Great Yarmouth and Waveney Joint Health Scrutiny Committee

(Quorum 3)

Date: Friday, 13 November 2015

Venue: Conference Room 1 and 2
Riverside Campus
4 Canning Road
Lowestoft, Suffolk, NR33 0EQ

Time: 10:30 am

Membership:

Cllr Colin Aldred	Norfolk County Council
Cllr Alison Cackett	Waveney District Council
Cllr Michael Carttiss	Norfolk County Council
Cllr Michael Ladd	Suffolk County Council (Chairman)
Cllr Bert Poole	Suffolk County Council
Cllr Shirley Weymouth	Great Yarmouth Borough Council

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For further information on any of the agenda items, please contact Rebekah Butcher, Democratic Services Officer, on 01473 264371 or rebekah.butcher@suffolk.gov.uk

Business to be taken in public

1. **Public Participation Session**

   A member of the public who is resident, or is on the Register of Electors for Norfolk or Suffolk, may speak for up to five minutes on a matter relating to the following agenda.

   A speaker will need to give written notice of their wish to speak at the meeting using the contact details under 'Public Participation in Meetings' by no later than 12 noon on 9 November 2015.

   The public participation session will not exceed 20 minutes to enable the Joint Health Scrutiny Committee to consider its other business.

2. **Apologies for Absence and Substitutions**

   To note and record any apologies for absence or substitutions received.

3. **Declarations of Interest and Dispensations**

   To receive any declarations of interests, and the nature of that interest, in respect of any matter to be considered at this meeting.

4. **Minutes of the Previous Meeting** Pages 5-10

   To approve as a correct record, the minutes of the meeting held on 22 July 2015.

5. **'GP practice premises in Gorleston and Bradwell' consultation** Pages 11-75

   Great Yarmouth and Waveney Clinical Commissioning Group (CCG) will consult the joint committee about proposals for relocation of three GP practices.

6. **'Shape of the System' consultation** Pages 77-200

   Great Yarmouth and Waveney Clinical Commissioning Group (CCG) will consult the joint committee about proposals for integrated health and social care services.

7. **Information Bulletin** Pages 201-211

   These items are not intended for discussion at the Committee meeting. Further information may be obtained by contacting the named officer for each item. If there are any matters arising from this information that warrant specific aspects being added to the forward work programme or future information items, Members

are invited to make the relevant suggestion at the time that the forward work programme is discussed. Topics include:

a) Briefing update (October) on Marine Parade and Oulton Village practices. (There will be in addition a verbal update on the most recent status.)
b) Briefing update (September) regarding a number of GP practices in the Gt Yarmouth, Lowestoft and Gorleston area;
c) Waveney Acute Services (Carlton Court) update;
d) Myalgic Encephalomyelitis (ME)/Chronic Fatigue Service (CFS) update; and
e) Winter Planning.

8. **Forward Work Programme** Pages 213-214

To consider and agree the forward work programme.

9. **Urgent Business**

To consider any other item of business which, in the opinion of the Chairman, should be considered by reason of special circumstances (to be specified in the minutes), as a matter of urgency.

Date of next scheduled meeting

Friday, 22 January 2016, 10.30am, Riverside Campus, Lowestoft.

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Email: Committee.Services@suffolk.gov.uk; or by writing to:

Democratic Services, Suffolk County Council, Endeavour House, 8 Russell Road, Ipswich, Suffolk IP1 2BX.

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and complete the online form: www.suffolk.gov.uk/apply-to-speak

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2. Follow the signs directing you to Fire Exits.
3. Use the stairs, NOT the lifts.
4. Do not re-enter the building until told it is safe to do so.

Deborah Cadman OBE
Chief Executive
Suffolk County Council

Chris Walton
Head of Democratic Services
Norfolk County Council

Suffolk County Council

Norfolk County Council at your service

Unconfirmed

Minutes of the Great Yarmouth and Waveney Joint Health Scrutiny Committee Meeting held on 22 July 2015 at 10:30 am in the Assembly Room, Town Hall, Great Yarmouth.

Present:	Councillors Michael Ladd (Chairman), Michael Carttiss (Vice Chairman), Colin Aldred, Alison Cackett, Bert Poole and Shirley Weymouth.
Supporting officers present:	Paul Banjo (Scrutiny Officer), Rebekah Butcher (Democratic Services Officer) and Maureen Orr (Democratic Support and Scrutiny Team Manager).

1. Election of Chairman and Vice Chairman

On the proposition of Councillor Michael Carttiss, seconded by Councillor Alison Cackett, it was agreed that Councillor Michael Ladd be elected as Chairman for the 2015/2016 municipal year.

On the proposition of Councillor Michael Ladd, seconded by Councillor Shirley Weymouth, it was agreed that Councillor Michael Carttiss be elected as Vice Chairman for the 2015/2016 municipal year.

2. Apologies for Absence and Substitutions

There were no apologies received.

3. Minutes of the Previous Meeting

The minutes of the meeting held on 8 April 2015 were confirmed as a correct record and signed by the Chairman.

4. Declarations of Interest and Dispensations

Councillor Colin Aldred declared a non-pecuniary interest in Agenda Item 6: GP practice premises in Gorleston and Bradwell consultation', by virtue of the fact he attended a surgery subject to the consultation.

5. Public Participation Session

The Joint Committee heard from the following members of the public.

Mr Jeff Keighley, Regional Organiser, Unison Norfolk and Suffolk Team spoke in relation to Agenda Item 7: 'Shape of the System' consultation. Mr Keighley informed the Joint Committee of his concerns regarding the need for the proposal and questioned whether the CCG had ever determined that existing services were not working. Mr Keighley also expressed concern that nothing had been discussed with staff; 24/7 hour working and about the closure of the Patrick Stead. In conclusion, Mr Keighley informed the Joint Committee that

UNISON was not opposed to a sensible case and urged the Committee to be careful of the proposal.

Mrs Jennifer Beesley, a member of the public, spoke in relation to Agenda Item 6: 'GP practice premises in Gorleston and Bradwell' consultation and Agenda Item 7: 'Shape of the System' consultation. Mrs Beesley informed the Joint Committee that it was important for the public to have access to good GPs and quality services which were maintained into the future. Mrs Beesley was concerned that the closure of community hospitals and beds would mean traveling greater distances. She questioned how long providers would be in business; that costs could not be capped; and equitability of services. In conclusion, Ms Beesley felt the inadequacy of services would be unacceptable and asked it to be looked at again.

Mr Patrick Thompson, a member of the public, spoke in relation to Agenda Item 6: 'GP practice premises in Gorleston and Bradwell' consultation. Mr Thompson informed the Joint Committee that the consultation response form was inadequate as it only allowed for one person per household to comment on the proposal. Mr Thompson felt that providing integrated teams in the community would be far better as members of the public would not need to attend hospital. He added that Shrublands was already earmarked for a permanent building and there was space on-site.

6. 'GP practice premises in Gorleston and Bradwell' consultation

At Agenda Item 6, the Joint Committee received a suggested approach from the Democratic Support and Scrutiny Team Manager (Norfolk County Council) to a report from the NHS Great Yarmouth and Waveney Clinical Commissioning Group (CCG) about its public consultation on GP practice premises in Gorleston and Bradwell.

The Chairman welcomed the following witnesses to the meeting:

Dr Jamie Wyllie – Director of Clinical Transformation, Great Yarmouth & Waveney CCG.

Kate Gill – Director of Operations, Great Yarmouth and Waveney CCG.

Dr John Stammers – Chairman of the Great Yarmouth and Waveney CCG.

Rebecca Driver – Director of Engagement, Great Yarmouth and Waveney CCG

Members noted that the consultation was about the locations rather than the services, and asked questions about car parking; public transport facilities including bus services; accessibility by patients in Norfolk and Suffolk; the likely timescales for development and occupancy of new houses at Beacon park; the possibility of Section 106 Developers' Contributions toward a surgery; GP recruitment difficulties; and the likely timescales for NHS England implementing the proposed changes.

Recommendation: The Joint Committee agreed that the Great Yarmouth and Waveney Joint Health Scrutiny Committee should receive the recommendations that the CCG makes to NHS England at its meeting on 13 November 2015, and the decisions that NHS England makes in response to those recommendations.

Reason for recommendation: The Joint Committee noted that whilst the GP premises were in Norfolk, there were patients impacted in both Norfolk and Suffolk.

Alternative options: There were none considered.

Declarations of interest: Councillor Colin Aldred declared a non-pecuniary interest in Agenda Item 6 by virtue of the fact he attended a surgery subject to the consultation.

Dispensations: There were none noted.

7. 'Shape of the System' consultation

At Agenda Item 7, the Joint Committee received a suggested approach from the Democratic Support and Scrutiny Team Manager (Norfolk County Council) to a report from the Great Yarmouth and Waveney Clinical Commissioning Group (CCG) about its public consultation on 'The Shape of the System' – developing modern and sustainable health services in Great Yarmouth and Waveney.

The Chairman welcomed the following witnesses to the meeting:

Dr Jamie Wyllie – Director of Clinical Transformation, Great Yarmouth & Waveney CCG.

Kate Gill – Director of Operations, Great Yarmouth and Waveney CCG.

Dr John Stammers – Chairman of the Great Yarmouth and Waveney CCG.

Rebecca Driver – Director of Engagement, Great Yarmouth and Waveney CCG

Members noted that the consultation proposed a new model of care, at home or as close to home as possible, as already trialled successfully with the Lowestoft Out-of-Hospital team.

Members asked questions about the interim/transitional arrangements and risks; concerns about the risk of Southwold and Patrick Stead hospital's closing before new beds are available; involvement of the staff affected by the consultation; travel and transport to the proposed intermediate beds in Beccles; public preferences about who provided various services; the relationship between GPs and specific care homes; the capacity and availability of the new 'beds with care'; outpatient services; and assurance that the provision would be in place before closure of community hospital beds.

A member drew attention to the proposed submission to the CCG from Great Yarmouth Borough Council, as agreed by its scrutiny committee on 15 July 2015.

Recommendation: The Joint Committee agreed that HealthEast take on board the need to give assurance that the new provision would be in place before closure of community hospital beds.

The Joint Committee also noted:

a) Several members' concerns about the travel and transport implications of each of the options in the consultation documents.

b) That the clarification that the proposed 'use of Beccles Hospital inpatient beds to provide an intermediate care facility' represented an additional tier of care that is not currently provided by community hospitals.

c) That the clarification that the proposed 'beds with care' in local nursing and residential homes would be block-booked to ensure availability when needed.

d) That a member would provide to the CCG any evidence of specific concerns regarding East Coast Community Healthcare staffing arrangements at Patrick Stead hospital.

e) That a member would provide to the CCG details of a specific recent case of fragmented provision of care.

f) That members were encouraged to watch the 'YouTube' videos associated with the consultation document:

https://www.youtube.com/channel/UCPBhmZiL8qL6mZXYG0EyhIA

Reason for recommendation: Members expressed concern around the potential closure of beds at the Southwold and Patrick Stead hospital's before alternative arrangements were made; although they accepted that there were often operational staffing issues outside of the CCGs control. The Joint Committee noted that the CCG would closely monitor the situation.

Alternative options: There were none considered.

Declarations of interest: There were none declared.

Dispensations: There were none noted.

8. Policing and mental health services

At Agenda Item 8, the Joint Committee received a suggested approach from the Democratic Support and Scrutiny Team Manager (Norfolk County Council) to a report from the Great Yarmouth and Waveney Clinical Commissioning Group (CCG) on the different models of liaison between police and mental health services.

The Chairman welcomed the following witnesses to the meeting:

Michael Scott – Chief Executive, Norfolk and Suffolk NHS Foundation Trust

Chris Galley – Inspector, Community Safety, Suffolk Constabulary

Amanda Ellis – Chief Inspector, Harm Reduction, Norfolk Constabulary

Members noted that the Control Room (Norfolk) and Triage Car (Suffolk) approaches were both good models, with different benefits, but that it was unlikely to be affordable to do both in the long term. Academic assessments were awaited by November and funding decisions would be required by March 2016.

Members asked about the frequency of occurrence of the scenario whereby the triage car gets diverted to a higher priority call not requiring a mental health nurse, the staffing of the control room model, and autism training for police officers.

Recommendation: The Joint Committee commended the Norfolk and Suffolk NHS Foundation Trust and both Constabularies for the work done so far and awaited, in the next several months, the outcome of the objective academic evaluation of each of the approaches and the decision on the approach to be adopted in Great Yarmouth and Waveney from 2016 onwards.

Reason for recommendation: In neither case was there yet a proposal beyond 2015/16 in what form the service should continue. An independent evaluation was expected to be published over the coming months.

Alternative options: There were none considered.

Declarations of interest: There were none declared.

Dispensations: There were none noted.

9. Information Bulletin

The Joint Committee noted the information bulletin at Agenda Item 9.

10. Forward Work Programme

At Agenda Item 10, the Joint Committee considered its forward work programme.

Recommendation: The Joint Committee agreed:

a) To consider the CCG's decisions following the 'Shape of the System' consultation at its meeting on 13 November 2015.

b) To consider the CCG's decisions and proposal to NHS England following the 'GP practice premises in Gorleston and Waveney' consultation at its meeting on 13 November 2015.

c) To be provided with an update report subject to confirmation from the CCG, on 'Adult and dementia mental health services in Great Yarmouth and Waveney'.

d) Agreed the following dates for future meetings:

   i) 22 January 2016;

   ii) 15 April 2016; and

   iii) 15 July 2016.

Reason for recommendation: The Joint Committee wanted an opportunity to further scrutinise the consultations.

Alternative options: There were none considered.

Declarations of interest: There were none declared.

Dispensations: There were none noted.

11. Urgent Business

There was no urgent business.

The meeting closed at 1:23 pm.

Chairman

Norfolk County Council at your service

Suffolk County Council

Agenda Item 5

Great Yarmouth and Waveney Joint Health Scrutiny Committee

13 November 2015

The CCG's proposal to NHS England following the 'GP practice premises in Gorleston and Bradwell' consultation

Suggested approach from the Scrutiny Officer.

Great Yarmouth and Waveney Clinical Commissioning Group (CCG) will present to the Joint Committee its proposal to NHS England for their decision, following the public consultation on 'GP practice premises in Gorleston and Bradwell'.

Background

1. At its meeting on 22 July the Joint Committee received a report from the NHS Great Yarmouth and Waveney Clinical Commissioning Group (GY&W CCG) on the emerging themes from its public consultation on 'GP practice premises in Gorleston and Bradwell'.

2. The consultation period ran from 3 June 2015 until 2 September 2015. The CCG's Governing Body considered feedback, questions and issues at its meetings on 24 September and 22 October, and the CCG's proposal to NHS England, for their decision, was to be made by the Governing Body at their meeting in public on Thursday 5 November 2015.

3. This item provides the Committee with an opportunity to consider the CCG's proposals following the consultation, prior to consideration in January 2016 of NHS England's decision on the matter.

Suggested approach

4. Representatives from the CCG will attend today's meeting to present the CCG's proposal and to receive any comments that the joint committee may wish to make. Representatives from NHS England are also expected to attend the meeting.

5. The following documents are attached:

   a) Appendix A – GY&W CCG Briefing Note [3 pages].

      [The CCG decision statement will be available on 9 November, following the CCG Governing Body meeting on 5 November]

   b) Appendix B – Consultation feedback [27 pages], 'GP Premises in Gorleston – Public Consultation', Dr S Wilkinson, September 2015.

   c) Appendix C – 'GP Practice Premises in Gorleston and Bradwell – a response to the Public Consultation' [9 Pages], CCG Governing Body meeting, 22 October 2015.

   d) Appendix D – 'Recommendation on next steps for the GP Practice Premises in Gorleston and Bradwell public consultation', [21 Pages], CCG Governing Body meeting, 5 November 2015.

6. The Joint Committee is asked to consider:

   a) Whether the consultation process with the joint committee has been adequate in relation to content or time allowed.

   b) Whether the final proposals, as agreed by GY&W CCG, are in the interests of the local health service.

   c) Any recommendations that it wishes to make to GY&W CCG.

   d) Any recommendations that it wishes to make to NHS England for its Corporate Management Team to take into account when making its decisions.

Next steps

7. Once the CCG recommendations are reported to NHS England – Midlands and East (East), these will be considered by the East regional Corporate Management Team which meets fortnightly. These are internal decision making meetings and are not held in public.

8. The Great Yarmouth and Waveney Joint Health Scrutiny Committee (JHSC) on 22 July decided that it would itself undertake the final consideration of this matter. The JHSC's next meeting is on 22 January 2016, when it expects to undertake the final stage of its consideration of the proposed changes. It will consider whether it has been adequately consulted and whether the changes are in the best interests of the local health service.

9. NHS England and the CCG will ensure that planned changes are not progressed until after Joint HSC has met in January 2016.

Contact details

Paul Banjo, Scrutiny Officer; Email: paul.banjo@suffolk.gov.uk; Tel: 01473 265187

NHS
Great Yarmouth and Waveney Clinical Commissioning Group

HealthEast

Briefing for Great Yarmouth and Waveney Health Scrutiny Committee: 13 November 2015

GP Practice premises in Gorleston and Bradwell.

NHS Great Yarmouth and Waveney CCG launched a public consultation called 'GP practice premises in Gorleston and Bradwell' on Wednesday 3 June 2015 which ran for 13 weeks until Tuesday 2 September 2015.

Three GP practices in Gorleston and Bradwell are currently working out of premises which can't keep working as they are for much longer. These are:

- Family Health – the current building is cramped and not owned by the existing GP, which prevents any changes to the premises being made. There is no capacity for the practice to expand.
- Gorleston Medical Centre - is working from a temporary building on the Shrublands site and the long term future needs to be established.
- Falkland Surgery – there is no capacity to expand, this has already been explored by the practice.

There are a number of issues which mean that we have to change the shape of GP services in Gorleston and Bradwell. These are:

- The population of Gorleston and Bradwell is expanding rapidly. New houses are being built in the south of the town, further away from where practices are currently located. Over the next 10 years there is a predicted increase of 3,500 people on the Beacon Park site.
- Major issues with current practice accommodation in the following GP surgeries: Falkland Surgery, Gorleston Medical Centre on the Shrublands site and Family Healthcare Centre. These practices are in buildings which are not fit for 21st century healthcare, and cannot be expanded to make them fit for the future to handle the growing population.
- We know that one of the main predictors of whether people will attend an accident and emergency department is how close they live to it. We also know that national and local figures suggest that up to one in three people who attend accident and emergency would be better seen by their GP. New housing next to the James Paget University Hospital and further away from current practice locations therefore risks swamping our local A&E department while not always providing best care for these families.

This consultation did not propose any changes to Millwood Surgery or Central Surgery who are both well established in their existing premises and are not currently looking to relocate. Indeed Millwood Surgery has well developed plans to grow their existing premises even more on their current site.

We know that the current services in these three GP practices are under pressure because of the issues with their accommodation. Doing nothing is not an option.

The proposal in the consultation document was to relocate the three GP practices into one new primary care centre based at one of the following three locations:

- James Paget University Hospitals NHS Foundation Trust
- Shrublands Health Centre
- Beacon Park

The CCG received 731 responses to the consultation from staff, patients, clinicians, healthcare providers, social care, District, County and Parish Councils, voluntary agencies and the wider public. When asked if they understood the proposals 97.88% of respondents said yes.

During the public consultation two public meetings were held, 21,000 consultation documents were distributed across Gorleston and Bradwell.

Feedback from the public consultation

The feedback report from the public consultation was presented to the Governing Body at their meeting in public on 24 September 2015 by Dr Steven Wilkinson, an independent analyst.

The Executive Summary from the report is set out below:

Of the three proposals, proposal two (a new purpose-built Primary Care Centre on the Shrublands site) had the greatest support.

Proposal One – James Paget Hospital site (Yes = 10.5%, No = 87%). The responses to this proposal discuss:

- Concerns about parking, (including cost, allocation, and provision).
- Accessibility (including distance, patient fitness, roads and location)
- Overcrowding (including space, population size and referrals)
- Public transport – (including bus links, journey times, acceptable journeys, consequences and costs)
- Patient preferences – (including choice, proximity to home, avoidance of acute care, satisfaction with surgeries and centralisation).
- No support – (including the principle being unacceptable, the location, preferring alternative options, potential waste and the JPUH perspective).
- Support for the proposal – (including advantages, location, transport, size and information needs).

Proposal Two – The Shrublands site (Yes = 53.5%, No = 42.4%). The responses to this proposal discuss:

- Support – (including the promise of upgrading Shrublands, benefits, integration and registration with a GP practice)
- Transport – (including problems, routes and distances)
- Access – (including ease, traffic and fitness to travel)

- Parking – (including concerns, impact on the neighbourhood and charges)
- Patient preferences – (including choice, GP's and practice size)
- No Support – (including disagreement, practice size, preference for the status quo and alternatives)
- Overcrowding – (including practice size, referral to other services and other information requirements around proposal details, finance and the consultation).

Proposal Three – The Beacon Park site (Yes = 29.6%, No = 64.9%). The responses to this proposal discuss:

- Transport – (including accessibility concerns, routes, costs and roads)
- Support – (including advantages, benefits, location and alternatives)
- No Support – (including disagreement, central location preference, status quo, policy, alternatives and location)
- Location – (including preference)
- Parking – (including concerns)
- Patient preferences – (including choice, population, GPs and facilities)
- Finance – (including implications and contributions)
- Information – (including needs).

The CCG's Governing Body responded to the questions and issues raised during the consultation at their Governing Body meeting in public on Thursday 22 October 2015.

An 'options appraisal' workshop was held on Friday 9 October 2015 when key stakeholders and invited patients completed a structured exercise to develop recommendations for the Governing Body.

On 5 November the CCG's Governing Body are expected to make a recommendation on the final site for the primary care centre. This recommendation will then go to NHS England who will make the final decision on relocating the three practices. At the time of writing this paper that meeting had not yet been held.

Andy Evans, Chief Executive of NHS Great Yarmouth and Waveney will be attending the Joint Health Overview and Scrutiny meeting on 13 November to verbally update the HOSC about the Governing Body decision.

The feedback report from the public consultation is available here:
http://www.greatyarmouthandwaveneyccg.nhs.uk/_store/documents/gp_practices_final_report.pdf

The CCGs response to the questions from the public consultation is available here:
http://www.greatyarmouthandwaveneyccg.nhs.uk/uploads/files/ITEM%207%20GP%20Practice%20Premises%20in%20Gorleston%20and%20Bradwell%20-%20a%20response%20to%20the%20Public%20Consultation.pdf

Lorraine Rollo

Head of Communications and Engagement
NHS Great Yarmouth and Waveney
29 October 2015

NHS
Great Yarmouth and Waveney Clinical Commissioning Group

HealthEast

Meeting of the Governing Body
Thursday, September 24, 2015. Agenda Item 7

Title of Paper	Feedback report on the GP Practice Premises in Gorleston and Bradwell public consultation.
What the Governing Body is being asked to decide or approve	The Governing Body is being asked to receive and note the public feedback report for the GP Practice Premises in Gorleston and Bradwell public consultation which has been developed by Dr Steve Wilkinson, an independent analyst from Consulting the Community.
Executive summary	A thirteen week public consultation about GP Practice Premises in Gorleston and Bradwell closed on Wednesday 2 September 2015. The CCG received 787 responses to the consultation from staff, patients, clinicians, healthcare providers, social care, councils, voluntary agencies and the wider public. The CCG's Governing Body will respond to the questions and issues raised in this report at their next Governing Body meeting in public on Thursday 22 October 2015. A decision support workshop is being held on Friday 9 October 2015 when key stakeholders and invited members of the public will undertake a structured exercise to develop recommendations for the Governing Body. At their meeting in public on Thursday 5 November 2015 the Governing Body will agree their recommendations to NHS England. A final decision on the proposals will be made by NHS England. A reminder of the proposals… The proposals were developed as a result of major estates issues with the accommodation at Family Healthcare Centre, Gorleston Medical Centre and the Falkland Surgery. There was also a need to prepare for an estimated 3,500 increase in

	the local population in Gorleston and Bradwell over the coming decade who will need a GP. The CCG hopes to bring the three GP practices together into one building, known as a 'primary care centre'. As well as providing new better facilities, this would also allow them to share IT systems, reception areas and other support services while increasing the opportunity to recruit and retain more staff. Three possible sites for the primary care centre have been identified, which are: • The James Paget University Hospital site • The Shrublands site • The Beacon Park site People were also invited to suggest any other sites which they feel should be considered.
Risks attached to this proposal/initiative: • Reputational • Financial • Service Quality	
Resource implications: We estimate the combined costs of the two public consultations will be in the order of £65,000.	

Name	Rebecca Driver
Job title	Director of Engagement
Date	16 September 2015

Consulting the Community

GP Premises in Gorleston - Public Consultation

FEEDBACK REPORT

September 2015

Dr Steven Wilkinson
Consulting the Community
September 2015

Executive Summary

Of the three proposals, proposal 2 (a new purpose-built Primary Care Centre on the Shrublands site) had the greatest support.

Proposal One – James Paget Hospital site (Yes = 10.5%, No = 87%). The responses to this proposal discuss:

- Concerns about parking, (including cost, allocation, and provision).
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- Support – (including advantages, benefits, location and alternatives)
- No Support – (including disagreement, central location preference, status quo, policy, alternatives and location)
- Location – (including preference)
- Parking – (including concerns)
- Patient preferences – (including choice, population, GPs and facilities)
- Finance – (including implications and contributions)
- Information – (including needs).

Suggestions for alternative locations have been included.

Dr Steven Wilkinson
Consulting the Community
September 2015

Contents

1 Background

1.1 From the consultation document:
GP practice premises in Gorleston and Bradwell
GP practice premises in Gorleston and Bradwell need to change. We have listened to your views and developed three proposals on where to relocate the three GP surgeries. We also want your views on any other options that we may not have thought about. This consultation is your opportunity to have your say on the future of GP services in Gorleston and Bradwell.
(https://www.greatyarmouthandwaveneyccg.nhs.uk/uploads/files/GP_practice_premises_consultation_document.pdf accessed September 2015)

1.2 This NHS public consultation was conducted between 3rd June 2015 and 2nd September. Feedback was provided to a survey found within this document and also via an on-line link and further feedback was collected from public meetings and written submissions. This consultation received 731 responses, including all response types. All data has been entered for analysis and formed the basis for developing this report.

2 Process and Outputs

2.1 A database of all feedback was developed. A First Stage Analysis codes all responses. The Second Stage Analysis provides a summary of coded responses organised into *themes*. The first and second stage analysis documents are working documents and may contain personal information. Therefore, these are not available to the public. This final report has been drafted using the analysis and can be made available to the public as all personal or identifiable information has been removed.

2.2 In the survey respondents were asked two types of question ('rating' and 'open response'). These questions have been presented in this report in the order they appear in the survey.

2.3 This report has been written using (as far as possible) the words and phrases used in the responses. No corrections of fact, grammar or syntax have been made.

2.4 This report summarises the *themes.* The *themes* with the most responses are discussed first followed by the next in descending order. This provides a relative indication of the weighting of each response. Every attempt has been made to report the feedback provided for each of the respective questions, therefore there is some repetition within this summary.

2.5 Questions raised by respondents have been summarized and reported at

the end of the summary for each question.

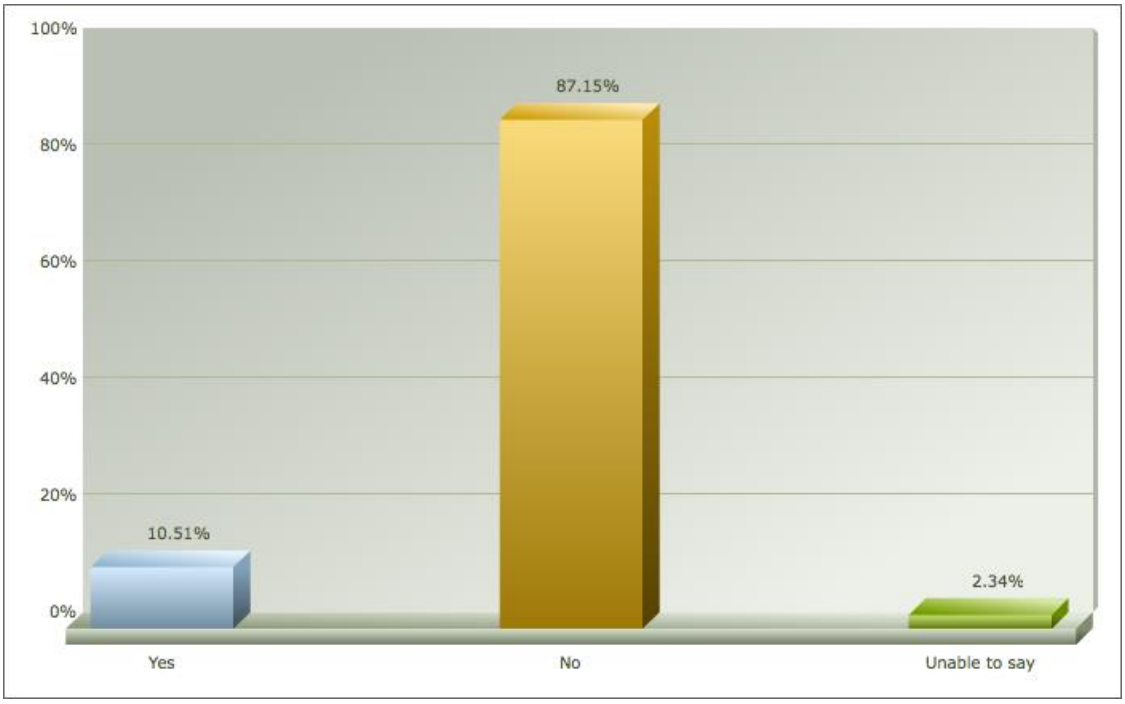
2.6 None of the views expressed in this report are those of the author or any organisation for whom the author may work.

2.7 The following table shows the response to the question;

We want to make sure that you have the opportunity to fully understand the proposals in this consultation before commenting on them. Based on the information you have read in the consultation document, do you understand the proposals?

3 Proposal One: Relocating the three GP practices to a new purpose-built Primary Care Centre on the James Paget University Hospital site.

3.1 Qu 6 – Do you support proposal one?



3.1.1 Parking

Availability - Parking issues at the James Paget would need to be addressed. Parking at JPUH is a great concern, (diabolical, horrendous, a nightmare, a big problem, completely unworkable) and at crisis point. With the influx of patients and professionals space may become limited. It will be impossible to park especially parking for an appointment during visiting hours. There is no scope to effectively increase parking on site. Visitors are currently causing a major problem in nearby residential roads.

Cost - Some of us can currently walk to our GP surgery, this would no longer be the case in the event of the surgery being relocated. If we did drive to JPHU we would have to get a ticket and pay for parking which is expensive (extortionate, prohibitive) and isn't fair - especially if you have to wait for your appointment for a while. This will add stress to the visit during the event of an illness and for the disabled. There are very few disabled parking spaces, and those there are, are a long way from the main entrance.

Allocation - What is there to stop Hospital Visitors parking in allocated GP surgery spaces in order to escape the extortionate charges they currently pay

on the main car park? The hospital currently makes a profit from car parking, I have no confidence free parking will be provided.

Provision - Ample parking must be provided separate from hospital parking, near to the GP surgery and it should be free. A parking solution is yet to be defined.

3.1.2 Accessibility

Distance - I am concerned about some patient's travelling greater distances particularly if elderly, disabled, with children or dependent on others for transport. It will stop many people from being able to reach a doctors surgery, particularly when they are sick. The JPUH site is too far away for population centres for many.

Fitness - A child can be too sick to go on a bus. This is more difficult with multiple small children. I would avoid non-urgent appointments (cervical smears, annual blood sugar test) if there were access difficulties. It would mean more house calls by GPs and more admittance to hospital for those who can't get to a GP and so wait to become acutely ill.

Roads - We will all have to drive, meaning more cars on our already overstretched road system, causing congestion. The roads are congested and the entrance to the hospital is narrow and poor.

Location - I go to a local GP because it is local. Currently we can walk to our GP practice. GP & community services should be provided in the community, convenient and easily accessible by the community, not at a general hospital.

3.1.3 Overcrowding

Space - JPUH is too crowded already and not large enough to include this surgery as well. This proposal will put more pressure on the James Paget Hospital site and services. You may be using land which might later on be needed to continue to expand the JPUH itself. There is already talk of palliative care beds being made available. The remaining building space at the hospital is becoming limited and should be reserved for the development of the hospital as some facilities are already cramped/unsuitable

Population size - With more housing more people will be using the hospital site. One surgery for this whole area will be mobbed and service will deteriorate – this could cause chaos. There will be an increase in patient numbers from the local area. You cannot get an appointment at the doctors now. This is made worse during the holiday season with visitors using local services. How can merging 3 into 1 help? This proposal will result in a larger 'practice' with patients becoming a number and having to see whichever doctor is available. Plus more people mingling together leading to more spreading of virus and colds and flu.

Referral - It would encourage more ambulances to be called. People will just use the A&E department, as this is close by, if an appointment with the GP is not available. There is also a risk of too many A&E patients being shunted to the GP facilities, overloading it with non-registered people and increasing waiting times. The areas of care are better separated i.e. a) A&E, b) GP Services.

3.1.4 Public Transport

Links - We do not all have our own transport. We rely on good public transport links. Often there is a lack of transport.

Journey - Residents in Belton and Bradwell have to get a bus to Gorleston and then to the JPUH. From Castle we have a bus an hour with last one at 5ish.

Acceptable - There is good public transport from most of S.Gorleston - the new development west of Beacon Park is the exception. The JPH site is very accessible by car or bus.

Consequences - Co-coordinating appointments with public transport is a problem. The elderly cannot get buses until 9:30 am. Buses are not always on time and sometimes do not turn up at all. Standing about waiting for two different buses in the winter is just not acceptable, especially when unwell.

Costs - Taxis are prohibitively expensive and Bus fares are also expensive (unrealistic) and it is unfair that people have to pay. Paying to go and see a GP either through bus fares, fuel or parking charges will put a lot of people on low income off seeking medical attention.

3.1.5 Patient Preference

Patients - We need assurance that the Practices concerned wish to move given patients have expressed opposition to the proposals. Patients of the practices were not directly informed or involved in the pre-consultation process. This proposal should be what the GPs and patients want. Patients feel this proposal is inconvenient, less accessible.

Proximity - People have made life changes in order to be close to medical care in their existing locations. Including moving homes. I see the importance of a local surgery for local people to allow the young, single parents, those that aren't mobile, those that can’t drive and the elderly to have a GP closer to home.

Avoidance - I want to avoid any hospital premises wherever possible. The whole atmosphere in the hospital environment (and general area) is not conducive to a low stress visit to the doctors.

Choice - I have a very excellent surgery. This is taking choice away from patients who may have been with their GP for years. I don't think you would see the same GP twice. I thought your GP was meant to be your family doctor

but it seems we are not allowed to have that any more. I don't want to be just another number. It would lose the local feel. I am quite happy as we are.

Centralising - Centralising healthcare is a poor decision, and the hospital is badly placed to serve the needs of the people losing their GP office. Do not like the idea of our surgery joining together with two other practices. We have had enough change of Doctors recently, but at least we can still see just one Doctor. This probably won't happen if this proposal goes ahead.

3.1 6 Don't Support Proposal

Unacceptable - Totally unacceptable - definitely not! (Silly, crazy, ridiculous, ludicrous, stupid, ill conceived, round the bend, a recipe for disaster). To me this will lead to a nightmare of bad consequences. Would not work. This is an unnecessary and uncaring change. Not in the best interests of the patient. I strongly oppose this. The system is fine how it is. Leave all the doctors surgeries alone where they are.

Location - It will take away locality, which past experience tells me the structure gets bigger with too many "chiefs" with a much-reduced service. No nearby pharmacy - using the hospital pharmacy is not an option. Job losses will occur as there is blood test facilities at the JPH, the "blood nurse" would soon loose her job as patients would be given a form, left with a long walk and a longer wait.

Alternatives - Other sites in the Gorleston area should be considered. We are in favour of new locations / hubs made to meet the demand of new residents where services are currently over subscribed but not on any form of relocation. Open a new doctors' site but do not close the surgeries now. There are other options. The Shrublands site is most suited for access and would be in the centre of the areas currently served. Plans and agreements had previously been made for this development with NCC and the former GYW PCT. Any large scale centre should be central, JP hospital is not central, even with the intended south Gorleston housing development.

Waste - The proposal means money being spent on facilities which we already have. I feel it would be a waste of money to build a new practice so close to the hospital. Use the NHS money more wisely. The money that is going to be wasted on new buildings would be better spent on improving services which we are continually told are stretched because of lack of money. For example, reopen cottage hospitals. The report makes statements to the effect that this is not a cost saving exercise but through out the years the public have heard this from many public bodies and found it difficult if not impossible to believe them. No changes to the system should be made until all capital funding and sites area confirmed and assured.

JPUH - Please accept this response submitted on behalf of the [JPUH] Trust. In the spirit of partnership working, we had agreed to include the James Paget site as one of the consultation options. However, having spoken to our Governors and taking account of feedback from some of our patients, we would support the Shrublands option.

3.1.7 Support Proposal

Advantages - We support this proposal. I like the idea of having the surgery near to the hospital. This is particularly important to those who need regular appointments, transfusions, diagnostic testing, x-ray, urgent specialist attention or repeat prescriptions. Once the patient is at the hospital, things like bloods or other investigations could (theoretically) take place soon after seeing the GP. It will be close to main services and it will save money. It would also help with people turning up in A&E unnecessarily. The emergency protocol at the GP surgery within hospital site will need very clear regarding transporting a patient to A&E. I would support this site 100%.

Location - This is an ideal site for a lot of people. There are no surgeries south of Gorleston so I feel this would cover this area perfectly. Everyone knows where JPH is.

Transport - Transport is excellent, there is a regular bus service to the JPH. It is easy to access. It is within walking distance of the Cliff and Beacon Park housing. A separate parking facility for GP clinics could be provided.

Size - What is provided with a small acute hospital will need to be looked at over the next 10 years and putting other services on site is in a way to save it. It is a way of keeping all medical services centralised.

Information - There is not enough information. The proposal does not address other practice premises in the geographical area, which require upgrading to 21st century standards. Nor does it say how much of a presence will be at Shrublands

3.1.8 Option One Questions

Why do the surgeries need to relocate?

What's wrong with the way they are working?

How much will it cost?

How will the site be configured (i.e. as one large surgery or as three separate surgeries)?

Can the Falkland's Surgery site be extended?

Will there be sufficient parking for patients at JPUH?

Would patients have to pay for parking? – if so, what would the fees be used for?

How will the parking for GP surgery be managed to ensure access to GP patients?

Have you considered how unwell patients can manage to get from the car park to the surgery?

Will finance be available to increase patient transport to and from the JPUH?

Is the hospital already overcrowded with buildings and services? (Considering there are already plans in place for a hospice)

Will the surgery be accessible by JPUH patients?

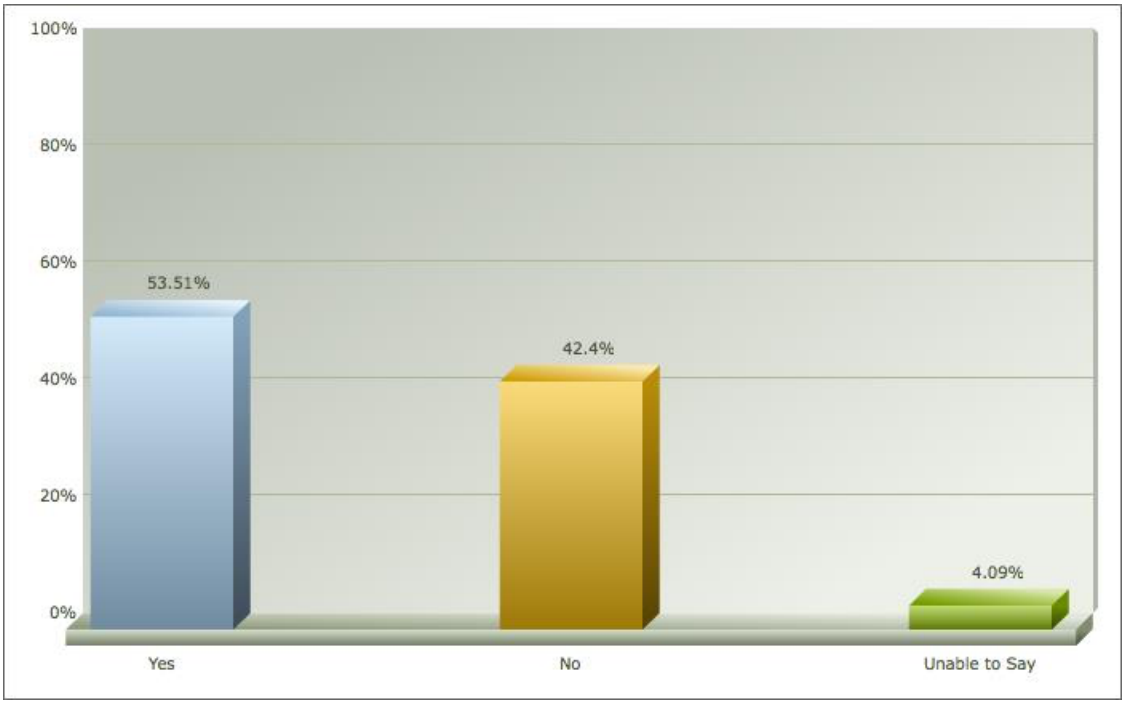
If so, will this lead to overcrowding?

Will patients be able to see their own Dr?

Would there be special treatment available for chronically ill people?

4 Proposal Two: Relocating the three GP practices to a new purpose-built Primary Care Centre on the Shrublands site.

4.1 Qu 7 – Do you support proposal Two?



4.1.1 Support

Promise - This surgery was opened following a public consultation to relocate the former Stuart Close medical centre which concluded in September 2010 - less than 5 years ago. The relocation was proposed in 2 parts: the first of which was the present situation with the surgery housed in a purpose built,

fully accessible temporary building, Part 2 was the subsequent move of the health centre to a purpose built, permanent building on the same site.

Benefits - This is the best option of the 3, a fantastic idea, makes the most sense and would benefit most patients. It is an ideal site for a new purpose built centre and provides more flexibility with the planning. It is the most accessible (particularly for an aging population). It would not be as busy like it would at the hospital. It keeps Primary Care in the community where it belongs. It is more central which is regarded by many to be an important factor. It is nearer (for some patients), has much easier access and free and better parking, including disabled parking. People can walk, ride bikes or use mobility scooters. Buses are regular. There is less traffic. A more convenient location means shorter taxi rides and less expense. When I need to see my GP as an emergency it will only take me 15mins to get there not 30-45 mins if the other proposals are chosen. There is plenty of space to expand in the future. This feels more community based than JPUH.

Integration - I can see the benefit of professionals working alongside one another in a purpose built building. There are several health facilities there already. Appointments are made quickly. It would seem to be advantageous to patients and should improve communication between professionals and patients. Put all of the GPs from the three surgeries together along with the teams that would support the community and prevent admission to the JPH. This site is good for community health such as family planning, mental health and counselling. Shrublands works well as a MDT site for health and social care. There are available pharmacies – (Lloyds and Coop are just a few minutes away). The site is not far from the JPH should an immediate referral be required. You could train doctors here.

Registration - It will also continue to offer a community feel of a local surgery meeting the needs of local people. You would only have to relocate approximately two thirds of the patients as the other third would already be registered there. All the new residents could register here. If this means a full GP surgery then that would be a good thing.

4.1.2 Transport

Problems - There continues to be issues of transport links. Transport problems are even worse with this site than option one. There is no direct bus route. The site is not well served by public transport. Particularly from Blue Sky, Bradwell, Belton or Burgh Castle. This option involves one bus, which only runs every 30 minutes. If I've just missed a bus I would have to wait in the open for the next bus, and there is no shelter - not good if you are feeling unwell. It would again involve relying on a bus that may or may not run. A cancelled bus would mean a cancelled appointment.

Routes - Negotiations need to take place with local public transport providers re inclusion of site on existing / new routes. Buses will have to be diverted to the clinic as the nearest bus stop is at the hospital which is a long way to walk. Public Transport Links are good. This site is readily accessible by public transport running along Magdalen Way - services 1, 1A, 8 and X1 pass the

medical centre. Services 2, 6, 6A, 7 81A and 577 stop by the Magdalen Arms public house which is only a short walk away.

Distance - For many, it is too far to travel. This means I would drive. Not everyone has a car though and not all sick people are drivers or well enough to drive on medication at the time. The traffic on this estate is a nightmare yet alone more traffic. Small roads.

4.1.3 Access

Ease - We need a surgery that is easy accessible that is within walking distance. This option would be harder to get to than the current surgery locations. This option only works better for local patients that walk to the surgery. For disable patients who are unable to travel on public transport, it would be virtually impossible to get to see their Doctor. Access will be difficult with no transport. Patients would not like to walk a long way to see a doctor in the middle of winter when they are not well and/or elderly. If people are fit enough to go on two bus journeys and walk 20 mins each way to get to the practice, they shouldn't need to take up the GP's time! I would not want to walk in that area on own.

Traffic - I worry about traffic in what is a reasonably busy part of town, particularly in the summer. This would lead to much increased traffic volumes through Gorleston rat-runs. I envisage more people using the residential lanes of Gorleston to access the site. Increased traffic flow would lead to greater problems joining the road of which Shrublands is sited - the potential for traffic accidents rises. The entrance is a nightmare, as it is a two way. Could do with separate entrance for one-way traffic in/out.

Fitness - A person with poor mobility or lack of funds to pay for transport should not be impeded from accessing healthcare. Poor access means a lot more people will be calling the Doctor for a house visit.

4.1.4 Parking

Concerns - Parking would probably be an issue with the number of people using the service. It is important to ensure sufficient car parking compatible with increased usage. The current car park is constantly full with the existing GP surgery. It must have more disabled parking and more parking in general – and not time limited. You would need parking for at least 120 cars, and if you continue all three surgeries at least 12 disabled bays. This will destroy more green space. The single access to this site would be woefully inadequate.

Impact - This could affect the nearby neighbourhood as people would park on the streets and potentially block the main busy road.

Charges - It would be disgusting if we had to pay.

4.1.5 Patient Preferences

Choice - Depends on assurance from the Practices concerned that they wish to move. People have made life changes in order to be close to medical care in their existing locations. Including moving homes. Losing my family practitioner and having to mix with a mass of people is not my idea of a good NHS service - remember the NHS is our service - the United Kingdom's - not governments trying to cut more corners. I am extremely upset about this, the patients and staff will loose out massively on a fabulous service. These patients are going to get lost in the system. It should be "patient first" in all ways forward.

GP's - My main concern is with merging three GP practices - would you be able to stay with your own GP with who you have built up a relationship over many years and who knows your medical needs - rather than having to explain everything ever time you see a different GP (some of whom it has to be said come from practices which have a very poor reputation)? Not being able to see just one Doctor would still be an issue. I do not wish to change my doctor and I do find, as I get older I need their services more and more.

Size - There is a sense of reassurance about the cosy size of my current practice. So much might be lost in big premises and centralisation. We have a very good practice - very caring. We would be very sorry to lose this. Would prefer to stay at my surgery. The waiting room has less than just a few patients and waiting time less than 10 minutes.

4.1.6 Don't Support

Disagree - No way, (silly idea, stupid). For the following reasons:

- This still does not cover a wide enough area
- I do not believe in centralising local GP facilities at all
- There is a school on site for children excluded from school that already cause issues for the healthcare on that site
- There are several practices in Gorleston centre already
- Shrublands is limited in space and access
- Patients are not satisfied - mainly due to the nightmare automated appointment service and lack of availability of appointments.

Size - I do not understand why it is necessary to relocate the patients from 3 surgeries - around 19500 people, simply to relieve the pressure on A&E by those who are unable to identify what an emergency really is.

Status Quo - I would prefer my doctors to remain the same in the same place. The system is fine how it is. Bigger is not better. I am satisfied with the service and treatment I am getting. We already have a purpose built GP Practice.

Alternatives - It is a good option but I prefer another option. This is my second choice. The Shrublands area already have local GP surgeries. A new surgery should be built further south, especially with the new estates being built at

Browston and Bradwell. Build a new unit for new homes and leave the surgeries as they are.

4.1.7 Overcrowding

Size - If you are envisaging an increase in the population of South Gorleston/Bradwell why do you think combining these surgeries can handle the additional medical needs when the existing surgeries are already over subscribed and getting an appointment is very difficult. More people less appointments. Most people who see a doctor need to see one almost straight away.

Referral - This will not prevent people attending the A&E department at the JPH, which is more convenient. I would rather go to the A&E Department and see a proper Doctor and get fast tracked to a specialist who will sort me out rather than being fobbed off by my GP. People might just as well call an ambulance and go straight to A&E at hospital. If the idea is to stop unnecessary visits to A&E this would not help as most new housing would still be nearer to JPH than GP's surgery.

Size - The site is too small. This area is too crowded. Too limiting for any expansion if patients and/or facilities are increased. I would not be confident that it would be able to handle all GP practices on one site efficiently.

4.1.8 Other

Information - In principle this appears the best option, but there really is not enough detail. Difficult to answer this without knowing what is meant by '...space for a GP presence at Shrublands'. It would be interesting to know how many practices are involved with these 3 practices.

Finance - Again finance seems to be the main reason for doing this and the cost of inconvenience to users would not be reflected in the overall assessment of concentrating everything on one site. Between proposal 2 and proposal 3 the benefits are equal and rely on the individual costs of each proposal. Don't waste our money on what we already have! Economics of scale.

Consultation - But knowing the powers to be, who may not have local knowledge, I think that it has already been decided.

4.1.9 Options Two Questions

Is there sufficient parking at Shrublands should the 3 existing surgeries relocate to there?

Will the location be big enough to provide the services and to expand if needed?

How confident are you that your bid for capital money will be successful?

Does GYC own the land?

Are you in discussions with local transport providers?

Have you considered how elderly patients will access this site?

Will patients have access to a GP 24/7?

Would there be home visits if necessary?

Can patients see their own doctor after the relocation?

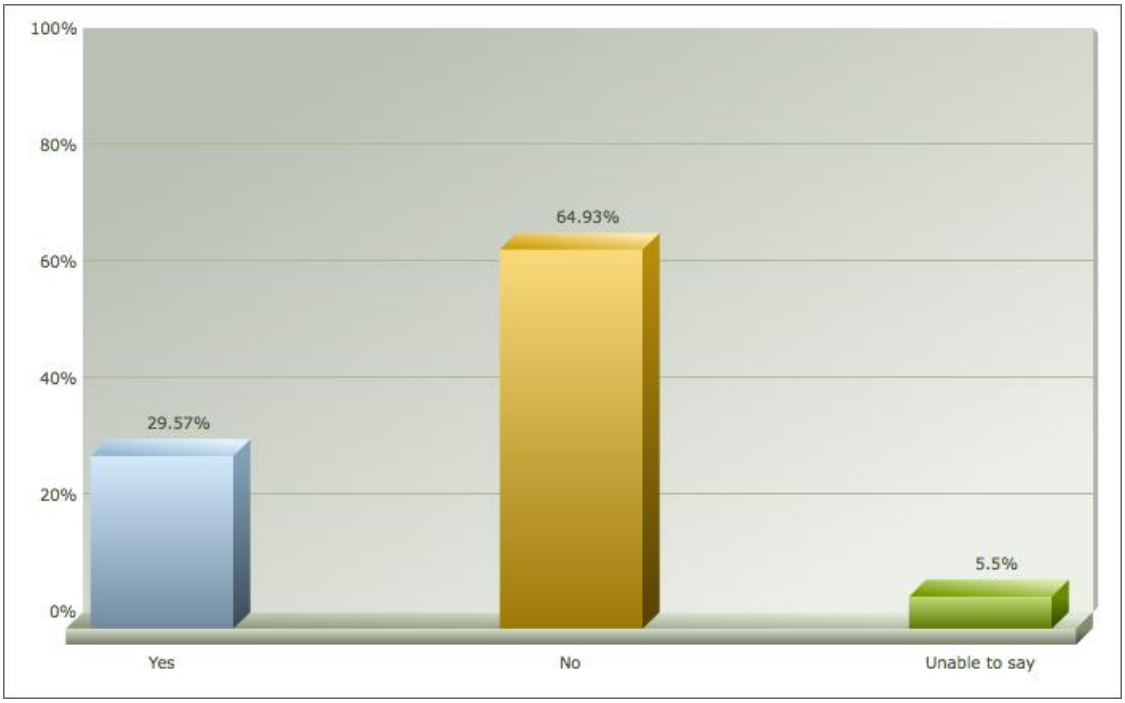
What appointment booking system will you use?

Which Drs from these Practices would relocate to the Shrublands site?

Does this proposal account for an expanding population?

5 Proposal Three: Relocating the three GP practices to a new purpose-built Primary Care Centre on the Beacon Park site.

5.1 Qu 8 – Do you support proposal Three?



5.1.1 Transport

Accessibility - Accessibility is worse than JPUH. It's too remote & the distance existing patients will have to travel is too far. It’s even further away. It would

only be suitable for those on the Beacon site making them a priority over everyone else. Transport is very poor to this area from the villages (Belton, Bradwell. Beacon Park, Burgh Castle, and Gorleston). The elderly or people with walking disabilities would have problems. No means of crossing A12. Wouldn't fancy the trek when I'm ill, let alone elderly, frail or disabled.

Routes - There is no public transport into Beacon Park or bus stops. Buses will have to be diverted to the clinic. You cannot build a facility for the public on a site with no public transport whatsoever! This is utterly ludicrous, (sod that, pigs might fly!!!). The roads in beacon park estate are too narrow for buses. Public transport is unreliable, as bus drivers are known to refuse people who are ill or have ill children. There may be a bus route when new road opens.

Cars - Not all people drive. The nearest bus stop is at JPH. I personally cannot walk the distance from JPH to the ambulance station in the time you have stated it takes from JPH to proposed new surgery.

Costs - And again fares. It would be costly for transport there and not easy for elderly or disabled or mothers (patients) with small or ill children. Many patients are elderly and on low incomes and cannot afford a taxi.

Roads - Those with cars will not have a problem once the new road is finalised between Bradwell and Beacon park. Access is likely to be easier for everyone both for public transport and private travel. Footway access is also needed (JPH doesn't have proper paths) and scarce cycle storage. Accessibility would be poor with the intended closure of Woodfarm Lane - this would mean a round trip for many patients in Gorleston.

5.1.2 Support

Advantages - Of the proposals, this is the most preferable option. A new state of the art purpose built facility looking to serve the community for the next decade and beyond. Plenty of space to expand in the future. Adequate parking close the JPH, ambulance station and Wrightway healthcare on your doorstep serving the occupational needs of the offshore industry and other sectors. There is a need for more GPs this side of town.

Benefits - I have experienced the benefits of closing down outdated surgeries and replacing them with multi-function premises in another part of the country and it seemed to work well. On the plus side, the buildings may be more functional for people's varying health needs or abilities. Combining surgeries would also mean that the population of the practice would vary. With the new link road, this would probably be the easiest to get to. There are no surgeries in that area and there is the land to build a good size one with plenty of parking.

Location - This proposal differs from proposal one by placing the care centre away from the congestion of the hospital site and the associated parking difficulties. It may also make the Beacon Park community more viable for investors and new businesses. Beacon Park has cheap rates to help companies who move there. These are subsidised by the council. So the GP

practices will benefit from lower rates. It will support the new housing development. The expanding areas will be catered for. The close proximity to the James Paget would be beneficial in reducing A&E visits. Those patients not wishing to travel to the Beacon Park can relocate to Millwood or Central.

Alternatives - Second choice. I am happy with either proposal 2 or 3 but against 1. Out of the three, this in my opinion is the only workable one. Least worst.

5.1.3 Don't Support

Disagree - Silly idea, definitely no. Feel proposals so far are the same just in a different place. It is difficult envisioning a new facility. I have little faith that it will be any improvement on the current state of affairs. In fact I am almost certain that any of the proposals will prove detrimental to patient care.

Central - Not central enough. This would offer no benefit to the people of Bradwell and would force them away from their current GP. If the surgery is too far away elderly people will not bother to attend, then they'll be more people attending casualty at JPH, or would end up with more pressure being put on Central and Millwood surgeries for those people not wanting or able to travel to Beacon Park.

Status quo - Leave them where they are, I am at the surgery I am because it's where I want to be. Moving it will make it so much more difficult to see my doctor. I am on disability and feel this will severely disrupt my ability to see my doctor.

Policy - Proposals to concentrate everything on one site surely go against Government policy on green issues. All three proposals generate additional traffic compared to the current situation. In view of Government policy it would be a shame to base something on a population centre for 10 years ahead. Who knows whether the NHS will still exist! We need the centres now.

Alternatives - I do not support three surgeries combining. I would much prefer to maintain the status quo. Create a smaller surgery for the newcomers here and let the others remain open. I would however more fully support an option 4 which would be to build a new GPs Surgery on / near the new Bradwell housing development just off the A143. Put the money into making each practice the best it can possibly be.

Location - It's a business park not a place for a doctor's surgery. This is no place for children and elderly people to be accessing heath care near the busy A12.

5.1.4 Location

Preference - I think the purpose built building would be better placed within the centre of Gorleston to make it more accessible for residents. This proposal is completely against the idea of being a central medical facility for the people of Gorleston and Bradwell. Would only be useful for South side! Too close to

JPH. This seems to be the worst site in terms of central access. To ambiguous "GP presence" in the proposal - would need 50/50 spilt of surgeries on 2 sites to be fair for all residents. This proposal contravenes the third aim of your proposal i.e. service to be closer to people homes.

5.1.5 Parking

Concerns - Parking would be a huge consideration. Parking at Beacon Park would need to be a high priority. Plenty of free parking will need to be provided. Many patients will, by necessity, arrive by car and there is nothing more annoying (for the healthcare professionals as well I suspect) than being late for your appointment because there is nowhere to park on arrival.

5.1.6 Patient Preference

Choice - I feel that the 'personal' aspect of GP practice would be lost, and a conveyor belt system would emerge. It will become too big and impersonal. I feel that waiting times at the moment are not good to see a GP generally, however my GP surgery is usually good. Because of my long term illness, I need to be able to see my GP and due to my job I sometimes only have an hour to get seen. There will also be a huge amount of people seeing the GP at one time. People have made life changes in order to be close to medical care in their existing locations - including moving homes. I don't wish to travel to Beacon Park to see a GP. It wouldn't feel like a local surgery. My Surgery is situated this end of Bradwell for the convenience of local people. This has worked for a number of years fine. I'm happy with my Surgery. My husband and I are registered at our Surgery and we would like to stay there. I currently am part of an extremely well run practice and see my own doctor consistently and when I need to. I feel with a large practice such as these proposals this service would not be the same.

Population - If you are envisaging an increase in the population of South Gorleston / Bradwell why do you think combining these surgeries can handle the additional medical needs when the existing surgeries are already over subscribed and getting an appointment is very difficult.

GPs - Relocating all under one roof would mean only one thing. The chances of seeing your regular GP would cease to exist and we (the patients) would have to see whoever was available. Probably a GP who hasn't a clue who we are, what are medical background is, and who is too busy to read the notes.

Facilities - Without pharmacy facilities there will be another journey for the patient to make after the consultation if a prescription has been given. There are no pharmacies nearby.

5.1.7 Finance

Implications - And then there are the financial implications. The cost involved in land purchase, planning approval and time involved in new project. The cost of this transition will be expensive. Already a purpose built building was

put up recently, (Shrublands medical centre), and now there's going to be another one built. Cost effective? - I think not! And it seems pointless spending money when there is adequate buildings already built. Don't waste our money on what we already have!

Contribution - The building contractors who are putting up the new houses should be asked to contribute to the cost as they are making profits from bringing people into the area. There are many precedents for this concept: community centres and sports facilities have in the past been put up by such companies. I understand that there is publically owned land at Beacon Park so some of that could be used. Instead of inconveniencing patients why not look to means of saving money.

5.1.8 Information

Needs - I have said yes to all 3 proposals as the options need to be looked at in more detail. Not enough information at all. I don't know where site will be. How convenient it will be for buses or parking. Unsure what infrastructure will be made available to people to be able to attend and get there.

5.1.9 Option Three Questions

When will the Beacon Park site be completed?

What transportation will be provided?

Have the additional travel costs been considered?

Can you justify the cost of relocating GP surgeries?

How will GPs address the health and social care needs of the varying and increasing population?

Can the empty GP practices be privatised?

Can the empty GP practices be satellites for the new surgery?

Why are Shrubland continuing with their 'out reach' GPs but Belton and Bradwell will not?

Will patients still be able to see their own GP?

Will 'Persimmon' contribute to build costs?

6 Question 9 – If you have any suggestions about where the new Primary Care Centre could be located, please add them here.

6.1 Status Quo

Preference - My surgery needs to remain where it is! Leave it as it is now and invest in the ones we got. Not necessary at all.

Location - Services are required in the current locations. All the practices have scope to expand as required. Centralising services will reduce the local knowledge, one to one service currently provided. Why not staff existing surgeries and build another smaller practice. The 3 practices involved should decide on the best location based on their patient address files and public transport access.

Centralisation - A "new Primary Care Centre" is not needed or wanted by the community, anywhere. We will lose our 'family practitioner values' proper care and knowing the individual will be lost. Taking services away from patients with no guarantee that services will improve.

Funding - It seems pointless as money is the driver here and not patient service. People are living longer and we need more facilities not less (despite you saying it will be big enough) travel to surgeries is costly, and time consuming.

Transport - Any of these proposals are not viable, as elderly patients do not necessarily have their own transport, and have to rely on public transport, for which if they had an appointment before 9.30am they would have to pay (Mon-Fri) another expense which many can ill afford, apart from having to rely on, to turn up for various reasons, particularly in the holiday season we all know how quick the area comes to a standstill, for many reasons.

Size - A suggestion from the PPG Forum is that there could be a ‘super surgery’ based at the James Paget hospital site with satellite local GP surgeries at or close to the existing. This could also be applied to a Shrublands hub.

6.2 Belton & Bradwell

Preference - The suggestions so far are detrimental to people living in Bradwell, Belton, Browston, Burgh Castle and Hopton. A new GP surgery needs to be located in Bradwell certainly because of the building of all the new houses. These areas are growing in population. Beacon Park is the preferred option for Belton and Bradwell patients - or alternatively a new site close to these villages.

6.3 Shrublands

Preference - The current Shrublands health centre is in an ideal location for most people with plenty of parking and on a regular bus route. Admittedly it is a temporary building but I feel if a permanent surgery was provided it would be an ideal location. The Magdalen Estate around the current Shrublands surgery is most central so would allow the best access.

6.4 Access

Population - Our older population will need to be able to access the service in the best interest of patients & effective primary patient care. A location should be considered that allows easy access for the existing practice populations.

Transport - Transport is a Major issue for the area. First group are the bus service provider and the number 8 is the main route. The drivers have already been told that they can refuse to allow on board anyone who may cause a problem on the bus or may cause the bus to have to go out of commission, eg be sick on the bus so has to return to depo with immediate effect or spread a contagious illness. Also with transport disabled customers won't be able to use it as much. With buses they do not have to allow disabled people on. Some drivers have refused wheel chair users. Along with this if there is already a wheel chair users on the bus then other disabled users will be refused. Scooter users are also the same they park there scooter in the wheel chair bay and then stopping people who need the space access to the bus. One of the key issues raised is the issue of transport and the difficulty some patients will face if their GP practice moves. People on low incomes will suffer financially having to pay bus fares and the logistics of travelling may make it a nightmare for the elderly and people with children. The location must have ample free parking - and think about future needs.

6.5 Expand

Upgrade - Why not use the money to update existing premises – particularly where there is available space. I am quite happy with my present GP practice premises, although it could do with and upgrade. Will you be hiring more Drs and/or nurses to do the job?

Expand - Although it says you couldn't expand Falklands you could if you really tried. Or more geographically the area around the existing surgery on Falkland Way. Would it be possible to have new Primary Care Centre built on the grassland in Primrose Road just along from Falkland Surgery. There is a big field adjoining Falkland Surgery, why can't it be there.

Increase - We need more practices not less. I'm sure the new housing developments will provide enough patients for a whole new practice. A further purpose-built primary care Centre could be built on the new Beacon Park site as the site grows. Why don't you just build another GP surgery in Southern Gorleston to handle the expansion of the population?

Services - More services are needed, including:

- NHS transport service to get people to medical centre
- More doctors and medical staff on call and available for 24 hour service
- Provide mobile services for physiotherapy,
- Chiropodists to see patients at home (I believe this only available privately currently)
- Consider a hairdressing service at home for convalescent or elderly patients - a 'feel good' factor e.g. for someone recovering after chemo

6.6 Proposed Sites

Alternatives - The following sites were suggested:

- Beacon Park
- Magdalen
- Old Clayden High School
- Hetford Way
- Merge Gorelston surgeries
- Gorelston High Street
- Gorelston medical centre
- Millwood
- Riverside Road
- Alderman Leach School.
- Addison road
- Browston Corner
- Crab Lane
- Malthouse
- Mill Lane
- near New Surgery
- Priory Park
- Longs industrial estate
- James Paget
- Anglian Way

6.7 Patient Preference

Choice - I do not wish to attend a 'Primary Care Centre' to visit my GP. I like the fact that I can always get an appointment when I need one and that my GP knows myself and family members. An over riding concern is the untold pressure that the amalgamation of these GP practices will have on those that remain, for example Central surgery, this is a practise that is obviously struggling to serve it's current population, and will therefore not be able to absorb the increase in demand that will evidently take place due to the fact that a large population will not want to move to the new premises and will choose to register at existing practises.

6.8 Consultation

Concerns - I have heard rumours that it has already been decided that this will be at JPH, and that these questionnaires and consultations will make no difference. Hopefully that is not the case and that the views of the community will be taken into account. At the end of the consultation the public should be supplied with full figures and reasons for the ultimate decision.

Response - Will you listen to what the public want!!! I doubt this complaint will do any good as I think minds are already made up! In fact I have little faith in my complaint being read!! - And why run 2 proposals in tandem. Ridiculous.

6.9 Finance

Concerns - You will take the cheapest option what ever!! We all know the main reason for this great upheaval is all down to money which cannot be denied. I do not see the sense of wasting taxpayers' money on an unnecessary reorganisation. As we have a government that is hell bent of cutting the public expenditure (at any cost) therefore I cannot see the logic of the CCG spending a vast amount of money in this project. If the CCG has got this money 'spare' in its coffers I suggest that it is spent in providing the population of Gorleston with additional medical facilities.

Contributions - The developer making money out of the 100's of new houses in Bradwell should be obliged to provide a new surgery. Should definitely approach developers of new build to contribute then maybe able to stretch the finances. Let the building companies give something back to the community they have invaded.

6.10 Primary Care

Support - I should not really state a preference as we are very happy with the service we receive from there both with the doctors and the staff. By re allocating these surgeries you are taking the care away from patients but I thought the governments aim was to bring care into the communities where the patients live. I would support any of the options as I feel that co-location and strength in numbers will help Primary Care Services to be more sustainable.

6.11 Information

Needs - Much more thought on this should be given. There is insufficient information. Would not know what land would be available or the acres that would be required.

Definitions - What is a primary care centre - may be worth defining in the question again, and also reiterating summarising the options in the other questions.

Collaboration - Another concern was around the three practices that would be co-located and how they would work together as three separate businesses.

6.12 Alternatives Questions

Why could you not have satellite surgeries as well as main centre?

Will patients be able to see their own GP?

Can any of the existing surgeries expand?

Can a surgery be located at Belton?

Why was this planning not included in the new road system being done at Bradwell?

If you have £5million to spend on a new centre, why not just concentrate on improving the existing surgeries?

As the government are granting a further 8 billion why has it been necessary to do this now?

How much is it going to cost?

There are nearly 2000 new residents in Bradwell at the Bradwell Meadows site where in the plan there was supposed to be a school and a GP Practice, what's happened to that?

Will patients be moved to a new doctor within the new practice?

7 Report Outcomes

This report has been developed independently using the feedback provide. All queries concerning this report can be forwarded to the author. All further correspondence should be forwarded to the GY&W CCG.

Final Report developed by
Dr Steven Wilkinson – Consulting the Community*
Steve.Wilkinson@consultingthecommunity.co.uk
September 2015

* Consulting the community is a research centre of academics from the social sciences. This method for analyzing feedback has been developed by colleagues from this centre. Enquiries can be made by contacting the CCG.
Website – www.consultingthecommunity.co.uk

NHS
Great Yarmouth and Waveney
Clinical Commissioning Group

HealthEast

Meeting of the Governing Body PART 1

22 October 2015 Agenda Item 7

Title of Paper	GP Practice Premises in Gorleston and Bradwell - a response to the Public Consultation
What the Governing Body is being asked to decide or approve	The Governing Body is being asked to note our response to this public consultation.
Executive summary	Following the thirteen week public consultation on GP practice premises in Gorleston and Bradwell, the response from the CCG to questions raised during the process is presented. The report is written for the public and is available for any member of the public to access on our website. We received 731 responses , and this document endeavours to answers questions raised during the consultation.
Risks attached to this proposal/initiative: None.	
Resource implications: None for this response document.	
Name	Rebecca Driver
Job title	Director of Engagement
Date	19 October 2015

NHS
Great Yarmouth and Waveney
Clinical Commissioning Group

HealthEast

GP Practice Premises in Gorleston and Bradwell

A response to the Public Consultation

1. Introduction and Purpose of this Report

NHS Great Yarmouth and Waveney Clinical Commissioning Group (locally known as 'HealthEast') would like to thank everyone who took the time to respond to the recent public consultation about GP practice premises in Gorleston and Bradwell. We received an excellent response to the consultation with 731 people and organisations responding. The full report which includes all the responses is available on our website. Answers to the many questions you raised can be found in Appendix 1 of this report.

This is our response to the consultation and sets out once again for clarity the background to the consultation, how it was conducted and steps taken since it closed. We will also tell you what happens next and bring out some of the major issues raised by you, letting you know what we intend to do about those things in particular.

This response report is subject to a final decision being made on the outcome of the consultation by the CCG's Governing Body meeting in public on 5 November 2015.

2. Background

This consultation gave people the chance to share their views on plans to update and improve the premises from which GP services are delivered in Bradwell and Gorleston. It seeks to address issues with the buildings currently used by Family Health, Gorleston Medical Centre and the Falkland Surgery while helping the surgeries prepare for an estimated 3,500 increase in the local population over the coming decade.

The CCG hopes to bring the three GP practices together into one building, known as a 'primary care centre'. As well as providing new better facilities, this would also allow them to share IT systems, reception areas and other support services while increasing the opportunity to recruit and retain more staff. The practices would retain their independence.

Three possible sites for the primary care centre were identified, which are:

- The James Paget University Hospital site
- The Shrublands site
- The Beacon Park site

People were also invited to suggest any other sites which they feel should be considered.

3. The Public Consultation Process

Patients and the public expect to be involved in decisions about the services they receive, especially those that shape the delivery of care in their area. The CCG and NHS England (who are the commissioners of primary care services) are committed to listening to you, and there are also regulatory and legal requirements for the NHS and CCGs to do so. Public involvement and consultation are at the heart of good decision making, and the CCG takes this duty very seriously. In the case of GP practice premises in Gorleston and Bradwell, we considered that the changes under consideration constituted a 'substantial variation' and we therefore decided to complete a full public consultation on these proposals.

Throughout the process, we have worked very closely with our local Great Yarmouth and Waveney Health Scrutiny Committee (HOSC), NHS England and the East of England Clinical Senate, and we have made sure that we comply with the four reconfiguration tests that were introduced in May 2010. These are:

- Support from GP commissioners
- Strengthened public and patient engagement
- Clarity on the clinical evidence base
- Consistency with current and prospective patient choice

In preparation for the public consultation, a series of pre-consultation meetings and events were held which included patient representatives, members of the community, voluntary organisations, charities, local authorities and local NHS staff. This exercise was invaluable in making sure we had a better idea of what difficulties people faced in accessing services and what is important to local people. Most of the consultation document was written following discussions within this group, and the final public document and summary were those who were involved.

We have also engaged extensively with a variety of groups and stakeholders throughout the public consultation.

4. Consultation Timetable

The consultation timetable was as follows:

3 June 2015 Launch public consultation

The consultation was widely publicised and summary documents were sent to households in the Gorleston, Bradwell and Hopton areas via local newspapers, and distributed to the GP practices, libraries and voluntary organisations in the locality.

Public Meetings

24 June 2015: MESH Building, Shrublands

8 July 2015: MESH Building, Shrublands

The public consultation closed at 2nd September 2015.

25 September 2015:	Consultation feedback report presented to the CCG Governing Body
22 October 2015:	Response report presented to the CCG Governing Body
5 November 2015:	Recommendations for decision made by the CCG Governing Body, and referred to NHS England for final decision making.

5. What you said about the options in the consultation, and our response

All your responses from the public meetings, consultation questionnaires and emails were considered and analysed. We asked you if, based on the information you had read in the consultation document, if you understood the three proposals; 98% of you said that you did understand the proposals.

The initial results showed:

Primary care centre location	Agree	Disagree	Unable to say
James Paget University Hospital site	10.51%	87.15%	2.34%
Shrublands site	53.51%	42.40%	4.09%
Beacon Park site	29.57%	64.93%	5.50%

6. Your questions and our answers

You asked many questions through the consultation and we have done our best to answer them as fully as we can. Your questions and our answers can be found in Appendix 1 of this document. If you would like a copy of the answers to every single question asked during the consultation, please get in touch with the CCG via the email your-views-matter@nhs.net to request a copy.

7. What happens next?

We are currently reviewing the consultation responses with a view to making recommendations to our Governing Body. Those recommendations will be discussed, and final decisions made, at the Governing Body's meeting in public on 5 November 2015.

Once again, many thanks for your responses to the consultation. We will continue to communicate with you as decisions are made on primary care practice premises in the Gorleston and Bradwell area of Great Yarmouth and Waveney.

Rebecca Driver
Director of Engagement
NHS Great Yarmouth and Waveney CCG
October 2015

Appendix 1: Your Questions and our Answers

There were many questions raised during the consultation. Set out below are short answers in red to the questions we received. We have grouped these questions into themes. We have attempted to answer the questions that you posed in response to the main consultation document.

Proposal One Questions: Relocating the three GP Practices to a new purpose-built primary care centre on the James Paget University Hospital (JPUH) site.

1. Why do the surgeries need to relocate?

   A: The surgeries need to relocate to improve the facilities for patients and allow for expansion of the services the practices can offer. Gorleston Medical Practice is currently based within a temporary building on the Shrublands site and will need to be moved into a permanent build at some point within the next few years. Both Falkland surgery and Family Health provide services from inadequate premises and find it difficult to offer the services they would like. There are access issues for patients within these surgeries.

2. What's wrong with the way they are working?

   A: The buildings are not fit for purpose and fail to meet the current recommended standards.

3. How much will it cost?

   A: This will depend on the chosen location. We do not know a definitive cost to build a new primary care centre because each of the three sites will have different costs associated with it. However, similar buildings in both Kirkley and Reydon have cost around £5 to £6 million to build.

4. How will the site be configured (i.e. as one large surgery or as three separate surgeries)?

   A: The practices will share a building but remain separate. There will be an opportunity to share a reception and some clinical rooms.

5. Can the Falkland's Surgery site be extended?

   A: Applications have been made previously to extend the surgery and failed. Nothing has changed to enable a fresh application with better prospects of success.

6. Will there be sufficient parking for patients at JPUH?

   A: Yes there is scope for additional parking on site if required.

7. Would patients have to pay for parking? If so, what would the fees be used for?

   A: GP patients will not pay to park.

8. How will the parking for GP surgery be managed to ensure access to GP patients?

A: This would be negotiated with the JPUH.

9. Have you considered how unwell patients can manage to get from the car park to the surgery?

   A: There will be a drop off point just outside the new primary care centre.

10. Will finance be available to increase patient transport to and from the JPUH?

    A: Public transport to JPUH is already very good. Wherever the centre is based, we will work with the transport department to ensure adequate public transport to the new centre.

11. Is the hospital already overcrowded with buildings and services? (Considering there are already plans in place for a hospice).

    A: There is sufficient space on the total site to provide this service.

12. Will the surgery be accessible by JPUH inpatients?

    A: Patients registered with these practices who are inpatients at JPUH will be able to use the new primary care centre once discharged, if it is located on the JPUH site. During their hospital admission, they will have a hospital doctor allocated to them.

13. If so, will this lead to overcrowding?

    A: It is not envisaged that this will be the case.

14. Will patients be able to see their own Doctor?

    A: Yes they will, as patients do at the moment.

15. Would there be special treatment available for chronically ill people?

    A: The services will transfer to the new building as currently provided in the existing surgeries. The new building will offer the opportunity for service expansion which the others currently do not.

Proposal Two Questions: Relocating the three GP practices to a new purpose-built primary care centre on the Shrublands site.

16. Is there sufficient parking at Shrublands should the three existing surgeries relocate to there?

    A: The surgery premises will be developed as part of a whole site strategy and there will be sufficient parking allocated.

17. Will the location be big enough to provide the services and to expand if needed?

    A: Yes it will, particularly as it is expected that organisations will work much more closely together to make best use of the available space.

18. How confident are you that your bid for capital money will be successful?

    A: The public consultation was supported by NHS England who are responsible for the allocation of capital money and we are confident that this bid will be supported.

19. Does Great Yarmouth Borough council own the land at Shrublands?

    A: Norfolk County Council currently own the land.

20. Are you in discussions with local transport providers?

    A: We are regularly in discussion with local transport providers. We will specifically discuss this issue once a site has been selected.

21. Have you considered how elderly patients will access this site?

    A: Access for **all** patients will be a key priority once a site has been selected.

22. Will patients have access to a GP 24/7?

    A: Yes, as they currently do through the out of hours service.

23. Would there be home visits if necessary?

    A: Yes, this will not change.

24. Can patients see their own doctor after the relocation?

    A: Yes they can.

25. What appointment booking system will you use?

    A: This will be considered as part of the implementation phase.

26. Which doctors from these Practices would relocate to the Shrublands site?

    A: All of them.

27. Does this proposal account for an expanding population?

    A: Yes it does. The size and facilities within the new building will reflect this.

Proposal Three Questions: Relocating the three GP practices to a new purpose-built primary care centre on the Beacon Park site.

28. When will the Beacon Park site be completed?

    A: This is not known currently.

29. What transportation will be provided?

A: This will be considered once a decision is made.

30. Have the additional travel costs been considered?

    A: This will be considered as part of the implementation phase.

31. Can you justify the cost of relocating GP surgeries?

    A: Yes we can. It is better to spend the money available on a purpose-built facility which is future proofed to some degree than to spend small amounts of money on refurbishing inadequate buildings, which would still remain inadequate.

32. How will GPs address the health and social care needs of the varying and increasing population?

    A: Our other recent public consultation, the 'Shape of the System', is specifically designed to consider this, and to focus on the pressures being faced by staff in the NHS, and especially in primary care. We also have a new plan to support GP practices called our 'Primary Care Improvement Plan' which was approved by the CCG's Governing Body in September 2015.

33. Can the empty GP practices be privatised?

    A: The empty practices are in private ownership currently apart from the temporary building on the Shrublands site which is owned by NHS Property Services.

34. Can the empty GP practices be satellites for the new surgery?

    A: This is very unlikely. Whilst everyone would prefer to have a GP practice very close to their home, increasingly the NHS does not have the resource in terms of GPs and nurses to offer this. As a result, a model where more services are centred in one building is becoming increasingly popular across the country. Page 4 of the original consultation document explains why this model can work better for patients and staff, and help to keep costs down.

35. Why are Shrublands continuing with their 'outreach' GPs but Belton and Bradwell will not?

    A: The Gorleston Medical Practice (GMC) runs a service on the Shrublands site and also at Hopton. Both services were running at the time of the public consultation, and so were included. The service at Belton closed in June 2012, there are no plans to re-open it, and therefore it was not included as part of this recent public consultation.

36. Will patients still be able to see their own GP?

    A: Yes they will.

37. Will 'Persimmon' contribute to build costs?

    A: This would be negotiated if this option is selected.

Proposed Sites Alternatives - The following questions were asked about alternative site options:

38. Why could you not have satellite surgeries as well as main centre?

    A: This may be possible and will be considered in the implementation phase.

39. Will patients be able to see their own GP?

    A: Yes they will.

40. Can any of the existing surgeries expand?

    A: Not to the size required.

41. Can a surgery be located at Belton?

    A: The small surgery in Belton which was part of the Millwood practice was closed in June 2012, and there are no plans to re-open it. It was not considered as part of this public consultation.

42. Why was this planning not included in the new road system being done at Bradwell?

    A: The needs of the additional population are considered regularly through the CCG's Infrastructure Planning Group which has representation from Great Yarmouth Borough Council Planning Department on it.

43. If you have £5 million to spend on a new centre, why not just concentrate on improving the existing surgeries?

    A: Given their location and restrictions, it is not possible to do this.

44. As the government are granting a further £8 billion why has it been necessary to do this now?

    A: It is not known how or when any promised additional NHS money will become available. The CCG needs to act now to improve primary care premises in Gorleston and Bradwell, which is why the CCG did this public consultation.

45. How much is it going to cost?

    A: This will not be known in detail until the location is decided - see answer to Q3 above.

46. There are nearly 2,000 new residents in Bradwell at the Bradwell Meadows site where in the plan there was supposed to be a school and a GP Practice, what's happened to that?

    A: Sorry, but the CCG is unaware of this development plan, and it was not part of this public consultation. Any decision on this would be outside the control of the CCG.

47. Will patients be moved to a new doctor within the new practice?
    A: Not as a result of this plan.

ends

NHS
Great Yarmouth and Waveney Clinical Commissioning Group

HealthEast

Meeting of the Governing Body PART 1

5 November 2015 Agenda Item 9

Title of Paper	Recommendation on next steps for the GP Practice Premises in Gorleston and Bradwell public consultation.
What the Governing Body is being asked to decide or approve	• Approve the recommendations under section six of the attached report • Endorse the implementation phase under section seven of the report • Make any recommendations for further action, if required.
Executive summary	A thirteen week public consultation on GP practice premises in Gorleston and Bradwell closed on Wednesday 2 September 2015. Three GP practices in Gorleston and Bradwell are currently working out of premises which can't keep working as they are for much longer. These are: • Family Health – the current building is cramped and not owned by the current GP, which prevents any changes to the premises being made. There is no capacity for the practice to expand. • Gorleston Medical Centre - is working from a temporary building on the Shrublands site and the long term future needs to be established. • Falkland Surgery – there is no capacity to expand, this has already been explored by the practice. The CCG received 731 responses to the consultation from staff, patients, clinicians, healthcare providers, social care, District, County and Parish Councils, voluntary agencies and the wider public. During the public consultation two public meetings were held, 21,000 consultation documents were distributed across

	Gorleston and Bradwell. The CCG's Governing Body responded to the questions and issues raised during the consultation at their Governing Body meeting in public on Thursday 22 October 2015. A decision support 'options appraisal' workshop was held on Friday 9 October 2015 when key stakeholders and invited patients and members of the public completed a structured exercise to develop recommendations for the Governing Body. The recommendations were produced from the views of the stakeholders at the event on the day. Now the Governing Body is being asked to make a recommendation on the final site for the primary care centre. This recommendation will then go to NHS England who will make the final decision on relocating the three practices. **A reminder of the proposals…….** **Proposal one:** relocating the three GP practices to a new purpose-built primary care centre on the James Paget University Hospital site. **Proposal two:** relocating the three GP practices to a new purpose-built primary care centre on the Shrublands site. **Proposal three:** relocating the three GP practices to a new purpose-built primary care centre on the Beacon Park site. We also asked the public to identify any other sites that the primary care centre could be built on. This paper sets out the background to the consultation and the proposals and steps taken since the consultation closed. It asks the Governing Body to make a recommendation to NHS England on the next steps.

Risks attached to this proposal/initiative:

- There is a risk that if a new Primary Care Centre is not developed then the three GP practices will not be able to continue to deliver quality services to their patients because of the issues with the practice premises.

Resource implications:

Implementation of the decision made will be dependent on the availability of future capital funding and the CCG will need to plan for increased revenue costs from the potential increase in GP estates costs.

Name	Rebecca Driver
Job title	Director of Engagement
Date	29 October 2015

NHS
Great Yarmouth and Waveney Clinical Commissioning Group

HealthEast

A report on the next steps for the GP Practice Premises in Gorleston and Bradwell public consultation

1. Introduction and Background

1.1 The twelve week public consultation on GP Practice Premises in Gorleston and Bradwell closed on 2 September, 2015.

1.2 NHS Great Yarmouth and Waveney Clinical Commissioning Group received 731 responses to the consultation from staff, patients, clinicians, local health, social care and voluntary agencies, and the wider public.

1.3 The CCG's Governing Body responded to the issues raised in this report at their Governing Body meeting in public on Thursday 22 October.

1.4 The CCG has run a genuine and open public consultation. We have listened hard to the views of the public and all our stakeholders and we have worked to take these views into account in our decision making, along with those from clinicians, the voluntary sector, local health providers and local councils.

1.5 The public consultation closed on 2 September. Following this, the CCG has worked with a stakeholders and patient groups to consider the findings of the consultation now we have heard what people think. This process has taken into account the future quality of services and how they should be provided and afforded. This work culminated in an 'Options Appraisal Workshop' on 9 October 2015 (see appendix one).

1.6 This work and the responses to the public consultation have formed the basis of the recommendations on the specific questions in the consultation for the Governing Body to approve.

1.7 The purpose of this paper is for the CCG's Governing Body to make a decision on their proposed approach to the GP Practice Premises in Gorleston and Bradwell public consultations. The Governing Body is then being asked to make are recommendation to NHS England. Any reference within this report to any changes that "will" take place is subject to the recommendation of the Governing Body and the decision of NHS England.

2. The case for change

2.1 GP practice premises in Gorleston and Bradwell need to change. Currently there are five GP practices in the northern part of Gorleston to meet the needs of local people.

2.2 However, there are a number of issues which mean that we have to change the shape of GP services in Gorleston and Bradwell. These are:

- The population of Gorleston and Bradwell is expanding rapidly. New houses are being built in the south of the town, further away from where practices are currently located. Over the next 10 years there is a predicted increase of 3,500 people on the Beacon Park site.

- Major issues with current practice accommodation in the following GP surgeries: Falkland Surgery, Gorleston Medical Centre on the Shrublands site and Family Healthcare Centre. These practices are in buildings which are not fit for 21st century healthcare, and cannot be expanded to make them fit for the future to handle the growing population.

- We know that one of the main predictors of whether people will attend an accident and emergency department is how close they live to it. We also know that national and local figures suggest that up to one in three people who attend accident and emergency would be better seen by their GP. New housing next to the James Paget University Hospital and further away from current practice locations therefore risks swamping our local A&E department while not always providing best care for these families.

2.3 We know that the current services in these three GP practices are under pressure because of the issues with their accommodation. Doing nothing is not an option.

2.4 The following do not form part of this consultation:

- Hopton surgery premises provided by Gorleston Medical Centre
- Other services based at the Shrublands site, Gorleston. This site also hosts a range of services which are not included in this public consultation such as outpatient clinics, therapy services, staff base, a base for Norfolk First Support and for some mental health services.

2.5 The specific issues in each of the three GP practices are:

- Family Health – the current building is cramped and not owned by the current GP, which prevents any changes to the premises being made. There is no capacity for the practice to expand.

- Gorleston Medical Centre - is working from a temporary building on the Shrublands site and the long term future needs to be established.

- Falkland Surgery – there is no capacity to expand, this has already been explored by the practice. A recent Care Quality Commission (CQC) inspection highlighted space constraints.

3. The Proposals

3.1 **Proposal one:** relocating the three GP practices to a new purpose-built primary care centre on the James Paget University Hospital site.

We know that people are concerned about paying to park to visit their GP so we would work alongside the hospital to secure a parking solution. If this proposal went ahead we would also keep a GP presence on the Shrublands site so that we can keep the important links that already exist between GPs and all other health and social care professionals that are based there.

3.2 **Proposal two:** relocating the three GP practices to a new purpose-built primary care centre on the Shrublands site.

The current building is only temporary with expiring planning permission later this year. We have already submitted a bid for capital money to NHS England to build a new permanent building on the Shrublands site.

The current plan is that this will accommodate a range of health and social care community services such as therapists, community matrons and a range of clinics. This new building will include space for a GP presence at Shrublands which is important to keep the links that already exist between GPs and all the other health and social care professionals that are based there.

If this proposal went ahead we could work alongside NHS England and Great Yarmouth Borough Council to develop a primary care centre as part of the permanent building on the site.

3.3 **Proposal three:** relocating the three GP practices to a new purpose-built primary care centre on the Beacon Park site.

We know that there will be a lot of development on the Beacon Park site of Gorleston over the next ten years and that current GP services are largely based in north Gorleston. By working alongside Great Yarmouth Borough Council and NHS England we can develop a new primary care centre on the Beacon Park site to serve the growing population in the South of the town.

If this proposal goes ahead we would also keep a GP presence on the Shrublands site so that we can keep the important links that already exist between GPs and all other health and social care professionals that are based there.

We also asked the public to identify any other sites that the primary care centre could be built on.

4. Options Appraisal Workshop: 9 October 2015

4.1 To help the Governing Body to make carefully considered and objective decisions, a structured and robust process has been completed with a wide range of local stakeholders to appraise the options.

4.2 The full report can be found at **appendix one.**

4.3 The appraisal process used a structured weighting and scoring approach with the following key elements:

- A shortlist of options to be evaluated.
- A list of benefit criteria and key factors to be considered for each criterion. These were ranked in order of importance and allocated a weighting at the workshop.

- A Factsheet Pack (including a summary of the responses from the public consultation) provided workshop attendees with information for each of the key factors.
- At the appraisal workshop, each option was scored in turn against the benefit criteria to generate a weighted score for each option.

4.4 The weighting and scoring exercise was undertaken by a representative group of stakeholders from the local health and social care community, local authority organisations, third sector and patient groups.

4.5 This approach is based on HM Treasury Guidance on option appraisal which states:

“A method in common use within option appraisal is to weight and score the non-financial benefits for each option. This is preferable to simply ranking the benefits, as placing them in their order of priority does not in itself provide any objective assessment of how the incidence of these benefits varies from option to option. “

“Weighting and scoring provides a technique for comparing and ranking options in terms of their associated non-financial benefits.”

“It is important to recognise that the assigned weights and the scores given to options are value judgments. In order to assign weights and scores, negotiation and compromise needs to take place. It is the number of people involved in the process and their expertise that lends credibility to these value judgments.”

4.6 Conclusions and recommendations

This option appraisal was undertaken to provide a further piece of evidence to support the CCG’s Governing Body in its decision making process. The conclusions from the workshop provide a clear view that the Shrublands site is the most appropriate location for a new primary care centre.

It is recommended that as part of the implementation of this proposal there is a particular focus on ensuring sufficient free parking is available and that the public will need to be assured that the site is large enough to locate a range of clinical services to ensure integration can be delivered.

5. Feedback from the public consultation

5.1 The feedback report from the public consultation was presented to the Governing Body at their meeting in public on 24 September 2015 by Dr Steven Wilkinson, an independent analyst.

The Executive Summary from the report is set out below for the Governing Body to consider as part of their decision making:

5.2 Executive Summary

Of the three proposals, proposal two (a new purpose-built Primary Care Centre on the Shrublands site) had the greatest support.

Proposal One – James Paget Hospital site (Yes = 10.5%, No = 87%). The responses to this proposal discuss:

- Concerns about parking, (including cost, allocation, and provision).
- Accessibility (including distance, patient fitness, roads and location)
- Overcrowding (including space, population size and referrals)
- Public transport – (including bus links, journey times, acceptable journeys,

consequences and costs)
- Patient preferences – (including choice, proximity to home, avoidance of acute care, satisfaction with surgeries and centralisation).
- No support – (including the principle being unacceptable, the location, preferring alternative options, potential waste and the JPUH perspective).
- Support for the proposal – (including advantages, location, transport, size and information needs).

Proposal Two – The Shrublands site (Yes = 53.5%, No = 42.4%). The responses to this proposal discuss:

- Support – (including the promise of upgrading Shrublands, benefits, integration and registration with a GP practice)
- Transport – (including problems, routes and distances)
- Access – (including ease, traffic and fitness to travel)
- Parking – (including concerns, impact on the neighbourhood and charges)
- Patient preferences – (including choice, GP's and practice size)
- No Support – (including disagreement, practice size, preference for the status quo and alternatives)
- Overcrowding – (including practice size, referral to other services and other information requirements around proposal details, finance and the consultation).

Proposal Three – The Beacon Park site (Yes = 29.6%, No = 64.9%). The responses to this proposal discuss:

- Transport – (including accessibility concerns, routes, costs and roads)
- Support – (including advantages, benefits, location and alternatives)
- No Support – (including disagreement, central location preference, status quo, policy, alternatives and location)
- Location – (including preference)
- Parking – (including concerns)
- Patient preferences – (including choice, population, GPs and facilities)
- Finance – (including implications and contributions)
- Information – (including needs).

6. Recommendations for the Governing Body to approve

6.1 The Governing Body is asked to approve the following recommendation:

- Endorse the Shrublands site as the CCG's preferred location for a new Primary Care Centre for Gorleston and Bradwell.

If the Governing Body approves the recommendation the CCG will inform NHS England that this is the preferred location for a new Primary Care Centre.

7. Implementation

7.1 Once a decision has been made by NHS England then this project will move into an implementation phase. This will be overseen by a stakeholder Steering Group, chaired by the CCG. A project manager will be appointed to deliver the work required by the Steering Group. The Steering Group will report jointly to the CCG's Governing Body. A governance structure for this process has already been developed **(appendix two)** which includes the

essential work on finance. This process will link very closely with staff in the affected practices to ensure they are fully engaged throughout this process.

7.2 The Governing Body is asked to endorse this further work.

8. Conclusions

8.1 Doing nothing is not an option. We know that the current services in these three GP practices are under pressure because of the issues with their accommodation which mean that these practices are in buildings which are not fit for 21st Century healthcare and cannot be expanded to make them fit for the future and the growing population.

8.2 The CCG is confident that we have followed a robust decision making process to arrive at these recommendations. This included a full public consultation.

8.3 We recognise and acknowledge that whilst we have been able to deliver recommendations that match the views of many of the replies to the consultation our recommendations will not be satisfactory to everyone.

8.4 We are confident that these recommendations are correct for the Governing Body to approve. We have listened to what the people of Gorleston and Bradwell have told us, and we have adapted our plans to respond to their views. They provide the best quality services designed with current best practice in mind and in an affordable way.

8.5 Finally, the CCG would like to assure everyone who has any interest in health services that we will continue to monitor the implementation of these proposals very carefully with providers, local clinicians, staff and patient representatives to make sure that patients remain safe, that the quality of services is good, and that staff are fully engaged throughout the next phase of this project.

8.6 NHS England will make a final decision about the capital funding being available to develop a new Primary Care Centre.

Rebecca Driver
Director of Engagement
29 October 2015

Appendix one: GP practice premises in Gorleston and Bradwell Option Appraisal report.

NHS
Great Yarmouth and Waveney
Clinical Commissioning Group

HealthEast

GP practice premises in Gorleston and Bradwell: Option Appraisal Report

1. Introduction

1.1. Purpose of this paper

Currently there are five GP practices in the northern part of Gorleston, but with the local population expanding rapidly and poor current accommodation that is not fit for the delivery of healthcare in the 21st century and which cannot be expanded, the shape of GP services cannot stay as it is.

The CCG embarked on a consultation process to help assess the views of service users, health and other care professionals and the wider public, as reported to the CCG's Governing Body in September. The consultation document put forward the proposal to bring together three practices – Family Health, Gorleston Medical Centre and Falkland Surgery – into one new purpose built Primary Care Centre. The consultation did not propose any changes to Millwood Surgery or Central Surgery as they are both well established in their existing premises and are not currently looking to relocate.

In order to help the CCG's Governing Body to make carefully considered and objective decisions, a structured and robust process has been undertaken with a wide range of local stakeholders to appraise the options for the provision of a new purpose built primary care centre on three possible location options:

- The James Paget University Hospital site.
- The Shrublands site.
- The Beacon Park site.

The purpose of this paper is to report the conclusions of an option appraisal workshop held on 9 October 2015.

1.2. Contents

This paper sets out:

- The process undertaken, using a structured "weighting and scoring" approach.
- The options evaluated for each service.
- The results: weighted scores and ranked list of options in order of preference.
- The rationale for the scoring.

- Sensitivity analysis to test the robustness of the results.

2. The appraisal process

2.1. Overview

The appraisal process used a structured weighting and scoring approach with the following key elements:

- A shortlist of **options** to be evaluated.
- A list of **benefit criteria** and key factors to be considered for each criterion. These were ranked in order of importance and allocated a weighting at the workshop.
- A **Factsheet Pack** (including a summary of the responses from the public consultation) provided workshop attendees with information for each of the key factors.
- At the appraisal workshop, each option was scored in turn against the benefit criteria to generate a **weighted score** for each option.

The weighting and scoring exercise was undertaken by a representative group of stakeholders from the local health and social care community, local authority organisations, third sector and patient groups (see Appendix 1).

This approach is based on HM Treasury Guidance on option appraisal which states: "A method in common use within option appraisal is to weight and score the non-financial benefits for each option. This is preferable to simply ranking the benefits, as placing them in their order of priority does not in itself provide any objective assessment of how the incidence of these benefits varies from option to option. "

"Weighting and scoring provides a technique for comparing and ranking options in terms of their associated non-financial benefits."

"It is important to recognise that the assigned weights and the scores given to options are value judgments. In order to assign weights and scores, negotiation and compromise needs to take place. It is the number of people involved in the process and their expertise that lends credibility to these value judgments."

2.2. Weighting and scoring process

The process for each appraisal was as follows:

- Participants were allocated to four small groups of 6-7 with individuals pre-allocated in order to ensure a mix of backgrounds and service perspectives in each group.
- Each group considered and discussed the benefit criteria and reached a consensus view to:
  - Rank the criteria in order of importance (equal rankings were allowed).
  - Allocate a weight out of 100 to reflect that ranking, i.e. the first ranked should have more points than the second, etc.

  Any individuals dissenting from the consensus view had the opportunity to submit separate rankings or weightings.
- Each group presented their proposed rankings and weighting with reasons for their decisions for plenary discussion.

- The results from the different groups were aggregated and presented back to the plenary group to "sense check" that the differential weightings appropriately reflect the discussions.
- 'Scoring' describes how well each option meets each of the benefits criteria. The process for scoring the options followed the same principles, i.e. group consensus scores, aggregation and discussion, sense check. Participants recorded their scores out of 10 using the following scoring guide.

Score	What it means
10	Could hardly be better
9	Excellently
8	Very well
7	Well
6	Quite well
5	Adequately
4	Somewhat inadequately
3	Badly
2	Very badly
1	Extremely badly
0	Could hardly be worse

- The scores for each option were then multiplied by the weights for each criterion, and a total weighted score was calculated for each option.

The Factsheet Pack provided supporting information to inform both exercises.

2.3. Benefit criteria

The six benefit criteria and the key factors considered are described below.

	Benefit Criteria	Factors to be considered
1	To achieve more integrated service delivery	• Proximity to other (non-primary care) health care services. • Proximity to other local services e.g. social care services, pharmacy, housing and other community services.
2	To achieve sustainable delivery of clinical services	• Provides a platform for the delivery of sustainable high quality primary care services in the area. • Provides flexibility for "future proofing" provision to meet the needs of an increasing population and enhanced services.

	Benefit Criteria	Factors to be considered
3	Ease of deliverability	• Availability of the location and site proposed to deliver primary care services. • Site constraints that could limit the scope or capacity of the proposed development. • Level of public and political support. • Costs of implementation. • Timescales for delivery.
4	To improve access to primary care services	• Ease of access to local primary care services by public transport. • Ease of access to local primary care services by car.

		• Availability of parking on the site, including provision of disabled spaces.
5	To provide equitable access across the population of Gorleston and Bradwell	• The configuration of services achieves equitable access across the Gorleston and Bradwell area.
6	To assist workforce development	• Provides a location and environment that will aid recruitment and retention of GPs. • Provides a location and environment that will aid recruitment and retention of other key staff, for example Practice Nurses.

3. The Options

The three locations proposed in the consultation paper are:

- Option 1. A new purpose-built primary care centre on the James Paget Hospital site.
- Option 2. A new purpose-built primary care centre on the Shrublands site. The current building on this site is only temporary and would be replaced by a new permanent building which would also accommodate a range of other health and social care community services.
- Option 3. A new purpose-built primary care centre on the Beacon Park site.

4. Results

The results of the appraisals are summarised in the sections below. A more detailed table is included in Appendix 2.

4.1. Ranking and weighting the benefit criteria

The six criteria were ranked and weighted out of 100 as follows:

	Benefit Criteria	Ranking	Weighting out of 100
1	Achieve more integrated service delivery	2	21.3
2	Achieve sustainable delivery of clinical services	1	26.0
3	Ease of deliverability	6	11.5
4	Improve access to primary care services	3	15.3
5	Provide equitable access	4	13.0
6	Workforce development	4	13.0
			100.0

- Criteria 1 and 2 were consistently ranked highly by the groups which is reflected in a total weighting of more than 47% for those criteria. Most groups gave criterion 2 the highest weight but with criteria 1 a close second.
- One group ranked improving access to primary care services as second, with a weighting one point ahead of criterion 2.
- Improving access to primary care was a clear third highest ranked, with group rankings ranging from second to fourth.

- The other three criteria were closely ranked and weighted, all with group rankings ranging from third to sixth and resulting in equal fourth ranking for equitable access and workforce development, just ahead of ease of deliverability.

4.2. Scoring the options

The raw scores (out of a maximum of 60) and weighted scores (out of a maximum of 100) were:

Scoring results	Option 1 JPH site	Option 2 Shrublands	Option 3 Beacon Park
Raw scores (out of 60)	29.0	42.0	33.0
Weighted scores (out of 100)	48.8	70.1	56.0
Rank	3.0	1.0	1.0
% of highest ranked	69.6%	100.0%	79.8%

- Option 2 for Shrublands had the highest raw score and highest weighted score overall, ahead of Beacon Park in second place and James Paget Hospital site in third place. Shrublands was significantly ahead with Beacon Park scoring more than 20% lower and James Paget scored more than 30% lower.
- Three groups gave Shrublands the highest score, well ahead of Beacon Park in second place, but one group scored Beacon Park highest just ahead of Shrublands.
- The Shrublands location was considered to be the most central for the majority of the relevant population and the potential for integration with other services was seen as best here given the current range of services already in the temporary building on site.
- Beacon Park was recognised as offering the best development opportunity as it would be a “clean slate”, an opportunity to do things differently and most developers would prefer a clear site. But it was considered to be more difficult to access by the existing patient population. One group gave it the lowest score mainly because of a concern about the level of integration with other services that would be achieved compared to the other two options.
- The James Paget site was ranked third overall (third by three groups and second by one group). A key concern was the ease of deliverability, particularly around availability and cost of car parking and the fact that the formal response by the Trust to the consultation was to support the Shrublands option.
- Issues that were raised for consideration by the Governing Body:
    - Shrublands is the right site but it may be appropriate to have a satellite service located at Beacon Park in the future.
    - Some concern that the Shrublands site is big enough for future proofing given the constraints on extending it further.
    - Sufficient parking is a high priority for all three sites.
    - The Beacon Park scores reflected an assumption that public transport would be provided in the future as the site is developed.

- Managing the transition of the Shrublands site will be an important factor, to maintain service delivery during implementation.

4.2.1. Sensitivity testing

Two tests were applied to see how either a change in weighting or in scoring would change the identity of the preferred option:

- Option 2 scores more than the other two options on all criteria therefore a change in the weightings would not change the order.
- Changing the scores for option 3 on the highest ranked criteria: it would require an increase in the score for option 3 on criterion 2 of 3.2 (48%) to 10.0 plus an increase in the score for option 3 on criterion 1 of 2.7 (55%) to 7.6 to give option 2 the highest score.

4.2.2. Conclusions on sensitivity testing

The sensitivity tests show that a change to the weightings would not change the preferred option and that the scoring would require a significant change, giving option 3 a perfect 10 on the highest ranked criterion and 7.6 on the second highest – higher than any of the actual overall scores recorded for any option - in order to change the result.

On this basis, the conclusion is that the Shrublands site is the preferred option, ahead of the Beacon Park site option.

Benefit Criteria	Weighting out of 100	Option 1 JPH site	Option 2 Shrublands	Option 3 Beacon Park
Raw Scores (out of a total of 60)				
1 Achieve more integrated service delivery	21.3	5.1	7.5	4.9
2 Achieve sustainable delivery of clinical services	26.0	4.8	6.9	6.8
3 Ease of deliverability	11.5	2.7	7.0	6.0
4 Improve access to primary care services	15.3	4.4	6.7	5.0
5 Provide equitable access	13.0	5.2	6.7	4.5
6 Workforce development	13.0	6.8	7.2	5.9
	100.0	**29.0**	**42.0**	**33.0**
Ranking		**3**	**1**	**2**
% of highest		69.1%	100.0%	78.7%
Weighted Scores (out of a total of 100)				
1 Achieve more integrated service delivery	21.3	10.9	15.9	10.5
2 Achieve sustainable delivery of clinical services	26.0	12.5	17.9	17.6
3 Ease of deliverability	11.5	3.1	8.1	6.8
4 Improve access to primary care services	15.3	6.7	10.2	7.6
5 Provide equitable access	13.0	6.8	8.7	5.8
6 Workforce development	13.0	8.8	9.3	7.7
	100.0	**48.8**	**70.1**	**56.0**
Ranking		**3**	**1**	**2**
% of highest		69.6%	100.0%	79.8%

Workshop attendees

Name	Organisation
Andy Evans	NHS Great Yarmouth & Waveney CCG (GYWCCG)
Kerry Harding	NHS England
Julie Woods	MESH
Sara Harvey	Family Health Care Centre
David Stock	Millwood Surgery
Kim Balls	Great Yarmouth Borough Council
Tricia Hagan	GYWCCG
Vicky George	Great Yarmouth Borough Council
Jonathan Williams	East Coast Community Healthcare
Nick Wright	East Coast Community Healthcare
Dr Jamie Wyllie	GYWCCG
Cath Gorman	GYWCCG
Zoe Pietrzak	GYWCCG
Tessa Litherland	GYWCCG
Tracey Bullard	GYWCCG
Louise Jordan-Hall	GYWCCG
Michaela Hewitt	Norfolk County Council Social Services and ECCH
Ruth Pillar	Norfolk and Suffolk NHS Foundation Trust
Alan Hopley	Voluntary Norfolk
Sean Asplin	Norfolk County Council Highways
Penny Carpenter (Cllr)	Great Yarmouth Borough Council
David Brown	PPG Gorleston Medical Centre
Linda Clemmit	PPG Family Healthcare
Rebecca Driver	GYWCCG
Fran O'Driscoll	GYWCCG
Lorraine Rollo	GYWCCG
Amara Cunningham	GYWCCG
Steve Wilkinson	Independent Analyst
Alan Kent	Litmus Health

People who were invited but were unable to attend:

Name	Organisation
Bernard Williamson (Cllr)	Great Yarmouth Borough Council
Niki Park	Norfolk County Council
Jackie Tierney	Age Concern Great Yarmouth

Michael Dennis	GYWCCG
Dawn Jermany	Central Surgery
Ian Burns	NHS Property Services
Phil Beck	Norfolk County Council
Louise Hampton	Great Yarmouth Borough Council
Robert Read	Great Yarmouth Borough Council
Dr John Stammers	NHS GYW CCG
Kate Gill	NHS GYW CCG
Deidre Delorme	Family Voice
Tim Morton	Local Medical Committee
Alex Stewart	Healthwatch Norfolk
Tony Rollo	Healthwatch Suffolk
Sean Perry	NHS Property Services
Dr Geoff Perry	GP Falkland Health Centre
Dr Keivan Malekei	GP Family Healthcare
Dr Verna	GP Shrublands
Jane Horton	Practice Manager Falkland
Dawn Barnham	Practice Manager Shrublands
Andrew Forrest	Seagull Centre
Supt Paul Sharp	Suffolk Constabulary
Supt Roger Wiltshire	Norfolk Constabulary
Julie Fulbrook	DIAL
John Lewis	Suffolk County Council

Appendix two:

Great Yarmouth and Waveney Clinical Commissioning Group

HealthEast

Version 3: 29 October 2015

Governance Structure for the GP Practice Premises in Gorleston and Bradwell Project: Implementation Steering Group

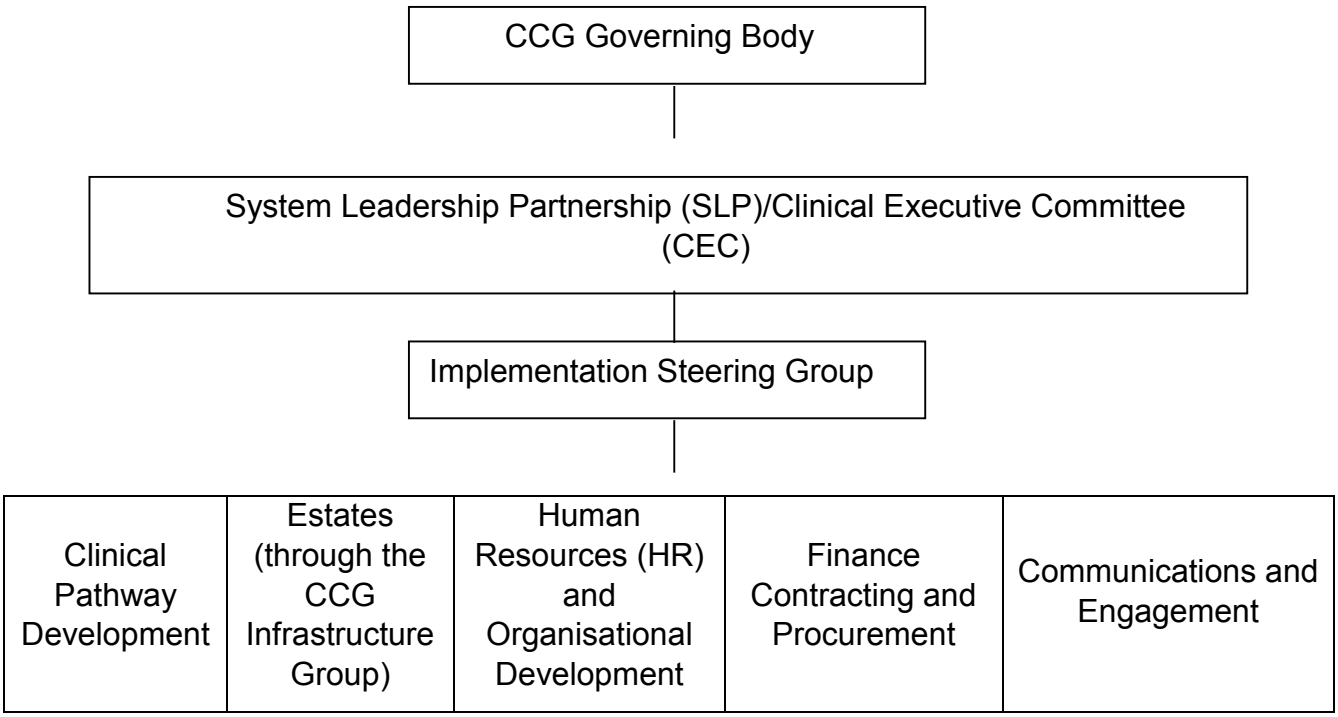
1 Introduction and purpose

1.1 This document sets out the proposed governance structure for the GP Practice Premises in Gorleston and Bradwell Implementation Steering Group, following the public consultation on practice accommodation provided in these areas. This will be confirmed as part of the implementation.

1.2 It is proposed that the project lead is Fran O'Driscoll, the Head of Infrastructure and Strategy Development.

2 Proposed structure

GP Practice Premises in Gorleston and Bradwell Implementation Steering Group Governance Structure



3. Objectives and purpose of group

3.1 The GP Practice Premises in Gorleston and Bradwell Implementation Steering Group will manage and oversee this project with the specific goal to facilitate the development of a new primary care centre at Shrublands (subject to final approval by NHS England), and the relocation of practices to this site, specifically Gorleston Medical Centre, Falkland and Family Health.

3.2 The objectives of the project have been defined as follows, to:

- Provide a new building of sufficient capacity for, and accessibility to, the defined population of Gorleston, Bradwell, and the surrounding area
- Provide appropriate and therapeutic care environments
- Provide flexible accommodation where use can be changed in future years to reflect new policy, working practices or needs
- Introduce new ways of working in line with the national agenda and to improve effective team working
- Maintain/increase the ability to recruit and develop high calibre staff by improving the working environment, facilities and overall model of care
- Improve the effectiveness of current resources used for the provision of local services

4. Responsibilities

4.1 The Steering Group will be responsible for:

- Confirming the service scope
- Revising the initial designs for service models, and, if necessary, submitting revised plans for approval
- Preparing further business case documentation as required

4.2 As the project progresses the Steering Group will also ensure :

- Benefits Realisation - The Steering Group will ensure that realisation of benefits to all of the stakeholders in the process is achieved through close monitoring by the CCG
- Risk Management - The Steering Group will ensure that risk in the project is managed through the CCG's management processes and Board Assurance Framework. Any associated construction project will include the operation and maintenance of a project risk register
- Post Project Evaluation (PPE) - The Steering Group will ensure that PPE takes place at the end of the initial project and at appropriate intervals thereafter.
- Public accountability and patient involvement in the project, as per the 2012 NHS Health and Social Care Act
- Leading and coordinating the work of the Implementation group and associated workstreams:
  - Infrastructure and estates
  - Human Resources and Organisational Development
  - Finance, contracting and procurement

- Clinical pathway development
- Communication and Engagement

- Ensuring that project timescales are delivered and allocated budget is not exceeded
- Any information written by the Engagement team for the public is approved (note need to link with NHS England)
- The distribution of all information to the media via the CCG's communications team (note need to link with NHS England)
- Information is added to relevant websites
- The Steering Group acts as an advisor to directorate leads and NHS England Leads and to ensure the process is followed and deadlines are met
- The Steering Group adheres to any deadlines prescribed by relevant Boards or Governing Bodies
- Proposals are presented in a timely way to the Great Yarmouth and Waveney Health Overview and Scrutiny Committee, and the Norfolk Scrutiny Committee as required

5. Frequency of meetings

5.1 Meetings will be held bi-monthly.

6. Reporting arrangements

6.1 The Steering Group will report to the CCG's Governing Body and the relevant NHS England body (to be confirmed). Delegated authority to act from the Governing Body will be in place through the Chief Executive, Andy Evans.

7. Membership

7.1 Membership of the Steering Group will comprise:

Name	Role	Organisation
Andy Evans (Chair)	Chief Executive	CCG
Tessa Litherland	Director of Contracting	CCG
Rebecca Driver	Director of Commissioning and Engagement	CCG
Name tbc	Director of Partnerships and Delivery	CCG
Fran O'Driscoll	Head of Infrastructure and Strategy Development	CCG
Tracey Bullard	Primary Care Development Manager	CCG

Name	Role	Organisation
Cath Gorman	Director of Commissioning and Quality and Chief Nurse	CCG
NHS England	Names to be confirmed	NHS England
Executive GP Lead	Name to be confirmed	CCG
GP/Practice Manager/ Patient reps from the three practices		To be confirmed
Leigh Fraser	Head of Financial Operations and Planning	CCG
Michaela Hewitt	Head Of Social Care-East	Norfolk County Council
Sean Perry	Strategic Projects and Asset Manager	NHS Property Services
Phil Beck		Children's services Norfolk County Council
Robert Read	Director of Housing and Neighbourhoods	Great Yarmouth Borough Council

7.2 Clinical Pathways Development Group

Clinical engagement and input into the delivery of this project will be provided through the Clinical Executive Committee and ad hoc specific group work on a locality basis as required.

This work will ensure that options are based on sound clinical evidence and made in the best interests of patients, and that we can explain this to users in a way they can understand.

7.3 Estates and Infrastructure

NHS Property Services has been invited to join the steering group in addition to the CCG's Infrastructure Group which manages estates matters. This workstream will also include IT. This group will be led by Fran O'Driscoll, Head of Infrastructure and Strategy Development. There will also be close links to the NHS England estates process.

7.4 Human Resources and Organisational Development

This group will be initially led by the NHS England primary care team (to be confirmed). It will report to the Implementation Steering Group.

Its remit will be to oversee all associated HR issues and training, and to ensure appropriate work with all staff side organisations during the implementation phase.

Terms of reference will be developed.

7.5 Finance, Contracting and Procurement Group

This Group will be led by Leigh Fraser, Head of Financial Operations and Planning and will include representatives from the ECCH finance team and general practice. Terms of reference will be developed.

7.6 Communications and Engagement

This will be led by Lorraine Rollo, Head of Communications and Engagement.

8. Next steps

These terms of reference will be considered and approved by NHS England as the commissioners of primary care services as part of the process to approve the recommendations following the public consultation. This process is expected to be completed in January 2016.

Rebecca Driver

Director of Engagement

October 2015

Norfolk County Council at your service

Suffolk County Council

Agenda Item 6

Great Yarmouth and Waveney Joint Health Scrutiny Committee

13 November 2015

The CCG's decisions following the 'Shape of the System' consultation

Suggested approach from the Scrutiny Officer.

Great Yarmouth and Waveney Clinical Commissioning Group (CCG) will present to the Joint Committee its decisions following the public consultation on 'The Shape of the System – Developing modern and sustainable health services in Great Yarmouth and Waveney'.

Background

1. At its meeting on 22 July the Joint Committee received a report from the NHS Great Yarmouth and Waveney Clinical Commissioning Group (GY&W CCG) on the emerging themes from its public consultation on 'The Shape of the System – Developing modern and sustainable health services in Great Yarmouth and Waveney'.
2. The consultation period ran from 3 June 2015 until 2 September 2015. The CCG's Governing Body considered feedback, questions and issues at its meetings on 24 September and 22 October, and a final decision on the Shape of the System was to be made by the Governing Body at their meeting in public on Thursday 5 November 2015.
3. This item provides the Committee with an opportunity to give its final consideration of the CCG's decisions following the consultation.

Suggested approach

4. Representatives from the CCG will attend today's meeting to present the CCG's decisions regarding the new service model and to receive any comments that the joint committee may wish to make.
5. The following documents are attached:
   a) Appendix A – GY&W CCG Briefing Note [3 pages].

[The CCG decision statement will be available on 9 November, following the CCG Governing Body meeting on 5 November.]

b) Appendix B – Consultation feedback [63 pages], 'Shape of the System Final Report', Dr S Wilkinson, September 2015.

c) Appendix C – 'Shape of the System – a response to the public consultation' [27 Pages], CCG Governing Body meeting, 22 October 2015.

d) Appendix D – 'Decision on next steps on the Shape of System Public Consultation – developing modern and sustainable health services in Great Yarmouth and Waveney' [26 pages], CCG Governing Body meeting, 5 November 2015.

6. The Joint Committee is asked to consider:

a) Whether the consultation process with the joint committee has been adequate in relation to content or time allowed.

b) Whether the final proposals, as agreed by GY&W CCG, are in the interests of the local health service.

c) Any recommendations that it wishes to make to GY&W CCG.

d) Any recommendations that it wishes to make to other NHS bodies.

7. The Joint Committee is asked to inform the CCG whether or not it intends to make a report to the Secretary of State under Section 23, paragraph (9) of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013

Contact details

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NHS
Great Yarmouth and Waveney Clinical Commissioning Group

HealthEast

Briefing for Great Yarmouth and Waveney Health Scrutiny Committee: 13 November 2015

'The Shape of the System – Developing modern and sustainable health services in Great Yarmouth and Waveney.'

NHS Great Yarmouth and Waveney CCG launched a public consultation called 'Shape of the System' on Wednesday 3 June 2015 that ran for 13 weeks until Tuesday 2 September 2015.

The CCG received 1,181 responses to the consultation from staff, patients, clinicians, healthcare providers, social care, District, County and Parish Councils, voluntary agencies and the wider public.

During the public consultation six public meetings were held, 100,000 consultation documents were distributed across Great Yarmouth and Waveney, 588 tweets were sent with 333 being retweeted, three twitter chats were held, three videos were produced which received over 720 views and our website page for Shape of the System was viewed 1,067 times.

The CCG's Governing Body received a full report on the feedback from the consultation at its meeting on 24 September. And the CCG responded to the questions and issues raised during the consultation at the Governing Body meeting in public on Thursday 22 October 2015.

An 'options appraisal' workshop was held on Tuesday 13 October 2015. At this event, key stakeholders and invited patients and members of the public completed a structured exercise to develop recommendations for the Governing Body.

A final decision on the Shape of the System will be made by the Governing Body at their meeting in public on Thursday 5 November 2015.

The CCG has kept the Great Yarmouth and Waveney Health Scrutiny Committee informed throughout this process and will be discussing this at their next meeting on 13 November 2015.

A reminder of the proposals…….

Proposal One

Developing more community based services, introducing out of hospital teams, supported by beds with care and new community hubs.

Proposal Two

Community Hospitals – permanently closing the GP community hospital beds at Southwold, Patrick Stead, Northgate and All Hallows and changing the use of beds at Beccles Hospital to provide an intermediate care facility.

Feedback from the public consultation

The feedback report from the public consultation was presented to the Governing Body at their meeting in public on 24 September 2015 by Dr Steven Wilkinson, an independent analyst.

The Executive Summary from the report is set out below:

Proposal One: Developing more community based services

There was 53% approval of this proposal with 37% disagreeing. Those who supported this proposal felt it was a good idea, preferable and sensible. This service was considered as being needed in addition to existing integrated services. Staffing issues were raised concerning availability and qualification. There is also concern that the impact of the consultation has had a destabilising effect on staff and services. Care quality is of concern and it is thought the region may be too large for this service. The location of the proposed hubs is an important consideration. Funding was of concern as was cost effectiveness.

Those who did not support this proposal felt that the model of care would not work. They do not agree with the principles and felt past experiences point to failure. More information is needed about the proposals and no changes should be made prior to the new services being in place. Patient choice should be considered. Patients form a relationship of trust with their doctor, and want to see this maintained. There is resistance to privatisation. Consideration should also be given to mental health, palliative care, management and management systems.

There was less support for the proposal to introduce beds with care in care home environments, with 42% agreeing and 46% disagreeing. Quality of care and availability of nursing/care home beds and concerns about privatisation were the main issues. The support for this proposal recognised the need to unblock hospital beds and to provide choice. Matters concerning finance integration of services, timing of the introduction of the new service, palliative care, carers and mental health and the need for more information were raised.

There was broad support for the provision of Community Hubs. These were regarded as helpful in preventing hospital admissions and reducing demand on GP and A&E services. Those who did not support Community Hubs felt they destabilised health care provision and would be ineffective.

Proposal 2: Community Hospitals

There was strong support for retaining Community Beds in all four of the hospitals with c.56% disagreeing with the proposal to close these hospital beds and c.17% - 20% agreeing with the proposals. It is felt these hospitals are needed. Those who supported their closure felt they were no longer sustainable and were satisfied with the alternative services proposed.

There was support for the proposal to change the use of beds at Beccles hospital. However, there was also concern that these would not be enough and that the location was too remote for many.

On 5 November the CCG's Governing Body were expected to make a decision on the future Shape of the System in Great Yarmouth and Waveney. At the time of writing this paper that meeting had not yet been held.

Andy Evans, Chief Executive of NHS Great Yarmouth and Waveney will be attending the Joint Health Overview and Scrutiny meeting on 13 November to verbally update the HOSC about the Governing Body decision.

The public feedback report for the Shape of the System consultation is available here: http://www.greatyarmouthandwaveneyccg.nhs.uk/_store/documents/sos_final_report.pdf

The CCGs response to the questions in the public consultation is available here: http://www.greatyarmouthandwaveneyccg.nhs.uk/uploads/files/ITEM%208%20Shape%20of%20the%20System%20%E2%80%93%20a%20response%20to%20the%20public%20consultation.pdf

Lorraine Rollo
Head of Communications and Engagement
NHS Great Yarmouth and Waveney
29 October 2015

NHS
Great Yarmouth and Waveney Clinical Commissioning Group

HealthEast

Meeting of the Governing Body
Thursday, September 24, 2015. Agenda Item 9

Title of Paper	Feedback report on the Shape of the System public consultation.
What the Governing Body is being asked to decide or approve	The Governing Body is being asked to receive and note the public feedback report for the Shape of the System consultation which has been developed by Dr Steve Wilkinson, an independent analyst from Consulting the Community.
Executive summary	A thirteen week public consultation on the Shape of the System – Developing modern and sustainable health services in Great Yarmouth and Waveney closed on Wednesday 2 September 2015. The CCG received 1,060 responses to the consultation from staff, patients, clinicians, healthcare providers, social care, District, County and Parish Councils, voluntary agencies and the wider public. During the public consultation six public meetings were held, 100,000 consultation documents were distributed across Great Yarmouth and Waveney, 588 tweets were sent with 333 being retweeted, three twitter chats were held, three videos were produced which received over 720 views and our website page for Shape of the System was viewed 1067 times. The CCG's Governing Body will respond to the questions and issues raised in this report at their next Governing Body meeting in public on Thursday 22 October 2015. A decision support workshop is being held on Tuesday 13 October 2015 when key stakeholders and invited members of the public will undertake a structured exercise to develop recommendations for the Governing Body. A final decision on the Shape of the System will be made by

	the Governing Body at their meeting in public on Thursday 5 November 2015. A reminder of the proposals……. 1. Developing more community-based services by: Introducing out of hospital teams across the whole of Great Yarmouth and Waveney. An out of hospital team is a team of staff with health and social care skills that work 24 hours a day, seven days a week to help support people going through a crisis. Supporting the out of hospital teams with NHS-funded 'beds with care' provided in local nursing and residential homes. These will provide short term care and treatment and help people recover and regain their independence, supported by professionals from the out of hospital teams. Basing the out of hospital teams in new community hubs across the area. 2. Community hospitals: Permanently closing the GP community hospital beds at Southwold, Patrick Stead, Northgate and All Hallows Hospitals and replace with out of hospital teams and local NHS 'beds with care' as set out in proposal one. GP community hospital beds are beds where the medical support is provided by GPs. Changing the use of Beccles Hospital inpatient beds to provide an intermediate care facility for Great Yarmouth and Waveney. Intermediate care is for patients who have longer term needs due to medical and/or social care issues which need to be sorted out before the patient can go home.
Risks attached to this proposal/initiative: • Reputational • Financial • Service Quality	
Resource implications: We estimate the combined costs of the two public consultations will be in the order of £65,000.	

Name	Rebecca Driver
Job title	Director of Engagement
Date	16 September 2015

Consulting the Community

The Shape of the System - Developing modern and sustainable health services in Great Yarmouth and Waveney - Public Consultation

FEEDBACK REPORT

September 2015

Dr Steven Wilkinson
Consulting the Community
September 2015

Executive Summary

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Those who did not support this proposal felt that the model of care would not work. They do not agree with the principles and felt past experiences point to failure. More information is needed about the proposals and no changes should be made prior to the new services being in place. Patient choice should be considered. Patients form a relationship of trust with their doctor, and want to see this maintained. There is resistance to privatisation. Consideration should also be given to mental health, palliative care, management and management systems.

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Dr Steven Wilkinson
Consulting the Community
September 2015

Contents

1 Background

1.1 From the consultation document:
The Shape of the System - Developing modern and sustainable health services in Great Yarmouth and Waveney:
We are talking to you about making substantial changes to the way we deliver better healthcare for patients in Great Yarmouth and Waveney. The services covered by this consultation are:

- *Community based services for Great Yarmouth and Waveney, with new out of hospital teams and integrated community hubs*
- *GP beds in community hospitals in Southwold, Halesworth (Patrick Stead Hospital), Beccles, Northgate Hospital in Great Yarmouth and All Hallows Hospital in Ditchingham, and include:*

Proposal one: developing more community based services,
Proposal two: community hospitals.
(https://www.greatyarmouthandwaveneyccg.nhs.uk/uploads/files/Shapeofthesystem_consultationdocument.pdf accessed September 2015)

1.2 This NHS public consultation was conducted between 3rd June 2015 and 2nd September. Feedback was provided to a survey found within this document and also via an on-line link and further feedback was collected from public meetings and written submissions. This consultation received 1181 responses. All data has been entered for analysis and formed the basis for developing this report.

2 Process and Outputs

2.1 A database of all feedback was developed. A First Stage Analysis codes all responses. The Second Stage Analysis provides a summary of coded responses organised into *themes*. The first and second stage analysis documents are working documents and may contain personal information. Therefore, these are not available to the public. This final report has been drafted using the analysis and can be made available to the public as all personal or identifiable information has been removed.

2.2 In the survey respondents were asked two types of question ('rating' and 'open response'). These questions have been presented in this report in the order they appear in the survey.

2.3 This report has been written using (as far as possible) the words and phrases used in the responses. No corrections of fact, grammar or syntax have been made.

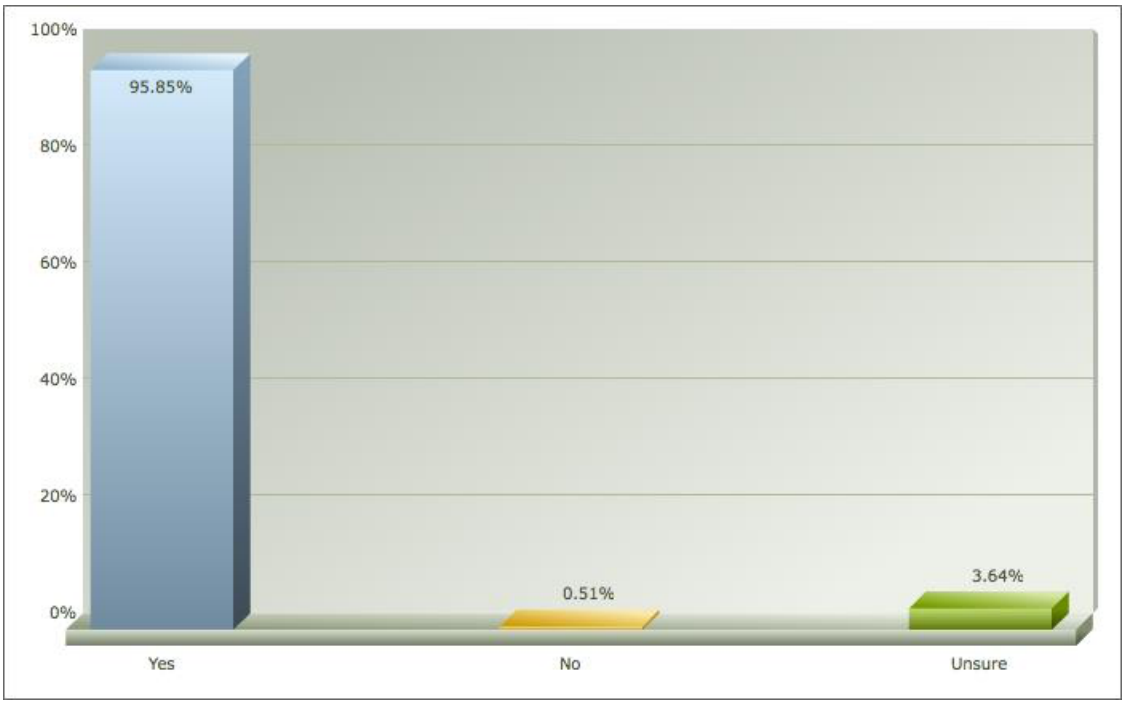
2.4 This report summarises the *themes.* The *themes* with the most responses are discussed first followed by the next in descending order. This provides a relative indication of the weighting of each response. Every attempt has been made to report the feedback provided for each of the respective questions, therefore there is some repetition within this summary.

2.5 Questions raised by respondents have been summarized and reported at the end of the summary for each question.

2.6 None of the views expressed in this report are those of the author or any organisation for whom the author may work.

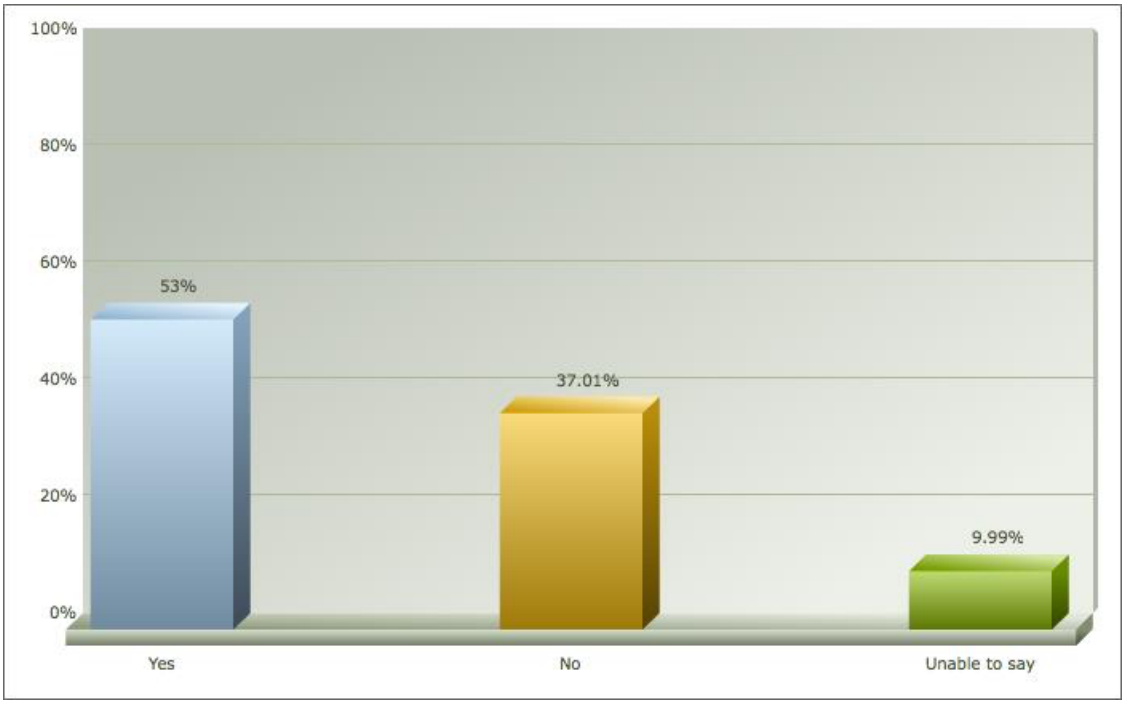
2.7 The following table shows the response to the question;

We want to make sure that you have the opportunity to fully understand the proposals in this consultation before commenting on them. Based on the information you have read in the consultation document, do you understand the proposals?



3 Proposal One: Developing more community based services

3.1 Qu 6 – Do you agree with the proposal to introduce new out of hospital teams in the community?



3.1.1 Support

Agree - This is a very good idea. Excellent (sensible, beneficial, sound, effective, appropriate, acceptable, convenient, reassuring, feasible, necessary) proposal! I agree with this proposal. Given the success of the Lowestoft team the proposal is an essential continuation of the development of integrated care in the community. People prefer to remain in their homes when ill and don't want to be separated from family. They heal quicker and would be:

- better off
- less stressed
- empowered
- more in control over their care packages
- better able to self-care, and have
- improved wellbeing.

Preferable - Being cared for at home or in a less alien environment, closer to home is preferable. Elderly people do not want to be a journey away from family and friends. Community based services are more effective at connecting discharged patients with the voluntary sector and supporting individuals to become independent of health and social care service.

Sensible - It sounds a sensible approach with a population which is living longer but obviously some with health issues. It seems not only beneficial to the individuals but also to hospitals who obviously struggle with the amount of people being admitted when perhaps they don't need to be. It will help patients being discharged earlier from hospital. Should improve access to services and reduce pressure on James A&E and GP surgeries.

In principle - I agree with the principle. You have to move with the times and the current system needs updating. Cautious support - only if things have to change.

Existing services - Care in the Community is currently provided by the following:

- an integrated homecare service is provided by All Hallows
- The Community and Social Integration Pilot (CSIP) is based at Beccles Hospital and was started at Southwold Surgery
- Adult and Community Services, Suffolk County Council has been part of the development of the Out of Hospital Team in Lowestoft and has developed services such as Home First
- East Coast Community Healthcare has a track record of success in providing the Lowestoft Out of Hospital team and firmly believes this model offers the best care for patients in that area
- Cutlers Hill Surgery embrace admissions prevention services and wish see the service they had 2 years ago reinstated.

3.1.2 Services

Additional - We need the GP unit, an adequate out of hours GP service, and the out of hospital team. You need to keep the community hospitals - you will need both. It is not a case of getting rid of one thing for another: it's a case of providing more of both of these services. I believe that the majority of those using these facilities are elderly usually with elderly spouses, or living alone with their network of friends being of a similar age. Closing the GP beds and only providing these facilities at Beccles would severely disadvantage local residents adding additional stress at an already difficult time, by adding transport considerations and possible expense to enable family and friends to visit patients.

Policy - Simon Stevens' well-received 5-year plan for the NHS supports greater facilities for care nearer to home, particularly important when the local population is almost 30 miles, or an hour by car, from any District Hospital. To deprive patients in the other rural areas of local intermediate care – particularly palliative and end of life care – is not true to the spirit of "local care at or close to home".

Rurality - There are some suggestions that rural populations only need an on-call system at night instead of a permanent night service. It is important to recognise the projected demographic changes and the increasing demand of patients with complex conditions and co-morbidities, medication and clinical management needs. These patients require overarching supervision from qualified nursing staff. Many of them are at the end of their lives following

palliative and terminal care plans. We do not believe it is safe or appropriate to leave this client group under the care of support workers.

Functionality - With the introduction of Lowestoft out of Hospital team and closure of Lowestoft Hospital, Lowestoft patients were then cared for in the remaining community hospitals. That meant that patients in the other areas needing hospital care ended up in JPUH. It is difficult to see how the out of hospital or patient teams will replace all of the functions of the community hospitals as some of the facility use non-portable equipment. They will not be able to stay with the patient 24 hours 7days a week. Nursing staff connects with their community and feel valued.

Family networks - Not everybody is born and stays here. There are a lot of professional people who moved here for work with no family support. Elderly people who live alone usually need hospital care when they are very ill. I am sure patients recover faster if they have human contact in a ward and should only go home when they are capable of resuming independent living. Hospital care should be in a large enough facility to cover all eventualities with fully trained and senior staff available at all times. The current intermediate care beds provide step up and step down admissions as well as proper palliative care, and day care for infusion and transfusion.

Care - We note however that the CCG website states that people will need to be in Beccles for infusion and transfusion. We now understand from that only very complex cases would be transferred to Beccles for a new level of ‘intermediate care' e.g. for chest aspiration, tapping ascites or people with unstable electrolytes needing blood tests twice a day at weekends. I do not feel that the proposals of out of hospital teams/nursing beds is an adequate replacement for inpatient beds that can provide 24 hour nursing care, therapy input and support for the increasing complexities of the patients requiring input.

Beds - We do not agree that 4 beds for South Waveney will be sufficient and recommend that Halesworth continue with at least 14 NHS commissioned beds in the first instance. Cannot some community hospitals be combined to provide more viable numbers of patients to staff and to give some safety net in case this proposal for the out of hospital teams does not prove as effective in the rural areas as the urban areas. More community intermediate care beds are needed. The CCG should continue to commission local intermediate level care for the local communities in All Hallows at Ditchingham, Beccles Hospital, Southwold and Halesworth and Northgate Hospital, with medical provision for this care from those community's own GPs.

3.1.3 Integration

Services - I do agree with the out of hospital team working alongside the G.P unit, the DGH’s (and outreach hospital services including for example podiatry, phlebotomy, physiotherapy, occupational therapy, hearing aid services), district nurses, social services, paramedics, pharmacists, walk in centres, older people's mental health, the help-line (111), the voluntary (third) sector, hospices, hospital transport, with the backup of unpaid carers, in a coordinated fashion to help prevent admissions into acute hospital. You are proposing a

very joined up organisation which sounds holistic. It would be nice to have all the teams operating under one roof so they could follow up procedures and using teams managed by the local practice.

Additional - As these proposals are implemented we believe that these teams will have an excellent opportunity to provide health improvement advice and services by having links with healthy lifestyle services such as drug and alcohol treatment, sexual health services, stop smoking and weight management.

Systems - The provision of this service will clearly need a great deal of support from the staff running the whole of the support infrastructure 24/7, appointments/ logistics/ medications/ services co-ordination to identify but a few, clearly "out of hospital teams" cannot travel out from any hub on their own initiative and community hubs will naturally be extensions of existing Hospital facilities for pharmacy services, equipment supply, control, returns. Cumbria have developed a truly integrated community model making the best use of local community hospitals by integrating them into their equivalent out of hospital teams.

IT - There is already a big problem with the JPH and NNH hospitals unable to pass records of patient care between sites! Lack of co-ordination between health and social care, and poor communication, is a continuing theme from the feedback that we receive on health and social care services. Practices are organisationally separate. Because of our geographical separation, and the fact that the practices are very different (for example, Beccles Medical Centre is not a dispensing practice) – there is very little collaboration between practices.

3.1.4 Staffing

Issues - The team must be sufficiently well staffed, qualified, have the right skill mix and be well managed and funded to afford each patient the quality care and time they require and to provide support for the staff to do what can be a lonely job. New training and local living accommodation will be required.

Doctors - Doctors surgeries need to have a doctor who can visit as soon as a request is made, not hours later - given the lack of appointments available and shortage of GPs. Teams appear to have poor staffing and no provision for overnight care. There will always be a problem with recruitment issue of appropriate staff. We are unable to recruit suitable staff currently to jobs which have been vacant for six months. We have the North Sea to our back and no great areas of population to recruit from.

Transfer - Current NHS employees may have their terms and conditions of service changed. The staff who are currently employed in the community hospitals, although assured of being re-deployed in other areas, might not be able or willing to carry out other jobs. A number of the staff from the community hospitals work there because it is close to home and they can walk or bike to work rather than having to have the expense of running another car. Some do not feel they could manage to work without the support of colleagues around

them at all times and others physically could not manage to go out and about into people's homes. There are many existing staff who will not be able to move to 24/7 contracts due to family or partner/spouse's working pattern commitments. They may well be forced to leave.

Carers - There isn't enough community carers in the areas of Gt Yarmouth and Waveney to cover patients in need of help especially at weekends, it takes so long for them to come to their patients. There are not enough nurses in the James Paget or N&N now. Plans like this are just increasing the stresses placed on acute trust doctors and nurses, and I'm not sure if they can take much more. Large turnover of staff might mean that the patient never sees the same face twice, and could lead to greater distress.

Anticipation - The proposals in the Consultation Document indicated a 'possible' closure of community hospitals next year. As feared, this appears to have precipitated staff exploring other opportunities for employment. This has resulted already in staff shortages and the closure of a number of overnight beds. The consultation has precipitated a major staffing crisis in our community hospitals and endangered their viability not only in the long term but also in the short term without any clear interim plan. The staff are demoralised.

3.1.5 Care Quality

Preference - Most patients would prefer nursing care in their own environment provided that they are assured the appointments will be kept at times given and the care is consistent 24/7 with the same level of care and expertise at all times. A high standard of care would be required and should be monitored.

Standards - Whilst this may be a more cost effective method of delivering care it must not be of lower quality than the existing system. Patients in hospitals on food/fluid charts are monitored hourly and encouraged regularly. I'm not convinced that this will be a better system. Due to the amount of staff needed, travelling costs, lack of sterile environment and no care for patient in between OOH visits. People needing rehabilitation and re-enablement, palliative care and general recuperation are not receiving the care in a residential setting and are often not assessed as suitable to receive care in the community setting.

Experience - I have not had good experiences of care in the community. I do not believe the care will be safely provided at home. I found that personnel were not well trained, and the standard of care, in most cases, not good. Their ability to monitor patients' conditions was not of a good standard. They failed to fill in reports, and did not date drug records. Trying to provide rehabilitation or care in unsuitable home environments, without on-site availability of parallel walking bars, Standaid hoists, or the ability to quickly call on extra staff to assist when things go wrong, is a recipe for disaster for both patients and staff. Lack of access to some technologies for example intravenous antibiotics and some diagnostics for example ultrasound and x-ray.

Time frames - Although I think it would be a good idea my concerns are that if based on the 15min rule then people would get a bad service. Currently it is

virtually impossible to arrange a home visit in an acceptable time frame. People living on their own could be left for large parts of the day and night without any care. I know people who have had to wait 11 weeks for physiotherapy: also patients who wait 3-4 months between podiatry visits. I know someone with a new hip sent home with a DIY self-catheterisation kit!

Comparisons - The television coverage showing the gentlemen being cared for in a "hospital" bed, with all the equipment etc. in his own home is a bit misleading as not everyone has a home/room big enough to take this kind of equipment - thus rendering the care impossible. Homes require basic/essential maintenance as well. Light bulbs need changing, fuses blow, boilers need servicing. Additional laundry and house cleaning needs doing on occasion. Taps drip, sink plugs become blocked. None of these are major, but they need sorting and the resident, particularly if they are on their own, may no longer have the capability to do this.

Monitoring - Carer satisfaction can only come with patient consent. Many people do not invite strangers into their homes. We also expect that there will be a monitoring and evaluation plan in place, including capturing the views of the patients (e.g. patient satisfaction survey), service users and the general public: with regular reports produced to demonstrate that the needs of the local population are appropriately met.

3.1.6 Area

Size - The CCG area of Great Yarmouth and Waveney is too large and widespread for this to work. Although the out of hospital teams are working well in Lowestoft and have been introduced in Great Yarmouth providing a similar level of care out in rural areas would be much harder to achieve. The experience from Liverpool and other areas, is that these teams work well in a limited area.

Demographics - Lowestoft and Carlton Colville has a very different geography and demography. 24% of the population (16800) of Lowestoft is over 65 years. The population of urban Lowestoft is about 71000 as compared to South Waveney which has a population of 50000 which is 50% urban in the towns of Bungay Beccles Kessingland Southwold and Halesworth. However 50% of the South Waveney population is scattered across the rural area, in the Halesworth practice which covers an area of 300 square miles, 50% of the population is scattered in the villages – ie 5000 people. Halesworth is more rurally isolated than any other town in England, with the ambulance service unable to meet their targets without our attached community paramedic. Travel time to any DGH by car is about one hour, and by public transport two hours. Beccles is 10 miles and 20–30minutes by car, but by public transport (train or bus) is only easy during the week and would take at least an hour. Our registered population is 10312, with a high proportion of elderly – currently 42% over 60.

Time wasting - Time will be wasted travelling, not allowing enough time to carry out tasks. For a Doctor to spend 30% of their working day travelling between patients, would be an inappropriate waste of Doctor time. There can

be appalling traffic congestion and poor roads, especially in poor weather. With the amount of traffic on the road today, regular time keeping cannot be assured and relied upon giving patients stress and concern as there is no back-up.

3.1.7 Location of Hubs

Locality - We feel it is imperative that the CCG recognises the importance of the huge population increase. It would be better to have satellite teams based locally, who can call on the central team. We should be looking to have a team and base in both South and North Lowestoft as proposed in the last consultation. Capital funding must be in place to provide 21st century hubs in Gorleston, Great Yarmouth and the Northern Villages i.e. Martham. The Martham hub needs investment to ensure it has the capacity to meet the growing needs in the Northern Villages. In the case of Beccles, Bungay, Southwold, Halesworth and Kessingland Practices we support a Practice based system. Set in this context it would seem sensible to continue to commission beds at All Hallows.

Hospitals - The health teams should work from the existing community hospitals. The Northgate Hospital site must have as part of these changes a new medical centre and designed hub. It should be borne in mind that Longshore Surgeries, which are based in Kessingland, Wrentham and Wangford cover a large area and sizeable population, which as well as Kessingland include these two large villages, the adjoining rural area and parts of Pakefield. The Bungay area should not be served from Beccles, but from a separate Hub located at the All Hallows Hospital.

3.1.8 Finance

Funding - Only if there is adequate funding. Such care must be available solely on the basis of need - not according to means!

Economy - This is just a cost cutting measure. In itself, it is a waste of money. I feel, however, that these proposals are more about saving the £4.3M for NHS England annually than enhancing the provision of healthcare in the community. Much is made of this proposal being the right thing to do for patients, but it is also considerably cheaper than current arrangements. I wonder if it would still be the right thing to do for patients if it was considerably more expensive than current arrangements. The idea should be to provide quality healthcare at the appropriate cost - not what healthcare can be supplied within a target savings plan. Reducing management is likely to create £5m savings not cutting frontline essential services.

Waste - Why spend money on 'new services'. Spend the money on recruiting more GPs, Community Nurses etc. To my mind, it is grotesque that when we have an ageing population and greater numbers of disabled people living longer, we should be seeking to cut essential services, including mental health services, district nursing and similar roles. Those who are now old have been paying for the NHS since 1944, and it should be there for them in their time of need.

Cost effective - I believe this to be a far less cost effective way of treating these patients - it would be better to have them all in one place. The NHS is stretched enough as it is. I do not think funding will be readily available for "out of hospital teams" to be established and to offer the same service as Hospital beds in community based hospitals. In looking into this issue I would urge you to obtain the specific views of both Beccles and Bungay GPs and to analyse carefully the cost of operating this service from both sites. It may be that due to the availability of existing facilities and services at both hospitals, better economies of scale can be achieved by operating from two sites. This proposal could prove very expensive in the country areas due to them being less populated, requiring more travelling.

Cost sharing - One specific concern is that additional investment by Suffolk County Council in the adult social care services that are part of this model is extremely unlikely to be forthcoming in the current financial climate facing the Council. Without additional funding from other sources such as targeted Better Care Fund monies for example, social care support to Out of Hospital Teams could only be switched from existing community services that already work alongside Primary Care Teams. It is imperative that capital funding and land assets are secured before these changes are implemented. - I feel very strongly that NHS/ Social Services should be funding all the care required and not (as now) a charity such as The Sole Bay Care Fund.

Investment - I know from my work on the transitional arrangements for community care that I did when I was in the Audit Commission with the local PCT that considerable investment has been made at Halesworth and Southwold and this project completely undermines this investment. The funds raised from the disposal of Southwold hospital should be ring fenced for the provision of the proposed Care facility in Reydon adjacent to Sole Bay Health Centre.

3.1.9 Don’t Support

Concerns - The proposals in the Consultation document do not stand up at a number of levels. They are not consistent with national NHS policy as set out in the Five Year Forward View: they will have the effect of dismantling established procedures which have been developed over many years and which work effectively: and the specific actions proposed do not look feasible. We do not agree with the proposal to introduce new out of hospital teams in the community. Care in the community does not work. There is little to no continuity of care, no understanding of patient or system needs. It is wrong and incorrect to suggest patients do not care who delivers care.

Experience - This was previously tried with the local mental health trust and that trust is now in special measures. Patients are being placed 100s of miles away due to lack of available beds. Their outreach teams going to patients homes have not worked in conjunction with the reduction of beds. All it was, was a cost cutting exercise which has obviously failed. The proposal lacks realism and feasibility (atrocious unworkable, half-baked proposal and a dubious high risk plan). Out of hospital teams will neither be cost effective or appropriate. This is quite a big change and let’s be honest, the NHS has not

got a good track record on change. On the face of it, in theory it should be better, but I feel that there is a big risk that it could all go bottoms up. If it is positively working already why change it. Patients in "crisis" could feel isolated if left in their own homes or placed in a "bed with care" that is not in the area they live. My experience of community nurses was a deeply negative one. They are unhelpful, uncooperative and unpleasant, overall very unprofessional. More responsibilities are put on the carers with no increase in pay. Families aren't trained medically.

Vision - The use of short-term contracts leads to short-term goals and are a disincentive to planning for 15 to 20 years ahead. The NHS Five Year Plan should be a twenty year plan in order to be ready for the evolving demographic and health needs of a changing population. This is a very short term proposal and saving £5m is a drop in the ocean. The number of households is increasing and the number of single person households is multiplying rapidly. Care at home doesn't work when people live on their own. I have seen this personally - you lose having any sort of life outside receiving your care and it increases depression.

Impact - Your proposals as they currently stand could have an unintended consequence of a negative knock-on effect to the provision of other services.

3.1.10 Information

Requested - Information on the following is requested:

- The OHT patient referral system
- Community hospital admissions statistics
- Community hospital patient audit method
- DGH admission statistics (showing a reduction in bed use)
- References used in the consultation document relating to reduction in bed use
- Proposed OHT patient quotas
- Proposed care model ('hands-on' care at home eg washing, dressing, feeding)
- OHT staff numbers, make up and recruitment (and availability of suitable housing)
- Evidence of consultation with staff, social services, voluntary sector
- Costs per patient for the old and new systems
- Overall costs and a guarantee of funding and timeframe for funding to be in place
- Administration of new systems
- The future role of technology (NHS 5 Year Forward View)
- Proposed time spent with patients
- Pilot schemes/feasibility assessments (for rural localities)
- Hub locations
- An explanation of ‘contingency arrangements’ to continue to use NHS buildings
- Communication strategy (for implementation)
- Details of the Lowestoft evaluation
- Assurances about care provision during the implementation of OHT.
- The immediate future of community hospitals

- The impact of closing one community hospital on the remaining hospitals.
- Proposals for mental health patients
- How 999, 111 and OHT services will be integrated
- The future of other services provided through community hospitals (e.g. x-ray).

3.1.11 Timing

Sequence - A good idea if the full teams are all in place and working efficiently before the hospitals are closed. Keep our beds till there is proper (adequate, full, superior, better, resourced, suitable) provision in place and functioning first. Must ensure that by closing hospital beds this service at least covers the loss of beds.

Phasing - There should be a phased introduction of new services to iron out any issues that were found with the introduction of the Lowestoft out of hospital team. There is a worry that the transitional arrangements to cover this period have not been properly thought through. I would urge you to take some time, initiate another trial of the proposed services whilst keeping the community hospital open. Please go as steadily as you can get away with.

Care Homes - But please only close Southwold Hospital after the new care home at the Sole Bay Centre is built and up and running. I do feel the hospital should stay open until there is evidence of a new one, or at least shared care beds built in Reydon. I would like to thank you for confirming that if Patrick Stead is closed, this will not happen until “suitable alternative facilities” are available in Castlemeadow's new building providing an equivalent level of care. I know the executive promised, on camera, to keep our hospital open till care centres built, but he will probably be long gone before that happens/retired/moved on! Premature closure of community hospitals will have dire (disastrous) consequences.

3.1.12 Consultation

Access - It is almost impossible to find the consultation documents on your website - please ensure you advertise this consultation better and don't just rely on electronic means. Your consultation document was only distributed within the town of Halesworth and to none of the villages.

Document - A few points on the public consultation document:

- Question 1 - I find the wording, grammar, terminology and general (non)sense of the proposal document both ambiguous, confusing, obscure, and at times contradictory.
- We were surprised to see on Page 4 that there was no mention of the document being developed in conjunction with clinicians and staff from primary care, as that is where so much of what the CCG is proposing to change actually occurs.
- Page 7: To try to persuade us that by comparing us with Kirkley Mill and Lowestoft as an example of a community which is pleased with increased home care is wrong, as no community hospital was closed in the process.

- Page 9: "We know that people ..."/"We know that for many people ..."/"... we will need to change ..." This is ambiguous. In each case, is it the same "we", i.e. the CCG?
- I made an attempt to read what I think you call the "simplified" version, and find it EVEN more unproductive. You really need to get your act together when it comes to communicating with the public.
- I'm disappointed, and dismayed that this "generic proposal" should have been so shabbily constructed. The consultation document is not fit for purpose (confusing) and anxieties were raised in the local population which were unnecessary. If the correct information had been given at the time, this wouldn't have happened.
- The terminology has caused difficulty in understanding for people generally, and concern from professionals about the level of care that will be offered in 'beds with care.' The beds in community hospitals have always been called 'intermediate care beds.' Now the CCG are referring to them as 'beds with care'.
- Apart from being a confusingly biased document it is difficult to see/hear what the proposals are - or even if they're an actual option!
- The document, is not appropriate for Halesworth and its hinterland.

Questionnaire - On a technical issue to do with the construction of the questionnaire: Respondents should be given a scale, say from 1-10, where they can indicate their level of agreement with each proposal. The Yes/No/Unable-to-say format is likely to give misleading results. The questionnaire for feedback at the rear of the document was confusing and difficult to answer. We have had to help numerous people who were struggling to complete it.

Dialogue - The initial process of consultation on the proposed changes has been tightly managed. The hope is that there will be opportunity for ongoing dialogue on the detailed implementation of any changes. Healthwatch, Patient Participation Groups, or a forum of community representatives would no doubt be able to fulfil such a role. There is a sense of helplessness to influence (no effective engagement) amongst the local community and the CCG will want to explore ways to demonstrate they value active participation. If there had been more consultation and collaboration between CCG and local practitioners and services then I believe we could have got much further down the line of urgent decisions about the future of our local health care by now. Any forward strategic planning must surely incorporate knowledge of the large anticipated increase in population, and that the subsequent actual consultation would make reference to this fact. We are disappointed that the consultation lacks the quantitative and qualitative evidence which would make this argument more compelling.

Decision - I really don't know why you are wasting this money when you have already made up your mind. It seems decided (a "fait accompli"). The responses we are asked to give are on specific short term issues on local organization, indeed issues which have changed within the time span of the consultation. Too late for consultation when changes are already in place. Why bother to ask us. Whatever the public's opinion you will go ahead with your option. I would suggest that you reconsider urgently.

Response - Since the document was produced we acknowledge that the CCG has made certain changes in response to great concern from the public and from local professionals. We appreciate that the CCG has taken the time and care to say publicly that this was a generic document, and that the needs of different areas must be taken into account - particularly in order to address the specific requirements of rural communities such as Halesworth. There has been limited opportunity to discuss or influence these proposals between the CCG and our practice prior to the consultation. We believe that this consultation, is untimely, ill-advised and misinformed. This has wasted the time (and money) of so many people. We have written to NHS GYW on previous occasions with no reply. All the money that this consultation and reorganisation costs could have been better spent. Our view is that the present consultation should be abandoned and replaced with one which truly involves the people of Halesworth and the surrounding area. We were also pleased to hear that local Halesworth GP's and the care provider (Castlemeadow Care) would be able to decide the level of care, - the acuteness - and the type of patient being admitted to the NHS commissioned beds.

Satisfaction - The PPG Forum would like to congratulate the CCG on running a good consultation process. Praise was given to the public meetings in particular which had been well organised. We expect that the local population will be kept informed about the progress of the implementation of these proposals.

3.1.13 Patient Preference

Choice - Also needs to be patient choice and flexibility - so that those who require significant levels of care/support /not appropriate to be cared for at home have options. Patient choice needs to be at the centre of this. You need to listen to the people on the end of the phone. It makes sense to work together. I do believe people care which specific organisation is providing their health care in those communities where there is a popular community hospital, which may be outside the NHS, where there is a strong and flourishing League of Friends raising significant local funds for investment in local health facilities. They have served our communities well and are greatly valued by the people.

Goodwill - Any business knows that goodwill is an essential element on the balance sheet. So it is with local Health Services. In rural areas in particular, people become closely identified with their locally based public services, including health practitioners and hospitals. Sleeping partners they may be, but when change is suggested they are understandably uneasy. Not always, as some might interpret, because they are resistant to change, but because they know from experience the value of what is available. To retain that goodwill must be the aim. Patients need a feeling of security – and continuity of care. And that is why it's so important to have practice based, locally led services.

Confidence - This is a very complex and emotive subject and a worry to all of us who live in these rural areas, where getting from A-B is often very difficult. Any service that replaces these beds must not only tick the modernity, efficiency, clinical skills boxes, but also reliably engage the confidence of the

local population that it will be there for them when they need it and in ways that they need.

Support - Generally I believe that it is very much to be welcomed that you are coming forward with proposals to better provide for the changing and growing health demands of those living in the Great Yarmouth and Waveney area. You are right to point to the success of Kirkley Mill in Lowestoft and it is appropriate to look to provide a similar form of integrated health, care and support across the area. I would hope the OHT would be more personal to the sick person, knowing they would have regular contact with a community team, rather than lots of different staff in a hospital environment.

3.1.14 Privatisation

Concern - No more privatisation in any form. This could be profoundly risky. Ensure that the care proposed will be quality and not compromised by using businesses where profit making is more important that standards of care. As long as staff are still employed by the NHS not privatised. As long as these services are not provided by low paid care assistants working for private companies. Community equipment service was unsuccessfully managed by SERCO. It should be non-profit ran, as people do care about who provides their healthcare and are oblivious that their GP surgery is ran by other companies and not NHS.

Standards - Reliance on the private sector must not be allowed to leave the CCG vulnerable to lowering of standards and excessive price increases. Anything less will reinforce the sense of creeping privatisation and weakening of Health Service control over a fragmented range of services. The public sector is very bad at productivity. Both Labour and Conservative governments have encouraged creeping privatisation of the NHS which may still be free at the point of delivery but someone has to pay for management and company profits and that is the taxpayer - you and me.

3.1.15 Mental Health

Need - There is no mention of mental health as part of this. I think this is essential as care is not just about physical wellbeing but also mental wellbeing. Having had personal experience of schemes in the Mental Health field which aimed to reduce hospital beds and improve care in the community, I think it is pertinent to refer the CCG to the current parlous state of Mental Health provision in GYW which has resulted ultimately in the service being put on special measures. I believe that the proposed community based service will not be provided. I remember the concept of closing NHS mental hospitals and introduce community base psychiatric services - this concept failed completely and the community based service never materialised.

Beds - Elderly frail demented patients will always need beds, that will not change. Dementia patients need the utmost care but lack of beds means these closures are unacceptable. I feel that the CCG should look at the dementia patient and how these proposals will help these patient's to stay at home and support those in a caring role. It is essential that mental health staff are an integral part of any out of hospital team and not working ‘outside’ of the teams.

At a time when funding from Government is restricted, it is important that every opportunity is taken to encourage and to promote such social enterprises and community assets. All Hallows are considering an ambitious project of building a Dementia Unit. There is a concern that your proposal to close the community hospital beds could be interpreted as a lack of support for the hospital in general and might deter the Trustees from embarking on what is an exciting and much needed project.

3.1.16 Palliative Care

Need - This is only a good idea if the patient is dying and wishes to die at home. This service should include respite care and peaceful management of terminal patients.

Location - Not everyone wishes or is able to die at home and Community Hospital beds are an alternative to the district general hospital thus enabling choice, one of the goals of the NHS plan. Also admitting palliative patients for very difficult symptoms, not manageable at home, can be very 'productive': it allows a return to a better quality of life for patients, better and rational use of medication and enables the carers to regain their strength for coping with their loved ones' final weeks of life, if they subsequently wish to care for them at home. We do not want to lose the oncology, palliative and end-of-life care skills currently available to us which can continue to be developed with input from Macmillan Nurses and GPs. I can understand that changes need to be made to save money but do not agree that the changes will improve services to those at end of life who do not wish to die at home. Asking people to wait a number of hours in order to have trained staff to respond to a patient's needs could lead to suffering and distress for all concerned). I have seen first-hand that the out of hospital team does not seem to be functioning well in the Great Yarmouth area and have concerns that the staff in the team do not have the appropriate experience to be caring for patients needs at the end of their lives.

Services - Northgate looks after end of life patients and is very well known for the outstanding level of care that they provide for these patient's and ensures the end of life dignity that all patients should have. The PSH was a godsend as my father came to the end of his life. We are aware of people who have utilised the special environment that All Hallows hospital Ditchingham provides, in the provision of care at end of life. Halesworth Health wish to see the exemplary Halesworth palliative and end of life care maintained. There is a difference between the End of Life we all want – and the End of Life we are likely to get

3.1.17 Management

Effectiveness - As long as the system works effectively. They would need very tight management and control to ensure proper care and value for money. Adequate time needs to be given to ensure these teams are set up with the right staff who are fully trained and motivated. Failure to do this could result in staff sickness due to stress or staff leaving and this will ultimately have a negative experience for the patient. If it takes a little longer, but if done properly it will give a long term benefit. Adequate staffing also encompasses quality of supervision. Here quality includes a supportive, constructive

approach to management of staff and engendering a co-operative attitude among work colleagues. I have had experience where staff visited me at home. You never knew when they were turning up, their computers did not work and they were always complaining about the planning of their visits. Unless there is someone with logistic experience planning the visits and providing access to the information they need about a patient and any relevant history, it will not be cost effective and will stress staff.

Systems - Out of Hospital Models rely heavily on technology, as staff have to 'hot desk' and are required to work in a 'paperless' environment. My experiences, whilst working for ECCH, are that the technology and IT support are simply not up to the job whilst signal coverage is poor or non-existent. The software systems that staff are required to use to book appointments, write up notes, complete generic templates, and receive tasks and messages, frequently crash. Considerable time is then taken contacting IT and reverting to hardcopy methods which is time taken away from clinical work (by which I mean our patients!). We have to complete Datix reports every time we experience these problems which again impacts on clinical time. Faced with insufficient longer term home care, the CCG will also need to consider with Suffolk County Council Adult and Community Care Service how they propose to manage the "revolving door" syndrome. Not between home and hospital, but home and the Out of Hospital Team.

3.1 18 Questions about community based services.

Why are changes being proposed?

Is a lack of funding behind the decision for change?

Will this approach be financially viable?

What analysis have you done to determine demand?

Is this model based on evidence of a system that works somewhere already?

How will End of Life patients be cared for?

How will mental health patients be cared for?

How many community teams will there be?

Considering the difficulties with staffing existing services, how will this service be staffed?

What will be the makeup of the teams?

Does the staffing level account for potential growth in demands on this service?

How will this service affect the present teams of Community Nurses?

Are staff prepared to work the required hours?

Will this model work in the more rural parts of your area where population is thinly spread?

Who will administer drugs in either a community care or beds with care situation?

What notice will patients be given prior to a visit from a healthcare worker?

How will the teams be managed?

How do you resolve issues/disagreements re individuals support by either GP or hub team?

What will be the qualifications of the team leaders?

Will the community staff be appropriately trained and qualified?

Will healthcare workers be provided sufficient time with patients during a home visit?

How long will it take for a patient to be assessed by the team?

What clinical back up will be available?

Will there be a GP on duty 24hr a day?

Will more GP's be recruited to meet the increased workload?

How safe is this system?

Will patients get the same or better care than they would receive in hospital?

How will these changes and the new services be monitored?

Will this service also provide phlebotomy services?

Will patients who are not admitted to care homes, nursing homes and residential homes be safe at home?

Will hubs provide a 'walk in' service?

How will seriously ill patients access walk in centres?

How will patients understand how to use the new services?

How will records be kept, updated and accessed?

To what extent would these services meet the government's new proposals for seven day services?

Why not integrate community hubs into the existing hospitals?

How do ‘hubs’ differ from the existing surgeries?

Do we need both beds with care and hubs?

What is the role of the voluntary sector?

How will these changes effect waiting times?

Have you proof that this system really works?

In bad weather, are the teams fully able to cope with their care duties?

Why have these Hubs already been started in the north?

What plans are in place to mitigate risks to providers if the anticipated reductions in admissions do not happen?

CCG data for the year to date shows a significant increase in medical admissions this year for the original OHT cohort area and an increase across the wider patch. Does this mean there is a non-recurrent impact of the OHT or is a much higher increase in admissions being prevented by the team? Will the team provide recurrent year on year reductions in admissions to stay ahead of demographic trends?

Have all system partners confirmed agreement to the data used as the basis for the proposal?

Has the CCG undertaken a Clinical Quality Risk Assessment (CQRA) on this proposal and developed mitigation plans for issues such as staff leaving posts due to uncertainty, higher than expected demographic increases in admissions being beyond the capacity of the team or other factors important to maintaining a sustainable service both during the consultation and after implementation?

Is the CQRA published?

Is there a formal business case including capacity and demand modelling and detailed costings for the proposal, and a benefits realisation and VFM assessment for the phase already completed? Is this published?

How will the CCG mitigate the risk of fragmented care and any potential subsequent negative impact upon patients, affordability and sustainability?

How will the ongoing monitoring and evaluation of quality, operational performance and value for money relating to this service change take place and where will this be reported in the public domain?

What KPIs and quality measures will be monitored post implementation?

How will the CCG ensure that these patients receive the right care outside of hospital by the appropriate clinicians?

Where patients are receiving EOL care and may have chosen to end their lives outside of an acute Trust environment, what assurances can the CCG provide that where complex needs cannot be met or service capacity is an issue that this will not result in an avoidable acute admission which would be inconsistent with the patient's wishes?

Will services be equitable and consistent 7 days a week, 24 hours a day including across all of the geographical areas covered the team, e.g. in the most rural areas?

How will patient choice be accommodated by the new service?

How do the CCG's proposals shape up against the Five Year Forward View?

Out of hospital teams as described in your consultation document appear to offer short term support only: what happens in the longer term?

Won't people need additional social and personal care if they are living at home?

What happens if people are living alone and there is no-one to support them?

And what support will be available to family carers if they are providing the frontline support for the sick person?

Why are you doing this when other areas of the country are building new community hospitals?

From which Community Hub will Kessingland be served?

Where are all the extra staff coming from to service all the hospital teams?

While the further integration of services may well remove obstacles to "joined up care", the question needs to be asked whether the fundamental shortcoming in the present working arrangements has been the sufficiency of primary health and social care practitioners and budgets, to pay for people and places?

Also where is the money coming from for all the extra supportive equipment needed in people's homes for rehabilitation purposes and what about the extra admissions into acute services because of the increase in falls with patients at home?

Is there a comprehensive transitional business plan for the staffing and financial resources necessary to ensure this transition is effective and sustainable?

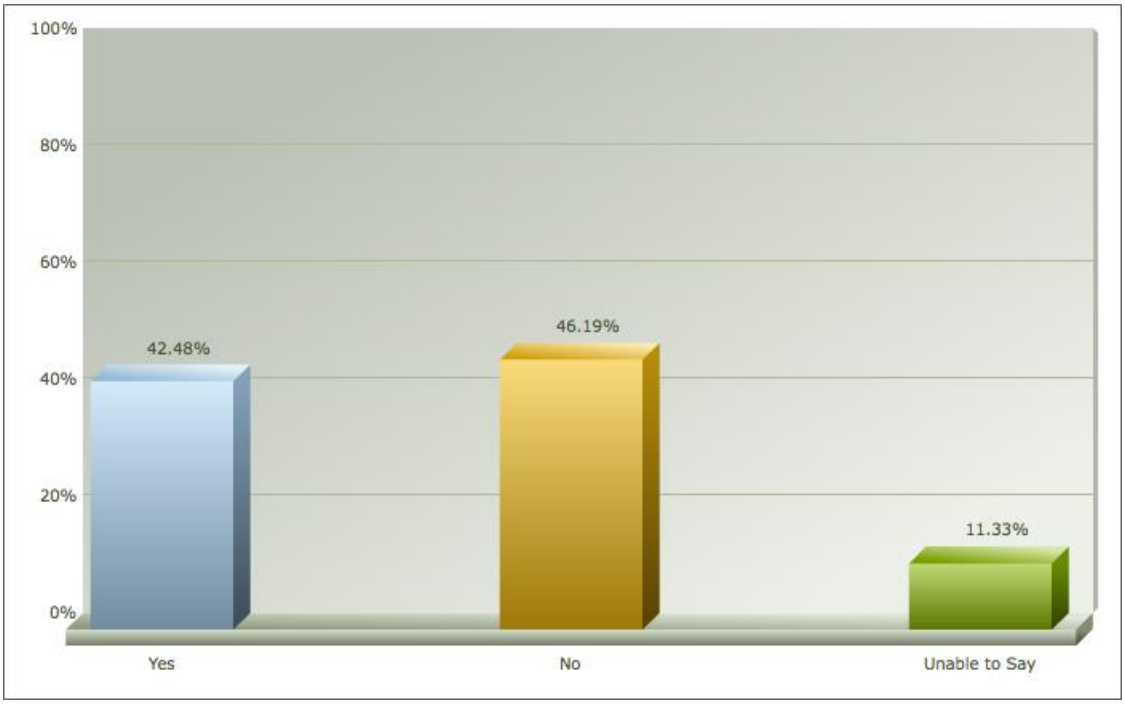
It doesn't say who will employ the staff on these teams. Will it be ECCH and subject to future tendering process or will it be the NHS?

Will the patient would have to pay for this service?

Are private care agencies involved?

If the Care Commissioning Group is going to save up to £7.9 million by closing community hospitals and is proposing to reinvest £3.6 million of this in out-of-hospital schemes and the £4.3 million left will go to pay off debts in the next two years, may we hope to see an equivalent percentage cut in management costs to match the percentage cut in clinical costs?

3.2 Qu 7 – Do you agree with the proposal to provide 'beds with care' in a care home environment?



3.2.1 Quality

Standards - NHS standards of care must be met. You cannot promise the same level of care and attention in a nursing or residential home as you can in a hospital. I have seen care at home in operation. It goes unmonitored. It only pays lip service to the actual care that is required and fails to deliver. It is not appropriate to use "local nursing homes". Where care is provided in care homes now it is consistently proven that staff are under-trained, the dignity and needs of the patient is not considered, there is a lack of transparency, no continuity of care, no universal standards and no accountability. Inquiry after inquiry into private care homes identifies serious problems with patient care, poor standards and demoralised and underpaid staff. People who pay privately for residential care subsidise those who are paid for by the local authority, surely an outrageous situation. Private care homes go bust or are taken over

by large organisations with a business mentality rather than an ethos like that of the NHS. Abuse is rife and care home owners are just there to make a profit.

Services - There will be a lack of readily available rehabilitation and on-site access to specialist nursing, physiotherapy and occupational therapy, palliative care, neurological and speech therapy and intravenous capabilities. I am thinking of urgent medical attention should I need it whilst in the bed with care facility. Will these care homes have the appropriate space and equipment and be able to administer oxygen therapy and have enough room to use a hoist.

Monitoring - I understand the CQC will inspect these homes. If a care home falls below this standard, it should be removed from the list. Very important to ensure these care homes are of good standard. Superficial visits will not be enough. We also expect that there will be a monitoring and evaluation plan in place, including capturing the views of the patients (e.g. patient satisfaction survey), service users and the general public: with regular reports produced to demonstrate that the needs of the local population are appropriately met. The costs need to be carefully monitored to ensure value is achieved, and beds are available when needed. If this model is taken forward alongside other changes it would be helpful to audit the numbers of patients using the services who then are discharged or remain in long term care or are readmitted to acute care as compared with the current models. Maximum stay times must be vigorously monitored.

3.2.2 Availability

Stock - In principle this is a reasonable idea but I have grave doubts whether enough beds will ever be available in private sector nursing homes never mind retirement homes. They are already being squeezed by government cuts to social care budgets. We are also anxious that the local care homes always have a waiting list so this would increase the number of people in a care home setting, adversely affecting those who really need to be there. We have been bereft of proper hospice care in our area, and it needs to be addressed.

Investment - Any changes to the provision of beds must be with a guaranteed investment in dedicated private care home beds. More beds are necessary than are proposed. Reports suggest that the number of homes may decrease because of increasing running costs as a consequence of planned legal minimum pay and an obligation or provide staff pensions. The CCG will commission beds, in a new/local nursing home. This would be acceptable. This care would include intravenous therapies – antibiotics, blood products, and bisphosphonates, controlled drugs administration, and higher level palliative care – and would be supported by our GPs who have the skills to supervise this care.

Timing - The new nursing home to be provided is not likely to be available until 2017. There are no guarantees that new care homes will actually go ahead. We are concerned by the CCG statement in the document that beds in the community hospitals could close from April 2016, despite alternative facilities being unlikely to be available. This statement has clearly unsettled the

community hospital staff as well as caused great anxiety amongst local residents. There is a suggestion that residential homes could be used to fill the gap until the nursing homes are built. Most residential homes/ nursing homes have waiting lists. I should also like an assurance that there will be an adequate number of ring-fenced 'beds with care', sufficient to deal with admissions in the winter months.

3.2.3 Support

Bed blocking - There is still a huge backlog of elderly patients in District General Hospitals who no longer require acute care but need intermediate (step down) care which could be provided locally to their own communities, where skilled nursing and intensive Occupational Therapy and Physiotherapy are available for rehabilitation, enabling discharge either to their own homes or into a residential setting.

Support - This is an excellent proposal (A very good idea: a good plan: this could help: vitally necessary: works well: is more modern: sensible: to be welcomed). I agree with the concept, it makes common sense. This will be very much needed for patients who need beds with care and in care homes. Certainly for some people with physical conditions this could work well. This is the safest proposal for people who are not well enough to go home. This is the obvious solution to bed blocking and will reduce pressure on JPH A&E and GP surgeries.

Choice - When the population gets older, loneliness is becoming a big issue. I think there should be more places for the retired older population as an option they can chose. Beds in a care home are a much more friendly environment, more relaxed and comfortable - rather than a clinical hospital bed. The individual will be better provided for. I think that people will recover a lot quicker than being in hospital. I think that it would be homely for them.

3.2.4 Local Services

Location - The NHS is supposed to be fully supporting 'care closer to home' but if there are not enough 'beds with care' near to where someone lives (within 6 miles) they will be have to go much further away, meaning their often frail/elderly loved ones cannot visit especially if public transport is limited. Beds with care and nursing are already provided in the community hospitals. We already have All Hallows, Patrick Stead, Southwold, Northgate, Beccles, Lowestoft. Use the facilities we have.

3.2.5 Don’t Support

Preference - We do not agree with the proposal to provide ‘beds with care’ in a care home environment. (Horrible, ghastly, absurd, unrealistic idea, how dare you suggest such a thing). I prefer a community hospital with trained staff.

Safety - Moving vulnerable patients from hospital to a lower dependency unit often causes relapses (meaning the patient needs to be returned to hospital due to lack of trained staff and equipment) and can even result in death. Many elderly people are left in hospital to die or to vacate their homes by uncaring

families in order that they be placed in care homes in order to free up their houses and or possessions.

Choice - The atmosphere would make me feel worse. It is not appropriate to put a person of working age in a care home.

3.2.6 Staff

Quality - The correct level of staff with correct capabilities must be assured. Care homes send a lot of patients to hospital because they can't catheterise and give IV medication. I believe a trained nurse in the care homes would be a must. There are horror stories about the staff being brutal with OAPs - it frightens me to death! It is unacceptable and appalling, and my fear is that I shall end up with this abysmal service, that is presently being given. They are not paid a living wage.

Qualifications - The staff should be educated and supported to much higher standards, for them to provide the care required at the correct standard and to understand the full implications of potential conditions and co-morbidities of the patients who would be placed in their care even for a limited period of time.

Supply - There are enough staff who have the required training to carry out this care.

3.2.7 Privatisation

Disagree - I think the idea of using private sector nursing and care homes requires very careful consideration. The NHS should not be paying private business for beds. Simply this is privatisation by the back door. Putting clients to be cared for next to "free NHS" people would prove to be controversial. I feel this could lead to a 2-tier service in a care home between permanent residents and those in care beds being differently supported.

Quality - For all the examples of good care in the for profit nursing home and home-caring services there are also gross failures and the motives of the financial backers of these organisations may owe and offer, no respect or duty to anything other than financial returns - and not its clients. There is also the potential for perverse incentives to operate in that the care homes have a financial need to keep their beds fully occupied which might mean patients are encouraged to stay.

Agree - Provided that the company running the residential/nursing home can guarantee to provide adequate number of beds and that they will be NHS funded for the duration of the patients stay.

3.2.8 Finance

Considerations - We support this only if there is adequate funding, considering the following:

- funding for training will be necessary
- insurance facilities will be prohibitive for Private facilities so the NHS will no doubt be encumbered with supporting Private Industry

- there will be no robust audit of standards as the supervision required to cover all arrangements will not be affordable
- there is concern about the on-going costs of paying to keep these beds free until they are neededt
- it should be made clear to patients in the 'beds with care' that these beds are NHS-funded only as long as the patient is assessed as needing this care. If they wish subsequently to stay in the care home, NHS funding will not continue
- faster hospital throughput will not reduce costs
- this may rapidly become more costly than the present hospital solution.

Concerns - I do not like the idea that this is NHS Funded. There will need to be a significant increase in the number of residential and nursing home beds, not clear how or if this would be funded or adequately resourced by April 2016. Presumably the money made by selling off community hospitals will be the money needed to build new facilities.

Management - These would be managed by the GP teams and would have the economies of scale, in terms of basic services, administration etc that have been highlighted as a reason to put these beds in a private care home.

3.2.9 Integration

Services - Full 'nursing' support for this pathway is not sufficient, there needs to be an MDT approach including the GPs, outpatient clinics, the Out of Hospital Team, qualified therapists, family and carers and other services. This emphasises the integrated nature of out of hospital working, offering staff the ability to work flexibly across the system.

Provision - We already work closely with the locals GP’s and would welcome working to provide medical care.

3.2.10 Palliative Care

Provision - There is no specific mention in the document of end of life care. Some people do not wish to die at home - it can place stresses on families, make people feel like a burden, and sometimes it is less of a worry for everyone involved if they know there are the nurses and doctors on hand to look after them. Not clear that this model would be adequately resourced for providing end of life care

Community Hospitals - I have witnessed end of life care in our community hospitals and the care they provide to both patients and relatives is excellent. Care home staff are not trained in working in a palliative role. A care home cannot provide this.

Hospice - End of life should be provided by designated hospice care providing suitable surroundings and trained staff. Seriously unwell or dying patients should have continuity of staffing and care such as provided by Marie Curie.

3.2.11 Timing

Anxieties - Following the consultation meeting many of our anxieties regarding the proposal were explained in more detail and it was good to have the reassurance that NHS funded beds provided locally would continue to be provided until the new nursing home facility is built is built and ready to take admissions.

Volume - Only if the number of "beds with care" is at least equal to the number of proposed beds to be cut from hospitals and an agreement is in place with care homes and new facilities are built and these beds and staff should are in place and any ‘snags’ ironed out before hospitals are closed.

3.2.12 Information

Requested - The following information has been requested:

- an assessment of the current capacity of local nursing and residential homes or the impact upon available bed numbers overall
- evidence that the local care homes have been consulted on their ability to fulfil the function suggested in the proposal
- clarity as to whether the proposed care homes will be built, and/or define where the beds with care will be sourced otherwise
- A more detailed plan on who would provide support in these settings
- care home user payment information
- Lowestoft 'trial' data.
- details of building contracts
- a definition of what is meant by ‘Appropriate facilities’
- Information relating to public transport access to ‘beds with care’
- a description of how the system will work
- reassurance that services and quality will be maintained
- details of how many ‘beds with care’ will be purchased in each area
- commissioning arrangements
- confirmation that the DGH’s will not be the only alternative escalation option for these patients if the number of beds is insufficient to meet demand.

3.2.13 Carers

Needs - Younger carers also need respite. You cannot predict the needs of partners or carers, who may also need somewhere to stay if their family or loved ones are unwell. Families and carers should have a say or choice about where their loved ones will be.

3.2.14 Mental Health

Provision - There is no mention of how this might affect people with mental health conditions. Adequate numbers of beds should be provided for dementia sufferers. Dementia patients could be houses in care homes instead of having to go to Lowestoft, Kirkley, Yarmouth, or Darsham as at present. Beds with care for patients with dementia would need to be in nursing or residential homes that have suitably trained staff not just general nurses or carers. Dementia patients do not need such medical attention. They need help, safety and care for which an old building in adequate.

3.2.15 Satisfaction

Community Hospitals - The NHS level of care in the community hospital has always been exemplary. The regular, day to day brilliant work they do, supporting the care of patients with worsening conditions, rehab for those after surgery, also support in palliative care. I do not think a large part of our community are actually aware of the fantastic work that currently goes on in the community hospitals as they have not been in a position to have needed them yet.

3.2 16 Questions about beds with care.

Would the 'beds with care' also be for EOL/palliative patients?

If not what arrangements will there be for them?

Will the chosen homes be subjected to a more rigorous inspection and quality requirement?

As a patient will I get the same or better care than I would receive in hospital?

What happens if all the beds are occupied?

How will staff be prepared for caring for and monitoring these patients to ensure that acute deterioration is recognised and appropriately acted on promptly?

Why get rid of well-loved services like the community beds?

Are older people with mental health needs able to access ‘beds with care’?

How would younger people manage in care homes?

Would such care be NHS funded or be extra cost to the patient’s family?

Will these beds be means tested?

How many care homes will provide this service?

Who will monitor beds in private care homes?

Is this model based on evidence of one system that works somewhere already?

Is there the capacity in residential/nursing homes to do this?

Where will the necessary staff come from?

Are these homes to be privately run?

Who will administer palliative drugs?

Will care homes be paid to keep a number of beds empty for when these needs arise?

How will you ensure that best care will be provided at a reasonable cost?

Will transport be provided?

How do you resolve issues/disagreements re individuals support by either GP or hub team?

How are these beds to be separated from 'care home' customers?

Will there be a GP on duty 24hr a day?

Will beds always be available close to the patients' homes and relatives?

Are the private sector homes signed up to this, or is it just an aspiration?

How can you ensure that there will always be enough beds available?

Is this the back door to further privatisation?

Who will grade the beds with care standards?

Will the community hospitals stay open until they're built?

Will full nursing support be for 24 hours per home?

What Policy will the care homes be following when looking for the patients that will be in the beds with care?

A patient could have diabetic control issues, heart failure, infection and immobility. Can a residential home really cope with this between visits of the community care team?

Have the aforementioned care homes been consulted on this proposal?

Have the criteria for admission and subsequent discharge or escalation to an acute bed been agreed and shared with clinicians from all providers with an interest?

Is this criteria published?

What is the default position should the beds not be able to be staffed 24/7 or a patient's complex needs cannot be met?

Will the capacity be flexible and able to respond to demand increases at short notice (within hours), specifically in regards to winter planning and escalation?

To enable the Trust to work with its partners to support the multidisciplinary

needs of these patients the locations need to be optimally placed and 'right sized' to make this work. Is the data analysis behind this available to provide assurance that this risk has been evaluated?

How will patient choice be accommodated by the new service?

How will GPs oversee these patients in beds with care if primary care is experiencing significant capacity pressures?

How will continuity of care between other providers and providers of 'beds with care' be ensured, particularly for vulnerable patient groups sensitive to transitional arrangements such as patients with dementia?

How will you ensure staff are well supported, fairly paid and well treated?

3.3 Qu 8 – Community Hubs - Please give your views about this proposal here:

3.3.1 Support

Prevention - Prevention of admission to hospital is a good idea. (I can see the benefit: brilliant idea: excellent proposal: I agree: sounds good: agree in principle: sensible move: wonderful: very much needed: should have been done long ago: a sound idea). A much better way of integrating services - and an opportunity to provide clinics closer to home rather than patients having to travel. These seem to work well. It appears to be an uplift of the Walk in centre – e.g. Castle Mall Norwich and Shrublands, Kirkly Mill and Sole Bay work well. There needs to be more of them.

Demand - Something is needed to prevent the huge numbers attending A&E, often needlessly and the huge wait for a GP appointment, especially for any patient who has problems getting around. The hospital must change to cope with rising numbers and more old age problems. It will take some time for people and especially the elderly to understand the system and learn how to access the combined care and health facility - but it is a good idea and well worth trying. A community hub is now the intelligent and compassionate way to meet the demands of an ageing population. Can meet people and share experiences.

Support - We welcome the idea that a hub is where treatments and consultations take place. We welcome the idea that staff will travel from them to see patients in their own homes. We welcome the intention that hubs will support patients to prevent admission to hospital and support discharge from hospital. Most elderly people would feel less stressed and happier being cared for at home.

Availability - To be of real use a hub must provide more surgery time including weekends and be equipped to deal with minor injuries, x-rays and other services such as eye clinics.

3.3.2 Don’t Support

Disagree - Don’t agree (don’t think so: don’t support: a joke: not a good idea: appalling: not impressed: laughable). If not broken, why try and fix it. Care in the community is not and never will be sufficient to avoid hospital admissions.

Disjointedness - I'm concerned that so many different care institutes are created that patients won't know where to go in the end, and just keep going to GP or A&E. Different nurses going in there home only a couple of times a day will never ever give the care these patients currently receive. These are fine for people who are not seriously ill.

Quality - This sounds like a drop in centre, free for all social club where resources will get abused. I can see it grid-locked with mobility scooters where dressing changes will be favourite and people with mental health issues will be looking for a friendly ear. Once again, this community hub will end up like all of these so called new establishments, based on staff – not patients, the public end up with an unacceptable service, and when it fails to produce the goods, we revert back to the old system, whilst in the process - an enormous amount of money has been wasted. If you want to provide a "hub", use what facilities you already have available. Enhance these facilities and offer a "modern environment for patient care".

3.3.3 Services

Provision - This model can only benefit the staff and patient groups alike, by way of allowing improved communication, true multidisciplinary working and therefore an improved effectiveness and efficiency of community work forces. May be a good idea if it is properly organised and all agencies really do work together to provide a good service and of course that appointments are easily available when needed.

Coordination - Currently admission prevention, community matrons, district nurses and therapists all doing a great job but not coordinated together. As long as there is support for mental health issues too which again is not mentioned. There is a potential here for massive, continuous conflict and confusion over who does what and when and why that may well not provide good medical outcomes. It would appear that perhaps there are too many layers of management and administration requirements in the NHS. I think what is needed is one number, where an operator can put you through to who you need.

Additional - It would be better if these hubs had beds and minor injuries unit. Would recommend these aren't stand alone, new building: instead be co-located with GP surgeries. Hubs sound like a good idea as an additional facility to existing community hospitals. With an ageing population it is essential to keep community hospitals open - more services are needed, not fewer. These hospitals are also invaluable in the case of epidemics and pandemics it is also not usual for major hospitals to be closed with infection. Retain community hospitals.

3.3.4 Location

Accessibility - The number of hubs will be crucial to the success of the concept and give confidence to patients who will want there be one near them. There should be enough community hubs so that no-one has to travel a long way to get to the nearest one. Community hubs in a number of local areas, as shown on Page 5, seem a good idea as they are so locally convenient. Also ensure that there are regular bus services. Wherever the hubs are based they will not be truly local to all patients. Hubs are needed on both sides of the river. I would also like to point out that there does not appear to be any mention of Bungay, nor of which community hub would cover the Bungay area. All Hallows Hospital already meets the needs as described in the proposal and serves Bungay district well.

Logistics - Hubs can be located in existing unused buildings. Transport needs considering.

3.3.5 Staff

Considerations - This has the potential to provide better continuity of care as long as it can be staffed without too much use of agency staff - GPs and Nurses. Doctors are already over stretched and over stressed, and are difficult to find owing to a shortage, through lack of spending and training. The demands of knowledge, business and keeping up with new developments are blinding recruitment. Whilst there has to be a degree of flexibility of staff, the same core group should be retained wherever possible. However there ultimate success may depend on the quality of skills of the staff and their ability to work as a team. There does need to be a lead person/ organisation in each hub to oversee the general building day-to-day business otherwise each team tends to continue as separate entities.

Travel - Travelling to patients will take a lot of extra time for staff and overall cut down on time spent on actual patient care. In closing the community hospitals it doesn't follow that all of the staff presently employed would want to transfer to the new out of hospital teams.

3.3.6 Finance

Funding - Community hubs sound good but there is a need to ensure adequate funding. This is good, as it will save money. Money could be saved by streamlining organisations and reducing bureaucracy.

Economy - You propose shutting already availably facilities and spending millions on building another building. Can it really be cost effective? All we hear about is no money in NHS. The value of such assets must remain within their communities and not transferred to private providers.

Priority - Sadly I feel this consultation is driven more by the need to save money than what is in the best interests of patients and the local community. It seems you'll be spending an awful lot on something, which in the long run does not benefit the patients at all.

Investment - Put more doctors and nurses into surgeries. We already have the 'hub' in place!! Stop wasting money.

3.3.7 Service Quality

Standards - Any systems to join up care can only be a good thing, however I feel there appears to be a distinct lack of knowledge and understanding as to the level of care required. I support this on the basis the care is of the same NHS standard. And also that you get the care when you need it. This will work as long as there is a commitment to good communication and as long as workers have enough time to get from place to place and devote adequate hours to the patient and their carers.

Experience - I have heard negative comments regarding quality of services at Kirkley Mill and that Sole Bay is largely empty. At Reydon Health Centre you still have to wait 3 weeks before you can get to see your own Doctor. This would be positive if it also means that waiting times for an appointment with GPs would be reduced. It would be better to re-start the twilight service.

Concerns - Staff will be overworked and stressed. Mistakes will be made. As a trained nurse I always respected the older person. I don't see this today! A lot of nurses seem quite heartless. In my experience care in the community often means poorly qualified, poorly paid, often young, inexperienced staff employed by private agencies. Staff will/may have difficulty establishing trusting relationships with patients/clients - and their relatives.

3.3.8 Access

Transport - I like the idea of community hubs, but they need to be well placed and easily accessible for all age groups. They must have good road network capabilities and the ability to be able to park for free is a must. Also, they must be close to bus routes, as for some people, this is their only mode of transport. Thought needs to be given to how sick people will travel to these hubs particularly those without transport or mobility problems, and how the service will remain accessible to vulnerable groups ensuring there is no discrimination of access. The community hub in my area is very inaccessible for patients that are deaf/hard of hearing.

Location - I believe a hub within the All Hallows Hospital would be a good idea as its central to Bungay and their surrounding villages. For the people of Southwold, the Sole Bay Health Centre has taken care further away from their homes. Thought we had this at the one time at Northgate hospital. My family and I have had good care from Beccles Health Centre in the 24 years we have lived in the town. People in North Lowestoft find it hard to get to Kirkley Mill Centre. It is important that the Yarmouth Hub use buildings in Yarmouth itself.

Contact - Experience of myself and those around me is that service such as NHS Direct/111 is of very limited value, as in most cases they say "go and see your GP" or "go to A&E". I'm concerned that the community hubs will be a similar intermediate layer which delays access to medical staff. Older people often find it difficult to cope with new technology and a time is wasted on people not knowing where or when to go. My GPs surgery is based in a

community hub and I can never get an appointment with them. Time factor is important here, how much time allotted to each patient. No point visiting if the patient's needs are not fully met.

3.3.9 Information

Requested - More information is needed on the following:

- opening hours and days the Hubs would be open
- hub locations and proximity to public transport
- what range of services are envisaged.
- an indication of the benefits over what is already in place (i.e. the difference between a Hub and a surgery)
- Information about the scope and ability of the teams
- which services will remain in community hospitals
- evidence that this will work
- evidence of hard planning of the scheme (including planning permission, lead time, construction time frames)
- plans for monitoring/quality assuring the service
- details of the costs of building and patient and staff transport (including savings)

3.3.10 Timing

Sequence - Certainly no closure should even be considered without every new Hub being up and running and proven to work. If there is a gap between the closure of existing services and the opening of the new, this proposal will be totally unacceptable.

Concerns - I cannot see any hope of much development by 2016 (2017, 2018). Planning and construction lead in times need to be considered and the full implementation plans produced for public consideration.

3.3.11 Consultation

Concerns - I really do not understand why this has been put up for the public consultation. The end result will not be or have any reflection on any comments or public view. Seems you have already made up your minds what will be happening, so why spend all this time and money sending out these glossy surveys at great cost!

Questions - This survey only gives answers to the questions you want us to have. There is no box provided to address relevant issues, which are not directly involved in these proposals. No freepost address was provided to return this form.

Availability - We are told ' it's all on the web' however, many oldies have no access, or means, to the web. There was no public meeting in Lowestoft

3.3.12 Carers

Provision - There are not enough beds available for respite care in care homes at present - a particular issue for people living with dementia and their carers who desperately need a break to continue in their caring role. This definitely needs to be addressed along with your proposals.

Health - Often patients have to rely on an elderly partner for support - who then gets ill themselves because of all stress etc caring for someone at a time in their life when they should be able to rest and be happy.

Reliance - Carers will end up bearing the brunt of care for patients - this is grossly unfair and it should not be left to "carers" to look after patients in inappropriate settings. I am lucky I have family near, but they cannot be with me every day and night if needed. Care must be taken not to burden family members/carers beyond reasonable levels.

3.3.13 Mental Health

Support - This service will be much better for those who have early staged of Dementia. To be supported at home is very important as going into hospital can be upsetting and strange if you have dementia like me.

Provision - The Mental Health services have been dramatically reduced and I am concerned that this aspect of health provision will not be adequate for the needs of the population.

3.3.14 Voluntary Sector

Involvement - Yes I like the idea of flexible, holistic centres where the voluntary sector would contribute. Community based hubs will only work efficiently if friends and relatives worked alongside them and this is not always possible. Charities will be expected to take a greater role (but hopefully not in place of the NHS). I would like to see more involvement of local, voluntary groups in these hubs, like Suffolk, DIAL.

3.3.15 Questions about Community Hubs

To what extent would these services meet the government's new proposals for seven day services?

Why not integrate these facilities into the existing hospitals?

The majority of patients would not choose to be admitted in a care home so what happens to choice then?

Where are these hubs going to be located?

How do Hubs differ from surgeries?

Is the GP shortage addressed by these proposals?

Is this really a viable alternative to closing hospitals if the aim of the closures is to reduce costs and improve patient care?

Who will pick up the increased costs of transporting patients to/from the "hubs"?

Has the safety of the staff visiting patient homes been taken into account?

Will the carers be qualified?

What happens if these trials fail for any reason?

With reference to Lowestoft are there any plans for a centre in the north of the town?

Has the size of the area been taken into consideration regarding travel time?

Who bears the cost of the transport involved?

Will gynaecology out patients appointments be available in Reydon?

If more beds are taken in care homes for out of hospital care, does this mean there will be even fewer respite beds?

What transport would be available to out-patients with limited mobility and no public transport access direct to the hub? And what about evening visits when buses finish by 6pm?

Why not train volunteer support workers to work alongside professionals?

Where are the staff?

Why should people from Bungay have to travel to Beccles and the reverse?

Where is the provision for older people's mental health?

Where will the community hub be closest to Hemsby?

Can we see a trained member of staff each day when necessary?

Will these hubs work?

What will the future be for the Patrick Stead building?

Why spend money on something new when the current system works?

Where do the services offered locally in GP Practices fit into this new model of provision?

Has any consideration been made in converting the existing hospital sites into community hubs?

Will the time frames for GP appointments improve?

Will the nursing care beds really be available to work next to the community hub?

Has any study been done on where people prefer to die?

What situations will home visits cover?

Will future cost of services for support at home ever be a consideration?

How have you determined the number of beds outside of the home you need?

If you live in Lowestoft will you always use the Lowestoft hub e.g. if you work in Halesworth could you go to that hub for services?

Are the out of hospital team working in the hub, in people's homes or both?

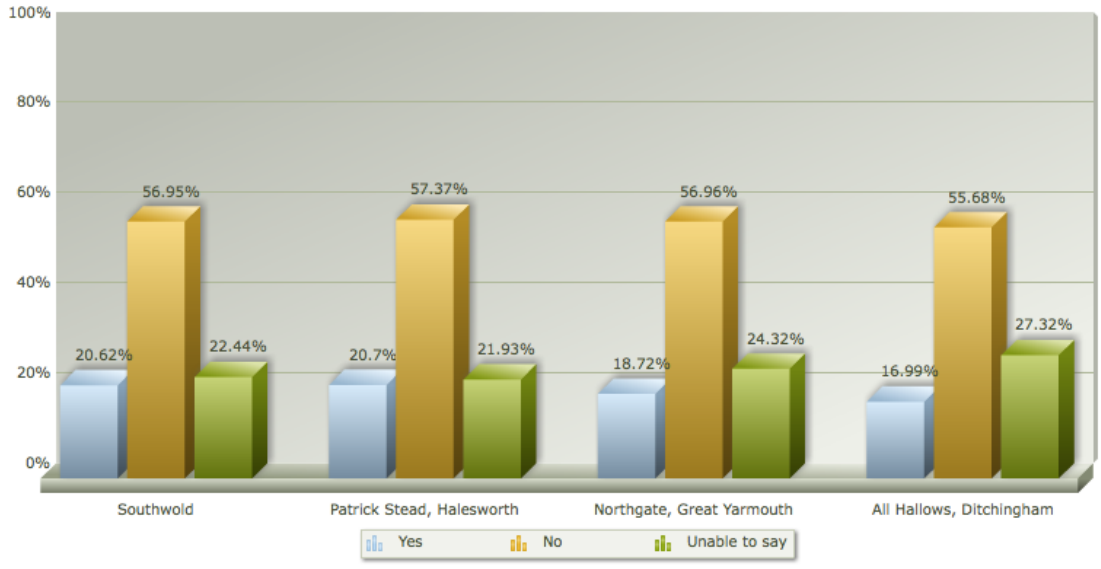
Can people walk in off the street to ask about healthcare?

Will this mean district nurses will no longer be assigned to GP Practices and then loose the GP contact?

How is this proposal going to help elderly people who end up in hospital after a fall, and then need rehabilitation?

4 Proposal 2: Community Hospitals

4.1 Qu 9 & 10. Do you agree with the proposal to permanently close GP hospital beds at the following hospitals with the introduction of the Out of Hospital teams?



4.1.1 Southwold – Comments

4.1.1.1 Services

Needed - Southwold hospital is still needed in the community. Don't close it. Community hospitals are expected to play a key role in the new care models proposed in the Five Year Forward View (NHS England, 2014). People thrive better when they get to come back to Southwold hospital near their home,

family and friends. Distances are considerable and road links poor. Patients recover more quickly in the cottage hospitals. Patients feel safe, they know they have help when they need it, nursing and equipment facilities, they have a caring supportive environment. There is no GP within "out of hospital teams". The proposed Hub could include Southwold Hospital.

Preference - The idea of closing community hospitals in favour of funded beds is frankly alarming, (a total travesty, ludicrous, disastrous, shocking, short sighted, massive opposition to this, it will be missed, worrying, disgraceful, madness).

Uses - Since Lowestoft hospital closed Southwold hospital has had to be used for Lowestoft patients. It is a valuable resource (has fabulous facilities: is vital: needed: essential: a respected and helpful local resource, bastion of good practice, valuable, excellent, important lifeline, a great loss). I have also known many many people who spent their last days here. Hospitals struggle immensely to get patients out of the acute ward into a community rehab bed. Some patients are seen as medically fit to leave the acute hospital but are not ready to go home and only rely on an out of hospital team visiting. We need this in between service. Closing these beds would continue the 'bed blocking' situation we have in our acute hospitals. Beccles Hospital would not be able to cope with the number of patients who need these beds. There is a huge elderly population served by this hospital. There is a lack of care homes in this area.

Not needed - This is a much smaller population than Lowestoft who have managed with 5 beds with care and out of hospital teams allowing patients to remain at home - so it is not needed. Most patients seem to be admitted to JPH, N&N anyway. Looks like it is redundant by the provision of the Sole Bay HC. Close to Beccles so community can use beds there. Needs to be closed as it is an old building. I think the treatment given at this hospital could be given in the patient's own home as there is no full time doctor at the hospital so see no point in keeping it. I would not choose to go there now. It is never full. An un-needed hospital that no longer fits its original purpose.

Closed - From discussion, it would appear that this has closed in all reality.

4.1.1.2 Timing

Timing - Should not be closed before the new nursing home next to Sole Bay health centre is in place and ready to take over with immediate effect and the Hubs are up and running. You must define where the "beds with care" will be based before closure. Seems ridiculous to consider closing the beds before adequate care home beds are available. We would be concerned that this would have an adverse effect through increasing demand on other local services.

4.1.1.3 Care Quality

Care - This hospital works well. I have had experience of this from a personal level. I cannot fault that care which takes place here in a calm atmosphere with kind support and help from both staff and fellow patients. The local team

are fantastic and well thought of. The staff were very good and the food was excellent. I was also impressed by the level of cleanliness. Everyone loves this facility and it is well known. No private care could match the care supported by this hospital.

Reassurances - As long as the care is appropriate within their community or home. Not sure that 'private nursing homes' will be able to provide the service expected of in hospital. They need to be staffed by NHS nurses, not poorly paid contractor staff. This scheme would need good quality caring people to operate it.

Beds - Not convinced that the closure of 44 existing intermediate care beds can be effectively replaced by the proposed new service models without putting extra pressure on the acute hospitals leading to more older frail people being admitted through the acute system, with potentially worse outcomes.

4.1.1.4 Travel

Transport - To work the availability of transport must be considered. Many old people are not allowed to drive. Southwold is an isolated seaside town away from Beccles/Lowestoft/JPUH. The Trust needs to be mindful that travelling to the JPH from Southwold takes nearly two hours by public transport or 1 hour by car in peak times and is not much quicker outside peak time. Winter brings its own challenges. No power, no phone, never a mobile signal, with dangerous snow and ice-covered roads. Many roads become impassable. You would be asking a lot of other people to risk their lives on dangerous roads.

4.1.1.5 Buildings

Age - Lovely building but old and probably does not meet modern clinical needs. Now in the wrong location. This facility has history, but is not viable any longer. It is the fault of previous PCTs/CCGs that this hospital is not fit for purpose as it stands.

Uses - The building could be converted to a hub or outpatient facility. This is a useful an easily accessible pleasantly located site.

4.1.1.6 Support

Rationale - GP and community services seem good and I can imagine the proposal might work. Southwold, it seems, now has a population of a littler more than 800 residents, a small village by today's figures: how can the few people against closure justify their argument. The Southwold Hospital should be closed as soon as possible and the financial gain put to good use. This makes best use of the limited services available and financial resources. I also know many people often get secondary problems when hospitalised, so keeping older people out seems a good idea.

Advantages - Not cost effective to run small hospital. Most people think of hospitals as having doctors and operating theatres etc. This is not able to be provided at such small places. Services can be provided through Hubs. If the beds provided are of a high standard and suit the patients who use them then that could be a big improvement.

4.1.1.7 Information

Needs - The following information is requested:

- details of the outline planning permission for the care home on the site next to the Sole Bay Health Centre, (I believe it has expired).
- details of how you are going to ensure the quality of care
- the capacity of the local nursing/care homes
- a feasibility assessment to show this is practical, achievable, affordable or desirable
- current figures showing bed use compared with capacity.
- details of the most recent bed use audits
- details of how the new out of hospital teams will maximise the experience and expertise available
- an audit of the current acute hospital beds to determine the number of people who would have been better placed in both the current and proposed models of service, to identify the capacity required to best serve local people
- sight of the transitional plan for the service models and the implementation plan for the closures to understand the timing of the future closures and the impact of this on the Trust and the health system, specifically during peak seasonal periods
- information regarding the sites future after any closure takes place.

4.1.1.8 Palliative Care

Considerations - For those needing end of life care, and who do not wish to die at home, the community hospitals provide expert staff, in a location close to home. There is concern about where this will be provided in future. Closing this hospital reduces options for patients and for them to make decisions that are right for them at a specific time.

4.1.1.9 Carers

Support - Respite care is also needed. Hospice care needs to continue to support families. I think too much pressure will be put on families to care for elderly and frail patients. These community beds provide a lifeline for family carers, who are often under intense pressure. They give these carers a breathing space whilst their relative recover, which then allows them to recover themselves and continue to care for their relative again at home. Respite care and day centre places are extremely difficult, if not impossible to find and the CCG and ECCH need to put some thought into providing these much needed facilities as well as 'beds with care'. Without the support of these informal carers many more people would have to be admitted to care homes permanently.

4.1.1.10 Finance

Concerns - I personally believe this is a pure cost cutting measure. If decisions are being based on the principle, then it is a fallacy. Your proposals are not contingent on closing all the hospitals and you would still make a "profit" if Southwold stays open.

Costs -The big issue is beds in a community hospital are free - beds in a designated nursing/care home are not! This new attempt to replace hospital beds with home visits could actually be much more expensive.

Disposal - The Southwold Hospital site was advertised for sale with a Southwold Estate Agency in June - before even the first public meeting was held. There has been a hospital at Southwold since 1897 and it is not clear if the NHS would be able to sell it anyway, as various non-NHS organisations are involved in the ownership of the land, covenants, buildings and contents - the research into and resolution of which would doubtless involve lengthy timescales, as well as significant legal costs, which have not been factored into your costs section.

Savings - So far as cost cutting is concerned, the NHS could save millions, simply by such easy housekeeping solutions, for example,

- charging foreign health tourists using NHS services
- employing NHS staff instead of agency personnel
- not retiring NHS staff on pensions in excess of double the average wage, only to appoint them (e.g. chairmen of commissioning groups), the very next day.

4.1.1.11 Mental Health

Provision - I am very sorry to witness the closure of this hospital as I received the best care - it is ideal for housing dementia patients there is concern about adequate mental health provision.

4.1.1.12 Questions about the proposals to close Southwold Hospital

How many teams in a scattered rural area will be required to cover 40 'at home' patients?

If April 2016 is not your target for start-up why mention any date at all?

How can closing hospitals/cutting the number of hospital beds be a sensible plan for the future when the population is already increasing?

What will happen to Southwold Hospital after it is sold? What will happen to the buildings? Who owns them?

Why change a good, popular working system?

Why scrap an area of such excellence?

What guarantee do we have that a care home will be built in Reydon?

As part of the review has an assessment been undertaken to evaluate whether currently people are being both inappropriately admitted and staying longer than they should in the acute hospital?

Is the CCG able to provide assurance to the DGH's that they will not be the only alternative capacity available for patients should the community 'run out of beds'?

4.1.2 Patrick Stead, Halesworth comments

4.1.2.1 Services

Needed - This hospital is needed – don't close it. The arguments to close it ignore the successful work done by our Patrick Stead Hospital in bridging the gap between the care patients need in District General Hospitals (DGHs) and the partial supervision when they go home. Patients who are unable to find beds in local hospitals block beds in DGHs. These people, also often elderly or disabled, sometimes living alone or in isolation, need constant nursing and monitoring, but not as intensively as in a DGH. These beds are needed by the community.

Advantages - Patients recover more quickly in the cottage hospitals. Patients feel safe, they know they have help when they need it, nursing and equipment facilities, they have a caring supportive environment. This is a much loved hospital which gives all kinds of support to its town. I believe all beds are in demand. Another well used facility, not just for the elderly, but for all, it is local, a pleasant environment and right next to the doctors. What it means in terms of health and security to the local community should not be underestimated. There is a shortage of places in Suffolk care homes at this moment in time.

Location - Local hospitals are vital in outlying communities, particularly where transport is an issue, not only for patients but for the social support they get from their family and friends

Not needed - There are enough community beds in the Suffolk area. Most patients seem to be admitted to JPH, N&N anyway. Most people think of hospitals as having doctors and operating theatres etc. This is not provided at such small places. Turn these hospitals into care homes. This hospital is not fit for purpose. It is never full, extremely old and a cost burden on the NHS.

4.1.2.2 Timing

Sequence - We would only be happy to see Patrick Stead hospital close when the new facility planned alongside Cutlers Hill Surgery is built and fully functioning providing at least the same levels of qualified care that we get at present. Do not close PSH until beds are available at the new nursing/care home due to be built on Dairy Hill. Qualified staff are required to give the same level of care already provided. Also other things i.e. blood testing, clinics etc. must be maintained at the same level either at local GPs or new care/nursing home (mutatis mutandis).

Concerns - I doubt if the local nursing/care homes could provide an extra 12 beds. A new nursing home is vital before closure. As no planned permission has yet been applied for I think the closure in 2016 is ridiculous.

4.1.2.3 Support

Agree - Sensible, if you have Hubs. The Beccles Hospital care facility would be a suitable replacement together with OOH teams. The Hospital is too small to be cost effective. It only serves a very small population and is not accessible for all. It is in an awkward location - miles away from most patients. As a new nursing home is being built, GP beds won't be needed.

Advantages - Patrick Stead is expensive and the resources spent would be better utilised in the community. Patrick Stead is at the heart of the southern Waveney catchment area and has good public transport from Southwold. It should be replaced by an enlarged new-build facility (as part of the Halesworth Campus) to cater for Southwold as well as the Halesworth catchment. I also know many people often get secondary problems when hospitalised, so keeping older people out seems a good idea.

4.1.2.4 Building

Age - Lovely building but old and probably does not meet modern clinical needs. Maintaining this hospital will not be cost effective. It is an out of date facility and not viable any longer. I agree that PS is not fit for purpose so we will need new premises to cope with ageing population.

Use - It seems very unfortunate that better use has not been made of these hospitals to ease the 'bed blocking' pressure at JPH. The hospital could be converted to flats for NHS staff when no longer needed. Also perhaps the hospital could have become a community hub instead of the necessity to build expensive buildings for the purpose.

4.1.2.5 Care Quality

Satisfied - Well thought of by local people - we know what a vital support this has been. It is a well-known and very useful service and site. This hospital has met local needs for many years and its closure would leave a huge gap in the care provided locally. I have been a patient in this hospital and received excellent treatment and care on all occasions. It is better than many care homes.

Integration - We need integrated services according to the needs of the individual patient. The nearest and dearest to this client group are more likely to be elderly with associated needs. Out of hospital teams must be easily available. We fear that its replacement will lead to worse treatment.

4.1.2.6 Travel

Difficulties - To work the availability of transport must be considered. Many old people are not allowed to drive. Having a local convalescent hospital makes visiting easier. Halesworth is also too far from the suggested hubs and a long way to the main hospitals. Transport facilities are appalling in this area. We are at the extremity of the CCG area.

Staff - The staff might well have difficulty travelling the greater distances involved with working out in the community and are reliant on having transport

to get them out to people's homes. Although there is a rail connection at Halesworth this would not help staff to get to the patients in the rural areas.

4.1.2.7 Finance

Concerns - I personally believe this is a pure cost cutting measure. Concerned that any money made from the sale would go into the black hole of the NHS. Money should be spent locally: our needs are different from towns/cities. We are a rural area and health care is more costly as more time is needed to cover distances involved for the Health teams. Don't believe what you are proposing will work or be cost effective in rural areas - it will end up being expensive. A lot of money has just been spent to reopen the unit.

4.1.2.8 Information

Needs - The following information is requested:

- a feasibility assessment to show this is practical, achievable, affordable or desirable
- current figures showing bed use compared with capacity
- details of the most recent bed use audits
- details of how the new out of hospital teams will maximise the experience and expertise available
- an audit of the current acute hospital beds to determine the number of people who would have been better placed in both the current and proposed models of service, to identify the capacity required to best serve local people
- sight of the transitional plan for the service models and the implementation plan for the closures to understand the timing of the future closures and the impact of this on the Trust and the health system, specifically during peak seasonal periods
- information regarding the sites future after any closure takes place
- The future of the other units in the hospital grounds
- sight of the transitional plan for the service models and the implementation plan for the closures to understand the timing of the future closures and the impact of this on the Trust and the health system, specifically during peak seasonal periods.

4.1.2.9 Palliative Care

Considerations - Allowance should be made for end of life care in a non-acute environment. This proposal reduces options for patients and for them to make decisions that are right for them at a specific time. Not everyone wants to die at home or in DG people need a choice! One large hospice facility should be built.

4.1.2.10 Carers

Needs - Respite care is needed. Hospice care needs to continue to support families.

4.1.2.11 Mental Health

Needs - Consider mental health provision

4.1.2.12 Questions about the proposal to close Patrick Stead

Why has this hospital not allowed to fill all fourteen beds when staffing levels are adequate?

What happens to the beds until the new home is up & running?

Why change a good, popular working system?

Where will the other services e.g. Phlebotomy operating out of Partick Stead be housed post April 2016?

What provision will be made for minor injuries?

Where is the nearest hospital bed or care home?

What's happening to the building when it's finished?

Where are all these professionals going to be recruited from and how many will be needed to cover the Halesworth area as well as all the other areas?

Will Southwold patients be able to access these beds too?

If PSH is sold what will happen to the cash?

Where is the local evidence for Halesworth to show that with out of hospital teams, the best place to care for people is at home?

Have the logistics of the demands and costs of travel time for medical and social care provided in people's own homes in rural areas around Halesworth, with extending life spans and increase in multiple diagnoses, along with a doubling of the elderly population, been properly taken into consideration?

Is the CCG able to provide assurance that the DGH's will not be the only alternative capacity available for patients should the community 'run out of beds'?

4.1.3 Northgate, Great Yarmouth Comments

4.1.3.1 Services

Needed - The hospital is needed – don't close it. It is the only place in the local area offering respite and (essential, important, vital, necessary, useful, accessible, irreplaceable, amazing, brilliant) care to patients and the relatives who support them. This is a much needed service in Great Yarmouth, especially those who live alone. We will be putting patients at risk if we closed them. Closing these beds would have a disastrous (shocking, short sighted) affect and continue the 'bed blocking' situation we have in our acute hospitals. The only community hospital this side of the water - with constant full beds, a waiting list, A1 modern equipment and facilities in a large building. We must also keep the GP unit at Northgate open – there will be an outcry if you close

it. The beds at Northgate could be used as an intermediate care facility for people in this area.

Advantages - Patients recover more quickly in the cottage hospitals. They feel safe, they know they have help when they need it, nursing and equipment facilities and a caring supportive environment.

Not needed - This one must go. Most patients seem to be admitted to JPH, N&N anyway. Most people think of hospitals as having doctors and operating theatres etc. This is not provided at such small places. Northgate is the place they take the elderly to die. Local enough to JPH not to be as significant. I was not provided with access to this when I need it anyway.

4.1.3 2 Care Quality

Satisfied - Provides excellent (essential, amazing, irreplaceable, fantastic, very good, wonderful, vital) care. Staff are highly trained, dedicated, wonderful and compassionate. Northgate is an outstanding and well-loved community hospital. A bastion of good practice.

Concerns - The service the OOH team has been providing in GY is chaotic with clearly under skilled staff: there are no clear pathways for referrals and Northgate has had many patients that they could not manage even though they have been simple. The staff I encountered lacked caring skills and I would not like to see them working unsupervised in the community. A poorly run ward, poor care given and dreadful food.

4.1.3.3 Timing

Sequencing - Might be more sensible to phase out the beds over a few years and certainly not to close any before other services are in place. Hopefully, the beds in care homes, a new nursing home, OHT and alternative arrangements will be available and up and running before closure.

4.1.3.4 Support

Not needed - This hospital is uneconomical and it would be sensible and necessary to eventually close it. Beds are rarely available when needed. They are wasted with patients using them as a rest for 2 weeks at a time: this is a dreadful waste of NHS money and bed space when desperate patients need them more.

Services - The beds with care option should be more flexible. And patients will be more effectively served by out of hospital teams. Great Yarmouth has an accessible hospital in James Paget.

Advantages - I also know many people often get secondary problems when hospitalised, so keeping older people out seems a good idea. A care home would be less traumatic.

4.1.3.4 Travel

Concerns - Northgate serves a very deprived area where incomes are severely restricted, making transport difficult. To work the availability of transport must be considered. People would not be keen to be transported all the way to Beccles - difficult for relatives to get to/from here. Many old people are not allowed to drive. Having a local convalescent hospital makes visiting easier. This Hospital is located in a very central area.

4.1.3.5 Building

Age - I realise they are old buildings and likely to need to be replaced and refurbishment is necessary and to do so may will not be cost effective. Outdated facilities - not viable any longer. It seems very unfortunate that better use has not been made of these hospitals.

4.1.3 6. Staff

Concerns - My experience of Northgate is one of lack of staff especially qualified staff. Might envisage difficulties recruiting to an out of hospital team based in GY / Gorleston (like community matron recruitment for example), staff generally want to work in more affluent areas. Not enough qualified people in care and nursing homes. Better in one place so nurses and doctors do not have to waste their time travelling.

4.1.3.7 Mental Health

Considerations - This is the only hospital in the north that would make mental health beds unviable. Northgate hospital needs to be closed so the Northgate site can be used for other purposes like mental health. Mental health services beds should be maintained/increased, the area needs it - there is a huge gap. This is a great hospital for mental health patients.

4.1.3 8 Finance

Concerns - This has had an enormous amount of money spent on upgrading the ward. I personally believe this is a pure cost cutting measure. You may need to save or budget but I don't think there is any consideration for the emotional needs of the patients, carers and extended family or friends at the time they most need it.

4.1.3.9 Care Beds

Locations - You need to consider where beds with care will be. I would not want to have to go to Beccles for intermediate care if needed. I'd rather be close to family in Gt Yarmouth. We need something each side of bridge.

4.1.3.10 Palliative Care

Considerations - Northgate hospital has a completely different patient type to SW and PSH hospital, especially the palliative patients. They work very closely with the Macmillian team and receive a large number of referrals from them. They have a reputation of providing fantastic end of life care. This service is needed in the area as many patients do not want to die at home (even though they may initially say they do), their families cannot manage them at home or they do not want to die in the acute hospital. This means there is nowhere else

for these patients to go. I feel that as there are no other end of life facilities or hospices in the area this should not be closed.

4.1.3.11 Information

Needs - The following information is requested:

- a feasibility assessment to show this is practical, achievable, affordable or desirable
- current figures showing bed use compared with capacity.
- details of the most recent bed use audits
- an audit of the current acute hospital beds to determine the number of people who would have been better placed in both the current and proposed models of service, to identify the capacity required to best serve local people
- sight of the transitional plan for the service models and the implementation plan for the closures to understand the timing of the future closures and the impact of this on the Trust and the health system, specifically during peak seasonal periods.
- information regarding the sites future after any closure takes place
- sight of the transitional plan for the service models and the implementation plan for the closures to understand the timing of the future closures and the impact of this on the Trust and the health system, specifically during peak seasonal periods.

4.1.3.12 Questions about the proposal to close beds at Northgate Hospital.

What will happen to the buildings?

Why close a successful hospital?

If you close this hospital does this mean these patients will have to go to Beccles?

How will elderly relatives access Beccles from Northern Villages and Gt Yarmouth?

Is the CCG able to provide assurance that the DGH's will not be the only alternative capacity available for patients should the community 'run out of beds'?

4.1.4 All Hallows, Ditchingham - Comments

4.1.4.1 Services

Needed - This hospital is needed (respected, helpful, excellent, lovely place, much used, well known, well run, precious, vulnerable) – don't close it. There is still a religious element at the hospital which serves people well. The environment is very peaceful. It is needed by the residents of this area, especially those who live alone. For some people it is their nearest hospital. This reduces the pressure on other local and acute services. It provides local employment and serves the community.

Advantages - You do not have to pay for its upkeep. It has served the local population for over 100 years and it is an amazing facility. I think you should continue to support the GP beds there as they have so much more to offer than a nursing or residential home.

Securing services - The closure of beds undermines the viability of other hospital services (Specialist Continuing Care, outpatients, meals on wheels, physiotherapy, care in homes, plans for the Dementia unit). Stroke victims end up here, as do cancer patients. It provides valuable end of life care for all ages. It has excellent equipment and day care facilities.

Choice - Patients recover more quickly in the cottage hospitals. Patients feel safe: they know they have help when they need it, nursing and equipment facilities and a caring supportive environment.

Not needed - Most patients seem to be admitted to JPH, N&N anyway. Most people think of hospitals as having doctors and operating theatres etc. This is not provided in such small places. The number of beds here is too small-better to have those beds elsewhere.

4.1.4.2 Care Quality

Satisfied - I know people who have had relatives here and couldn't praise it enough – it is exemplary, (excellent, vital, top quality) and well respected: the best in the area. This has always had a lot of local and voluntary support by faith and community groups. There is a religious aspect, which is lacking elsewhere, but the psycho-spiritual benefits should be available to those who need them. Fabulous respite and end of life care.

4.1.4.3 Support

Not needed - Support the closure. Sensible - too small and too few beds to be economically viable. Is close to Beccles so patients could go there instead. The Beccles Hospital care facility would be a suitable replacement together with OOH teams. Patients will be more effectively served by out of hospital teams. I also know many people often get secondary problems when hospitalised, so keeping older people out seems a good idea.

4.1.4.4 Timing

Sequencing - Only close if alternative beds, nursing homes, beds with care, OHT and other services are available and up and running locally before closure.

4.1.4.5 Information

Needs - The following information is requested:

- clarity on what is proposed and the quality of care you are going to offer.
- a feasibility assessment to show this is practical, achievable, affordable or desirable
- current figures showing bed use compared with capacity
- details of the most recent bed use audits
- an audit of the current acute hospital beds to determine the number of people who would have been better placed in both the current and

proposed models of service, to identify the capacity required to best serve local people
- sight of the transitional plan for the service models and the implementation plan for the closures to understand the timing of the future closures and the impact of this on the Trust and the health system, specifically during peak seasonal periods.
- information regarding the sites future after any closure takes place
- sight of the transitional plan for the service models and the implementation plan for the closures to understand the timing of the future closures and the impact of this on the Trust and the health system, specifically during peak seasonal periods.

4.1.4.6 Travel

Difficulties - To work the availability of transport must be considered. Many old people are not allowed to drive. Having a local convalescent hospital makes visiting easier. Beccles is too far for family to visit and it is a long way to main hospitals and there are such few transport links. Patients need some community beds close to their homes. Distances are considerable and road links poor

4.1.4.7 Building

Age - These are old buildings and likely to need to be replaced. They are not viable any longer and are not cost effective. Not fit for purpose to NHS standard.

Use - It seems very unfortunate that better use has not been made of these hospitals to ease the 'bed blocking' pressure at JPH. Consider using these hospitals as community hubs or care homes.

4.1.4.8 Finance

Concerns - AHH is not an NHS hospital and so you cannot close it. These beds are purchased from this provider. I personally believe this is a pure cost cutting measure. You may need to save or budget but I don't think there is any consideration for the emotional needs of the patients, carers and extended family or friends at the time they most need it.

4.1.4.9 Location

Choice - I am not sure if geographically this is the right approach. All Hallows would make a better 'intermediary care' environment than Beccles - quieter and with better grounds - but would need to be enlarged and incorporate some form of adequate local transport to and from Beccles (which also has the advantage of being on a railway line).

Access - Only if there is adequate re-provision of beds in an accessible location for Bungay patients. Medical care is needed at Bungay and Ditchingham

4.1.4.10 Palliative Care

Considerations - This is particularly relevant in palliative care. No Beccles GPs want to be in a situation of admitting people at the end of their lives to JPUH or NNUH because Beccles Hospital is full of complex medical cases and there is no space for the dying. Hospice care and beds seem essential. Always a calm, reassuring, caring environment. Not perfect - but no-where is.

4.1.4.11 Questions about withdrawing funding for beds at All Hallows Hospital

I presume we will still purchase Nursing home beds with care from all Hallows?

Would this make the nursing home less viable?

Do they share staff or services?

Where is the nearest hospital bed or care home?

Again, why scrap an area of such excellence?

Will this be a beds with care location?
Is the CCG able to provide assurance that the DGH's will not be the only alternative capacity available for patients should the community 'run out of beds'?

4.2 Qu 11. We propose to change the use of Beccles Hospital inpatient beds. Please give your views on this proposal here:

4.2.1 Support

Advantages - I support this excellent (fantastic, great, reasonable, fine, very good, sensible, appropriate, brilliant, preferable, ok) proposal! There is a definite need for those patients who are not ill enough to remain in acute care but not well enough to return home. It will reduce strain on busy wards at the James Paget. Saves money and better treatment for those concerned. Greater flexibility makes sense in maximising both response and resources. It is apparent that a good intermediate care facility is required in the GYW area and as Beccles is in the centre of this area, it would appear that this is the logical location. Excellent for cancer care and support.

Conditions - Inpatient beds at Beccles Hospital are very much needed providing:

- sufficient numbers are allocated
- GPs have their say about how it is run
- this does not have a detrimental effect on the Beccles Accident and Emergency service
- an x-ray unit was in there
- a triage unit was included, and
- it is managed and run efficiently with a team of qualified staff.

4.2.2 Don't Support

Disagree - Relying solely on Beccles Hospital to provide care for patients across GY and Waveney will not work. We do not require a centralised health service. I strongly disagree with this. In essence this would mean we are in effect losing inpatient beds in a total of 5 hospitals in the area – madness. Generally a progressive downgrade in services. This rather flies in the face of your pledge to have people treated close to home. Patients will be unable to have their own doctors. This is an unattractive venue for residents in the northern parishes of Gt Yarmouth. Appalling roads and lack of bridging points make transiting Yarmouth difficult and time consuming. Norwich is a much better option than Beccles for us. I think all the above hospitals should stay as they are. Leave the system as it is. It works well and doesn't need change.

4.2.3 Location

Preferences - Patients need to be kept in their community. There are so many care homes with vacancies that could be utilised. This saves monies on estate and enables better relocation of resources. People also heal better at home when given the support by the out of hospital team. Each area should have at least one facility to care for these people. This needs to be close to home so loved ones can visit, and in an emergency get quickly to the hospital or get to their loved ones in time so that they don't die alone.

Distribution - Whatever new facilities are to be provided they must do so fairly across the whole patch. What you are proposing for Beccles could also be provided at the existing community hospitals.

4.2.4 Access

Area - The geographical spread of the CCG means that having one site is not going to meet the needs of many families and patients. The area is too large. Beccles is not very central to the area. Access is difficult. Beccles is poorly served by public transport and roads are very poor. Transport for patients and friends and family will often be an issue.

Transport - Agree - providing transport is provided. Not everyone has access or the money to spend on travel by car/taxi or public transport. The elderly, ill and disabled will find it difficult to travel.

Parking - Sometimes there are parking issues on the hospital site. If more people are to use the facility these will need to be addressed.

4.2.5 Overcrowding

Demand - Demand for beds could well exceed availability. Beccles hospital will not provide sufficient in-patient beds for Southwold, Halesworth, Bungay, Beccles and the surrounding area. 21 beds to cover the whole CCG area will not be enough. This is a smallish hospital that is already very busy. No room for extension of capacity except upwards. A bigger care facility needs to be provided with a strict qualifying admission criteria in place. You already have problems with bed blocking where patients in JPH and other hospitals are ready for discharge but cannot go because the necessary arrangements

haven't been made, surely these proposals will only exasperate the problem and needs to be sorted before going down this path.

Staff - I am concerned for the extra duties it will place on Beccles GPs. The centre is already running short of GPs and unable to recruit anyone else to the practice. They may be swamped with demand. Local doctors agree.

4.2.6 Services

Needs - There will always be a patient group that require rehab for a longer period of time that such a few number of beds will allow. Also the area which these beds would cover is far too great to be suitable for the patients' needs. Not everyone has people to look after them at home. I believe in-patient beds would be better than using care homes or residential homes. I believe that the current use of the community hospitals provides an invaluable resource in enabling patients to be cared for within their own communities, making rehabilitation to home easier and more feasible and allows for greater support for their family members, who in many cases are aging themselves and unable to travel to other locations easily. Once closed they will never open again.

Provision - This services should be run by GPs, however contact with consultants may be needed at times. There may well be a conflict of issues. Who has priority and who makes appropriate decisions – therefore integration of services is important. We must share all facilities. Such as rehabilitation - physiotherapy departments. We should provide one to one and drop-in services and include other agencies like social services.

4.2.7 Care Quality

Satisfied - Beccles hospital as it is excellent and runs well. I have nothing but praise for this hospital. Beccles hospital restored our faith in the NHS. Always has been a good level of care. Our GP's, Nurses and carers are the best! Beccles Hospital is much advised for the care they provide, so I think the patients who need to go will be very happy to be there.

Concerns - The proposal looks good on paper but too mixed a type of patient's needs can lead to training and competency issues. There is a concern that what is being proposed is a second-class service for the most vulnerable patients. Family being unable to visit will be detrimental to the quality of patient care, patient well-being and patient recovery. The patient will endure more stress and greater expenses. Staff and patient preferences need to be understood. Problems will only become apparent after implementation. For instance ensuring enough appropriate staff for the amount of patients they have. This will all need to be monitored.

4.2.8 Finance

Concerns - Unfortunately lack of funding by the government is playing a big part in these proposals and I can well see that if they are implemented and there isn't a change of policy further savings will be demanded in the future resulting in job cuts and strain on the systems. Please be honest and admit the reasons for these proposals are to save money not to improve care. This will not save your proposed amount of money.

Economies - Good providing costs are lowered - needs funding and support. Anything that helps bed blocking is to be welcomed but it all comes down to money. If the finance is not in place none of it will work. Use money wisely to improve JPH.

Shortages - Not enough GP's, not enough nurses, not enough money. I fear the aims are laudable overall, but the funding may not arrive! You are bidding for £201/2 million to develop your ideas. But you also say that you can carry on even if your bid is not successful. Won't the "bean counters" in NHS England say "if you can do it without our money, then we won't give you any". Perhaps this might be an "own goal".

Privatisation - Prefer to keep care within the NHS and not have it tendered out to private care companies.

4.2.9 Information

Needed - The following information is requested:

- a definition of intermediate care
- the proposal for monitoring this service
- how GPs will develop their skills to deliver this service
- the implications of introducing this service
- JPUH bed usage
- how will this service differ to the "Intermediate care" already offered.

4.2.10 Palliative Care

Considerations - Also consider including palliative high level intensively clinical care beds here that cannot be provided through the "beds with extra care plus enhanced hospice at home services". Palliative patients do not always want to die at home. This new Hub of OOH team is fantastic 24-hour care by qualified staff – but will OOH staff sit and wipe the tears away from dying patients. They do not change them when they soil themselves and patients do not get the continuity of the same staff. Leading to a dignified death. All services should be linked and that those at the end of their life can be quickly transferred to quite hospice facilities. I feel that the area needs a hospice-type facility.

Location - End of life care in particular, this needs to be close to home so loved ones can visit and in an emergency get quickly to the hospital to their loved ones don't die alone. If end of life care was provided at District hospitals and even Beccles we would not get there in time.

4.2.11 Other

Considerations - Please consider the following:

- Mental Health (services and beds)
- Involve volunteers (and train them).
- The future employment and training of staff
- Carers needs (and respite care)
- The public's responses to this consultation.

4.2.12 Questions about the proposed change of use of beds at Beccles Hospital.

Will social care fund an element for those patients in an intermediate care bed with social needs - no health needs?

How many intermediate care beds will there be for the whole of GYW?

How does this differ from the care currently offered at Beccles Hospital?

Are you proposing that any patient in the GY&W area requiring intermediate care will be cared for at Beccles?

What will become of treatment for residents to the West of Yarmouth?

Have the needs of the patient has been considered at all?

What's wrong with it as it is now?

Is there enough beds for the demand to cover a large rural area?

How will they be staffed?

Will northern hub patients be sent there?

How much would the redundancy bill come to if you close the proposed sites?

What will happen to the patients Beccles currently have?

Why Beccles?

Where do people have end of life care?

Are GPs going to have the time to care for in-patients as well as their busy work in surgeries?

How will elderly family get to see their love ones?

Would you place someone with a long term condition who was the age of 30 in a care home?

Proposal only gives guidance on what beds will be used for until December 2015... what happens after then?

Will Beccles Drs still be able to admit their pts into these beds?

Is there a sufficient disabled policy?

How can help be given to those who find it difficult to travel so far?

Car parking is currently a nightmare. What provision is being made for this?

5 Report Outcomes

This report has been developed independently using the feedback provide. All queries concerning this report can be forwarded to the author. All further correspondence should be forwarded to the GY&W CCG.

Final Report developed by
Dr Steven Wilkinson – Consulting the Community*
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September 2015

* Consulting the community is a research centre of academics from the social sciences. This method for analyzing feedback has been developed by colleagues from this centre. Enquiries can be made by contacting the CCG.
Website – www.consultingthecommunity.co.uk

NHS
Great Yarmouth and Waveney
Clinical Commissioning Group

HealthEast

Meeting of the Governing Body PART 1

22 October 2015 Agenda Item 8

Title of Paper	Shape of the System – a response to the public consultation
What the Governing Body is being asked to decide or approve	The Governing Body is being asked to note our response to this public consultation.
Executive summary	Following the thirteen week public consultation on the Shape of the System, the response from the CCG to questions raised during the process is presented. The report is written for the public and is available for any member of the public to access on our website. We received 1,181 responses, and this document endeavours to answers questions raised during the consultation.
Risks attached to this proposal/initiative: None.	
Resource implications: None for this response document.	
Name	Rebecca Driver
Job title	Director of Engagement
Date	19 October 2015

NHS
Great Yarmouth and Waveney
Clinical Commissioning Group

HealthEast

Shape of the System consultation questions

A response to the Public Consultation

1. Introduction and Purpose of this Report

NHS Great Yarmouth and Waveney Clinical Commissioning Group (locally known as 'HealthEast') would like to thank everyone who took the time to respond to the recent public consultation 'The Shape of the System – Developing modern and sustainable health services in Great Yarmouth and Waveney'.

We received an excellent response to the consultation with 1,181 people and organisations responding. The full report which includes all the responses is available on our website. Answers to the many questions you raised can be found in Appendix 1 of this report.

This is our response to the consultation and sets out once again for clarity the background to the consultation, how it was conducted and steps taken since it closed. We will also tell you what happens next and bring out some of the major issues raised by you, letting you know what we intend to do about those things in particular.

This response report is subject to a final decision being made on the outcome of the consultation by the CCG's Governing Body meeting in public on 5 November 2015.

2. Background

This consultation gave people the chance to share their views on:

1. Developing more community-based services by:

   Introducing out of hospital teams across the whole of Great Yarmouth and Waveney. An out of hospital team is a team of staff with health and social care skills that work 24 hours a day, seven days a week to help support people going through a crisis.

   Supporting the out of hospital teams with NHS-funded 'beds with care' provided in local nursing and residential homes. These will provide short term care and treatment and help people recover and regain their independence, supported by professionals from the out of hospital teams.

   Basing the out of hospital teams in new community hubs across the area.

2. Community hospitals:

   Permanently closing the GP community hospital beds at Southwold, Patrick Stead, Northgate and All Hallows Hospitals and replace with out of hospital teams and local

NHS ‘beds with care’ as set out in proposal one. GP community hospital beds are beds where the medical support is provided by GPs.

Changing the use of Beccles Hospital inpatient beds to provide an intermediate care facility for Great Yarmouth and Waveney. Intermediate care is for patients who have longer term needs due to medical and/or social care issues which need to be sorted out before the patient can go home.

3. The Public Consultation Process

Patients and the public expect to be involved in decisions about the services they receive, especially those that shape the delivery of care in their area. The CCG are committed to listening to you, and there are also regulatory and legal requirements for the NHS and CCGs to do so. Public involvement and consultation are at the heart of good decision making, and the CCG takes this duty very seriously. In the case of this public consultation, we considered that the changes under consideration constituted a ‘substantial variation’ and we therefore decided to complete a full public consultation on these proposals. Throughout the process, we have worked very closely with our local Great Yarmouth and Waveney Health Scrutiny Committee (HOSC), NHS England and the East of England Clinical Senate, and we have made sure that we comply with the four reconfiguration tests that were introduced in May 2010. These are:

- Support from GP commissioners
- Strengthened public and patient engagement
- Clarity on the clinical evidence base
- Consistency with current and prospective patient choice

In preparation for the public consultation, a series of pre-consultation meetings and events were held which included patient representatives, members of the community, voluntary organisations, charities, local authorities and local NHS staff. This exercise was invaluable in making sure we had a better idea of what difficulties people faced in accessing services and what is important to local people. Most of the consultation document was written following discussions within this group, and the final public document and summary were those who were involved.

We have also engaged extensively with a variety of groups and stakeholders throughout the public consultation, in addition to the public meeting as set out below.

4. Consultation Timetable

The consultation timetable was as follows:

3 June 2015 Launch public consultation

The consultation was widely publicised and summary documents were sent to 100,000 households in the Great Yarmouth and Waveney area via local newspapers, and distributed to local GP practices, libraries, voluntary organisations and to care and nursing homes in the area.

Public Meetings

10 June 2015 Southwold

18 June 2015 Beccles

6 July 2015 Great Yarmouth

15 July 2015 Great Yarmouth

7 July 2015 Halesworth

13 July 2015 Southwold

The public consultation closed on at 2nd September 2015.

25 September 2015:	Consultation feedback report presented to the CCG Governing Body
22 October 2015:	Response report presented to the CCG Governing Body
5 November 2015:	Recommendations for decision made by the CCG Governing Body.

5. What you said about the options in the consultation, and our response

All your responses from the public meetings, consultation questionnaires and emails were considered and analysed. We asked if, based on the information you had read in the consultation document, you understood the three proposals; 96% of you said that you did understand the proposals.

The initial results showed:

Proposal	Agree	Disagree	Unable to say
Introduce new out of hospital teams in the community	53%	37.01%	9.99%
Provide beds with care in care homes to support the out of hospital teams	42.48%	46.19%	11.33%
Permanently close beds at Southwold Hospital	20.62%	56.95%	22.44%
Permanently close beds at Patrick Stead Hospital, Halesworth	20.7%	57.37%	21.93%
Permanently close beds at Northgate Hospital, Great Yarmouth	18.72%	56.96%	24.32%
Permanently close beds at All Hallows Hospital, Ditchingham	16.99%	55.68%	27.32%

6. Your questions and our answers

You asked many questions through the consultation and we have done our best to answer them as fully as we can. Your questions and our answers can be found in Appendix 1 of this

document. If you would like a copy of the answers to every single question asked during the consultation, please get in touch with the CCG via the email your-views-matter@nhs.net to request a copy.

7. What happens next?

We are currently reviewing the consultation responses with a view to making recommendations to our Governing Body. Those recommendations will be discussed, and final decisions made, at the Governing Body's meeting in public on 5 November 2015.

Once again, many thanks for your responses to the consultation. We will continue to communicate with you as decisions are made on the shape of the system in Great Yarmouth and Waveney.

Rebecca Driver
Director of Engagement
NHS Great Yarmouth and Waveney CCG
October 2015

Appendix 1: Your Questions and our Answers

There were many questions raised during the consultation. Set out below are short answers in red to the questions we received. We have grouped these questions into themes. We have attempted to answer the questions that you posed in response to the main consultation document.

Questions about community based services:

1. Why are changes being proposed?

A: We need to change because our population is changing; they are getting older and living longer with long-term conditions. There is much evidence (see the Case for Change for this project at http://www.greatyarmouthandwaveneyccg.nhs.uk/_store/documents/shape-of-the-system-case-for-change-refresh-website-final.pdf) to suggest that people recover quicker if cared for in their own home and this is what we propose to do with the development of out of hospital teams. We also need to ensure that we are getting the best value for money with the available health budget for the local population and that means spending as much as possible on health services and less on maintaining ageing buildings which are no longer fit for purpose.

2. Is a lack of funding behind the decision for change?

   A: No. It is true that there has been a change in the way that we are funded for the provision of local healthcare services to our population, but these changes are not about cuts. It is about changing the way services are provided to get best value for the Great Yarmouth and Waveney pound, and to provide the highest quality care possible with best possible outcomes for our patients

3. Will this approach be financially viable?

   A: Yes. The financial modelling was done before the consultation was launched, and has been fully assured by NHS England.

4. What analysis have you done to determine demand?

   A: We collect lots of data about attendances at A&E, emergency admissions and use of community hospital beds amongst others. This enables us to assess the way that demand is changing, and where demand is coming from, and being handled. We monitor the levels which we have estimated against what actually happens, and our predictions are normally accurate. Our work includes undertaking regular clinical audits in a variety of areas. All changes will be monitored rigorously to ensure that they are having the beneficial impact for patients.

5. Is this model based on evidence of a system that works somewhere already?

   A: We have piloted the out of hospital service model in the Lowestoft area with great success both in terms of the significant impact in reducing emergency admissions to hospital and patient and family satisfaction. We have evidence that this model has

supported patients to remain at home and not need to go into hospital. We will learn lessons from the information available from Lowestoft when launching the next phase of out of hospital team services. Out of hospital services have also been successfully implemented in different ways in England eg Torbay.

The CCG intends to make sure that our approach is tailor-made for each local community. The mix and configuration of beds with care, out of hospital teams and community hubs can be different in different localities . We will work with local stakeholders, particularly clinical colleagues, to design what is right for each community and their care providers.

6. How will End of Life patients be cared for?

   A: End of Life care will be managed by the out of hospital team in conjunction with specialist palliative services if required. Patients will be cared for as far as possible in their own homes or within a designated care home bed or intermediate care bed if this is more appropriate. Note: We have replied separately to specific feedback to the consultation from St Elizabeth's Hospice.

7. How will mental health patients be cared for?

   A: Within the new out of hospital teams there will be much closer working with colleagues from the mental health Trust (the Norfolk and Suffolk Foundation Trust). In some cases, these staff will be co-located with the out of hospital teams. When a referral is made for someone with a mental health problem who has developed other issues, the out of hospital team will work with the mental health team to ensure the best management plan for the patient.

8. How many community teams will there be?

   A: There will be two urban teams, Lowestoft and North (Gorleston, Bradwell, Great Yarmouth and Northern Villages). Work is on-going to determine the best configuration of teams within the more rural areas.

9. Considering the difficulties with staffing existing services, how will this service be staffed?

   A: Due to the success of the Lowestoft out of hospital team, we have seen increasing numbers of staff wanting to work in this community environment. We also have some very skilled staff working within the community hospitals and they may wish to continue their careers within the new services

10. What will be the makeup of the teams?

    A: The teams will be made up of professionally registered staff, nurses, therapists and social workers supported by a range of other staff. The team will also have access to other teams and services across all public sector and voluntary agencies.

11. Does the staffing level account for potential growth in demands on this service?

    A: Yes. It assumes that once a team is set up and well established, there will be many more referrals to the team and the staffing levels have been set to accommodate this increased demand

12. How will the out of hospital team service affect the present teams of Community Nurses?

    A: This service works very closely with and is complementary to the work currently carried out by community nursing. It will release more time for planned care within community nursing services.

13. Are staff prepared to work the required hours?
    A: East Coast Community Healthcare and CCG staff have worked closely with staff throughout the public consultation. We are confident that the necessary staffing resources will be available whatever model is implement. A staff consultation process will start as soon at the outcome of the consultation is known.

14. Will this model work in the more rural parts of your area where population is thinly spread?

    A: We realise that one size does not fit all and that an urban model will not necessarily fit a rural model. This is why we are doing more work to determine the structure of the teams for the more rural areas.

15. Who will administer drugs in either a community care or beds with care situation?

    A: Drugs are currently administered by a variety of appropriately qualified staff within the different settings and this will continue.

16. What notice will patients be given prior to a visit from a healthcare worker?

    A: The patient will be told that for an urgent referral a team member will visit them within two hours. For other referrals, the patient will be given an estimated visit time.

17. How will the teams be managed?

    A: There is a clear management structure for the teams. Out of hospital teams have team leaders, which enable day to day operational management as well as professional supervision for all staff.

18. How do you resolve issues/disagreements re individuals support by either GP or hub team?

    A: The multi-disciplinary teams will all work together in the patients' best interests.

19. What will be the qualifications of the team leaders?

    A: This will vary depending on the post, but the best person will be appointed for the job, with all the required qualifications for their profession and level of seniority within the team.

20. Will the community staff be appropriately trained and qualified?

    A: Yes.

21. Will healthcare workers be provided with sufficient time to spend with patients during a home visit?

    A: Yes.

22. How long will it take for a patient to be assessed by the team?

    A: This depends on the nature of the referral. If urgent, it will be within two hours, if non urgent, within 24 hours.

23. What clinical back up will be available?

    A: The out of hospital team will work in partnership with the patient's GP and they can ask the GP to visit the patient at home should this be necessary. Beds with care will have dedicated GP support. Should a patient become suddenly unwell, the out of hospital team can refer to the acute hospital or failing this, an ambulance can be called to take a patient to A&E.

24. Will there be a GP on duty 24 hours a day?

    A: Yes, as there is now.

25. Will more GPs be recruited to meet the increased workload?

    A: The experience from the Lowestoft out of hospital team is that the workload for the GP is not increased, and in some cases it decreases because the GP has to make just one referral to the out of hospital team when a patient needs help and support.

26. How safe is this system?

    A: Through the year that the Lowestoft out of hospital team has been in existence patient/carer feedback has been positive. Over 90% of patients expressed satisfaction with the service and no serious incidents. There have also been three clinical audits carried out with satisfactory outcomes.

27. Will patients get the same or better care than they would receive in hospital?

    A: We believe that patients benefit from receiving their care within their own home. Therefore we believe the answer is 'yes'. The focus of this consultation has always been to improve services for patients.

28. How will these changes and the new services be monitored?

    A: These will be monitored through the contracts with the different providers; this will include both clinical and financial audits to monitor performance against the specifications.

29. Will this service also provide phlebotomy services?

    A: If a patient is unable to attend a clinic or surgery for a phlebotomy test then this can be done by one of the community services. Staff in an out of hospital team will be skilled in taking bloods.

30. Will patients who are not admitted to care homes, nursing homes and residential homes be safe at home?

    A: Patient safety is paramount. We will contract with care home providers who meet the appropriate CQC (Care Quality Commission) and other standards. This care will be monitored throughout the duration of the contract and action taken if the standard is not as we want it to be.

31. Will hubs provide a 'walk in' service?

    A: This isn't currently planned, there will be access to services within the hubs and this will usually be on an appointment basis.

32. How will seriously ill patients access walk in centres?

    A: Seriously ill patients should use the services currently available 999, 111 or access A&E if their illness is deemed an emergency.

33. How will patients understand how to use the new services?

    A: Patients will be referred by health and social care professionals into the service. Once under the care of the out of hospital team, the patient and their family will be given information about how to contact the services thereafter. The care the patient receives will be discussed and agreed with the patient.

34. How will records be kept, updated and accessed?

    A: Electronic records will be maintained, accessible only to those who require the information to care for the patient with the patients consent.

35. To what extent would these services meet the government's new proposals for seven day services?

    A: These proposals are in line with the Government's Five Year Forward View. The services being proposed will operate across seven days.

36. Why not integrate community hubs into the existing hospitals?

    A: This will be considered as an option following the consultation.

37. How do 'hubs' differ from the existing surgeries?

    A: Hubs will be multi-agency centres which may, or may not, include primary care and will hopefully also accommodate other services provided by the local authority and the voluntary sector. They will also be able to host a wide range of community services.

38. Do we need both beds with care and hubs?

    A: Yes, there are no beds in hubs.

39. What is the role of the voluntary sector?

A: Voluntary sector services can also be accessed by the out of hospital team. It is hoped in the future that some voluntary organisations can provide services and be based within community hubs.

40. How will these changes effect waiting times?

A: Given that this way of working should 'free-up' beds within the acute hospital, it reduces the likelihood of operations being cancelled due to shortage of beds and therefore will positively impact on waiting times.

41. Have you proof that this system really works?

A: Yes. There is national evidence that it works and we also have 16 months information from the Lowestoft pilot which has been consistent in its improvement and performance

42. In bad weather, are the teams fully able to cope with their care duties?

A: There will always be peaks and troughs in any service and it is our experience that staff can get about in all but the most inclement weather. Clearly in extreme circumstances each patient's needs will be considered individually and if it isn't safe for a patient to stay at home, a bed will be found.

43. Why have these Hubs already been started in the North?

A: The hub in Lowestoft was implemented after the Lowestoft consultation and there has been a 'hub' approach on the Shrublands site for many years. A pilot team is being rolled out to the North given the success in Lowestoft .

44. What plans are in place to mitigate risks to providers if the anticipated reductions in admissions do not happen?

A: The service will be closely monitored and discussed through the contracting meetings which happen regularly with each provider.

45. Will the team provide recurrent year on year reductions in admissions to stay ahead of demographic trends?

A: The consultation aims to provide a service model fit for purpose for the next 10-20 years. It will have to be flexible to meet the changing needs of the population

46. Has the CCG undertaken a Clinical Quality Risk Assessment (CQRA) on this proposal and developed mitigation plans for issues such as staff leaving posts due to uncertainty, higher than expected demographic increases in admissions being beyond the capacity of the team or other factors important to maintaining a sustainable service both during the consultation and after implementation?

A: Yes this is being completed.

47. Is there a formal business case including capacity and demand modelling and detailed costings for the proposal, and a benefits realisation and VFM assessment for the phase already completed? Is this published?

    A: Yes there is and this has been agreed by NHS England and the East of England Clinical Senate. It is available on our website.

48. How will the CCG mitigate the risk of fragmented care and any potential subsequent negative impact upon patients, affordability and sustainability?

    A: During the implementation phase, we will agree a system of monitoring with system partners which will be reported through to the Shape of the System Steering Group.

49. How will the ongoing monitoring and evaluation of quality, operational performance and value for money relating to this service change take place and where will this be reported in the public domain?

    A: As Q 51, above, this will be considered through implementation and agreed by system partners.

50. What KPIs and quality measures will be monitored post implementation?

    A: Please see the answer to Q 52.

51. How will the CCG ensure that these patients receive the right care outside of hospital by the appropriate clinicians?

    A: A system of monitoring will be agreed through the implementation phase for this project.

52. Where patients are receiving end of life care and may have chosen to end their lives outside of an acute Trust environment, what assurances can the CCG provide that where complex needs cannot be met or service capacity is an issue that this will not result in an avoidable acute admission which would be inconsistent with the patient's wishes?

    A: It is clear within the consultation document that we seek to provide more choice for all patients including those in receipt of end of life care. We will work with providers during the implementation phase to describe the service model including how we link in with specialist services.

53. Will services be equitable and consistent 7 days a week, 24 hours a day including across all of the geographical areas covered the team, e.g. in the most rural areas?

    A: Yes they will.

54. How will patient choice be accommodated by the new service?

    A: Patients will be given more choice. They will have the additional option to stay at home, or in a bed with care, as well as access to intermediate care beds in a community hospital setting and if needed a bed in an acute hospital.

55. How do the CCG's proposals shape up against the Five Year Forward View?

A: Our proposals are fully in line with this strategy.

56. Out of hospital teams as described in your consultation document appear to offer short term support only: what happens in the longer term?

    A: There are other services currently available provided by both health and social care. The out of hospital team will arrange a smooth transition into these services.

57. Won't people need additional social and personal care if they are living at home?

    A: This may be the case and this will be provided.

58. What happens if people are living alone and there is no-one to support them?

    A: The services will be provided to meet the needs of individual patients. Where no family support is available, this will be taken into consideration when their care is planned.

59. What support will be available to family carers if they are providing the frontline support for the sick person?

    A: The out of hospital team will arrange for the necessary support services in discussion with the family carers.

60. Why are you doing this when other areas of the country are building new community hospitals?

    A: Population needs differ across the country. The evidence suggests that very few patients need to spend a great deal of time in a hospital bed. We have already, and will continue to invest in the local infrastructure. This will be through the development of community hubs and through our support to providers in the development of care homes.

61. From which community hub will Kessingland be served?

    A: This will be discussed with stakeholders during implementation.

62. Where are all the extra staff coming from to service all the hospital teams?

    A: Recruitment into the out of hospital has been good because staff are very positive about this new service model. Staff are being recruited from outside the CCG area as well as from within.

63. While the further integration of services may well remove obstacles to "joined up care", the question needs to be asked whether the fundamental shortcoming in the present working arrangements has been the sufficiency of primary health and social care practitioners and budgets, to pay for people and places?

    A: We have to work within our allocated budgets. What the CCG is seeking to do is to make sure we get the best value from our budget, and make the most of every Great Yarmouth and Waveney pound.

64. Also where is the money coming from for all the extra supportive equipment needed in people's homes for rehabilitation purposes and what about the extra admissions into acute services because of the increase in falls with patients at home?

    A: Ensuring access to equipment will be a key element of the implementation of this project.

65. Is there a comprehensive transitional business plan for the staffing and financial resources necessary to ensure this transition is effective and sustainable?

    A: This work has started and will be further developed once we know the outcome of the consultation.

66. It doesn't say who will employ the staff on these teams. Will it be ECCH and subject to future tendering process or will it be the NHS?

    A: The teams will be employed by our current providers who are working increasingly closely together.

67. Will the patient would have to pay for this service?

    A: No. The patient won't pay for NHS services.

68. Are private care agencies involved?

    A: Private care agencies are currently providing some NHS funded services (as they do across the country) and will continue to do so.

69. If the Clinical Commissioning Group is going to save up to £7.9 million by closing community hospitals and is proposing to reinvest £3.6 million of this in out of hospital schemes and the £4.3 million left will go to pay off debts in the next two years, may we hope to see an equivalent percentage cut in management costs to match the percentage cut in clinical costs?

    A: Management costs across the system are reviewed on a regular basis. As services become more integrated it is anticipated there will be a decrease in costs.

Questions about beds with care

70. Would the 'beds with care' also be for end of life/palliative patients?

    A: Yes. They will if they are appropriate for each patient's individual needs. The Lowestoft pilot has already cared for patients at the end of their life in beds with care.

71. If not what arrangements will there be for them?

    A: As with all patients we would hope that the majority can be cared for within their own home

72. Will the chosen homes be subjected to a more rigorous inspection and quality requirement?

A: There will be a specification agreed with the care home which will be rigorously monitored.

73. As a patient will I get the same or better care than I would receive in hospital?

A: You will receive the appropriate care in a different environment. As a CCG we would wish to see care of the highest quality provided for our population regardless of location

74. What happens if all the beds are occupied?

A: The CCG will endeavour to find an appropriate bed within another setting.

75. How will staff be prepared for caring for and monitoring these patients to ensure that acute deterioration is recognised and appropriately acted on promptly?

A: Full induction and training will be given.

76. Why get rid of well-loved services like the community beds?

A: We believe that to provide care for patients within their own home is a better model of care. This is because it enables patients to recover more quickly, to get back to optimum levels of independence and offers the best patient experience. Therefore this is an improvement of services for the population, some of whom may have otherwise been cared for in one of the community hospitals, or will have unnecessarily been admitted to an acute hospital due to the lack of out of hospital services across the 24 hours of the day.

77. Are older people with mental health needs able to access 'beds with care'?

A: Yes, if this provides an appropriate environment for those patients. This will be assessed on an individual basis.

78. How would younger people manage in care homes?

A: The services currently under consultation are for adults i.e. 18 years and over. This service would still be appropriate for younger adults.

79. Would such care be NHS funded or be extra cost to the patient's family?

A: This would be NHS funded.

80. Will these beds be means tested?

A: No – they will be NHS funded.

81. How many care homes will provide this service?

A: This will be decided through the implementation process. We want them to be as close to the patients home as possible.

82. Who will monitor beds in private care homes?

A: This will be monitored through the out of hospital team. Care homes are already subject to inspection and scrutiny from the CQC.

83. Is this model based on evidence of one system that works somewhere already?

A: Yes. This is based on service models across the country and more locally in Lowestoft.

84. Is there the capacity in residential/nursing homes to do this?

A: Capacity is always a concern. However, there will be extensive developments over the next few years to increase capacity both for care homes and very sheltered housing.

85. Where will the necessary staff come from?

A: The staff will be recruited by the care home and the out of hospital team will also provide services there.

86. Are these homes to be privately run?

A: Yes, as they are at present.

87. Who will administer palliative drugs?

A: The care home will ensure medicines are administered supported by the out of hospital team if patients at the end of their life are being cared for in beds with care.

88. Will care homes be paid to keep a number of beds empty for when these needs arise?

A: Yes they will.

89. How will you ensure that best care will be provided at a reasonable cost?

A: This will be negotiated with the care home. There will be a specification in place which will be monitored by the CCG.

90. Will transport be provided?

A: Yes for the patient if they meet the eligibility criteria for transport.

91. How do you resolve issues/disagreements re individuals support by either GP or hub team?

A: Any issues that arise will be discussed with the patient by a member of the out of hospital team. Where possible the team will resolve these and agree a solution.

92. How are these beds to be separated from 'care home' customers?

A: This will be agreed with the individual care homes as it may differ due to layout etc

93. Will there be a GP on duty 24hr a day?

A: Yes. This will be through the GP out of hours service which is already in place.

94. Will beds always be available close to the patients' homes and relatives?

A: As far as possible – yes.

95. Are the private sector homes signed up to this, or is it just an aspiration?

A: We have visited many care homes over the past few months and several are signed up.

96. How can you ensure that there will always be enough beds available?

A: We will flex the number of beds available in line with demand.

97. Is this the back door to further privatisation?

A: All services will be NHS funded

98. Who will grade the beds with care standards?

A: The CCG will specify the care required and monitor to make sure it is provided.

99. Will the community hospitals stay open until they're built?

A: Community hospitals will stay open if the staffing is maintained to make it safe to do this until alternative provision is found.

100. Will full nursing support be for 24 hours per home?

A: Yes through the out of hospital team.

101. What Policy will the care homes be following when looking for the patients that will be in the beds with care?

A: They will follow the specification agreed with the CCG.

102. A patient could have diabetic control issues, heart failure, infection and immobility. Can a residential home really cope with this between visits of the community care team?

A: The CCG believes they can and this has been the case in Lowestoft. The out of hospital team will provide many additional staff and so will have the capacity to visit, advise and monitor.

103. Have the aforementioned care homes been consulted on this proposal?

A: Yes they have.

104. Have the criteria for admission and subsequent discharge or escalation to an acute bed been agreed and shared with clinicians from all providers with an interest?

A: This has been shared for the Lowestoft beds with care. Other clinicians will be involved during the implementation phase for the rollout.

105. Are these criteria published?

A: They are available on request.

106. What is the default position should the beds not be able to be staffed 24/7 or a patient's complex needs cannot be met?

A: The patient will be admitted to either an intermediate or acute bed. The CCG believes this will be an infrequent occurrence.

107. Will the capacity be flexible and able to respond to demand increases at short notice (within hours), specifically in regards to winter planning and escalation?

A: The CCG will ensure a level of flexibility in the system. This will be worked through during the implementation phase.

108. How will patient choice be accommodated by the new service?

A: Patients will have more choice and any decisions will be discussed and agreed with them as at present.

109. How will GPs oversee these patients in beds with care if primary care is experiencing significant capacity pressures?

A: There will be a separate contract for this service.

110. How will continuity of care between other providers and providers of 'beds with care' be ensured, particularly for vulnerable patient groups sensitive to transitional arrangements such as patients with dementia?

A: The continuity will be provided through the out of hospital team using a case management approach.

111. How will you ensure staff are well supported, fairly paid and well treated?

A: Staff will be appointed on the appropriate pay band for the job description they are expected to carry out.

Questions about Community Hubs

112. To what extent would these services meet the government's new proposals for seven day services?

A: There is a separate project which has been in existence for the past two years looking at seven day services which is one of the Early Adopter sites nationally. We will ensure that the outcome of this project is considered as we move into the implementation phase.

113. Why not integrate these facilities into the existing hospitals?

A: Given that the majority of people will be cared for at home we will not need these beds and they will remain empty. The buildings are not fit for purpose and we can ensure a better environment within a care home setting.

114. The majority of patients would not choose to be admitted in a care home so what happens to choice then?
A: Patients will be admitted to a care home for a short time only when they cannot be safely looked after at home. The out of hospital team will make sure they are discharged back to their place of residence as soon as possible

115. Where are these hubs going to be located?

A: This is to be decided following the consultation decision.

116. How do Hubs differ from surgeries?

A: Some hubs will include GP surgeries but they provide many more services for patients to access which may be health, social care or voluntary sector.

117. Is the GP shortage addressed by these proposals?

A: The feedback from Lowestoft GPs is that the out of hospital team enables them to share the care of their patients in the community rather than trying to coordinate services for patients because this is done by the team.

118. Is this really a viable alternative to closing hospitals if the aim of the closures is to reduce costs and improve patient care?

A: Yes it is. It will improve patient care and the patient experience. Hospital bed days are expensive and if not the most appropriate environment for patients can have an adverse impact on them.

119. Who will pick up the increased costs of transporting patients to/from the "hubs"?

A: This will be considered in the implementation of the new service model.

120. Has the safety of the staff visiting patient homes been taken into account?

A: Staff currently visit patients in a wide variety of settings and providers have their own policies to ensure the safety of staff.

121. Will the carers be qualified?

A: Carers will have initial training and mandatory updates annually. Some carers will be encouraged to develop more advanced skills.

122. What happens if these trials fail for any reason?

A: Services will be monitored and adjusted accordingly. The CCG and our partners have learnt a great deal for the Lowestoft experience and so the set up in the North of the patch will be different because of these lessons learned.

123. With reference to Lowestoft are there any plans for a centre in the north of the town?

A: Through the Lowestoft consultation we committed to ensure some services remain in the North of the town e.g. phlebotomy (blood taking) this remains the case.

124. Has the size of the area been taken into consideration regarding travel time?

A: Yes, this has been considered and will be again during implementation.

125. Who bears the cost of the transport involved?

A: The transport will be funded by the NHS for patients who meet the eligibility criteria.

126. Will gynaecology out patients appointments be available in Reydon?

A: There are no plans to do this at present. Gynaecology services are provided in Halesworth which can be accessed by other patients.

127. If more beds are taken in care homes for out of hospital care, does this mean there will be even fewer respite beds?

A:The CCG is mindful of the impact on care home capacity of these changes and are working with other system partners to secure additional capacity for the future of both care homes and very sheltered housing.

128. What transport would be available to out-patients with limited mobility and no public transport access direct to the hub? And what about evening visits when buses finish by 6pm?

A: There will be no change to current provision which is down to eligibility.

129. Why not train volunteer support workers to work alongside professionals?

A: We will be looking at working more closely with the voluntary sector through implementation. The input of this sector has been invaluable through all our public consultations.

130. Where is the provision for older people's mental health?

A: Older people's mental health has been considered as part of a previous consultation which is in the implementation phase.

131. Where will the community hub be closest to Hemsby?

A: We will consider the best place for a hub in this area following the consultation decision. We will be working closely with Great Yarmouth Borough Council planners on this as we are aware of substantial housing developments in the future in this area.

132. Can we see a trained member of staff each day when necessary?

A: Yes.

133. Will these hubs work?

A: We have had very positive experiences with the new hubs in Lowestoft and Reydon.

134. What will the future be for the Patrick Stead building?

A: A: The building is the property of NHS Property Services and will be disposed of in line with their policies and processes once the decision about its future has been made.

135. Why spend money on something new when the current system works?

A: Because we can and want to improve the current system.

136. Where do the services offered locally in GP Practices fit into this new model of provision?

A: There will be no change to this as part of this consultation.

137. Has any consideration been made in converting the existing hospital sites into community hubs?

A: This will be considered as part of implementation.

138. Will the time frames for GP appointments improve?

A: Not part of this consultation.

139. Will the nursing care beds really be available to work next to the community hub?

A: In some case this will be true, it will differ according to locality.

140. Has any study been done on where people prefer to die?

A: Yes, but not part of this consultation.

141. What situations will home visits cover?

A: This will be assessed with each individual case.

142. Will future cost of services for support at home ever be a consideration?

A: We are making these changes to ensure improvements over the next 10-20 years and so there will be a long term financial plan.

143. How have you determined the number of beds outside of the home you need?

A: This has been based on the Lowestoft pilot. We are aware that this may not work for all areas and so ensure locality variations are considered.

144. If you live in Lowestoft will you always use the Lowestoft hub e.g. if you work in Halesworth could you go to that hub for services?

A: For services other than primary care yes you could.

145. Are the out of hospital team working in the hub, in people's homes or both?

A: Both.

146. Can people walk in off the street to ask about healthcare?

A: Yes there will always be someone to signpost to services.

147. Will this mean district nurses will no longer be assigned to GP Practices and then loose the GP contact?

A: This is not under consideration as part of this consultation.

Questions about the proposals to close Southwold Hospital

148. How many teams in a scattered rural area will be required to cover 40 'at home' patients?

A: There will be one team working closely with other colleagues.

149. If April 2016 is not your target for start-up why mention any date at all?

A: In any consultation on proposed changes there will be a target date for change if the decision is to go ahead and implement those changes. However, the purpose of consultation is to listen to views from the public and in this scenario proposals, including start dates, change.

150. How can closing hospitals/cutting the number of hospital beds be a sensible plan for the future when the population is already increasing?

A: Because we believe we can provide better care for the population at home.

151. What will happen to Southwold Hospital after it is sold? What will happen to the buildings?

A: The building is the property of NHS Property Services and will be disposed of in line with their policies and processes once a decision about its future has been made. .

152. Who owns them?

A: NHS Property Services.

153. Why change a good, popular working system?

A: The system works for some but not others and the CCG believes there is a better way to care for patients.

154. Why scrap an area of such excellence?

A: We will build on the excellent work already in place and any changes will be discussed with the team currently providing the excellent care.

155. What guarantee do we have that a care home will be built in Reydon?

A: We are working closely with NHSPS who are committed to doing just that. We anticipate that we will go to the market for developers by Spring 2016.

156. As part of the review has an assessment been undertaken to evaluate whether currently people are being both inappropriately admitted and staying longer than they should in the acute hospital?

A: Yes we have many audits over the past two years which show exactly that. This does vary from area to area.

157. Is the CCG able to provide assurance to the DGH that they will not be the only alternative capacity available for patients should the community 'run out of beds'?

A: The CCG will work closely with all our providers through the implementation and following that to closely monitor this scenario.

Questions about the proposal to close Patrick Stead

158. Why has this hospital not allowed to fill all fourteen beds when staffing levels are adequate?

A: Health and safety requirements within the building have been a concern as has ongoing safe staffing of the hospital.

159. What happens to the beds until the new home is up and running?

A: The beds will continue to be provided if they can be safely staffed until alternative provision is secured.

160. Why change a good, popular working system?

A: We believe that to provide care for patients within their own home is a better model of care as it enables patients to recover more quickly, to regain optimum levels of independence and offers the best patient experience. Therefore this is an improvement of services to the population, some of whom may have otherwise been cared for in Patrick Stead hospital, or will have unnecessarily been admitted to an acute hospital due to the current lack of out of hospital services across the 24 hours of the day.

161. Where will the other services e.g. Phlebotomy operating out of Patrick Stead be housed post April 2016?

A: These services will be re-provided, the setting is yet to be determined.

162. What provision will be made for minor injuries?

A: The CCG expects that this will continue to be provided via the GP practice.

163. Where is the nearest hospital bed or care home?

A: There are care homes in Halesworth currently with a new build planned adjacent to the hospital site. The nearest hospital bed is Beccles.

164. What's happening to the building when it's finished?
A: The building is the property of NHS Property Services and will be disposed of in line with their policies and processes.

165. Where are all these professionals going to be recruited from and how many will be needed to cover the Halesworth area as well as all the other areas?

A: This detailed work will be done through the implementation phase.

166. Will Southwold patients be able to access these beds too?

A: Patients will be allocated beds dependant on need.

167. If Patrick Stead Hospital is sold what will happen to the cash?

A: The building is the property of NHS Property Services and will be disposed of in line with their policies and processes.

168. Where is the local evidence for Halesworth to show that with out of hospital teams, the best place to care for people is at home?

A: Audits of patients within the beds at PSH demonstrated that the majority of them could be cared for at home with increased community staffing levels.

169. Have the logistics of the demands and costs of travel time for medical and social care provided in people's own homes in rural areas around Halesworth, with extending life spans and increase in multiple diagnoses, along with a doubling of the elderly population, been properly taken into consideration?

A: These issues have been considered, and will be considered further during any implementation phase. .

170. Is the CCG able to provide assurance that the DGH's will not be the only alternative capacity available for patients should the community 'run out of beds'?

A: The CCG will work closely with all our providers through the implementation and following that to closely monitor this scenario.

Questions about the proposal to close beds at Northgate Hospital

171. What will happen to the buildings?

A: There will be no change to the Northgate hospital site as it is owned by NSFT and the GP beds on the site form a very small proportion of it, this consultation is not about mental health beds.

172. Why close a successful hospital?

A: The CCG is not planning to close Northgate hospital, the proposal is to close the current GP beds at the hospital.

173. If you close this hospital does this mean these patients will have to go to Beccles?

A: The CCG is not planning to close Northgate hospital, the proposal is to close the current GP beds at the hospital. The majority of patients will be cared for in their own home or within care homes nearby. Some patients will be require intermediate care and these beds will be in Beccles.

174. How will elderly relatives access Beccles from Northern Villages and Gt Yarmouth?

A: The CCG anticipates that the length of stay in Beccles will be as short as possible and that patients can be transferred back to local care homes or to their own home under the care of the out of hospital team as soon as they are ready. We acknowledge that for some the distance to visit relatives will be greater than it is currently.

175. Is the CCG able to provide assurance that the DGH's will not be the only alternative capacity available for patients should the community 'run out of beds'?

A: The CCG will work closely with all our providers through the implementation and following that to closely monitor this scenario.

Questions about withdrawing funding for beds at All Hallows Hospital

176. I presume we will still purchase Nursing home beds with care from all Hallows?

A: This will be decided following a decision on the consultation by the CCG's Governing Body.

177. Would this make the nursing home less viable?

178. Do they share staff or services?

179. Where is the nearest hospital bed or care home?

180. Again, why scrap an area of such excellence?

181. Will this be a 'beds with care' location? 186 - 190

A: All of the above questions (183 to 187) will be considered through the implementation phase for this project .

182. Is the CCG able to provide assurance that the DGH will not be the only alternative capacity available for patients should the community 'run out of beds'?

A: The CCG will work closely with all our providers through the implementation and following that to closely monitor this scenario.

Questions about the proposed change of use of beds at Beccles Hospital

183. Will social care fund an element for those patients in an intermediate care bed with social needs - no health needs?

A: No. These will be patients with complex health needs, social care from the out of hospital team will in-reach.

184. How many intermediate care beds will there be for the whole of GYW?
A: This will be considered through the implementation phase.

185. How does this differ from the care currently offered at Beccles Hospital?

A: The environment and staffing levels will enable the provision of much more complex care.

186. Are you proposing that any patient in the GY&W area requiring intermediate care will be cared for at Beccles?

A: Yes that is the proposal.

187. Have the needs of the patient has been considered at all?

A: Yes we have had good feedback from patients and carers across Lowestoft regarding the changes to their services and have used this feedback to inform these proposals. Patient participation groups at GP practices have also played a key part in the consultation.

188. Are there enough beds for the demand to cover a large rural area?

A: The CCG anticipates that the combination of keeping more patients at home, beds with care and intermediate care beds will provide sufficient capacity.

189. How will they be staffed?

A: Staffing levels and mix of staff will be different to reflect the more complex patient needs.

190. Will northern hub patients be sent there?

A: Yes if appropriate.

191. How much would the redundancy bill come to if you close the proposed sites?

A: The CCG anticipates being able to offer all staff jobs and do not plan to make any members of staff redundant at this time. A full staff consultation process will be completed.

192. What will happen to the patients Beccles currently have?

A: They will be discharged as usual or into the care of the out of hospital team when it's up and running.

193. Why Beccles?

A: Beccles Hospital is centrally located in the Great Yarmouth and Waveney area. The physical environment and the size of the hospital are appropriate for re-development into an intermediate care facility

194. Where do people have end of life care?

A: Wherever is the safest, most appropriate place – own home, bed with care, intermediate care bed or an acute hospital bed.

195. Are GPs going to have the time to care for in-patients as well as their busy work in surgeries?

A: This will be taken into consideration when this element of the care is discussed.

196. Would you place someone with a long term condition who was the age of 30 in a care home?

A: This decision would be taken on a case by case basis.

197. Proposal only gives guidance on what beds will be used for until December 2015... what happens after then?

A: A commitment has been given that beds will remain open until such time as alternative provision is in place.

198. Will Beccles doctors still be able to admit their patients into these beds?

A: Yes they will if they have complex needs.

199. Is there a sufficient disabled policy?

A: The needs of patients with disabilities will be considered throughout the implementation phase.

Ends…

NHS
Great Yarmouth and Waveney
Clinical Commissioning Group

HealthEast

Meeting of the Governing Body Part one

5 November 2015 Agenda item 12

Title of Paper	Decision on next steps on the Shape of System Public Consultation – developing modern and sustainable health services in Great Yarmouth and Waveney
What the Governing Body is being asked to decide or approve	The Governing Body is being asked to: • Approve the recommendations under section 7 of the attached report • Endorse the implementation phase under section 7.3 of the report • Make any recommendations for further action, if required.
Executive summary	A thirteen week public consultation on the Shape of the System – Developing modern and sustainable health services in Great Yarmouth and Waveney - closed on Wednesday 2 September 2015. The CCG received 1,181 responses to the consultation from staff, patients, clinicians, healthcare providers, social care, District, County and Parish Councils, voluntary agencies and the wider public. During the public consultation six public meetings were held, 100,000 consultation documents were distributed across Great Yarmouth and Waveney, 588 tweets were sent with 333 being retweeted, three twitter chats were held, three videos were produced which received over 720 views and our website page for Shape of the System was viewed 1,067 times. The CCG's Governing Body received a full report on the feedback from the consultation at its meeting on 24 September. And the CCG responded to the questions and issues raised during the consultation at the Governing Body meeting in public on Thursday 22 October 2015. An 'options appraisal' workshop was held on Tuesday 13 October 2015. At this event, key stakeholders and invited patients and members of the public completed a structured exercise to develop recommendations for the Governing Body. The recommendations were produced from the views

	of the stakeholders at the event on the day. A final decision on the Shape of the System will be made by the Governing Body at their meeting in public on Thursday 5 November 2015. The CCG has kept the Great Yarmouth and Waveney Health Scrutiny Committee informed throughout this process and will be discussing this at their next meeting on 13 November 2015. A reminder of the proposals……. **Proposal One** Developing more community based services, introducing out of hospital teams, supported by beds with care and new community hubs. **Proposal Two** Community Hospitals – permanently closing the GP community hospital beds at Southwold, Patrick Stead, Northgate and All Hallows and changing the use of beds at Beccles Hospital to provide an intermediate care facility. This paper sets out the background to the consultation and the proposals and steps taken since the consultation closed. It asks the Governing Body to approve final decisions on next steps and to agree the implementation process.

Risks attached to this proposal/initiative:

Failure to implement these recommendations will:

- Impact on the CCG's ability to implement the wider integration agenda and provide care closer to patients' homes
- Potentially compromise patient quality and safety if we do not get these proposals right and implement them effectively
- Potentially increase costs to the CCG

Resource implications:

The financial consequences of the implementation of these proposals are complex**.** Nationally for the NHS the financial position is very challenging and locally the health system is dealing with the impact. The CCG needs to ensure that the best possible value for money is achieved from our limited resources. These resources will continue to be used for either the current models of care or the proposed models of care as set out in this paper but not both. Local design will need to help shape any changes to services within the current funding envelope. This will be reflected in our commissioning intentions and our contractual negotiations for 2016/2017, across the CCG's commissioning budget for local health care.

Name	Rebecca Driver
Job title	Director of Engagement
Date	29 October 2015

NHS
Great Yarmouth and Waveney
Clinical Commissioning Group

HealthEast

Decision on next steps on the Shape of System Public Consultation – Developing modern and sustainable health services in Great Yarmouth and Waveney

1. Introduction and Background

1.1 The twelve week public consultation on the Shape of the System the Great Yarmouth and Waveney closed on 2 September 2015.

1.2 NHS Great Yarmouth and Waveney Clinical Commissioning Group (locally known as 'HealthEast') received 1,181 responses to the consultation from staff, patients, clinicians, local health, social care and voluntary agencies, and the wider public.

1.3 The CCG's Governing Body received a full report on the feedback from the consultation at its meeting on 24 September. The CCG's Governing Body responded to the issues raised in this report at their Governing Body meeting in public on Thursday 22 October.

1.4 The CCG has run a genuine and open public consultation. We have listened to the views of the public and all our stakeholders and we have worked hard to take these views into account when reviewing our proposals, along with those from clinicians, the voluntary sector, local health providers and local councils.

1.5 Throughout this process, the CCG has engaged with people who use local health services, their carers and voluntary organisations that represent them.

1.6 The public consultation closed on 2 September. Following this, the CCG has worked with a stakeholders and patient group to consider the findings of the consultation now we have heard what people think. This process has taken into account the future quality and sustainability of services and how they should be provided and afforded. This work culminated in an 'Options Appraisal Workshop' on 13 October 2015 (see section 4). This has been the basis of the recommendations on the specific questions in the consultation for the Governing Body to approve.

1.7 The purpose of this paper is for the CCG's Governing Body to make a final decision on the configuration of services and how they will be commissioned for the future. References within this paper to changes that 'will' be made or future services that 'will' be in place are of course subject to whether the Governing Body decides to implement the proposed changes.

2. The Case for Change

2.1 Great Yarmouth and Waveney faces a rise in the number of older people over the next 20 years. Alongside this rising demand for services, our population is changing. People are living longer, often with a range of different health and social care needs. We need to make sure that when people need care and support, the care they receive is joined up and closer to peoples' homes and communities. It should be the exception that people have to be admitted to hospital. Working together, health and social care and the voluntary sector can deliver joined up 'integrated' services, improving quality and safety, and at the same time, getting better value for taxpayer's money.

2.2 Our aim is to change the emphasis of care to be targeted at keeping people well and, if they become ill, to treating them quickly, locally and, where possible, in their own home.

3. The Proposals

3.1 During the public consultation, people were asked for their views on making substantial changes to the way we commission to deliver better healthcare for patients in Great Yarmouth and Waveney. It asked people to think about how care is provided in our communities, and where services are based.

3.2 The proposals were:

Proposal One: Developing more community-based services by:

Introducing out of hospital teams across the whole of Great Yarmouth and Waveney - an out of hospital team is a team of staff with health and social care skills covering 24 hours a day, seven days a week to help support people going through a crisis.

The proposed out of hospital teams, if introduced, will be supported by NHS-funded 'beds with care' provided in local nursing and residential homes. These will provide short term care and treatment and help people recover and regain their independence, supported by professionals from the out of hospital teams.

The out of hospital teams will be based in new community hubs across the area.

Proposal Two: Community hospitals:

Permanently closing the GP community hospital beds at Southwold, Patrick Stead, Northgate and All Hallows Hospitals and replacing them with out of hospital teams and local NHS 'beds with care' as set out in proposal one. GP community hospital beds are beds where the medical support is provided by GPs.

Changing the use of Beccles Hospital inpatient beds to provide an 'intermediate' care facility for Great Yarmouth and Waveney. Intermediate care is for patients who have longer term needs due to medical and/or social care issues which need to be resolved before the patient can go home.

4. Options Appraisal Workshop: 13 October 2015

4.1 To help the Governing Body to follow a carefully considered and objective decision making process, a structured and robust options appraisal event was completed involving a wide range of local stakeholders to appraise the options for future service provision.

4.2 A copy of the report setting out the conclusions of this Options Appraisal Workshop including a list of attendees is attached at **Appendix One**.

4.3 This report was fully considered by the HealthEast's Governing Body on 22 October in their meeting in private and by the Clinical Executive Committee on 29 October 2015.

4.4 **The appraisal process**

Overview

The same process was carried out for each service using a structured weighting and scoring approach with the following key elements:

- A shortlist of **options** to be evaluated, which included maintaining the current service model, was drawn up by stakeholders
- A list of **benefit criteria** and key factors to be considered for each option was also drawn up by stakeholders.
- An **evidence pack** was provided, before the workshop, to all attendees with information relating to each of the key factors.

At the Options Appraisal Workshop, each option was scored in turn against the benefit criteria (above) to generate a **weighted score** for each option. The weighting and scoring exercise at the workshop was completed by a representative group of stakeholders from the local health, social care community, third sector, patient and carer groups (see Appendix One). In addition, the results of the public consultation were represented as a separate view by the independent expert, who analysed the responses on behalf of the CCG.

4.5 **Conclusions and recommendations from the Options Appraisal Workshop**

The Options Appraisal was completed to provide a quantitative assessment process of each possible option, including maintaining the current service model, and evidence to support the CCG's Governing Body in its decision making process. The conclusions from the workshop provide clear views.

The conclusions from the options appraisal workshop were:

> The results show that **the proposed service model is the preferred option**.
>
> The proposed services option was given the highest raw score and the highest weighted score. The gap between the two options, proposed service model and maintaining the current service model,was more than 33% - a significant difference.
>
> All six groups gave higher scores to the proposed service model on all seven criteria – this shows a high level of consistency across the groups.

5. Feedback from the public consultation

5.1 The feedback report from the public consultation was presented to the Governing Body at their meeting in public on 24 September 2015 by Dr Steven Wilkinson, an independent analyst.

The Executive Summary from the report is set out below for the Governing Body to consider as part of their decision making:

5.2 Executive Summary

Proposal One: Developing more community based services

There was 53% approval of this proposal with 37% disagreeing. Those who supported this proposal felt it was a good idea, preferable and sensible. This service was considered as being needed in addition to existing integrated services. Staffing issues were raised concerning availability and qualification. There is also concern that the impact of the consultation has had a destabilising effect on staff and services. Care quality is of concern and some are concerned that the region may be too large for this service. The location of the proposed hubs is an important consideration. Funding was of concern as was cost effectiveness.

Those who did not support this proposal felt that the model of care would not work. They do not agree with the principles and felt past experiences point to failure. They felt that more information is needed about the proposals and no changes should be made prior to the new services being in place. Patient choice should be considered. Patients form a relationship of trust with their doctor, and want to see this maintained. There is resistance to privatisation. Consideration should also be given to mental health, palliative care, management and management systems.

There was less support for the proposal to introduce beds with care in care home environments, with 42% agreeing and 46% disagreeing. Quality of care and availability of nursing/care home beds and concerns about privatisation were the main issues. The support for this proposal recognised the need to unblock hospital beds and to provide choice. Matters concerning finance, integration of services, timing of the introduction of the new service, palliative care, carers and mental health and the need for more information were raised.

There was broad support for the provision of Community Hubs. These were regarded as helpful in preventing hospital admissions and reducing demand on GP and A&E services. Those who did not support Community Hubs felt they destabilised health care provision and would be ineffective.

Proposal 2: Community Hospitals

There was strong support for retaining GP community hospital beds in all four of the hospitals with c.56% disagreeing with the proposal to close these hospital beds and c.17% - 20% agreeing with the proposals. It is felt these hospitals are needed. Those who supported their closure felt they were no longer sustainable and were satisfied with the alternative services proposed.

There was support for the proposal to change the use of beds at Beccles hospital. However, there was also concern that these would not be enough and that the location was too remote for many.

6. Future commissioning

6.1 Throughout the public consultation period, the CCG has been working closely with communities and clinicians across Great Yarmouth and Waveney. To provide both support and reassurance, a number of key messages have been published by the CCG. These will form part of our ongoing commissioning arrangements, subject to Governing Body approval.

6.2 The CCG will develop a commissioning approach that is built on prevention, early care, care based in local communities, in community hubs, with access to local beds with care right across the CCG area, but where we take into account prevailing local circumstances.

7. Recommendations for the Governing Body to approve

7.1 The Governing Body has been able to review all the responses from the public consultation, the guidance that exists from NHS England, emerging evidence from organisations like the King's Fund, the recommendation reached by the options appraisal workshop on 13 October and the results of the Lowestoft out of hospital team pilot.

There is support for the development of a general model of care based on more community services providing care closer to people's homes and where possible, in their own home. Having weighed all of that evidence the Governing Body is being asked to decide on the following specific recommendations:

7.2 Recommendation one: All Hallows Hospital

Develop out of hospital services supported by beds with care in the Bungay area. These will be developed with local clinicians. Once these services are in place we would anticipate that there will not be a need for the GP community hospital beds at All Hallows Hospital and we will then be able to close those beds.

7.3 Recommendation two: Beccles Hospital

Change the use of the GP community hospital beds at Beccles Hospital to provide an intermediate care facility for the whole of Great Yarmouth and Waveney. This will be for patients who have longer term needs due to medical and/or social care issues which need to be resolved before the patient goes home. This would include locally designed out of hospital services and appropriate support in beds with care within Beccles.

7.4 Recommendation three: Northgate Hospital

Fully implement a North out of hospital team and beds with care across the local area. These will be developed with local clinicians and will need to take into account appropriate provision for the rural areas of the Northern villages. Once these services are in place we would anticipate that there will not be a need for the GP community hospital beds at Northgate Hospital and we will then be able to close those beds.

7.5 Recommendation four: Patrick Stead Hospital

Halesworth have put a strong case for their bedded care being a successful model in such a rural area and we will develop a new service with local clinicians. This will include beds with care being available and we hope that this will be in the new Castle Meadow facility. Out of hospital services will be developed to support this model of care. Once these services are in place we would anticipate that there will not be a need for the GP community hospital beds at Patrick Stead Hospital and we will then be able to close the hospital.

7.6 Recommendation five: Southwold Hospital

We have heard from the Southwold community that the current out of hospital model will not work in the same way in more rural areas. We will work with the local community and clinicians to design a model with out of hospital services and appropriate beds with care in the local area.

Southwold Hospital now only contains GP community hospital beds with all other services having relocated to the new Sole Bay Health Centre. GP community hospital beds at Southwold Hospital are temporarily suspended due to staffing issues. During this time the local community has been able to support patients well, we will work quickly with the local community to put the new out of hospital services in place to support this further.

We would anticipate that once they are in place there will not be a need for the GP community hospital beds at Southwold Hospital and we will then be able to permanently close the hospital.

There are a number of principles for the new services that we are recommending to the Governing Body:

- NHS funded beds with care will be provided in local nursing and residential homes and these will be provided to NHS quality and safety standards and be closely monitored.
- Out of hospital teams will be based in new community hubs across the area.
- The CCG will work with local providers to make sure services are tailored to the needs of the local population.
- The CCG will work with local providers to make sure staff are appropriately supported throughout the changes.

7.3 **The Governing Body is asked to endorse the following to support the implementation phase:**

The Governing Body should note that all changes will be subject to a phased implementation process. This means that community services will be in place before bed changes are implemented.

These changes, if supported by the Governing Body on 5 November, will be planned and implemented on a locality basis, with engagement and design carried out in conjunction with local stakeholders and local communities. They will also take account of the detailed points made in the options appraisal report under section 4.2.

The intent is to have **local implementation**. This means that the CCG will commit to a principle that the mix and configuration of beds with care / out of hospital teams / community hubs can and will be different in different localities. The CCG will work with local stakeholders, particularly clinical colleagues, to design what is right for each community and their care providers.

This implementation process will be overseen by the Shape of the System Implementation Steering Group, chaired by the CCG. A project manager will be appointed to deliver the work required by the Steering Group. The Steering Group will report jointly to the CCG's Governing Body

The CCG will hold the Steering Group to account for the implementation of these changes and recommendations formally through the contracting process. The governance structure for this group is attached at **Appendix Two**.

This proposed model is flexible, which, during implementation, will take into account local needs in each of the communities that we serve. This implementation process will be underpinned by some essential principles to localise out of hospital arrangements. These are:

- Out of hospital services will be designed according to local need and the running arrangements will be designed for local circumstances. There will not be a set model for an out of hospital team; services will be agreed on a locality by locality basis, designed with local partners.
- It will be acceptable for there to be a 'mixed economy' across Great Yarmouth and Waveney, with local and potentially different arrangements across the CCG area.
- Out of hospital services will cover all seven days a week. How this cover works will depend on locally agreed arrangements
- Each locality's arrangements will be sustainable and resilient – with some support probably coming from outside any individual locality
- Each locality will have access to appropriate resources eg specialist nursing inpatient beds.

The CCG accepts that savings from some parts of the CCG may be smaller than elsewhere in the CCG in view of the existing differentials in emergency admission rates. This will be taken into account at the design and development stage but arrangements for individual practice localities cannot exceed "fair share" levels.

8. Conclusions

8.1 The CCG is confident that we have followed a robust process to arrive at these recommendations. This included a full public consultation.

8.2 We recognise and acknowledge that whilst we have been able to deliver recommendations that match the views of many of the replies to the consultation our recommendations will not be satisfactory to everyone.

8.3 We are confident that these recommendations are correct for the Governing Body to approve. We have listened to what the people of Great Yarmouth and Waveney have told us, and we have adapted our plans to respond to their views. They provide the best quality services designed with current best practice in mind and in an affordable way.

8.4 We are confident that we have arrived at the best way to look after our residents and we will continue to make sure that the care being provided is high quality and we will monitor this on an on-going basis.

8.5 Finally, the CCG wishes to assure everyone who has any interest in health services that we will continue to monitor the implementation of these proposals very carefully with providers, local clinicians, staff and patient representatives to make sure that patients remain safe, that the quality of services is good, and that staff are fully engaged throughout the next phase of this project.

Rebecca Driver
Director of Engagement
October 2015

NHS
Great Yarmouth and Waveney
Clinical Commissioning Group

HealthEast

Shape of the System: Option Appraisal Report

1. Introduction

1.1. Purpose of this paper

GYWCCG has undertaken a public consultation on proposals for the development of modern and sustainable health services in Great Yarmouth and Waveney. The consultation covered community based services for Great Yarmouth and Waveney, with new out of hospital teams and integrated community hubs; GP beds in community hospitals in Southwold, Halesworth (Patrick Stead), Beccles, Northgate Hospital in Great Yarmouth and All Hallows in Ditchingham. The consultation was about:

- How care is provided in communities and community hospitals.
- Where services are based across the CCG area to ensure equity for everyone who lives in Great Yarmouth and Waveney.

The CCG embarked on a consultation process to help assess the views of service users, health and other care professionals and the wider public, as reported to the CCG's Governing Body in September.

In order to help the CCG's Governing Body to make carefully considered and objective decisions, a structured and robust process has been undertaken with a wide range of local stakeholders to appraise two options:

- The current service model.
- A proposed service model with a number of changed service elements.

The purpose of this paper is to report the conclusions of an option appraisal workshop held on 13 October 2015.

1.2. Contents

This paper sets out:

- The process undertaken, using a structured "weighting and scoring" approach.
- The options evaluated for each service.
- The results: weighted scores and ranked list of options in order of preference.
- The rationale for the scoring.
- Sensitivity analysis to test the robustness of the results.

2. The appraisal process

2.1. Overview

The appraisal process used a structured weighting and scoring approach with the following key elements:

- A shortlist of **options** to be evaluated.
- A list of **benefit criteria** and key factors to be considered for each criterion. These were ranked in order of importance and allocated a weighting at the workshop.
- A **Factsheet Pack** (including a summary of the responses from the public consultation) provided workshop attendees with information for each of the key factors.
- At the appraisal workshop, each option was scored in turn against the benefit criteria to generate a **weighted score** for each option.

The weighting and scoring exercise was undertaken by a representative group of stakeholders from the local health and social care community, local authority organisations, third sector and patient groups (see Appendix 1).

This approach is based on HM Treasury Guidance on option appraisal which states: "A method in common use within option appraisal is to weight and score the non-financial benefits for each option. This is preferable to simply ranking the benefits, as placing them in their order of priority does not in itself provide any objective assessment of how the incidence of these benefits varies from option to option. "

"Weighting and scoring provides a technique for comparing and ranking options in terms of their associated non-financial benefits."

"It is important to recognise that the assigned weights and the scores given to options are value judgments. In order to assign weights and scores, negotiation and compromise needs to take place. It is the number of people involved in the process and their expertise that lends credibility to these value judgments."

2.2. Weighting and scoring process

The process for each appraisal was as follows:

- Participants were allocated to six groups of 6-8 with individuals pre-allocated in order to ensure a mix of backgrounds and service perspectives in each group.
- Each group considered and discussed the benefit criteria and reached a consensus view to:
  - Rank the criteria in order of importance (equal rankings were allowed).
  - Allocate a weight out of 100 to reflect that ranking, i.e. the first ranked should have more points than the second, etc.

  Any individuals dissenting from the consensus view had the opportunity to submit separate rankings or weightings.
- Each group presented their proposed rankings and weighting with reasons for their decisions for plenary discussion.

- The results from the different groups were aggregated and presented back to the plenary group to "sense check" that the differential weightings appropriately reflect the discussions.
- 'Scoring' describes how well each option meets each of the benefits criteria. The process for scoring the options followed the same principles, i.e. group consensus scores, aggregation and discussion, sense check. Participants recorded their scores out of 10 using the following scoring guide.

Score	What it means
10	Could hardly be better
9	Excellently
8	Very well
7	Well
6	Quite well
5	Adequately
4	Somewhat inadequately
3	Badly
2	Very badly
1	Extremely badly
0	Could hardly be worse

- The scores for each option were then multiplied by the weights for each criterion, and a total weighted score was calculated for each option.

The Factsheet Pack provided supporting information to inform both exercises.

2.3. Benefit criteria

The seven benefit criteria and the key factors considered are described below.

	Benefit Criteria	Factors to be considered
1	To enable sustainable delivery of clinical services	• Provides a platform for the delivery of sustainable, high quality, NHS-standard healthcare services within the resources available, that are monitored and quality assured. • Provides the configuration and facilities to meet the projected demand for services, "future proofing" the provision of local healthcare services.

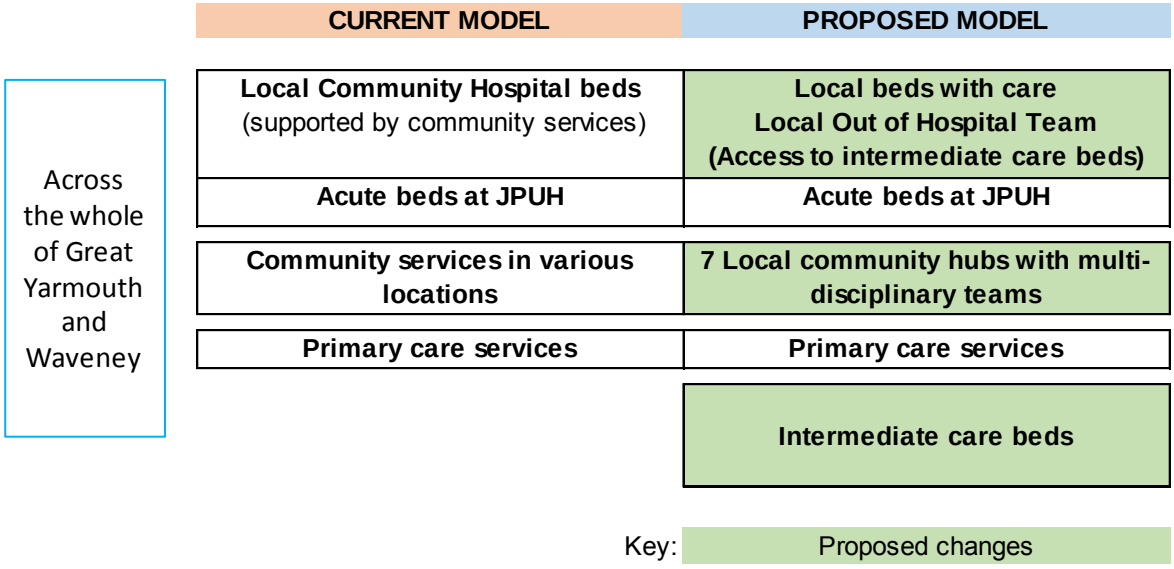
	Benefit Criteria	Factors to be considered
2	To improve outcomes for health and well being	• Supports the delivery of appropriate and safe health care for the local population. • Delivers the national and CCG objective to help and support people at home (when appropriate) rather than in hospital.
3	Ease of deliverability	• Level of public and political support. • Costs of implementation and ongoing services are affordable. • Suitability of estate and facilities for proposed changes, implications for return on previous capital investment. • Appropriate community services will be in place before any change in the inpatient service. • Timescales for delivery.
4	To provide equitable	• The configuration of services achieves equitable access across the

	access to services and resources across the population to reduce health inequalities	Great Yarmouth and Waveney area. • Helps to eliminate current health inequalities across the Great Yarmouth and Waveney population. • Allocation of resources reflects a "fair shares" basis.
5	To support the development of an Integrated Care System (ICS)	• Enables partner organisations to work together in an integrated way - including NHS, social care and third sector organisations. • Enables patients to be seen by the right person at the right time.
6	To improve the patient experience	• Provides local services (if not at home) in modern buildings and grounds that meet current environmental and therapeutic standards for patients and visitors, workforce and the wider community. • The site(s) provide space to extend, add or modify buildings and allow internal adaptation if service requirements change.
7	To assist workforce development	• Provides an environment to aid recruitment and retention - provides continuity of care through lower turnover of staff. • Enables the service to achieve high standards in staff development and health care practice. • Assists in complying with national priorities and guidelines around working hours and training.

3. The Options

The key service elements in the two options are summarised in the figure below, highlighting where changes to the current services are proposed:

- **Current** service model.
- **Proposed** service model with the elements as set out in the consultation document.



No changes were proposed to primary care or acute services in the future model. The proposed model will replace current community hospital bed provision with a mix of locally based beds with care, out of hospital teams and locality community hubs, together with a central facility with intermediate care beds serving all of Great Yarmouth and Waveney.

The CCG published a clarification statement at the outset of the consultation process regarding a number of essential principles that will underpin arrangements for localising Out of Hospital arrangements, as follows:

- Out of Hospital services will be designed according to local need and the running arrangements will be designed for local circumstances. There will not be a set model for an out of hospital team as services will be agreed on a locality by locality basis, designed with local partners.
- It will be acceptable for there to be a mixed economy and local, potentially different, arrangements across the CCG area.
- Out of Hospital services will cover all 7 days a week. How that cover operates will depend on local arrangements.
- Each locality's arrangements will be sustainable and resilient – with some support probably coming from outside any individual locality.
- Each locality will have access to appropriate resources e.g. specialist nursing, in-patient beds.

The proposed service option was, therefore, appraised on the basis that the above principles apply. It is important to note that the appraisal was to determine the best overall model of care going forward. It was not to determine the detailed models in each locality which would be undertaken as part of the implementation process.

Results

The results of the appraisals are summarised in the sections below. A more detailed table is included in Appendix 2.

3.1. Ranking and weighting the benefit criteria

The seven criteria were ranked and weighted out of 100 as follows:

	Benefit Criteria	Ranking	Weighting out of 100
1	Enable sustainable delivery of clinical services	2	21.7
2	Improve outcomes for health and well being	1	24.2
3	Ease of deliverability	6	10.5
4	Provide equitable access to services and resources across the population to reduce health inequalities	3	13.3
5	To support the development of an Integrated Care System (ICS)	4	11.2
6	To improve the patient experience	4	11.2
7	To assist workforce development	7	8.0
			100.0

- Criteria 1 and 2 were ranked top by all six groups which is reflected in a total weighting of nearly 46% for those criteria. Criterion 4 was ranked third overall (and by four of the six groups) but with a weighting significantly lower than the first two criterion (13.3%).
- The rankings and weightings for the remaining four criteria were closely grouped. Integration and the patient experience (criteria 5 and 6) were jointly ranked fourth with 11.2% weighting), just ahead of ease of deliverability on 10.5%. The workforce development criterion was lowest ranked.

- Discussion focussed on three issues:
    - There was concern that the workforce development criterion (7) was ranked lowest as all groups in discussion had identified that the availability of a suitably qualified and experienced workforce, with sufficient capacity, was essential to deliver the new service model. It was agreed to test the end results to check if a higher weighting would change the result.
    - A similar concern was expressed about the weighting for integration (4) which in discussion had been identified as a key element of services going forward. Again, it was agreed to test the end results to check if a higher weighting would change the result.
    - The factors under patient experience (6) are only about buildings and environment – clearly the patient experience takes in a much wider range of factors. It was agreed in discussion that these other factors were appropriately included in other criteria, particularly 1 and 2.

3.2. Scoring the options

The raw scores (out of a maximum of 70) and weighted scores (out of a maximum of 100) were:

Scoring results	Current services	Proposed services
Raw scores (out of 70)	32.7	48.1
Weighted scores (out of 100)	46.5	69.5
Rank	2	1
% of highest ranked	66.9%	100.0%

The results show that **the proposed service model is the preferred option**.

The proposed services option was given the highest raw score and the highest weighted score. The gap between the two options was more than 33% - a significant difference.

All six groups gave higher scores to the proposed service model on all seven criteria – this shows a high level of consistency across the groups.

Rationale for supporting the proposed model option

- While there is no indication that the current model of care is poor or unsatisfactory, it may not be fit for purpose for the future and will not help to achieve equity of services across the whole area.
- Integration of services is more likely to be achieved in the proposed model – integration across health (including mental health) and with social care was identified by all groups as a key requirement of a successful care model going forward.
- The patient experience is likely to be better in all aspects: sustainable high quality services, care provided at home when possible, benefits by having access to fit for purpose buildings.

- The current services are struggling to cope with insufficient staff and inadequate facilities – the proposed model was considered to be more sustainable and resilient for future requirements.
- The CCG commitment to flexible local implementation of out of hospital care means that the proposed model can offer greater flexibility that is matched to local needs.
- As noted in 4.1 above, all groups identified that the availability of a suitably qualified and experienced workforce, with sufficient capacity, was essential to deliver the new service model. New flexible models of care and new facilities will encourage staff retention and recruitment.
- The proposed services option was scored by groups on the assumption that the CCG will deliver what it has promised, particularly in terms of flexible local implementation.
- The groups scored from the perspective of the whole of the Great Yarmouth and Waveney area – it was noted that scores at a locality level would vary, particularly for criterion 3 (ease of deliverability).

Issues the CCG will need to address at implementation stage

The workshop groups delivered a robust endorsement of the proposed service model. They identified, however, that the model is largely conceptual at this stage so a number of key issues will need to be addressed by the CCG at the next stage of designing and implementing the model for each locality. These can be summarised as follows:

- **Service definitions**. A clearer definition of the service elements is required.
    - Defining what the “Out of Hospital service” looks like for each area so that it is clearly understood.
    - A clear definition of “intermediate care” setting out what value is added i.e. what will make it different from what already happens in the current community hospitals?
    - How will equity of access to the intermediate care beds be ensured?
    - Community hubs: what is their role, how is their location determined, what are the pathways to them, how do they link with other organisations, how will people travel to them, how do people contact them?
    - Who will co-ordinate the Out of Hospital teams?
- **Sequence of change**. The CCG will not remove services that are operating now until replacement services are in place.
- **Quality of care**. Care quality must be commissioned at NHS standard throughout and must be closely monitored.
- **Transition**. Transition arrangements need to be understood:
    - How will the workforce be retained through transition?
    - How will change in skills/training be delivered?
    - What are the timescales for delivery?

- **Capacity**. The CCG will need to ensure there is sufficient capacity in the new model:
    - Are there enough intermediate care beds (concern that this will push activity back to the acute sector if not)?
    - Are there sufficient beds with care to meet the stated quality standards?
    - What happens when the community team reaches full capacity – what are the back-up arrangements to ensure a 24/7 service? Community services must not close when capacity is stretched.
    - Responsive community services are vital when the acute hospitals are stretched.
- **Local models**. There are different issues and priorities across urban and rural areas – the area models will need to be developed to best meet local needs.
- **Palliative care**. The needs of palliative care patients must be built into the model, particularly for end of life access to a bed if required.
- **Voluntary/third sector** must be included as part of the locality models.
- **Costs**. A clearer understanding of current costs compared to future costs is required, area by area, to demonstrate that the new model provides value for money and is affordable.
- **Continuing engagement**. Engagement with stakeholders and the public has been good to this point - further engagement is essential at the next stage when the proposals are considered in detail at locality level.
- **Qualities in the current model**. The CCG should aim to take the best qualities out of the old system and embed in the new.

3.2.1. Sensitivity testing

Two tests were applied to see how either a change in weighting or in scoring would change the identity of the preferred option:

- The proposed service option scores more than the current service option on all criteria therefore a change in the weightings would not change the order.
- Changing the scores for the current service option on the highest ranked criteria: it would require an increase in the score for the current service option on criterion 2 of 4.9 (96%) to 10.0 plus an increase in the score on criterion 1 of 5.2 (123%) to 9.4 to give the current service option the highest score.

3.2.2. Conclusions on sensitivity testing

The sensitivity tests show that a change to the weightings would not change the preferred option and that the scoring would require a significant change, giving the current service option a perfect 10 on the highest ranked criterion and 9.4 on the second highest – higher than any of the actual overall scores recorded for any option - in order to change the result.

On this basis, the conclusion is that the results are robust and that the **proposed service model is confirmed as the preferred option**.

4. Conclusions

This option appraisal was undertaken to provide a further piece of evidence to support the CCG's Governing Body in its decision making process. The conclusion from the workshop provides a clear view that **the proposed service model is the preferred option**.

The workshop identified that the model is largely conceptual at this stage and that there are a number of key issues that will need to be addressed by the CCG at the next stage of designing and implementing the model for each locality. These are set out in detail in section 4.2 and cover:

- Clear definitions of the new services.
- New services in place before current services are withdrawn.
- Care quality is NHS standard and closely monitored.
- Transition arrangements are carefully considered.
- There is sufficient capacity in all elements of the new service.
- Local models are developed to best meet local needs and circumstances.
- Appropriate palliative care provision is included.
- Costs of the new service demonstrate value for money and are affordable.
- Engagement will continue.
- Take the best qualities from the old into the new.

APPENDIX 1: Workshop attendees

Name	Organisation
Andy Evans	NHS Great Yarmouth and Waveney CCG (GYWCCG)
Jonathan Williams	ECCH East Coast Community Healthcare (ECCH)
Adele Madin	ECCH
Gill Moorshead	NSFT Norfolk and Suffolk Foundation Trust (NSFT)
Ruth Pillar	NSFT
Nicole Rickard	Waveney District Council/GYWCCG
Tim Morton	Beccles Medical Centre
Kerry Overton	Healthwatch Suffolk
Kash Gopee	Longshore Surgery, Kessingland
Supt Paul Sharp	Suffolk Police
Mark Jackson	Suffolk Police
Sue Jenkins	ECCH
Dexter Kirk	Southwold and Reydon Society
Andrew Eastaugh	Sole Bay GP (retired)
Rigby Whitaker	Sole Bay Health Centre
Barbara Craddock	Beccles Medical Centre
Gillian Wright	ECCH
Di Rudge	Beccles Hospital
Jon Barber	James Paget University Hospital (JPUH)
Jenny Hyams	Bungay patient representative on the Patient Public Experience Group
Jonathan Knights	East Norfolk Medical Practice
Dr Liam Stevens	East Norfolk Medical Practice
Myles Duffield	Newtown Surgery
Richard Kell	Halesworth Health
Mary Rudd	Waveney District Council
Jason Peek	Suffolk County Council Out of Hospital Teams

Name	Organisation
John Lewis	Suffolk County Council (SCC)

Chonde Nkowani	Suffolk County Council Social Care
Vicky George	Great Yarmouth Borough Council (GYBC)
Andrew Palmer	JPUH
Sue Watkinson	JPUH
Sarah Hall	Norfolk County Council (NCC)
Rebecca Driver	GYWCCG
Dr John Stammers	Sole Bay GP
Cath Gorman	GYWCCG
Kate Gill	GYWCCG
Zoe Pietrzak	GYWCCG
Tessa Litherland	GYWCCG
Louise Jordan-Hall	GYWCCG
Ian Wakefield	GYWCCG
Amara Cunningham	GYWCCG
Steve Wilkinson	Independent Analyst
Alan Kent	Litmus Health

People who were invited but were unable to attend:

Name	Organisation
Michael Ladd	SCC
Howard Green	All Hallows Hospital
Jack Jones	PPG Chair
Alan Hopley	Voluntary Norfolk
Trevor Wainwright	GYBC
Cathy Ryan	Sole Bay Surgery
Kim Balls	GYBC
Tony Rollo	Healthwatch Suffolk
Kirstie Green	Suffolk County Council Social Care

APPENDIX Two: Workshop result schedule

Raw and weighted scores

Benefit Criteria	Weighting out of 100	Current services	Proposed services
Raw Scores (out of a total of 70)			
1 Enable sustainable delivery of clinical services	21.7	4.2	7.1
2 Improve outcomes for health and well being	24.2	5.1	7.2
3 Ease of deliverability	10.5	5.0	6.3
4 Provide equitable access to services and resources across the population to reduce health inequalities	13.3	4.3	6.8
5 To support the development of an Integrated Care System (ICS)	11.2	4.7	7.3
6 To improve the patient experience	11.2	4.1	6.7
7 To assist workforce development	8.0	5.2	6.6
	100.0	**32.7**	**48.1**
Ranking		**2**	**1**
% of highest		67.9%	100.0%
Weighted Scores (out of a total of 100)			
1 Enable sustainable delivery of clinical services	21.7	9.2	15.5
2 Improve outcomes for health and well being	24.2	12.3	17.3
3 Ease of deliverability	10.5	5.2	6.7
4 Provide equitable access to services and resources across the population to reduce health inequalities	13.3	5.8	9.0
5 To support the development of an Integrated Care System (ICS)	11.2	5.2	8.2
6 To improve the patient experience	11.2	4.6	7.5
7 To assist workforce development	8.0	4.1	5.3
	100.0	**46.5**	**69.5**
Ranking		**2**	**1**
% of highest		66.9%	100.0%

Great Yarmouth and Waveney Clinical Commissioning Group

HealthEast

Version 4: 29 October 2015

Governance Structure for the Shape of the System Project: Implementation Steering Group

1. Introduction and purpose

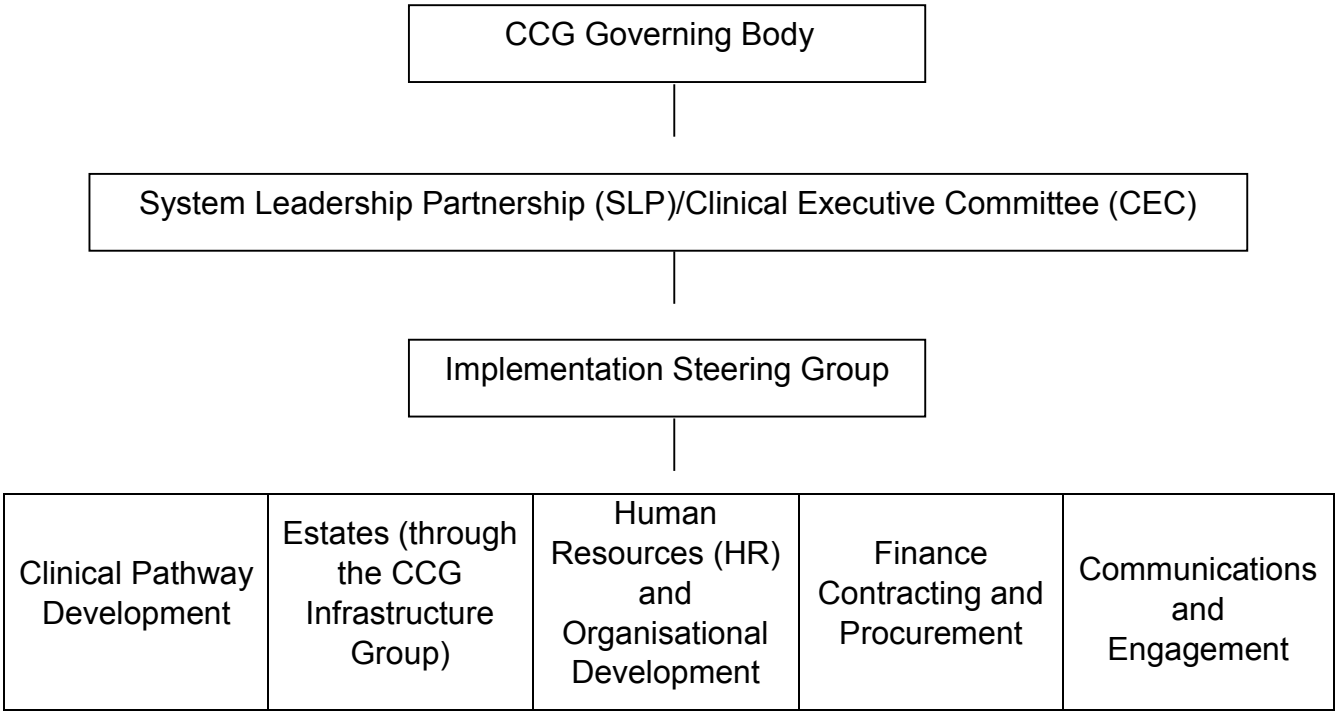
1.1 This document sets out the proposed governance structure for the Shape of the System Implementation Steering Group, following the public consultation on health services provided in the Great Yarmouth and Waveney area. This will be confirmed as part of the implementation.

1.2 The scope of this project reflects the CCG's Five Year Strategy and our Integration Strategy.

1.3 It is proposed that the project lead is Fran O'Driscoll, the Head of Infrastructure and Strategy Development, supported by Leigh Fraser, Head of Operational Finance and Planning.

2. Proposed structure

Shape of the System Implementation Steering Group Governance Structure



3. Objectives and purpose of group

3.1 The Shape of the System Project Implementation Steering Group will manage and oversee a multi-organisational project with the specific goal to:

Deliver new ways of working to provide health services closer to home through out of hospital teams, community hubs, intermediate care and beds with care in Great Yarmouth and Waveney, in accordance with the decisions made at a meeting of the NHS Great Yarmouth and Waveney CCG Governing Body on 5 November 2015.

3.2 The objectives of the project have been defined as follows, to:

- Provide services of sufficient capacity for, and accessibility to, the defined population
- Provide appropriate and therapeutic care environments
- Provide flexible accommodation where use can be changed in future years to reflect new policy, working practices or needs
- Introduce new ways of working in line with the national agenda and to improve effective team working
- Maintain/increase the ability to retain and recruit and develop high calibre staff by improving the working environment, facilities and overall model of care
- Improve the effectiveness of current resources used for the provision of local services

3.3 This implementation process will be underpinned by some essential principles to localise out of hospital arrangements. These are:

- Out of hospital services will be designed according to local need and the running arrangements will be designed for local circumstances. There will not be a set model for an out of hospital team; services will be agreed on a locality by locality basis, designed with local partners.
- It will be acceptable for there to be a 'mixed economy' across Great Yarmouth and Waveney, with local and potentially different arrangements across the CCG area.
- Out of hospital services will cover all 7 days a week. How this cover works will depend on locally agreed arrangements
- Each locality's arrangements will be sustainable and resilient – with some support probably coming from outside any individual locality
- Each locality will have access to appropriate resources eg specialist nursing inpatient beds.

4. Responsibilities

4.1 The Steering Group will be responsible for:

- Confirming the service scope
- Revising the initial designs for service models, and, if necessary, submitting revised plans for approval
- Preparing further business case documentation as required

4.2 As the project progresses the Steering Group will also ensure :

- Benefits Realisation - The Steering Group will ensure that realisation of benefits to all of the stakeholders in the process is achieved through close monitoring by the CCG
- Risk Management - The Steering Group will ensure that risk in the project is managed through the CCG's management processes and Board Assurance Framework. Any associated construction project will include the operation and maintenance of a project risk register
- Post Project Evaluation (PPE) - The Steering Group will ensure that PPE takes place at the end of the initial project and at appropriate intervals thereafter.
- Public accountability and patient involvement in the project, as per the 2012 NHS Health and Social Care Act
- Leading and coordinating the work of the Implementation group and associated workstreams:
  - Infrastructure and estates
  - Human Resources and Organisational Development
  - Finance, contracting and procurement
  - Clinical pathway development
  - Communication and Engagement

- Ensuring that project timescales are delivered and allocated budget is not exceeded
- Any information written by the Engagement team for the public is approved.
- The distribution of all information to the media via the CCG's communications team
- Information is added to relevant websites
- The Steering Group acts as an advisor to directorate leads and to ensure the process is followed and deadlines are met
- The Steering Group adheres to any deadlines prescribed by relevant Boards or Governing Bodies
- Proposals are presented in a timely way to the Great Yarmouth and Waveney Health Overview and Scrutiny Committee, and the Norfolk and Suffolk Scrutiny Committees as required

5. Frequency of meetings

5.1 Meetings will be held bi-monthly.

6. Reporting arrangements

6.1 The Steering Group will report to the CCG's Governing Body. Delegated authority to act from the Governing Body will be in place through the Chief Executive, Andy Evans.

7. Membership

7.1 Membership of the Steering Group will comprise:

Name	Role	Organisation
Andy Evans (Chair)	Chief Executive	CCG
Rebecca Driver –	Director of Commissioning and Engagement	CCG
Kate Gill	Director of Operations	CCG
Fran O'Driscoll	Head of Infrastructure and Strategy Development	CCG
Cath Gorman	Director of Commissioning and Quality and Chief Nurse	CCG
Leigh Fraser	Head of Financial Operations and Planning	CCG
Jane Hackett	Head of Unplanned Care	CCG
Jonathan Williams	Chief Executive	ECCH
Adele Madin	Director of Adult Services	ECCH
Clare Weller	Communications Lead	ECCH
Arthur Charvonia	Strategic Director	Waveney District Council
Robert Read	Director of Housing and Neighbourhoods	Great Yarmouth Borough Council
Michaela Hewitt	Head Of Social Care-East	Norfolk County Council
Cathy Craig	Assistant Director of Social Work (Adults)	Suffolk County Council
John Lewis	Interim Director of Commissioning and Market Development, Adult and Community Services	Suffolk County Council
Andrew Palmer	Director of Performance	James Paget University Hospital NHS Foundation Trust (JPUH)
Anna Hills	Associate Director of Governance, Safety and	James Paget University Hospital NHS Foundation

Name	Role	Organisation
	Compliance	Trust (JPUH)
Gill Moorshead	Great Yarmouth and Waveney Locality Manager	NSFT
Sean Perry	Strategic Projects and Asset Manager	NHS Property Services
Two GPs (urban and rural) tbc		

7.2 Clinical Pathways Development Group

Clinical engagement and input into the delivery of this project will be provided through the Clinical Executive Committee and ad hoc specific group work on a locality basis as required.

This work will ensure that options are based on sound clinical evidence and made in the best interests of patients, and that we can explain this to users in a way they can understand.

7.3 Estates and Infrastructure

NHS Property Services has been invited to join the steering group in addition to the CCG's Infrastructure Group which manages estates matters. This workstream will also include IT and digital road mapping. This group will be led by Fran O'Driscoll, Head of Infrastructure and Strategy Development.

7.4 Human Resources and Organisational Development

This group will include representatives from ECCH HR department, and be led and coordinated by Tracey Parkes, Head of System Integration Development. It will report to the Implementation Steering Group.

Its remit will be to oversee all associated HR issues and training, and to ensure appropriate work with all staff side organisations during the implementation phase.

Terms of reference will be developed.

7.5 Finance, Contracting and Procurement Group

This Group will be led by Leigh Fraser, Head of Financial Operations and Planning and will include representatives from the ECCH finance team and general practice. Terms of reference will be developed.

7.6 Communications and Engagement

This will be led by Lorraine Rollo, Head of Communications and Engagement.

Rebecca Driver
Director of Engagement
October 2015

Agenda Item 7

Great Yarmouth and Waveney Joint Health Scrutiny Committee, 13 November 2015

Information Bulletin

The Information Bulletin is a document that is made available to the public with the published agenda papers. It can include update information requested by the Committee as well as information that a service considers should be made known to the Committee.

This Information Bulletin covers the following items:

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1. Briefing update (October) on Marine Parade and Oulton Village practices

NHS
Great Yarmouth and Waveney Clinical Commissioning Group

HealthEast

On Tuesday, 13 October, the Care Quality Commission (CQC) took urgent legal action to protect the safety and welfare of patients at the Oulton Village and Marine Parade Practice. This resulted in the immediate closure of the Oulton Village surgery site, whilst Victoria Road Practice continued to run the Marine Parade site, based in the Kirkley Mill Health Centre.

This has been a worrying time for patients, but NHS Great Yarmouth and Waveney Clinical Commissioning Group (CCG) and NHS England are working together to make sure that stable services are resumed for patients as soon as possible from permanent GP practices. Following the CQC action, cover arrangements that were immediately put in place for patients have now been extended for three months.

These cover arrangements are:

Patients from Oulton Village Practice (NR32 postcodes) will continue to be cared for by the Bridge Road GP Practice at 1A Bridge Road, Oulton Broad (Tel: 01502 565936).

Patients from Marine Parade (NR33 postcodes) based at the Kirkley Mill Health campus (Tel: 01502 574072) will continue to be seen there, cared for by staff from the Victoria Road Surgery.

Some patients have chosen to re-register with other practices, but there is no need for them to do this at the moment. There is a GP service looking after patients, at either Bridge Road or Marine Parade in the Kirkley Mill Health Centre. Patients do, of course, have the option to register with a different practice at any time if that practice is open for new patients. No one will be left without a GP as a result of these changes.'

The focus now is on what happens next. The CCG and NHS England will make sure there are solid and permanent arrangements in place to look after every patient affected by this urgent CQC action. NHS England has sent a letter to all patients who were registered at the practices to explain exactly what has happened at their practice.

Over the next three months, work will continue with all the Lowestoft practices to find a permanent solution for all the Oulton and Marine Parade patients. By working with the practices we will be able to find a solution for every patient and provide them with a high quality GP service. All the staff in the Lowestoft practices have been outstanding in their response to this very urgent need.

29 October 2015

For further information please contact: Lorraine Rollo, Head of Communications and Engagement (HealthEast); Email: lrollo@nhs.net, Telephone: 01502 719582.

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2. Briefing update (September) regarding a number of GP practices in the Gt Yarmouth, Lowestoft and Gorleston area

Oulton Medical Centre, Lowestoft

Background

Oulton Medical Centre is a two partner husband and wife practice operating from two sites (Oulton and Marine Parade) in Lowestoft. The current registered list is approximately 5,200 patients.

CQC Findings

In March 2015, the Oulton Medical Centre was placed in special measures by the Care Quality Commission after being given an overall rating of 'inadequate'. The CQC also applied compliance actions requiring the provider to take action in relation to the provision of adequate clinical and management cover at the practice.

The CQC had previously undertaken an inspection in August 2014, which was followed by the announced comprehensive inspection in March 2015. The practice was rated as inadequate for safe, effective, responsive, and well-led services following the later visit.

The report highlighted areas where improvements were needed, which included:

- implementation of arrangements relating to the management of significant events;
- safety alerts, health and safety and fire safety;
- recruitment and management of staff, including effective training, and induction systems; and
- record keeping and governance arrangements.

There have been some long standing issues relating to this practice and NHS England had required that the practice address a range of issues identified in November 2014 which were also reflected in the CQC findings.

It should be noted that at the CQC visit, patients reported that they were satisfied with the care and treatment that they had received from the practice.

Current Situation *{as at September 2015 – see separate October update}*

The practice has now submitted an action plan to the CQC to address the findings of the CQC. The practice has shared this plan with NHS England, who will work jointly with NHS Great Yarmouth and Waveney to monitor progress and support the practice in delivery of this plan.

The practice has engaged with the Royal College of General Practitioners (RCGP) Pilot which is a programme designed to offer support to practices placed in Special Measures.

NHS England requires that the practice submits a weekly clinical rota, which is monitored by our medical team, to ensure compliance with both the CQC and GMC conditions.

The practice is currently awaiting a re-visit from the CQC for a full inspection.

Improvements Made and Next Steps

Due to the serious nature of the report and the nature of the concerns within it, NHS England is carrying out a formal review to determine whether the practice is meeting the terms of the GMS contract. This will inform NHS England of any further actions to be taken.

The Family Health Care Centre

Background

The Family Health Care Centre is a sole contract holder practice operating from one site in Gorleston-on-Sea, Great Yarmouth, Norfolk. The current registered list is approximately 5,300 patients.

CQC Findings

In March 2015, the Family Health Centre was placed in special measures by the Care Quality Commission after being given an overall rating of 'inadequate'. The CQC also applied compliance actions requiring the provider to take action in relation to the provision of adequate clinical and management cover at the practice. The practice is required to, develop a clear management and leadership structure, and ensure that systems to monitor the quality of the service are established so that learning and improvement takes place.

Current Situation

The practice has now submitted an action plan to the CQC to address the findings of the CQC. The practice has shared this plan with both NHS England and NHS Great Yarmouth and Waveney CCG, who are working jointly to monitor progress and support the practice in delivery of this plan.

The practice are not working with RCGP but have engaged support from a local Practice Manager to work with the practice team to implement the CQC action plan.

The CQC returned to the practice for a full inspection on Monday 14 September and positive feedback was given by the inspection team; however the formal report has not been published.

Improvements Made and Next Steps

NHS England and NHS Great Yarmouth and Waveney CCG made a joint visit to the practice in June 2015. The visit was to offer support with the implementation of the practices CQC plans and discuss progress towards the CQC re visit.

Kirkley Mill Health Centre

Background

Kirkley Mill Health Centre is a GP Partnership contract operating from one site in Lowestoft, Suffolk. The current registered list is approximately 4,600 patients.

CQC Findings

In February 2015 Kirkley Mill Health Centre was given an overall rating of 'Requires Improvement' by the Care Quality Commission.

Current Situation

Following a further inspection visit carried out in July 2015 the CQC issued a report in August 2015 rating Kirkley Mill Health centre as 'Good' overall.

Improvements Made and Next Steps

NHS England and NHS Great Yarmouth and Waveney CCG made a joint visit to the practice in June 2015. The visit was to offer support with the implementation of the practices CQC plans and discuss progress towards the CQC re visit. NHS England and NHS Great Yarmouth and Waveney CCG are pleased that following the CQC re visit the practice has been given the overall rating of 'Good'.

High Street Surgery Lowestoft,

Background

High Street Surgery is a GP Partnership contract operating from one site in Lowestoft, Suffolk. The current registered list is approximately 11,700 patients.

CQC Findings

Following an inspection visit in October 2014 and subsequent report issued In April 2015 High Street Surgery was given an overall rating of 'Requires Improvement' by the Care Quality Commission.

Current Situation

The CQC have re-inspected the areas of non-compliance and the formal report is awaited.

Improvements Made and Next Steps

NHS England and NHS Great Yarmouth and Waveney CCG made a joint visit to the practice in June 2015. The visit was to offer support with the implementation of the practices CQC plans and discuss progress towards the CQC re visit. NHS Great Yarmouth and Waveney CCG continue to support the practice in the areas of safeguarding and IT prior to the CQC re visit.

Cutlers Hill Surgery

Background

Cutlers Hill Surgery is a GP Partnership contract operating from one site in Halesworth, Suffolk. The current registered list is approximately 10,300 patients.

CQC Findings

Following an inspection visit in October 2014 and subsequent report issued In January 2015 Cutlers Hill Surgery was given an overall rating of 'Requires Improvement' by the Care Quality Commission.

Current Situation

The practice received a re-visit from the CQC on 6 July 2015 and are currently awaiting the CQC report, the practice has reported that the re visit went very well and they are expecting a positive outcome when the CQC report is published.

Improvements Made and Next Steps

NHS England and NHS Great Yarmouth and Waveney CCG made a joint visit to the practice in June 2015. The visit was to offer support with the implementation of the practices CQC plans and discuss progress towards the CQC re visit. NHS England and NHS Great Yarmouth and Waveney CCG were reassured that the practice had made good progress, and was ready for the CQC re visit.

September 2015

For further information please contact: Karen Hindle, Senior Associate (Communications) Interim Hub Manager (NHS England Midlands and East); Email: karen.hindle@nhs.net, Telephone: 0113 825 1667.

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3. Waveney Acute Services (Carlton Court) update

NHS
Great Yarmouth and Waveney Clinical Commissioning Group

HealthEast

The closure of the Waveney Acute Services unit was agreed following an extensive consultation by NHS Great Yarmouth and Waveney CCG and our Trust last year. It was agreed that adult acute mental health services would be relocated to Northgate Hospital, where a centre of excellence would be developed.

Since then, work has been taking place to build an additional five beds on the site to bring the number up to 20 adult acute beds. In the meantime the community-based services have been developed to support people better in their own homes and enabling a phased reduction in the beds at the Waveney Acute Unit.

Alongside these developments, there has been a detailed staffing transition plan to support staff through this change process and support them in moving to the new roles. Through this, patient and staff safety considerations have been paramount and regularly reviewed as the numbers of patients admitted to Waveney Acute Services reduced.

In September, it was decided that the two remaining patients on the Waveney Acute Unit would be moved to Northgate Hospital adult acute unit and the service would be suspended. This was ahead of the planned closure date on 31 October 2015.

Norfolk and Suffolk NHS Foundation Trust has agreed a plan with Great Yarmouth and Waveney CCG to develop the Waveney Acute Unit into a centre of excellence for young people, which was another outcome of the mental health consultation.

This year has seen NSFT implement a transition plan to ensure that the quality of services have not been compromised and any affected staff are embedded within the new teams.

29 October 2015

For further information please contact: Lorraine Rollo (Head of Communications and Engagement); Email: lrollo@nhs.net, Telephone: 01502 719582.

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4. ME/CFS update

The Myalgic Encephalomyelitis and Chronic Fatigue Service (ME & CFS) is commissioned by the Norfolk and Suffolk CCGs and is provided by East Coast Community Healthcare (ECCH). Ipswich and East Suffolk CCG is currently the lead commissioner for the service, responsible for working in partnership with the other CCGs in Norfolk and Suffolk and the ME & CFS User and Patient Group to support the development of the service.

In 2012 a new ME & CFS Service Specification was developed and agreed by the service users (led by Norfolk PCT). The search for an appropriate consultant was not successful, which meant it was unable to be implemented. ECCH currently provide services against the 'old' service specification and commissioners are working with the ME & CFS User and Patient Group and ECCH to agree a plan to implement the requirements of the new service specification. A draft transition plan has been developed to support the move to the new specification.

In the summer of 2015, the commissioners agreed to change the skill mix of the team and recruit a consultant to lead the service and support complex patients. An Expression of Interest advertisement has been published which closes at the end of October. The CCGs also agreed to implement a number of other changes detailed in the new specification. Decisions on some of the other new requirements are dependent on having the consultant in place and will be reviewed by in due course (pending successful recruitment).

The commissioners have confirmed their intention to continue to work with ECCH and the User and Patient Group, supporting the implementation of the new service specification.

For further information please contact: Isabel Cockayne, Head of Communications (West Suffolk CCG); Email: isabel.cockayne@suffolk.nhs.uk, Telephone: 01473 770012/07535 976832.

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5. Winter Planning

Attached is the paper that was produced for Suffolk HOSC around winter planning.

Funding has come as part of Great Yarmouth and Waveney Clinical Commissioning Group (GY&W CCG) allowance this year rather than as later winter funding, GY&W CCG received an additional £1.6m which is being used to fund the schemes in the paper.

For further information please contact: Lorraine Rollo, Head of Communications and Engagement (HealthEast); Email: lrollo@nhs.net, Telephone: 01502 719582.

The following item was published in the Information Bulletin for the Health Scrutiny Committee, 14 October 2015

Great Yarmouth and Waveney – Winter Planning 2015/16 and Delayed Transfers of Care Update

The Suffolk Health Overview and Scrutiny Committee has asked for an update on the planning for winter within the Great Yarmouth and Waveney system, and also the work taking place to reduce the number of delayed transfers of care at the James Paget University Hospital (JPUH).

Winter Planning – 2015/16

The system is finalising the Integrated Resilience Plan which will set out the steps being taken collectively across the Great Yarmouth and Waveney health and social care system to ensure that appropriate arrangements are in place to provide high quality and responsive services to patients.

This is supported by individual organisation plans which provide a more detailed description of operational systems and processes which will be in place to support winter 2015/16.

Operational Management – The system will draw upon tried and tested operational management processes put in place during 2014/15 to ensure operational resilience and stability.

These will include –

- 3 x daily dashboards (JPUH) including real-time activity data to inform the system of current demand, flow and pressures point
- A&E breach process to alert commissioners of potential issues regarding the A&E four hour wait target
- Fortnightly Urgent Care Board meetings which will change to weekly during the busy winter period to discuss operational issues to ensure plans are in place to address these
- A weekly telephone conference with senior members of the CCG and key providers to discuss system capacity and to highlight issues which may require intervention from senior managers
- The Systems Resilience Group will continue to meet on a fortnightly basis to provide operational scrutiny and oversee strategic developments
- During periods of increased pressure all system partners will be required to attend the James Paget University Hospital Operational meetings to discuss and agree mitigating plans, system capacity and delayed transfers of care. This includes support from senior colleagues within social care and community nursing.

Service Developments – Through operational resilience funding, CQUIN and other contractual agreements a number of developments are planned or are already in place to support continued operational resilience both year round and to support the periods of peak pressure over winter and Easter. These include –

- North Out of Hospital Team (NOHT) – the NOHT continues to embed in Great Yarmouth, Gorleston and the Northern Villages supporting those patients who may otherwise have been admitted to an acute or community bed. The service became operational on 1 April 2015 covering seven days a week 8am until 8pm. It is now available until midnight and from 1 October the service will provide 24/7 cover. The service supports facilitated discharges from JPUH

where patients are medically stable but require some rehabilitation and re-ablement in the community. Such a service is already in place and well established in Lowestoft.

- Ambulatory Care Unit (Ambu) – Ambu at JPUH is continuing to operate five days a week and this has supported same day discharge for a number of patients presenting with an ambulatory condition. The service has relocated within JPUH which will support the resilience of the service and reduce the likelihood of the unit being used for in-patient facilities during periods of peak pressure. From October 2015 Ambu will be operating seven days a week from 8.30am until 9.30pm. It is anticipated that the service will see approximately 20 patients a day with the majority being discharged on the same day.

- Hospital Ambulance Liaison Officer (HALO) – the HALO post will be reinstated from September/October 2015 until the end of March 2016. The primary purpose of this role is around integration, demand management and assistance with hospital turnaround delays and has operated successfully over the previous two winters. This year we strive to improve collaboration and integrate this role into the wider health economy to assist with frequent callers, admission avoidance access and allow timely feedback to EEAST clinicians regarding patient outcome from transports to A&E, creating a positive feedback loop to strengthen decision-making around admission avoidance.

- Mental Health Support in A&E – In line with the national CQUIN guidance Norfolk and Suffolk Foundation Trust and JPUH are working collaboratively to develop a service for patients presenting at A&E with a mental health issue. This is specifically targeted at frequent attenders who are accessing multiple services but will also target those presenting for a first time. The aim is to improve their experience and reduce the re-attendance rate of a specific cohort of mental health patients by engaging with them and providing appropriate dedicated services to minimise their need for emergency care. This is a targeted and focussed intervention aimed at reducing relapse. Crisis care plans will be shared with relevant organisations with patient consent.

- JPUH FLO Discharge Planning – From August 2015 JPUH have been implementing the visual hospital model as part of their patient flow initiatives. This includes a new system for monitoring patients to ensure real-time data to inform capacity and support flow throughout the hospital. This approach also includes bed managers visiting wards every two hours to see what patients are waiting for and why they are remaining on the wards to expedite actions. It is anticipated that this new process will improve flow throughout the hospital and through implementing now will ensure the new model is in place before winter. The second phase, plan for every patient, will be rolled out across ward areas from September 2015.

- Community Pharmacy Emergency Supply Service – the service will be in place over the Christmas and New Year bank holiday weekends to ensure patients can access an urgent supply of their regular prescription medicines where they are unable to obtain a prescription before they need to take their next dose. The service may be needed because the patient has run out of a medicine, or because they have lost or damaged their medicines, or because they have left home without them. The aim of this service is to relieve

pressure on urgent and emergency care services through patients being able to access their pharmacy directly rather than going to A&E or Out of Hours GP services.

- A winter communications plan has been developed and is being discussed with system partners to ensure a coordinated approach. This will be in line with the national campaign.

- During August the CCG's provider of NHS 111 services has implemented a re-triage process for Green Ambulance dispatches. This ensures every green ambulance dispatch is reviewed by a clinician for appropriateness and if an alternative is more suitable e.g. attendance in primary care, this will be advised to the patient. This process aims to reduce inappropriate use of ambulances by NHS 111 ensuring they are kept free for appropriate calls.

- Social Care at JPUH will be working weekends to ensure referrals can continue to the team over the weekend and discharge planning can continue.

- Seven discharge to assess beds have been commissioned to enable patients awaiting the NHS Continuing Healthcare (CHC) process to complete, to be discharged from the JPUH to an appropriate environment whilst this assessment takes place. This scheme has been in place since 1 April 2015. It provides an improved patient experience and enables early discharge of this patient group from the JPUH improving flow.

Delayed Transfers of Care (DTOC)

Over the past few months the system has worked collectively to reduce the number of delayed transfers of care. For January 2015 the DTOC rate was 10.5% and in July 2015 this was reduced to 4.3%, however the rate has been as low as 3%.

Nationally there is a drive from NHS England to reduce rates further from 3.5% as detailed in planning guidance to 2.5%.

The table below shows the split between those DTOCs attributable to health and those attributable to social care.

2015-16	Health	Social Care	Joint Health & Social Care
April	95%	0%	5%
May	91%	0%	9%
June	96%	0%	4%
July	98%	0%	2%

The system has been working on a number of initiatives to support discharge planning in order to reduce the number of DTOCs within our hospitals. These include –

- As described above, seven discharge to assess beds have been commissioned at a local residential home so that patients awaiting NHS Continuing Healthcare assessment but no longer requiring acute care can be discharged thus reducing the number of delayed transfers of care. The CCG is currently looking at opportunities to commission additional discharge to assess beds.

- JPUH has developed an internal discharge logger system to be able to monitor delays. This system is also accessed by social care. The discharge logger is currently reviewed three times a week with social care to support the transfer or discharge of those patients deemed medically stable. The expectation is that this will increase to daily action meetings during winter.

- An NHS CHC delay dashboard has been compiled by the JPUH which monitors and highlights delays allowing responsive actions. The dashboard is shared with key individuals both internally and externally from the JPUH.

- Out of hospital teams in Lowestoft and the North support a number of facilitated discharges from JPUH for those patients who no longer require acute care but are not yet safe to return home without some support or re-ablement needs. As the North team increases its operational hours to 24/7 in the lead up to winter this will support those referrals which require some form of support at night.

- Patients who require on-going therapy support but are medically fit can be referred to the Lowestoft or North out of hospital teams to continue their therapy at home.

- Supported discharge is also in place for stroke and more recently COPD patients who may have been admitted with an exacerbation of their condition but can be safely discharged home with support.

For further information please contact: Cath Gorman, Director of Commissioning and Quality (GY&W CCG); Email: catherine.gorman@nhs.net, Telephone: 01502 719500.

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Agenda Item 8

Great Yarmouth and Waveney Joint Health Scrutiny Committee
Forward Work Programme (Draft)

Friday 22 January 2016:-
(Venue: Lowestoft, to be confirmed).

1. 'GP practice premises in Gorleston and Bradwell' consultation - consideration of the NHS England decision, prior to implementation.

2. Adult and dementia mental health services in Great Yarmouth and Waveney – an update report on progress with:-
   - changes to adult and dementia mental health services
   - establishment of the children's service at Carlton Court
   - placement/location of Resource Information Centres
   - the results Norfolk and Suffolk NHS Foundation Trust (NSFT) staff survey, if available.

[Previously it was hoped to take this item at the Nov 2015 meeting]

Information Bulletin – to include the following:
- Update on Greyfriars Walk-In Centre

Friday 15 April 2016:-
(Venue: Lowestoft, or if possible, at JPUH premises?, to be confirmed).

1. James Paget University Hospital Transformation Plan and CQC Inspection follow-up – a progress update and action plan
   - savings,
   - patient feedback,
   - changes to the transformation plan
   - Impact of Out-of-Hospital Team
   - Action plan following the CQC inspection w/c 10 Aug 2015

Information Bulletin – to include the following:
- Policing and Mental Health services – Long term plan for GY&W area. – an update on the longer term budgeted plans for using control room nurse / triage car from 2016/17 onwards.

Friday 15 July 2016:-
(Venue: Lowestoft, to be confirmed).

1. 'Shape of the System' implementation – a six-month progress update

2. GP practice premises in Gorleston and Bradwell – a six-month implementation progress update

3. NSFT / Mental Health update – update on the outcomes and impacts for GY&W arising from the CQC inspection of NSFT.

Potential topics / events / Information items, not yet scheduled:

- Diabetes care within primary care services in Great Yarmouth and Waveney – Update on the Integrated Model of Diabetes care (ref. the Information Bulletin for the July 2015 meeting) – Possibly look at this in April?
- Possible site visit to the new mental health facilities at Northgate, when the building is ready? – As raised at the JHSC meeting in April 2015 – Need to pin down a date for this.
- Changes to treatment criteria for hip and knee replacements – update on the outcome and impact of the policy change (Ref. the Information Bulletin for the April 2015 meeting)
- 'Continuing Healthcare' assessment delays – as raised at the GY&W CCG Board – progress update (NB. There was some information on this issue in Ipswich and East Suffolk CCG and West Suffolk CCG at the Suffolk HSC on 14 Oct 2015)