Appendix 1

A sample sheet of questions asked by the Pathways for Change Task Group:

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2 November 2005

As mentioned yesterday, the Task Group are seeking some further information from the PCT and you agreed that I could direct this request to you in the first instance. The Task Group is asking for:

Sickness statistics across West Wiltshire PCT since the closure announcements

Statistics for the use of agency and bank staff prior to and following the announcements

Statistics for readmissions

Details of the status of all temporary closures across West Wiltshire and Kennet & North Wiltshire for the last eighteen months

Details of decisions to permanently close beds in community hospitals in Kennet, North and West Wiltshire over the last eighteen months

Evidence of the effectiveness of multidisciplinary community teams

Details of how the PCT will be working with transport and planning officers to ensure that issues of access are adequately addressed

27 March 2006

The Task Group is now seeking further information about some of the services, as listed below:

Westbury Hospital
Outpatients clinics – which have moved to Warminster and which have moved to Trowbridge?

Replacement for medical beds – are the Rapid Response and Community Rehab Teams now in place?

Physiotherapy Outpatients – at which other hospital sites is it being re-provided?

Bradford on Avon Hospital
Physiotherapy Outpatients – at which other hospital sites is it being re-provided?

28 June 2006

Equity:

What improvements could the communities without hospitals expect to receive as a result of each of these options?

The following improvements and changes in services will be accessible by those community areas with and without community hospitals as a result of each of the options.

- The introduction of Neighbourhood Teams

  Patients who can be successfully treated at home will have a health care package designed to meet their particular needs
  Health care will be available at home available throughout a 24 hour period where assessed as clinically appropriate and necessary.
  The number of people who currently are being admitted to a District General Hospital or Community Hospital because there isn't this level of care available in the community at the moment will be reduced. Those patients who wish to, and for whom it is considered clinically appropriate, can be transferred following an acute inpatient episode into the care of the Neighbourhood Team thus enabling them to return home sooner.

- Increased availability of locally commissioned physiotherapy services.

- Access to 24hour MIU service

- Equitable access to beds either in District General Hospital or locally commissioned from the independent sector as in option 1, or in new generation community hospitals in options 2 and 3.

- Some procedures normally accessible only in District General Hospitals could be undertaken in the New Generation Community Hospital(s) and/or Primary Care Centres, with a consequent reduction in the overall amount of travel by reducing the number of journeys that patients need to take to the major hospitals.

- Access to community midwifery led birthing unit within 35 minutes travelling time and to a community based model of team midwifery for antenatal and postnatal care.

How does the proposal for one midwife led maternity unit in Chippenham benefit the community or offer realistic choice of a community birth other than in the home?

There are clinical governance and clinical risk issues associated with operating small midwife led units with safe staffing levels 365 days per year. In addition, it was made clear during the consultation, that the current service model now provided by Wiltshire PCT costs around £2million more to provide than it receives under the national payment system in the NHS.

The future maternity services will rely heavily on having an appropriate workforce, we need to recast the present service design paying attention to the predicted workforce available as year on year the service provided by West Wiltshire PCT cares for and delivers approximately 5200 women.

The PCTs will commission maternity services starting from the principle that pregnancy and birth are normal life experiences with midwife-led care the predominant model of care.
The PCT aims to meet the standards in the National Service Framework for maternity services which states that PCTs should ensure that:

- The range of ante-natal, birth and post-care services available locally constitutes real choice for women (including home births), and
- Local options for midwife-led care will include a midwife-led unit in the community or on a hospital site, and births at home for women who have been appropriate assessed.

We want to see:

- Flexible individualised services designed to fit around the woman and her baby's journey through pregnancy and motherhood, with emphasis on the needs of vulnerable and disadvantaged women.
- Women being supported and encouraged to have as normal a pregnancy and birth as possible, with medical interventions recommended to them only if they are of benefit to the woman or her baby.
- Midwifery and obstetric care being based on providing good clinical and psychological outcomes for the woman and baby, while putting equal emphasis on helping new parents prepare for parenthood.

Maternity Services should provide the following;-

- Choice regarding place of delivery (home, birthing centre and district local hospital).
- Midwives as the lead professionals for normal pregnancy and birth.
- Comprehensive integrated multi-professional and flexible antenatal, intrapartum and postnatal care to support the family to facilitate a successful transition to motherhood and parenthood.
- One-to-one care for women when in established labour, wherever they choose to give birth.

The PCT's proposals will provide women with the choice of location for ante-natal, birth and post-natal services and provide for a choice of midwife or consultant-led care in the community, at home or in hospital.

In the future, women can continue to choose to give birth in the community service, or in the Princess Anne Wing in Bath, or in Swindon (where 587 babies were delivered in 2005/06) or in Salisbury (where 254 babies were delivered in 2005/06). Women will therefore continue to be able to choose midwife-led care either in a hospital unit (Bath, Swindon or Salisbury) or in the community at Chippenham. There are only 52 community units in England. Wiltshire is one of only 25 PCTs nationally (out of 120) who offer a community midwife-led unit as a choice for women.

It should be noted that, as happens now, only women who are clinically assessed as being low risk would be offered this facility. All other women would be referred to the

units depending on where they lived or choose to go to, in either The Princess Anne Wing at the RUH; Salisbury District Hospital or the Great Western Hospital, Swindon.

What consideration did the PCTs give to the report of the Maternity Reference Group prior to publishing its only proposal for maternity services?

The Maternity Reference Group's work and its recommendations were considered and the preferred model of care was one which the PCT is striving to ensure is available to all those mothers identified as being able clinically to take advantage of such a method.
The reference group provided a report to the PCT which identified a number of key issues for the provision of maternity services in the future.

The main recommendations can be summarised as a desire for a service where "women have a real choice of ante-natal, birth and post-natal care available locally with staff actively promoting midwife-led care to all women who have been appropriately assessed". They also stated that the options for midwife-led care should include community and hospital units and home births. All of these choices and options will be available through the proposals set out in Pathways for Change – as outlined in the previous answer

The reference group also concluded that the community-based service resulted in a lower caesarean rate than local hospital based services.
For 2005/06, for women from KNW and WW, there was no significant difference in the rate of caesarean section between our three main providers: WW = 21%, Salisbury = 22% and Swindon = 24%. The national rate is currently 22%.
The evidence from the National Institute for Clinical Effectiveness on reducing the rate of caesarean sections is clear. The main reason for a lower caesarean section rate is the availability of one-to-one midwife-led care and good quality information early on in pregnancy not the location of delivery (community or hospital-based unit).
The PCTs will, therefore, focus on commissioning maternity services which give every woman (unless clinically inappropriate) midwife-led care and good quality information throughout her pregnancy.

Finally, the reference group asked the PCTs to look at the opportunities for a community unit for people living in the East of Wiltshire. The majority of people living in this area access care from the Great Western Hospital in Swindon. We intend to follow the recommendation of the reference group and work with the hospital on the development of a community unit. The Trust has already stated its firm intention to develop such a unit in the future.

If most of the existing community maternity units close, where will ante and post natal classes be delivered?

With a community midwifery led birthing unit consolidated onto one site the PCT would be able to pursue the continued development of team midwifery. Antenatal and postnatal care will be available in each of the recognised community areas across Kennet, North and West Wiltshire It will be accessible from the proposed New Generation Community Hospitals, Primary Care Centres and GP practices sites or other suitable premises, with the ability to visit mothers at home if considered necessary. This will mean that women do not have to travel into the maternity units for antenatal care and postnatal care.

The PCT is also considering how it could commission antenatal care and postnatal care from the voluntary sector both to support general care and to provide more intensive care for women / families identified as “at risk” of, for example, post-natal depression.

What is the rationale behind siting the two 24 hour minor injury units to the far west of the PCT area?

The rationale was that of population density, access to 24hour medical cover and suitable facilities containing digital x-ray equipment with feed to A&E specialist department.

The PCT is mindful of the feedback on this matter during the consultation process on the subject of minor illness and minor injury management and the possible location of these services. In the engagement process and in developing the consultation document, the PCTs were made aware of dissatisfaction over the fact that a number of different models for providing this service were in operation. In some instances a GP based service is working well, and this was seen as a preferred model in terms of daytime access. However, in some towns the PCT has duplicate service/costs due to the relative proximity of the local GP based service to a community hospital. It is also clear that the overnight availability of MIU services is not heavily used and this could be more efficient.

The proposals set out in the consultation document were designed to:

1. change the inequalities of service provision
2. improve the efficiency of service provision
3. match the level and quality of service with appropriate accessibility and affordability
4. stimulate debate on an acceptable way forward.

It is clear that any 24-hour Minor Injury Unit must be efficient and staffed by experienced clinicians so as to effectively manage minor illnesses and injuries in a way which reduces the strain on current A&E level services provided at main hospital centres. This would in most cases provide care closer to patients’ homes than a main hospital A&E department, reducing travel and waiting times, and releasing the ambulance service for more urgent cases. Staffing and facilities must contribute to minimizing the number of onward referrals needed to hospital.

There will also need to be other ways of delivering a minor injury and illness service closer to where people live during the day-time hours. Options for these services are being explored, based on the experience of different arrangements currently in place, and in the light of future developments such as Primary Care Centres. General Practitioners and patient representatives will be at the centre of such discussions to ensure the appropriateness of the model to be commissioned for the local community.

The maps shown on page 11 of the consultation document do not illustrate that any more services will be provided in the disadvantaged east of the area. Can the PCTs demonstrate what service improvements will be delivered for these communities and how these proposals tie in with their stated aim of improving equity across the whole of the PCT area?

To look at the maps in isolation might lead to the perception that the east of the area is disadvantaged however patients living in the east of the PCT have access

to NHS services just as any other patient living anywhere else in the PCTs' area, albeit provided in different ways.

The PCT's proposals to disinvest in a concentration of resource centres in the West will enable a balanced reinvestment in community based services across the whole area.

Please refer to our answer to question 1.

The provision of an Out of Hours triage centre to serve South East Kennet is still under discussion and needs to be set in the context of both Pathways for Change , the imminent merger with South Wiltshire PCT and the work we are doing with the MOD in relation to services provided in that area.

Timeframe for Change:

What is the timeframe for change for each of the options?
Planning for the implementation of each option as it stands has been undertaken but we cannot complete this work until it is clear which option (and/or any variation as a consequence of our findings from the consultation) we are pursuing.

If a phased approach is to be taken, what will be included in each phase?
Local stakeholder involvement and consultation on detailed service planning will take place, as discussed with the health overview and scrutiny task group.
Whatever option is decided upon the PCT is committed to ensuring the transition of services in a safe and efficient manner. This could mean the temporary transfer of services to other sites and facilities.

How would the neighbourhood teams and other community workers be introduced?
We already have highly skilled and experienced district nursing services covering each of our community areas across the PCT areas, together with our existing intermediate care teams and rapid response teams. These existing community staff will support the phased transfer of staff currently working in community hospitals. The neighbourhood teams will be developed and managed to support the corresponding reduction in in-patient community hospital beds.

Transport:

Are the PCTs carrying out an impact assessment on the transport implications of their proposals?
Yes, we are assessing the impact on transport and access of the options as they relate to changes in outpatient services and inpatient services. We are considering this in terms of the impact for patients and public and for our staff.

If so, when will this work be finished, how has the County Council, as planning authority for transport been involved?
The PCT has had a number of discussions with officers who have advised on the sort of information to be addressed and the issue to be considered in an impact assessment.

Will the PCT Boards have the benefit of any analysis before being asked to make decisions about the future of services at the end of the consultation?

Yes. The PCT will make their decision with the benefit of this information. The proposals for change taken forward to the board will be supported by an assessment of what additional action may be required to in terms of transport.

Finance:

Are each of the options fully affordable and does the growing financial overspend affect the affordability of any of the proposals?

The recurring costs and benefits of the options have been calculated, with net savings as shown in the consultation document. Following consultation an outline business case will need to be drawn up to encapsulate the Boards' final decision. The recurring overspend continues to give cause for concern and the PCT is continuing to work with the *new* SHA on the long term financial strategy to ensure recurring balance. Each of the options will continue to a wider finical recovery plan and importantly establish a platform for sustaining affordable services.

Social Services:

How are the PCTs and DACS working together to ensure that their plans for financial recovery do not jeopardise those of the other?
The PCT and WCC are pleased that work since the beginning of May has led to the re-negotiation of their partnership agreements. To this end "letters of intent" have been agreed by the PCT Board and WCC Cabinet. It is expected that the new partnership agreements will be formally approved by the PCT board and WCC cabinet in December this year. The new agreements will provide a firm foundation on which to take forward joint planning and commissioning (from the NHS, independent and voluntary sectors) for Wiltshire.

How are the PCTs and DACS working together to ensure that patients will receive care packages that are integrated at the point of delivery?

Answer as previous question.

The activity of the respective providers has remained throughout the restructuring of the management arrangements of the health and social care teams

Children's Centres

What planning work has been done with the County Council regarding the inclusion of health services in children's centres?

The PCT is directly involved in the development and determination of the sorts of services that health can contribute to Children's Centres. These will vary at each Centre based on the needs of that child population and the levels of need within the wider community. There has been no agreement on the Children's Centres without health agreement and each and every children's' centres has health provision included

Which health care professionals would the PCT consider as being appropriately based in children's centres?
The children's centres planned for Wiltshire vary in size and location. Where practicable and appropriate health visitors, school nurses, speech and language therapists, dieticians, family therapists, health educationists and other specialist paediatrics therapists and nurses as well as midwives might work from a children's centre

Voluntary Sector:

Is there a comprehensive list of all the voluntary groups providing services in the community hospitals or other primary care settings?

Each of the three locality management structures will, through their Modern Matrons hold information about the different voluntary and community groups that are using facilities under their management.

The PCT works with the three CVS organisations, the Carers Support Organisations, Age Concern, Community First, the Wiltshire and Swindon Users Network and many others, (not just those who are funded in some way by the PCT), through its Patient and Public Involvement process and recognise health and social care groups in the voluntary sector as important stakeholders.

The PCT's Pathways for Change communication database includes health and social care voluntary groups. Representation of the groups mentioned above and of other larger voluntary groups was actively sought for the participation in the Assembly process

What consultation has been carried out with these groups to look at how they can continue with their valuable work in the future?

The Chairs of the Leagues of Friends met with the predecessor PCT Chairs and Chief Executive or Director of Planning and Partnerships during the engagement and consultation processes. This pattern of engagement is being continued by the PCT.

The health and social care groups referred to above have been considered as PCT stakeholders and their representatives have been invited to participate in the Pathways for Change Assembly process. The three CVSs, W&SUN, Wiltshire Racial Equality Council, the three Carers Support organisations and the Children's Fund have all been commissioned by the PCT to consult on the PCTs behalf with those they represent on the options

All NHS organisations are required by the Health and Social Care Act 2001 law to involve patients and the public in the planning of health services, developing and considering proposals for changes in the way those services are provided and decisions to be made that affect how those services operate.

Carers:

What work have the PCTs done with carers to ensure that their views on the consultation have been sought and that they have received information regarding the consultation in an environment in which they feel able to contribute?

The predecessor PCTs commissioned the three carers agencies to undertake consultation with carers. This report has been included in the consultation feedback which has been adopted and is being considered by the new PCT.

What analysis has been done on the level of respite care needed in the future under each of the options for change?

The PCT recognises the burden of care that relatives have in many instances and our proposals are designed to alleviate that burden in relation to health needs. PCTs as NHS organisations are funded to provide health care to people in accordance with their clinical needs and in accordance with national policy set by the Department of Health. Similarly Local Authorities through their Social Services Departments are funded to provide social care.

Currently, under the guidance of the Strategic Health Authority, NHS organisations are working with Local Authorities to clarify areas of responsibility whilst our frontline community and district nursing services continue to work together with social services staff to ensure that patients and clients needs are met as far as possible from the respective funding streams.

Respite care, designed to give temporary relief to carers who would benefit from a break or need treatment for their own health problems can, and currently is, funded where the person being cared for qualifies for 'NHS continuing health care' (whether or not it is being paid) and is cared for at home or in the community.

<u>The Options:</u>

How many Primary Care Centres do the PCTs think are needed and where would they ideally be situated?

During the consultation it was stated that Primary Care Centres would provide a focus for delivering Primary Care to a population of approximately 50,000 people, therefore based on those figure up to six PCCs could be considered for Kennet and North Wiltshire and West Wiltshire. The proposed locations of four PCC have been discussed during this period; Trowbridge, Malmesbury, Devizes and Westbury/Warminster. The development of further PCCs would be dependent upon decisions made about the siting of new generation community hospitals and affordability.

Does the existence of a Primary Care Centre depend on the willingness of local GPs?

Primary Care Centres require collaboration between several GP Practices and will be developed in conjunction with GP Practices

On what basis are those responding to the consultation expected to choose between Warminster and Westbury for the location of a Primary Care Centre?

The criteria set out in the Consultation document will inform the decision making process, together with the optimum range of services which could be provided within the envelope of resources identified for the Primary Care Centre for Westbury and Warminster.

From various face to face meetings since October 2005:

- What is the staff to vacancy ratio?
- Freezing posts surely has a double edged sword to it. Has sickness increased?
- Will redundancies by voluntary and not age related?
- When will retraining take place and where are the gaps in the service?
- Do you accept that changes to the Funded Nursing criteria have been causing DACS problems?
- Health and social care staff are based together and it seems best practice to base health & social care staff together, so how can we continue to do this?
- Is the level of savings anywhere near the level required?
- Will the RUH debt recur if money is taken out of acute centres?
- In a couple of years the PCT will probably change again, having agreed its new set up. So what will happen to the old debt?
- Is there a list of the services and where they will be provided in future?
- Are voluntary groups being taken into consideration?
- What is more pressing, Pathways for Change or the financial need?
- Readmission is running at 3%. Will more beds be needed and will rapid response be able to pick this up?
- How will the PCTs explain how services will be provided?
- How will they analyse responses and publish what people have said and then decide whatever they have to decide?
- And, although no one would presumably argue against the model of care, how will services be provided and does adopting this model of care automatically mean a greater draw on WCC resources?
- The PCTs often talk of reducing investment in acute services, but how far into the future are the PCTs looking in all of this planning?
- How do the PCTs plan to get rid of the inherited deficits?
- how do you reconcile not having community hospitals with your stated need to use the remaining hospitals to pick up the short fall left by the ones you have closed?
- What if the public want all services to remain the same?
- The Dept of Health and the Secretary of State are pushing financial recovery. Does this take precedence over current Pathways for Change discussions?
- What is the nature of the pressure from AGW?
- Is there any way that the national formula by which the amount of money granted to PCTs per head of population can be changed?
- And likewise the historical debt with which the PCTs in Wiltshire were set up with?
- Have you thought about the effect on patients of making shock closures?
- If you reduce services in the short term, will it affect DACS?