local health needs assessments.

The Clinical Redesign Group will continue to:

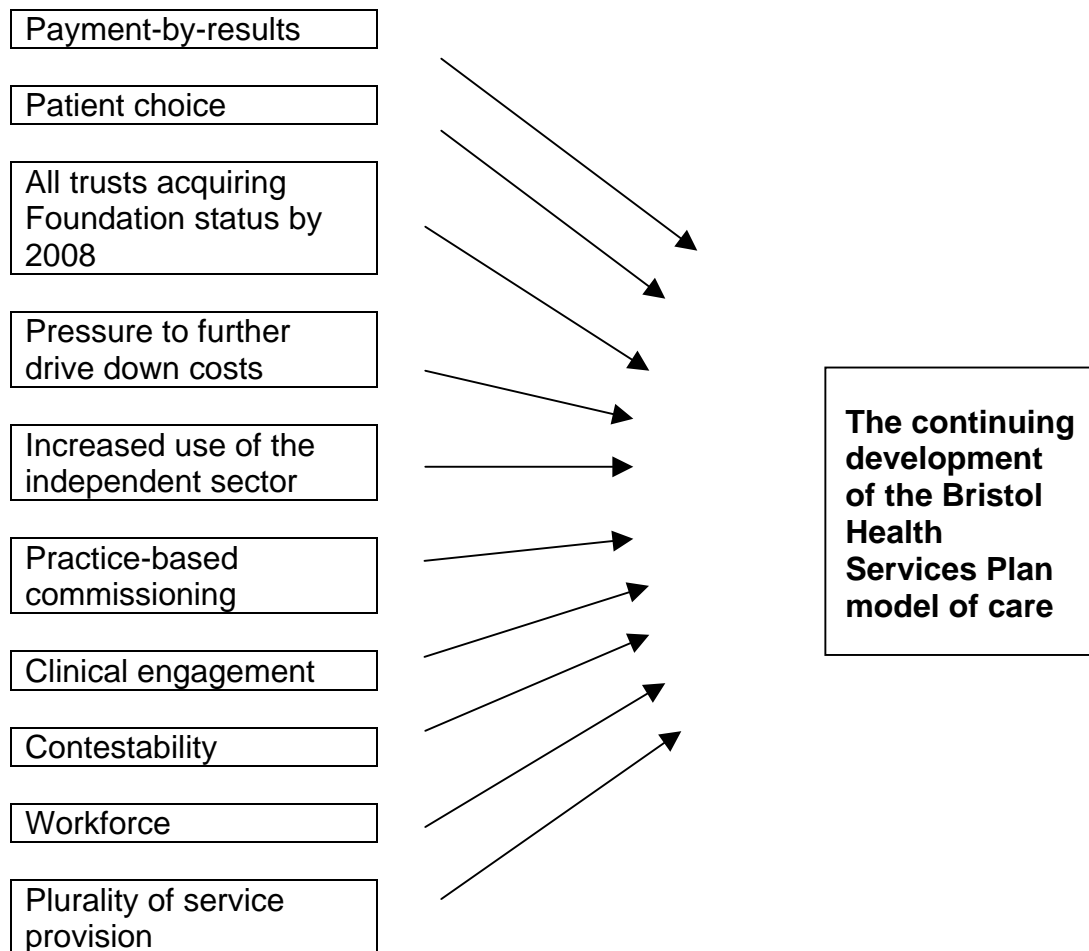
- confirm the clinical assumptions underpinning the model of care
- provide clinical leadership to the BHSP and ensure that clinical issues are fully considered by other key groups (e.g. Programme Board, Programme Management Group, cross-cutting groups, etc).

It will also continue to develop the model of care to ensure that it:

- provides optimal care and treatment for the population of BNSSG
- includes the strategic aims and approaches of the major service groups
- achieves the optimal configuration of services between settings and sites in the context of all drivers for change.

The Group will take particular account of the emerging impact of the factors shown in figure 6.

Figure 6: Major factors with an emerging impact on the development of the model of care



The Group will also advise on:

- the growth or reduction of referrals and their affordability
- mechanisms to constrain forecast of hospital activity to affordable levels
- making the BHSP proposals affordable through clinical rationalisation
- determining how the work will be delivered
- the likely impact of practice-based commissioning
- how patient flows can be managed to avoid duplication of capital build costs

-
- the impact of independent sector strategies
 - the assessment of comparative models of care.

Collaboration between all health, social care and independent sector partners will be key to ensuring that the model of care remains fit for purpose and delivers the ends for which it is designed. Staff, patients and the local community will continue to be involved in the development, implementation and communication of the model of care.

The BHSP Clinical Redesign Group will continue to develop this model of care. If you have any comments, or would like a copy of the full document, please contact the BHSP Programme office (details below).

Email	bhsp1@bristolnorth-pct.nhs.uk
Free phone	0800 015 5127
Address	The Bristol Health Services Plan FREEPOST BS1078 King Square House King Square Bristol BS2 8EE
Fax	0117 900 2514
Website	http://www.avon.nhs.uk/bhsp

APPENDIX TWO:
WORKFORCE

1. Introduction

- 1.1 This is the first attempt by NHS organisations across Bristol, North Somerset and South Gloucestershire (BNSSG) to take a whole system-wide, holistic and analytical approach to the workforce implications arising out of the Bristol Health Services Plan and other major developments. It relates directly to staff currently employed by the 3 acute Trusts and 4 PCTs across BNSSG and makes reference to changes in other parts of the healthcare sector – incl. the GP/primary care workforce, mental health, ambulance services – and other related sectors such as social care.
- 1.2 The workforce implications have been identified that arise out of the emerging national policy framework and associated local service changes in acute/emergency services, community-based services and primary care over the next 10 years.
- 1.3 Much progress has already been made by local NHS organisations to develop and implement a range of significant workforce initiatives – incl. new pay arrangements and role redesign. There is strong commitment to continue this work.

2. Key Facts

- 2.1 The NHS in BNSSG (excl. mental health, ambulance) employs nearly 20,000 staff (approx. 16,000 wte):-

<u>Employer</u>	<u>WTE</u>	<u>Staff-in-Post</u>
North Bristol NHS Trust	6588	8135
United Bristol Healthcare NHS Trust	5903	7061
Weston Area Health NHS Trust	1414	1789
Bristol North PCT	658	852
Bristol South & West PCT	545	709
South Gloucestershire PCT	381	503
North Somerset PCT	344	458

- 2.2 The local NHS (acute/PCT) employs 5% (1 in 20) of the total workforce in BNSSG (all sectors)
- 2.3 Staff costs constitute approx. 70% of local NHS expenditure - the single most significant resource and investment in the NHS.

- 2.4 Over half of all local NHS staff are employed in registered healthcare roles; 22% occupy healthcare support roles.
- 2.5 Nearly half of the local NHS workforce is aged over 45; 14% are aged over 55 and therefore eligible to retire in the next 10 years
- 2.6 Almost half (49%) of all locally employed NHS staff work part-time (compared to 25% in all sectors nationally)
- 2.7 4/5 (81%) of local NHS staff are female – similar to the national NHS profile (compared to approx. 50% in all sectors nationally)
- 2.8 On average, local NHS labour turnover equates to approx 14% (incl. rotational posts)

3. Key Drivers

- 3.1 There are 4 key drivers that will affect the shape of the future healthcare workforce in the area. These are :-

Changes in Service Models & Delivery

- Changes in the boundaries between secondary and primary care
- Extended primary care
- Self-care and care nearer to the home
- Intermediate care
- Chronic disease management
- Increase in day surgery/minimal stay
- Extended ambulatory care models
- Separation of emergency and planned care pathways
- Higher proportion of increased acuity and more complex cases in acute hospitals

Workforce supply

- Changing demographics
- European Working Time Directive 2009 - 48 hours
- Workforce availability - training post numbers (e.g. junior doctors, allied health professionals, nursing)
- Modernising Medical Careers
- Agenda for Change

National policy drivers

- Creating a Patient-Led NHS
- National Programme for Information Technology (NPfIT)
- Patient Choice
- Healthcare market
- Organisational reconfiguration

Affordability

- Gershon Review and Agenda for Productive Time
- Payment by Results
- Local affordability constraints
- Service rationalisation

4. Key Workforce Implications

- 4.1 In order to successfully deliver the Bristol Health Services Plan and other major developments in the area over the next 10 years, NHS organisations will be faced with the following key workforce implications :-

The Healthcare Marketplace

- 4.2 Patient choice, contestability, plurality and a greater drive towards quality improvement and clinical governance will force a more commercially-driven approach to workforce management and development.
- 4.3 A more fragmented healthcare market will provide a significant challenge to system-wide workforce planning and education and training strategic investment. As more employers enter the NHS marketplace, this will have significant legal (contractual, TUPE) and practical (motivational, career pathways, geographical, financial) consequences for NHS employers and employees.
- 4.4 The emergence of the independent sector will require sufficient planning to ensure that the resulting workforce changes are effectively managed.

Affordability

- 4.5 Affordability will be an ongoing constraint as healthcare organisations continue to drive hard towards greater efficiency. This will be further tested by payment-by-results and increased competition. Since staff costs constitute the largest single form of NHS expenditure (approx. 70%), financial recovery plans will drive further scrutiny of workforce numbers and a reduction in unit labour costs.
- 4.6 Key challenge to NHS employers : to deploy the most cost-effective workforce that is affordable within the challenging future affordability envelope.
- 4.7 Greater pressure to reduce transactional costs and costs of back-office functions.

Workforce Strategy

- 4.8 Unprecedented opportunities exist for healthcare employers to focus upon – and apply creative approaches to - workforce management and development as a key lever for organisational and service improvement.
- 4.9 NHS employers will be required to play a much more significant role in workforce market development and management. Opportunities exist to develop and manage cross-organisational/boundary strategies to address recruitment and retention, staff rotations, continuing professional development, etc.
- 4.10 Transitional arrangements to new organisational forms and functions will require clear planning and effective change management processes.
- 4.11 Employers will need to invest in and focus on critical organisation development interventions to ensure that organisational and workforce design and culture is fit-for-purpose.

Staff Numbers - Recruitment & Retention

- 4.12 The pressures to recruit and retain staff will not subside but are likely to increase given changing demographics and greater competition for skilled workers (and especially younger workers) in one of Europe's fastest growing and most prosperous economic sub-regions.

- 4.13 Healthcare employers will be required to focus further on recruiting and retaining high calibre staff - to become 'employers of choice'.
- 4.14 Overall staff numbers across BNSSG are expected to grow in line with increasing healthcare demand. Staff transfers and redeployment between organisations are also expected to grow in number in light of acute service rationalisation and transfers from acute settings to community-based settings and alternative providers of healthcare. This will strengthen the need for more effective workforce planning.

Labour Utilisation

- 4.15 All healthcare employers will seek to optimise workforce productivity through service and workforce redesign using extended roles and skill mix solutions.
- 4.16 Employers will seek greater flexibility in roles, skills, working patterns, location, as they seek to improve staff utilisation in tougher market conditions.
- 4.17 Employers will need to be more sensitive to changing the balance of workforce skill mix based on forecasted movement in activity along care pathways.
- 4.18 Choice and personalised care will require all NHS staff to engage differently with patients.
- 4.19 Improving health, managing long-term conditions and the enhancement of clinical networks will require role redesign and greater cross-working arrangements between primary, secondary and intermediate care - a greater challenge in the context of a competitive healthcare market.
- 4.20 Demand for, and utilisation of, staff skills will be dictated by the type of care and treatment being delivered in each organisational setting. A higher proportion of increased acuity and more complex cases in major hospitals will require increased specialisation, whilst an increase in the transfer of more routine work to community-based settings will require a necessary adjustment to staff deployment.
- 4.21 The overall number of management posts set to decline. This will present a significant challenge to employers to further engage clinicians in the management of change and transition.
- 4.22 High local labour turnover - including rotational posts - gives rise to added complexity in workforce management and utilisation.

Role Development

- 4.23 Opportunities exist to exploit new career pathways to enhance and redesign roles to create and deliver a strengthened primary care system, integrated rehabilitation and intermediate care services, specialist teams combining community and hospital expertise, an urgent care network, an emergency/acute assessment and treatment service, strengthened critical care teams, flexible inpatient services, systematic planned surgical services, community-based health and social children's services, rapid response diagnostic services and responsive support services.
- 4.24 Pressures will increase to seek new and innovative approaches to role development and the development of new skills and competencies to meet patient needs in the context of rapid access, rapid throughput and increasing patient expectations.
- 4.25 Role development will focus upon two major groups :- assistant practitioners (increasing the range of key generic skills), specialist practitioners (smaller range of highly specialised/technical skills); greatest growth will be at assistant practitioner levels.
- 4.26 A rapidly changing employment context will require a flexible, effective and productive link with education and training providers to ensure targeted, value-for-money and fit-for-purpose investment and outcomes.

Staff Expectations

- 4.27 Staff expectations of their employers are likely to grow - in particular, access to high quality training, acquisition and development of skills, career progression and better pay and conditions.
- 4.28 Strong and effective staff communication, engagement and involvement will become more critical as the NHS embarks upon radical and unprecedented change.
- 4.29 Employers will need to continue to work closely with staff and staff side organisations to build upon existing partnership working arrangements.

Workforce Planning

- 4.30 Key drivers - such as demographic changes, the European Working Time Directive 2009, Modernising Medical Careers, workforce availability, Agenda for Change, plurality - will require a step-change in workforce planning

arrangements - within organisations and across the local system of healthcare.

- 4.31 Workforce planning will need to focus increasingly on cost, productivity, numbers, grades, skills, utilisation – and develop a strong integrated approach with service planning.

5. Next Steps

- 5.1 This summary constitutes Phase 1 of the BHSP workforce process and sets out a series of workforce implications of the Bristol Health Services Plan and other major developments over the next 10 years.
- 5.2 This is work-in-progress and positive steps have already been taken to work jointly across organisational and professional boundaries to identify the key implications for future workforce planning, development and management. It is strongly recommended that the BHSP Workforce Project Group continues its work to complete the next phase. This will include :-
- Identifying ways in which the revised model of care can be best delivered in the context of '*Creating a Patient-Led NHS*'
 - Identifying the full implications of the BHSP affordability assessment
 - Developing a more sophisticated system of integrated service/workforce planning in the context of rapid service and organisational change
 - Developing a system-wide 'management of change' protocol and process
 - Developing a health community-wide workforce strategy
 - Identifying and funding senior level project management input for this work stream.
- 5.3 Assuming that the BHSP Programme Board approves the next phase of work, the BHSP Workforce Project Group will review its membership and set out a clear set of terms of reference for Phase 2. This work is expected to commence in late 2005.

6. Conclusions

- 6.1 Despite the significant challenges that lie ahead, local PCTs and NHS Trusts are confident in their ability to manage the workforce changes required to successfully deliver the Bristol Health Services Plan and other major

developments in the area. This will require a clear and holistic approach to workforce strategy, workforce planning and change management.

- 6.2 The total net effect on staff numbers as a result of BHSP implementation is as yet unknown. Activity growth, changes in the model of care and demand for healthcare, balanced with acute services rationalisation and ongoing financial recovery and management will be key factors that will affect overall staffing numbers in order to support future service provision. Further work will be needed in light of the BHSP Assessment due to be presented to the Strategic Health Authority in October 2005.
- 6.3 The benefits of a strong and collaborative approach to system-wide workforce issues are obvious. Through closer collaboration – whilst recognising the need to compete in a demanding labour market – local healthcare employers are able to review and monitor national policy changes, ensure a smooth transition to new organisational forms and functions, share best practice, resolve problems and contribute to the overall image of the BNSSG healthcare sector as an employment area of choice.

BHSP Workforce Project Group

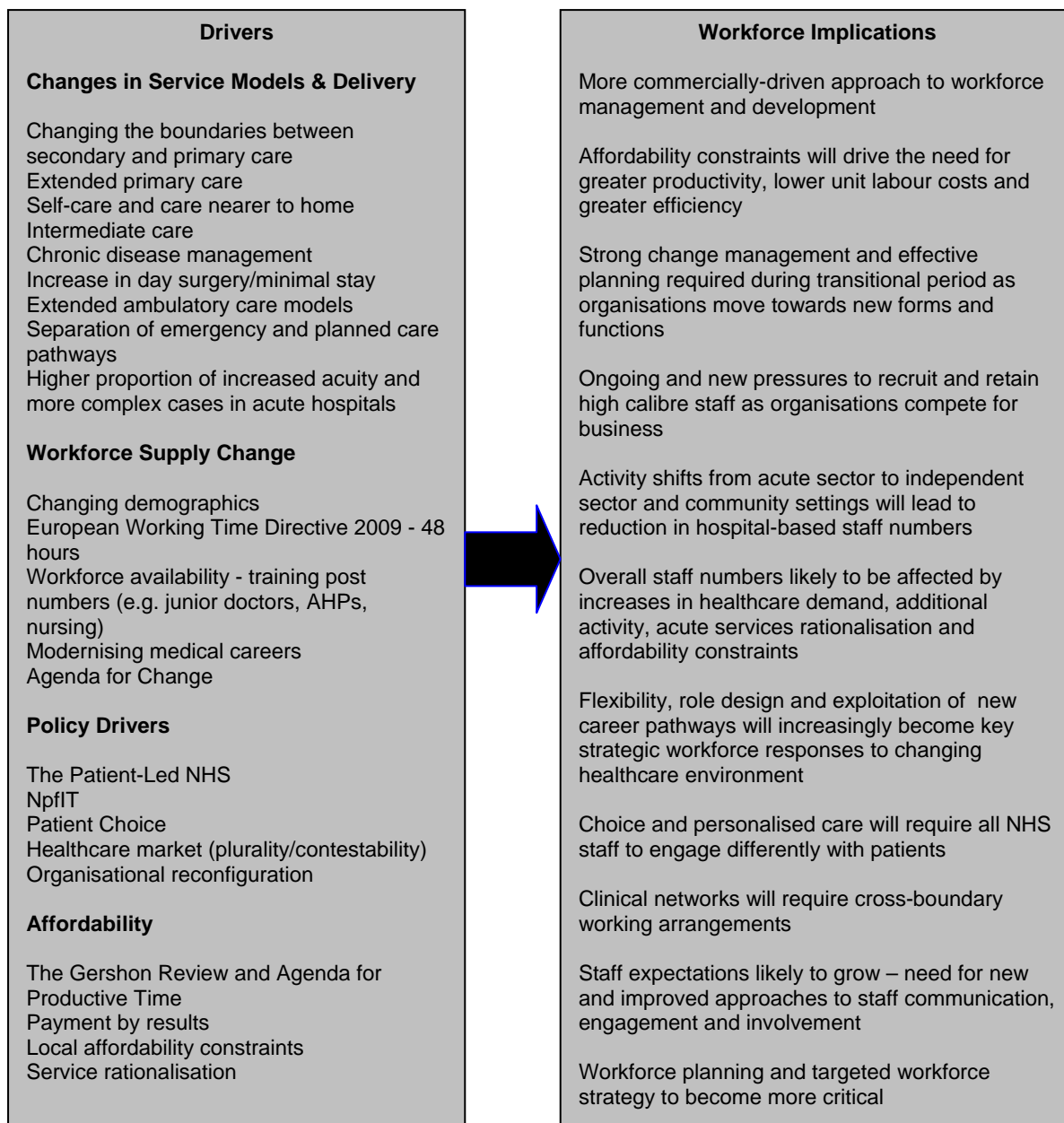
Project Director : Harry Hayer

Lead Chief Executive/Project Sponsor : Ron Kerr

Project Group Chair : Anne Coutts

October 2005

Drivers for Workforce Changes & Workforce Implications



APPENDIX THREE:

**SCHEDULE OF ALL CAPITAL
SCHEMES**

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Lead Organisation	Link	Scheme	Land purchase?	Est. Capital cost £m	Projected	
					Start	Finish
BS&W PCT	Bristol General Hospital Closure	South Bristol Community Hospital	Yes	36.40	2006	2008
NBT	Centralisation of Specialist services	Adult ENT - Interim centralisation at Frenchay (pending Southmead new Hospital)	No	4.80	2006	2007
UBHT	Centralisation of Specialist services	Breast Surgery Centralisation at St Michael's	No	0.55	2006	2007
BN PCT	NBT/S Glos New Hospital	North & West Community Hospital (Southmead)			2008	2012
NBT	NBT/S Glos New Hospital	N Bristol/S Glos Acute/Emergency Hospital including Southmead Community Hospital but excluding site works and equipment	No	345.00	2008	2012
S Glos PCT	NBT/S Glos New Hospital	Frenchay Community Hospital - assumed same timescale as Southmead PFI & Southmead Community Hospital	No	33.00	2008	2012
NBT	NBT/S Glos New Hospital	NBT/SG PFI and Frenchay - equipment & other costs - not yet split between sites	No	41.00	2010	2012
UBHT	Centralisation of Specialist services + Prior to construction of new Acute/Emergency Hospital at Southmead + UBHT	Centralisation of Children's ENT Surgery at UBHT	No	0.55	2006	2007
UBHT	Centralisation of Specialist services + Prior to construction of new Acute/Emergency Hospital at Southmead + UBHT schemes	Centralisation of Acute Paediatric (CAP) at UBHT (Southmead woodlands transfer) - to new build SOC cost has been used - currently under review	No	6.00	2005	2007
UBHT	Centralisation of Specialist services + NB/SG New Hospital PFI + UBHT schemes	Transfer of Specialist Paeds to UBHT	No	15.00	2008	2010
BN PCT	Bristol General Hospital Closure + Prior to construction of new Acute/Emergency Hospital at Southmead	Central & East Community Health Care Centre	Yes (part)	13.90	2006	2008
S Glos PCT	Prior to construction of new Acute/Emergency Hospital at Southmead	Yate Community Health-care Centre (34% of total = BHSP related. Rest is Health Centre replacement)	Yes	11.10	2006	2008
S Glos PCT	Prior to construction of new Acute/Emergency Hospital at Southmead	Thornbury Community Hospital	No	4.25	2008	2009
NBT	Standalone	Blackberry Hill	No	7.19	2005	2006
NBT	Cardiac	Interim Cardio Unit incl catheterisation lab. - Frenchay (pending Southmead New hospital)	No	7.60	2006	2006
UBHT	UBHT site	BRI Re-development including estimated 65 beds from Acute Emergency Flows at Frenchay		45.00		
UBHT	UBHT site	Reprovision of BRI "Old Building"	No	40.00	2008	2010
UBHT	Cardiac	Regional Adult Cardio-Thoracic Centre (RACC)	No	57.20	2006	2008
NBT/UBHT	Prior to construction of new Acute/Emergency Hospital at Southmead + UBHT	Centralisation of Pathology	No	18.00	2007	2008
TOTAL ESTIMATED COST				686.54		

BHSP pending Public Engagement / Consultation

N Somerset	Standalone	Community Developments		Not yet known	2007	2009
S Glos	NB/SG New Hospital PFI	Kingswood & District Bristol		Not yet known	2008	2009

APPENDIX FOUR:
PHASING OF CAPITAL SCHEMES

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Linkage	Scheme	Start	End	Projected construction (excludes commissioning) or bed transfers											Comments
				2006	2007	2008	2009	2010	2011	2012	2013	2014	2015		
Bristol General Hospital Closure	South Bristol Community Hospital	2006	2008	■	■	■									South Bristol CH is a scheme in its own right which results in closure of BGH. Outpatients from BGH will also transfer to Central & East Community Health Centre but whilst important this is not critical to the BGH closure programme
Cardiac - National Initiative	NBT Cardiac Cath Labs at Frenchay	2006	2007	■	■	■									Strategy for deploying the capital to be reviewed to ensure value for money, given 6 year lifespan at Frenchay
	UBHT Regional Adult Cardio-Thoracic Centre (RACC)	2006	2008	■	■	■									OBC approved but commitment given by UBHT to further review of scheme costs intended to reduce affordability risk further. Also in "UBHT Group"
Centralisation of specialist services	Adult ENT - interim centralisation at Frenchay (pending Southmead New Hospital)	2006	2007	■	■	■									Strategy for deploying the capital to be reviewed to ensure value for money given 6 year lifespan at Frenchay
	Breast Surgery centralisation at St Michaels	2007	2007	■											Currently dependent on Adult ENT tft to Frenchay (interim scheme). UBHT to assess whether Breast Surgery can be centralised at UBHT without reliance on adult ENT beds transferring to Frenchay. Also in "UBHT" group
	Centralisation of Acute Paeds at UBHT (Southmead, Woodlands)	2005	2007	■	■	■									Also within UBHT-linked schemes and "prior to Construction of Southmead New Hospital" group
	Centralisation of Children's ENT Surgery at UBHT	2006	2007	■	■	■									section
	Transfer Specialist Paeds to UBHT	2008	2010			■	■	■							Also, within UBHT-linked schemes & "by completion of Southmead New Hospital" group. Final sizing of scheme & functional content to be determined as part of OBC process
Prior to construction of new Acute/Emergency Hospital at Southmead	Centralisation of Acute Paeds at UBHT (Southmead Woodlands transfer)	2005	2007	■	■	■									Also within UBHT-linked schemes
	Centralisation of Children's ENT Surgery at UBHT	2006	2007	■	■	■									Also within UBHT-linked schemes
	Pathology centralisation	2007	2008	■	■	■									To be completed before Southmead site works commence if it is decided to locate Pathology at Southmead. Also included as potential site at UBHT in UBHT group. Final sizing of scheme to be determined + any link with IS as part of OBC process
	Central & East Community Health Care Centre	2006	2008	■	■	■									Final sizing & functional content to be agreed as part of OBC process.
	Yate Community Health Care Centre	2006	2008	■	■	■									Sizing may be influenced by IS. Final sizing & functional content to be agreed as part of OBC process
	Thornbury Community Hospital	2007	2009	■	■	■									Sizing & functional content of scheme to be finalised as part of OBC process. Scheme due to finish 1 year after start of Southmead PFI - this is considered this be manageable for this period given size of Thornbury scheme & impact on
NB/SG New Hospital PFI	New Acute/Emergency Hospital	2008	2012			■	■	■	■	■	■				Final sizing & functional content to be finalised as part of OBC process incl future use of existing good quality buildings incl. "Avon Orthopaedic Centre" building & impact on PFI sizing and functional content
	Southmead Community Hospital	2008	2012			■	■	■	■	■	■				Final sizing & functional content to be finalised as part of OBC process. Building integral to PFI new build
	Frenchay Community Hospital	2012	2013												Sizing will be influenced by IS & activity volume at Kingswood & to be determined as part of OBC process. Timing of scheme linked to of Southmead New Hospital PFI
	Weston 30 beds - transfer of N Somerset emergency cross boundary flows from NBT to Weston	2012	2012												Beds become available due to projected length of stay, "demand management" action & reduction in Independent Treatment Centre work undertaken for Bristol & Wales
	Transfer Specialist Paeds to UBHT	2008	2010			■	■	■							Also in UBHT-related group. Final sizing & functional content to be determined as part of OBC process
	Kingswood & District Health Centre (subject to Public Engagement & Consultation)	est. 2008	est. 2009												Sizing & functional to be determined during consultation and OBC preparation. It will be influenced by IS & activity volume at Frenchay Community Hospital. To be determined as part of OBC process
UBHT	Centralisation of Children's ENT Surgery	2006	2008	■	■	■									Sizing of NB/SG PFI assumes this scheme will proceed. Needs to complete alongside Woodlands Paediatric transfer from Southmead
	Centralisation of Acute Paeds at UBHT (Southmead Woodlands transfer)	2005	2008	■	■	■									Sizing of NB/SG PFI assumes this scheme will proceed.
	UBHT Regional Adult Cardio-Thoracic Centre (RACC)	2006	2008	■	■	■									Commitment given by UBHT to further review of scheme costs intended to reduce affordability risk further.
	Weston 24 beds - phased transfer of N Somerset emergency cross boundary flows from UBHT to Weston	2008	2010			■	■	■							Beds become available due to projected length of stay, "demand management" action & reduction in Independent Treatment Centre work undertaken for Bristol & Wales
	Breast Surgery centralisation at St Michaels	2007	2007	■	■	■									Currently dependent on Adult ENT tft to Frenchay (interim scheme). UBHT to assess whether Breast Surgery can be centralised at UBHT without reliance on adult ENT beds transferring to Frenchay. Also, in "Centralisation of Specialist Services" group
	Pathology centralisation	2007	2008	■	■	■									Need vacation of Pathology on levels 8 & 9 at UBHT by 2008. Also, potentially located at Southmead: Sizing & functional content of scheme + potential link with IS to be determined as part of OBC process
UBHT New builds:															
	Re-provision of Bristol Royal Infirmary "Old Building"	2008	2010			■	■	■							Timing critical to enable 24 "generic" beds to be provided whilst Cardiac Scheme in progress (due to site proximity). Sizing & functional content of scheme to be determined as part of OBC process
	Specialist Paediatrics - centralisation	2008	2010			■	■	■							Sizing & functional content of scheme to be determined as part of OBC process. Has to be completed before Frenchay Hospital closes
	BRI redevelopment incl. estimated 65 beds from Acute Emergency Flows at Frenchay	By 2010	By 2012			■	■	■							Sizing & functional content of scheme to be determined as part of OBC process. Has to be completed before Frenchay Hospital closes
Phase 2 Developments	Southmead Remaining Redevelopment	Est. 2012	Est. 2015												Remaining re-provision/upgrading of existing buildings on Southmead site. To be determined at SOC stage
	UBHT Remaining Redevelopment	Est. 2012	Est. 2015												Remaining upgrading/upgrading of existing buildings on BRI site & Bristol Haematology/Oncology Centre to make them "fit for purpose". To be determined at SOC stage
Self contained - no link to other schemes	Blackberry Hill	2006	2007	■	■	■									Includes transfer of stroke/rehab beds to Southmead & Frenchay by 2006 and 28 EMI beds to Frenchay by 2012/3
Self contained - no link to other schemes	N Somerset Community Developments- Subject to Public Engagement & Consultation	Est. 2007	Est. 2009			■	■	■							Sizing & functional content of scheme to be determined during Public consultation and OBC process including any potential impact on Weston General Hospital

APPENDIX FIVE:
**COMMUNITY SCHEMES –
MITIGATION OF RISK**

Risks and contingencies

The main risk facing community schemes is that the fixed costs of new or refurbished buildings will not be covered by the assumed activity and income. The activity could change because of patient or referral choice, changes in commissioners' intentions or increased plurality of providers. Income could change not only due to variation in activity but also to the structure of tariffs (especially the possibility of tariffs for community services being reduced) or the transfer of revenue streams to independent sector providers in other locations. Costs could increase due to either unexpected inflation or different treatment of public private partnerships.

Identified risks are listed in the table below.

The advantage of community schemes is their flexibility for a range of uses and providers. As a local facility, they can be adapted to the preferences of local populations, referrers and commissioners to provide a wide range of health and social care services. They can provide sessionally, in part or as a whole facilities for a wide range of independent and NHS providers. As comparatively small schemes, they can be sized, increased in efficiency and adapted comparatively easily.

A major risk of not providing community facilities is that the redesign of services will not be progressed. All the future schemes of the BHSP depend on a high level of activity being transferred to community settings. Redesigned services are already showing the demand for facilities which are not yet available in the community. So these schemes are responding to actual need as well as projected need resulting from the re-design of the whole health system envisaged in BHSP.

The table below shows the contingencies to meet the risks that have been identified:

	Risk	Contingency	
1	Financial		
1.1	<u>Reduction in tariff for "community" services arising from closer matching of actual costs and tariffs</u>	1.1	Worked up schemes assume affordability with a reduction of 5% (Southmead Community Hospital) and 6.3% (Central & East Community Health Care Centre) and 10% (Yate Community Health Care Centre) in tariff. Greater reductions would involve reviewing service mix for efficiency, converting non-clinical to clinical space, providing increased volume of service. This principle will be followed for the Kingswood & District and Frenchay schemes .

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	Risk	Contingency
1.2	<p><u>Variation in activity</u></p> <ul style="list-style-type: none"> • Increase • Decrease 	<p>1.2</p> <p>Worked up schemes have a margin of 7.5% increase or decrease in activity without changing costs. Increased activity improves affordability of the fixed costs. Higher reductions in activity would be managed by introducing additional services (and income) or providers (e.g. GPs), reducing staffing, bringing in outlying services ('spokes') or sub-leasing to other tenants.</p> <p>A conservative approach has been taken to activity projections and it is likely that activity levels will be higher (for example through longer opening hours). Costs may well fall below tariff allowing for reduction in activity or increase in additional services.</p>
1.3	<p><u>Changes in revenue costs</u> e.g. pay and inflation</p>	<p>1.3</p> <p>Worked up schemes show that they are able to withstand a 6.2% rise in costs. Additional measures include benchmarking pay and non-pay costs, reviewing skill mix and staffing requirements, introducing clinical services which have better margins of tariff over cost.</p>
1.4	<p><u>Transfer of revenue streams to Independent Sector</u> e.g. for out patients</p>	<p>1.4</p> <p>Schemes are being planned over an 8 year period. Each scheme will take account of the relevant emerging IS plans. The implementation of each scheme will influence what is planned for schemes that will follow. Where excess capacity is created as a result of activity moving into the IS, accommodation will be used to deliver additional demand management schemes, more primary/community care activity, especially as the impact of PbC increases, and opportunities to deliver services jointly with the LA will be more fully exploited.</p> <p>Worked up schemes have assumed that outpatient activity could reduce by 3% (if 15% of contestable elective work moves) up to 8% (if 15% of all elective work moves). A reduction of 8% is estimated to reduce income by 5% and costs by 1.8%. With the current planned mix of activity, schemes could accommodate this change.</p> <p>Diagnostic activity is divided into GP direct access and non-direct access work. Non-direct access work occurs as part of outpatient appointments and is funded through the tariff on that outpatient work. The cost of the diagnostic work would transfer to the independent sector reducing the impact of that transfer on affordability.</p> <p>GP Direct Access diagnostic work could also transfer to the independent sector compromising affordability. Schemes are working closely with Practice Based Commissioning consortia to ensure they provide the services that local GPs want for their patients.</p>

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	Risk	Contingency	
1.5	Inflation on rental of buildings	1.5	This risk is mitigated by the affordability cap (e.g. for NHS Lift), which sets rental at a reasonable level to be managed by the company. Once set, this becomes a fixed cost. Experience to date has shown this to be set at affordable levels.
1.6	Transfer of facilities to balance sheet (leading to capital charges as well as rental)	1.6	Experience to date has shown schemes such as those provided by LIFT are treated as off-balance sheet.
1.7	Changes in funding GP services	1.7	Schemes are now planned on the basis that there is very limited additional funding for GP premises. They assume that GP costs are funded as now by PCTs and the costs of GP schemes are fully reflected in PCTs LDPs.
1.8	Changes in capital borrowing regime under Prudential Borrowing Code		Guidance on the replacement for Public Dividend Capital is expected in November 2005. The new arrangements mean all NHS Trusts will follow the rules adopted for Foundation Trusts to fund capital developments. The impact on PCTs is not yet known, however they may remain within Public Dividend Capital arrangements.
2	Non-Financial		
2.1	Change in Commissioner intentions	2.1	The facilities are being designed in such a way as to be able to work flexibly with local practice based commissioning consortia to house and administrate the services they want to commission in a variety of models. The project teams are working closely with the local practice based commissioning consortia to ensure that the facility delivers their plans. Local practice based commissioning consortia and the Local Medical Committee are extremely supportive of these proposals, and see these community facilities as an opportunity rather than a threat: many local GPs consider that they would not be able to expand their own premises to deliver more services and are disposed to use community facilities for these services.
2.2	Increased plurality of providers	2.2	The buildings could provide serviced accommodation to a range of health and social care providers by session or by exclusive use of rooms, either with or without clinical support. Subleases of parts of the buildings could support a more significant range of care from a range of providers. The buildings will be designed with hard standing, power supplies and covered walkways to allow the use of additional modular buildings or tailored facilities providing (for example) diagnostic facilities such as MRI or day surgery theatres either permanently or on certain days.

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	Risk	Contingency
2.3	<p>Delays in major schemes e.g. NBSG Business Case</p>	<p>2.3</p> <p>These Schemes are coherent parts of the BHSP and support BNSSG Acute Trust and PCT strategies. These fit with and support the local financial recovery plans. These community facilities are the result of a service redesign programme agreed across the BNSSG community to deliver between 25% and 50% of clinical activity in local, non-acute settings. A network of minor injuries units/services in local settings will relieve the pressure on the city's A&E departments and improve access to services. Day surgery/minor surgery will be delivered in community settings wherever possible. This programme is designed to support service redesign that will reduce admissions and improve health in the local area and is being implemented across the area already.</p> <p>Whether the major facilities developments planned under BHSP go ahead or not, many of the schemes could be developed to house redesigned services. Some schemes (e.g. Yate and Central & East Bristol) include accommodation for GP practices. They are relatively small schemes, which are financially sustainable. They incur a revenue cost which is affordable on the income from tariff on the work they will carry out.</p>
2.4	<p>Double counting in activity in "neighbouring" schemes</p>	<p>Project teams have worked together to ensure there has been no double counting and to ensure that changes in activity in one scheme could be absorbed by its neighbours. For example, potential activity for Frenchay and Kingswood and East Bristol has been excluded from Central and East Bristol CHC, though the Bristol element could be absorbed by Central and East if necessary.</p> <p>The schemes are being phased (developed to different timetables) and hence will be able to be sized according to the precise requirements of the whole health care system.</p>

Conclusion

The table shows how the community schemes will meet the potential risks they face. Most schemes are comparatively small and of a design that can be adapted to changing conditions. They are an essential part of the jigsaw that allows a significant number of people to be treated closer to home, linked with their primary care services and ensuring that hospitals can concentrate on the specialist work which they will be designed for. The paper suggests that a conservative approach has been taken to assessing the transfer of work to the community. The main risk may be that facilities will need to be expanded as the community based approach, technology and introduction of a wider range of local commissioners and providers develops.

APPENDIX SIX:
GLOSSARY

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ACAD	Ambulatory Care and Diagnostic Centre
AGW SHA	Avon, Gloucestershire and Wiltshire Strategic Health Authority
AHP	Assistant Health Practitioner
AWP	Avon and Wiltshire Mental Health Partnership NHS Trust
BHSP	Bristol Health Services Plan
BNSSG	Bristol, North Somerset and South Gloucestershire
Business case	One of a series of documents outlining the plan for health-care in the area for presentation to the Strategic Health Authority (see FBC and OBC).
CHC	Community Health Centre
Capital Scheme	The means of acquiring capital for the implementation of the Bristol Health Services Plan.
Decant potential	The potential for moving capacity between hospitals
Elective	A patient who is a planned inpatient or day case. –
ENT	Ear, nose and throat
FBC	Final Business Case - The business case prepared by the health organisation (s), following selection of a preferred bidder, validating the affordability and value for money of the selected bid.
IS	Independent Sector
JLSTPU	Joint Local Strategic Transport Planning Unit
LDP	Local Delivery Plan
LIFT	Local Improvement Finance Trust – a new market for investment in primary care and community based facilities
LoS	Length of Stay
NB/SG	North Bristol and South Gloucestershire
NBT	North Bristol NHS Trust
NPfIT	National Programme for IT
NSF	National Skills Framework
Non-elective	Unplanned inpatient admissions
OBC	Outline Business Case
PbR	Payment by Results
PCT	Primary Care Trust

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PFI	Private Finance Initiative
Primary care	Health Services provided at your local Medical Centre and within your community.
Secondary care	Outpatient consultations and Inpatient care provided by your local hospital.
SG	South Gloucestershire
SHA	Strategic Health Authority
Tertiary care	Acute and very specialised care e.g. Hospitals
TUPE	Transfer of Undertakings (Protection of Employment) Regulations
UBHT	United Bristol Health-care Trust
Unitary Payment	The payment by the Public Partner to the Private Partner for the provision of the facility or service which is the subject of the Project Agreement. Generally, this is a base payment designed to service the Private Partner's financing cost of providing the facility.