Members are reminded that they must declare all relevant pecuniary and non-pecuniary interests relating to any items of business to be discussed at this meeting

BIRMINGHAM CITY COUNCIL

JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE (BIRMINGHAM AND SANDWELL)

WEDNESDAY, 01 JULY 2015 AT 14:00 HOURS
IN COMMITTEE ROOMS 3 & 4, COUNCIL HOUSE, VICTORIA SQUARE, BIRMINGHAM, B1 1BB

A G E N D A

1 **APOLOGIES**

To receive any apologies.

2 **DECLARATIONS OF INTERESTS**

Members are reminded that they must declare all relevant pecuniary interests and non-pecuniary interests relating to any items of business to be discussed at this meeting. If a pecuniary interest is declared a Member must not speak or take part in that agenda item. Any declarations will be recorded in the minutes of the meeting.

3 **MINUTES OF PREVIOUS MEETING** **3 - 8**

To confirm the Minutes of the meeting held on 3 December 2014.

4 **URGENT CARE** **9 - 32**

5 **CARDIOLOGY AND ACUTE SERVICES** **33 - 74**

6 **END OF LIFE CARE**

75 - 80

7 **DATE AND TIME OF NEXT MEETING**

To agree a date and time.

P R I V A T E A G E N D A

Birmingham City Council and Sandwell Metropolitan Borough Council

Minutes of the Joint Health Overview and Scrutiny Committee

3rd December, 2014, 10.30 am
at the Sandwell Council House, Oldbury

Present: Councillor Paul Sandars (Chair);
Councillors David Hosell, Elaine Costigan, Ann Jarvis, Bob Lloyd (Sandwell Metropolitan Borough Council).

Councillors Susan Barnett, Karen McCarthy, Andrew Hardie and Sue Anderson (Birmingham City Council).

Apologies: Councillor Eva Phillips (Birmingham City Council).

In Attendance: Andy Williams, Lisa Maxfield, Manir Aslam and Jayne Salter-Scott (Sandwell and West Birmingham Clinical Commissioning Group);
Jayne Dunn (Sandwell and West Birmingham NHS Trust);
Nighat Hussain (NHS England);
Sarah Sprung and Rebecca Hill (Sandwell Metropolitan Borough Council).

7/14 **Declarations of Interest**

Councillor Hardie declared his involvement with the General Practitioners Commissioning Group.

8/14 **Minutes**

Resolved that the minutes of the meeting held on 19th November 2014 be confirmed as a correct record.

9/14 **Urgent Care**

The Committee received a briefing from the Sandwell and West Birmingham Clinical Commissioning Group in relation to Urgent and Emergency care, and the wider picture of development of Right Care, Right Here.

Sandwell and West Birmingham Clinical Commissioning Group delivered a presentation entitled 'Urgent care transformation'.

The following challenges faced by Urgent Care were noted by the Committee:-

- in the previous two years 95% of Accident and Emergency waiting time standards had not been met;

- through various public consultations it was found that people were unsure of the best way to access the correct care, due to a fragmented system and confusion about accessibility and opening times – this resulted in people attending Accident and Emergency as this was 'familiar' to them.

  This was particularly prevalent in the 20-40 year age range and amongst students. These people used Accident and Emergency as their primary source of care due to being in full time work and/or having young children – they found it to be flexible and easily accessible;

- New national guidance had also been brought forward in the guise of the 'Barbara Haykins Intervention' and the 'Five Year Forward View 2014'. The 'Five Year Forward Plan 2014' recognised that it was time to stop reorganising and time to ensure services were delivered.

- The new '111' telephone service needed to be promoted, as despite the fact that it had begun to work well, it was only currently being used at 10% of its capacity. However this figure had begun to increase slowly.

- The Clinical Commissioning Group had liaised with other local authorities, such as Wolverhampton City Council and Dudley Metropolitan Council to endeavour to ensure that urgent care services might be unified locally.

The Urgent Care model was based upon the 'Principles of Sir Bruce Keogh's Review'. The review highlighted four key areas:-

- consistently high quality and safe care, 7 days a week; in the Urgent Care plan this included input from community nurses and General Practitioners.

- simple and guides good, informed choices by patients, their carer's and clinicians;

- Provides access to the right care in the right place, by those with the right skills, the first time;

- efficient and effective delivery of care and services for patients;

It was aimed to build on the already significant amount of urgent care undertaken by General Practitioners and 'real time information'.

Members noted that the current services within the Clinical Commissioning Group area comprised two hospital sites, and 107 primary care practices, with walk-in centres being located in closed proximity to Accident and Emergency Departments. There was a similar situation in regard to out of hour's services.

The approach to reconfiguration focused upon the need to build the infrastructure in relation to primary practice and ensure the '111' telephone line was built upon and strengthened.

The Committee noted that a simplified, yet unrestricting service would be developed, with a refined system of patient triage, and a change in patient behaviour encouraged – for an increased use of '111'.

The Clinical Commissioning Group stated that communications would start to be disseminated to highlight '111' as the 'first choice', and that original consultations may have focused upon the wrong sections of the public – a deeper knowledge was to be gained of the 20-40 year age group.

It wasrecognised that patient's relationships with their General Practitioner would be of utmost importance, and alternative staffing options would be considered. Examples would be the addition of physician assistants, to include the possibility of receptionists with a medical background.

The Committee voiced their confusion over the issue of GP closures in Wednesbury after being told by NHS England that the area 'had too many Doctors'. Patients located within that area were still unable to access an appointment with their Doctor.

Agreed:-

(1.) That the overarching strategy for consultation on Urgent Care in Sandwell and West Birmingham be supported;
(2.) That the Sandwell and West Birmingham Clinical Commissioning Group undertake a period of pre-consultation to further inform development of the Urgent Care Model;
(3.) That the results of the pre-consultation engagement, and the final proposed consultation plan on Urgent Care, be presented to the Joint Health Overview and Scrutiny Committee in June, 2015.

10/14 **Right Care Right Here**

Under the umbrella of Right Care Right Here it was proposed to commence consultation in relation to Interventional cardiology and acute surgery/orthopaedic trauma. The CCG proposed that a single set of listening events were used within the re-engagement phase to cover the strands of discussion as listed above.

The risk of confusion over the pre-consultation and the actual consultation must be acknowledged therefore a robust set of engagement plans would be designed.

The period of January 2015 to March 2015 would be used to ensure the public's opinion was gathered in relation to their feelings on the current state of urgent care and what their desired outcomes were.

Actual operational change would transpire after three months, but only in relation to Interventional cardiology and acute surgery/orthopaedic trauma, not Urgent Care. The three month period would result in either a further period of consultation or the beginnings of actual implementation.

The advantages to any changes should be promoted at a local level. Members felt that the public needed to be able to consider what the changes would actually mean for them personally, and on a town by town basis.

Agreed:-

(1) That engagement activity for acute surgery and cardiology, run parallel with the consultation process for Urgent Care under the umbrella of Right Care, Right Here;
(2) It be noted that the outcome of engagement for acute surgery and cardiology would result in operational change;
(3) That the Joint Health Overview and Scrutiny Committee be advised of the outcome of engagement activity.

(Meeting ended at 12.02pm)

Contact Officer: Rebecca Hill
Democratic Services Unit
0121 569 3834

Joint Health Overview and Scrutiny Panel

1 July 2015

Urgent and emergency care programme update

1. Summary

The Sandwell and West Birmingham CCG urgent and emergency care programme has been established to oversee the development of a sustainable system-wide approach to urgent and emergency care. This involves supporting patients to access the most appropriate care, wherever possible within the community instead of A&E.

In December 2014, the CCG's Governing Body and the Joint Health Overview and Scrutiny Committee endorsed the approach to engage with patients to shape the future urgent care system. As a result, a listening exercise was launched on 9 February 2015 to seek views from the public and stakeholders on what works well and what could be improved in the future.

Following feedback from partners the programme approach has been amended to extend the period of engagement, to support the co-design of a future model with providers.

This paper aims to update the Joint Health Overview and Scrutiny Committee on the programme's progress, including the findings of the recent listening exercise.

2. Programme overview

The CCG believes that urgent and emergency care services will be more effective and easier to access if they are provided closer to home, where appropriate, are accessible to patients and delivered in clinically- appropriate settings. The future model of urgent and emergency care will ensure that the system is simple to use, efficient and brings together services to improve quality, patient experience and outcomes.

The programme has been developed to review the existing urgent and emergency care system, to bring together existing workstreams and to determine the future model of urgent and emergency care for the local health system. The views of patients and stakeholders are fundamental in shaping the development of a future five year Urgent and Emergency Care Strategy. The programme will ensure that any future proposals work seamlessly and enhance the patient pathway.

The programme is clinically led by the CCG's urgent and emergency care GP leads, Dr Manir Aslam and Dr Sirjit Bath.

In addition to the listening exercise, the urgent and emergency care programme is focussing on the following key areas that support the development of a future model:

- Understanding baseline activity - how existing services are currently used
- Understanding national and local drivers for change including the impact of the national Sir Bruce Keogh Review, the Five Year Forward View and the Monitor review of walk-in centres
- Understanding the local population demographics and impact of the existing urgent and emergency care system on protected characteristic groups
- Considering the Right Care Right Here principles and the Midland Met Hospital business case to support the development of the future strategy and urgent and emergency care model
- Understanding the existing primary care offer, including current GP practice opening hours and the opportunity to create additional GP appointments
- Understanding what our patients and stakeholders think about the existing system – what works well and what improvements could be made through a listening exercise
- Developing proposed model(s) to improve access to urgent and emergency care, both in the community and hospital settings, including minimising unnecessary duplication of pathways
- Understanding what our patients and stakeholders think of the final proposal(s) through a public consultation, if appropriate
- Developing a five-year Urgent and Emergency Care Strategy for Sandwell and West Birmingham.

3. Listening exercise update

A six-week listening exercise was carried out from February to March 2015 to ensure patients and stakeholders were effectively engaged in helping the CCG to reach the right decision for their local populations.

At least 9,415 people were reached through electronic/ postal mailings and the distribution of materials within local communities. Discussions took place across 49 engagement activities with approximately 1,105 attendees.

276 survey responses were received and further anecdotal feedback was captured during wider discussions at the various meetings attended.

Feedback from the surveys and engagement events and meetings revealed:

- Ambulance and pharmacy services were highly rated for their efficiency and competent staff
- Seeing the right health professional was more important than a convenient place, time or seeing somebody quickly
- Most people thought they knew enough about where to go when they needed urgent and emergency care. This is positive but it must be built on with good signposting

services and education on how to get the most out of urgent and emergency services for the communities who need services most

- We should invest in information and education but target different communities with different methods, for example, more information in GP practices in areas where there are older generations and more use of new technologies in areas with younger populations

- Patients wanted improved access to primary care services

- Patients wanted somewhere that was local, open and that they could drop into, not an A&E service, but a large health centre or a walk-in centre

- Patients are open to the use of new technologies, especially younger age groups

- Not enough local people are aware of the Right Care Right Here vision

- Patients asked for better trained and more senior staff

- We should build on any work we have already carried out locally as well as national intelligence, for example, Keogh review

- Patients want better integration between health and social care.

3.1 Listening exercise conclusion

- It is clear that patients want an expanded primary care offer, including longer opening hours and increased access

- Patients would appreciate more local health services similar to the walk-in centre offer. These could be provided in existing healthcare buildings

- There should be better education and more accessible information on urgent and emergency care services; efforts should be taken to reach all age groups and communities in Sandwell and West Birmingham

- People have asked for an increase in urgent and emergency care services with more staff and less waiting times

- Ambulance and pharmacies were rated the best services by patients with GP out-of-hours the least well rated service

- Some patients are open to using new technologies, especially the young and those of working age; these could be piloted with relevant practices

- A communications and engagement strategy for urgent and emergency care services that considers the different needs of age groups and communities is recommended

- The results of the listening exercise report should be shared to inform any future engagement events, service specifications and key performance indicators for urgent and emergency care services.

4. Co-design approach

As part of the listening exercise, an urgent care provider stakeholder forum was held on 25 March 2015. Providers highlighted an appetite for greater involvement in the co-design of the future system. The Right Care Right Here Board in March 2015 supported the collaborative approach.

We believe that a collaborative co-designed model will be the best way forward to deliver more effective and sustainable outcomes and an improved experience for all involved. If the co-design events do not result in a satisfactory outcome, the programme will revert to the original programme plan of developing an options appraisal.

4.1 Co-design events

A co-design event is being planned for the 30 June 2015, in collaboration with partners, local providers and the voluntary sector.

A planning event took place on Wednesday 22 April 2015 with senior officers from partnership organisations. Partners have been involved in the design, planning and information requirements for the urgent care co-design event in June. The planning and timing of the co-design event will be critical to ensure that the programme keeps momentum.

The main co-design event will take place on 30 June 2015 and will involve relevant senior stakeholders from partner organisations, Monitor and the national urgent care lead. This will be led by an external facilitator, to support collaborative discussions around:

- **A joint definition of urgent and emergency care** - clarity on what the system defines as urgent and emergency care as this may not be mirrored by our patients – also any difference between perceived and actual need
- **Fixed points** - what are the fixed points in the system? Each partner organisation to describe this for themselves. The event will aim to reach collaborative agreement on what fixed points already exist and an understanding of the consequence(s) if these change, for example, Midland Met Hospital.

A process has been developed to ensure that where the co-design events do not result in a model(s) that can be used for the future system, the programme can revert to the original process. Appendix one outlines the process flow for the ‘co-design’ approach. Appendix two outlines the process flow for the original urgent and emergency care programme.

5. Future communications and engagement

Over the next few months we will be continuing to share the feedback from the listening exercise and keep patients, public and partners informed of the programme.

The co-design approach will identify the future model for urgent and emergency care in Sandwell and West Birmingham. This will inform the CCG’s approach to engagement. If significant change is planned, the CCG will want to undertake further engagement activity (potentially in the autumn) to seek views on any proposed changes.

6. Summary

The urgent and emergency care programme board has reached a recommendation to support the co-design event and extend the period of engagement to ensure that partners and stakeholders are involved robustly in shaping the future system.

The programme plan has been revised to support the co-design phase and the programme board will reach a decision in July 2015 on the outputs of the co-design phase. In the event that the co-design phase does not result in an outcome that can be used to design the future urgent and emergency care system, the urgent and emergency care programme board will seek to continue with the original optional appraisal process highlighted in appendix two. The information developed as part of the co-design event phase will be used to develop the short-list of options.

This work will inform the future model and approach to engagement. If significant change is identified, the CCG is committed to undertaking further engagement with the local population.

7. Recommendations

Members of the Joint Overview and Scrutiny Committee are asked to:

- Note the contents of the report
- Indicate any timescales for future updates to be presented to the committee.

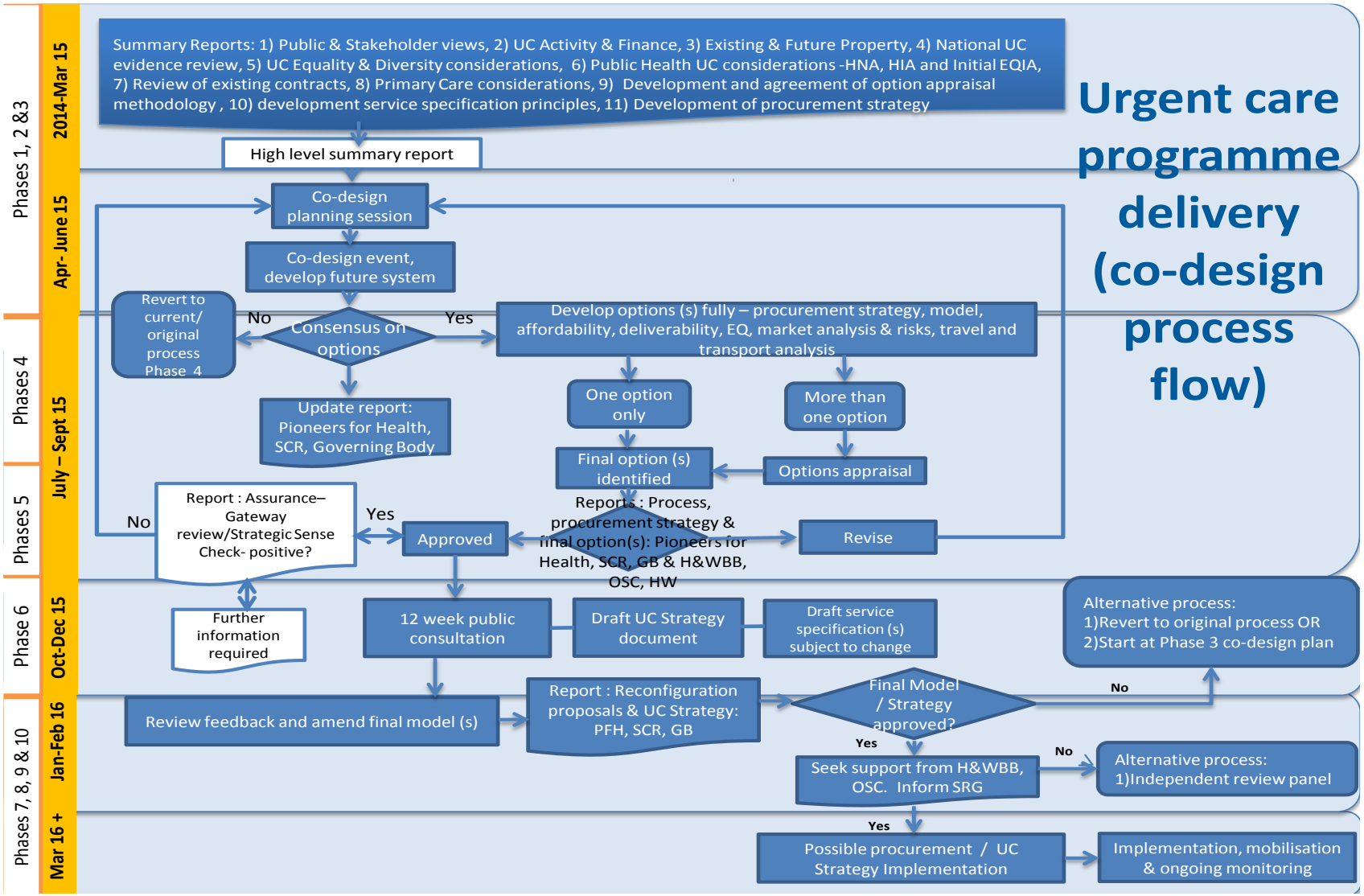
8. Paper presented by:

- Nighat Hussain, Programme Director
- Dr Manir Aslam, SWBCCG urgent care clinical lead

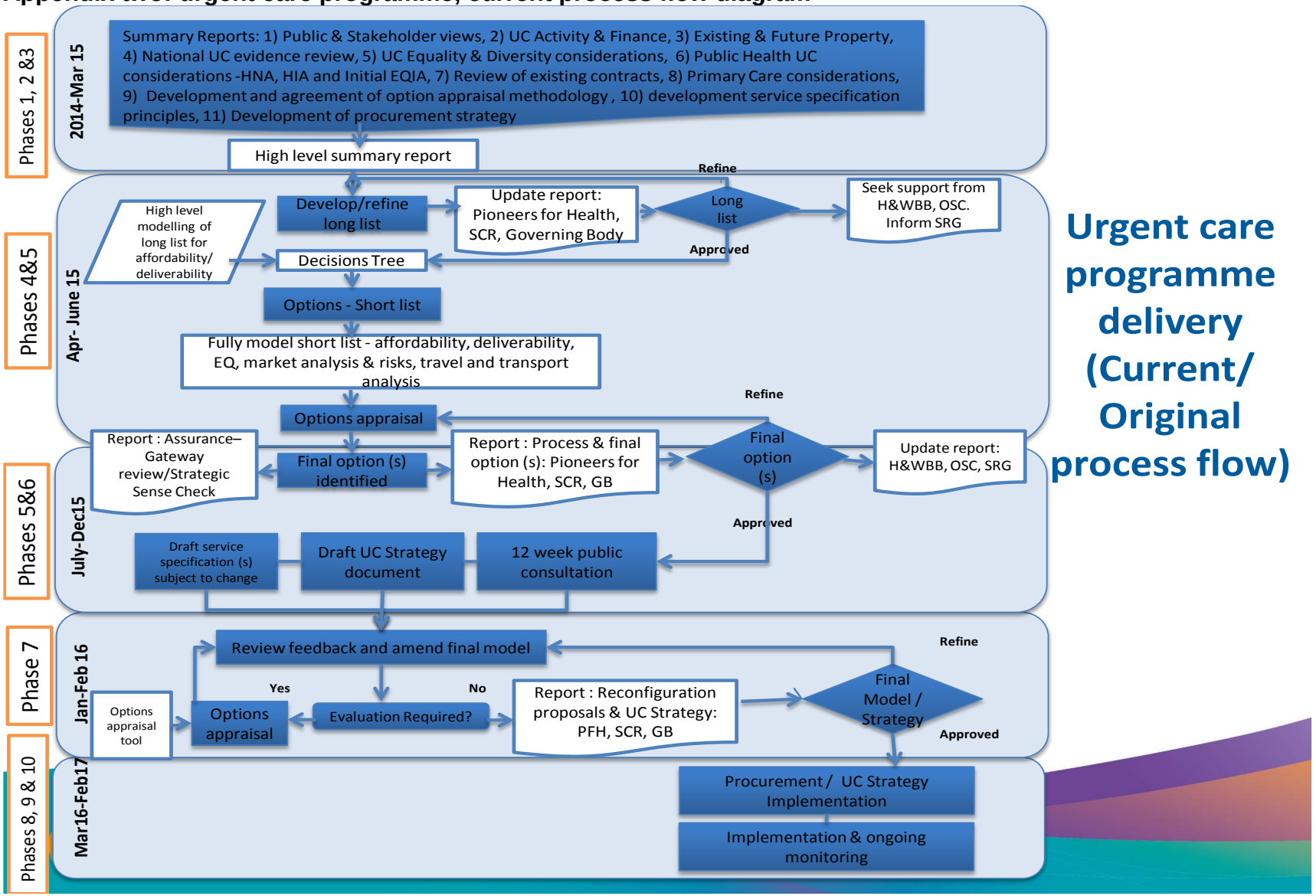
For further information contact:

- Nighat Hussain, nighathussain@nhs.net, Tel: 0121 612 1705
- Roxanna Modiri, rmodiri@nhs.net, Tel: 0121 612 2828

Appendix one: urgent care programme, co-design process flow diagram



Appendix two: urgent care programme, current process flow diagram



Urgent care programme delivery (Current/ Original process flow)

NHS
Sandwell and West Birmingham
Clinical Commissioning Group

Urgent Care Programme

Collaborative approach to the co-design of the future urgent and emergency care system

1 July 2015

healthcare without boundaries

What is urgent and emergency care?

Urgent care services provide help, advice and treatment when you need to see a nurse or doctor quickly (urgently) for a minor illness or injury, or if you have a serious illness or injury (an emergency)

What is urgent care?

Urgent care services offer advice and treatment for **minor illnesses or injuries** where you **cannot wait for a routine appointment with your GP**.

Some of the services that provide urgent care are:

- **NHS 111**
- **GP practice (urgent appointments)**
- **GP out of hours**
- **Walk-in centres**

What is emergency care?

Emergency care services provide treatment for **life threatening conditions**, this could be a serious illness or injury such as chest pain, severe loss of blood or choking.

Some of the services that provide emergency care are:

- **Ambulance service**
- **A&E**
- **Emergency admissions**

Why are we reviewing services?

- Urgent and emergency care services in Sandwell and West Birmingham have **evolved over time**
- **Previous commissioning strategies** have **focussed on diverting** activity away from A&E
- Current system is **complex with multiple connections and complex** patient flows
- We need to develop a **comprehensive approach to manage urgent and emergency care** locally
- Consider the impact and community support required for **Midland Met Hospital**
- Important to note that **no decisions on the future system have been made**

The urgent and emergency care system locally

- **101 GP practices** excluding branch and satellite practices (March 2015)
- **2 GP services in A&E**
- **1 ambulance service**
- **1 NHS 111 provider**
- **2 urgent care centres** (Summerfield and Parsonage Street)
- **2 GP out of hours providers**
- **2 Mental health providers**
- **3 hospital sites** – Sandwell, City and Rowley hospitals (SWBH)
- **2 community providers**.

National context

In 2013 a national consultation was undertaken, led by **Sir Bruce Keogh** (NHS England's National Medical Director).

The national guidance says that **all urgent care systems** should:

- Provide **better support** for people to **self-care**
- Help people with urgent care needs to get the **right advice** in **the right place, first time**
- Provide **highly responsive urgent care services outside of hospital** so people no longer choose to queue in A&E
- Ensure that those **people with more serious or life threatening emergency needs** receive **treatment in centres with the right facilities and expertise** in order to maximise chances of survival and a good recovery
- **Connect urgent and emergency care services** so the overall system becomes **more than just the sum of its parts.**

Listening exercise 9 February- 20 March 2015

- **28** community meetings
- **2** public meetings
- **7000** booklets distributed
- Webpage hits **537**
- Twitter reach of **242,000**
- **276** surveys returned
- **Thank you** to everyone who took part

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Patient feedback (what works well)

- Patients find local pharmacies useful
- Patients have a really good experience of GP practices
- They appreciate the walk-in and urgent care centres and would like more of them e.g. Finch Road
- Overall good patient experience at the emergency departments, the Ambulance Service and NHS 111
- Most patients continue to use their GP practice to find out information about their health condition.

Patient feedback: How can we improve urgent and emergency care services?

- Improving access to primary care was the clearest message from patients
- Local health centres for urgent care appointments
- Better information on what service to use and when
- More information on the GP out of hours service
- Increase the range of services offered at A&E e.g. access to adult social care.

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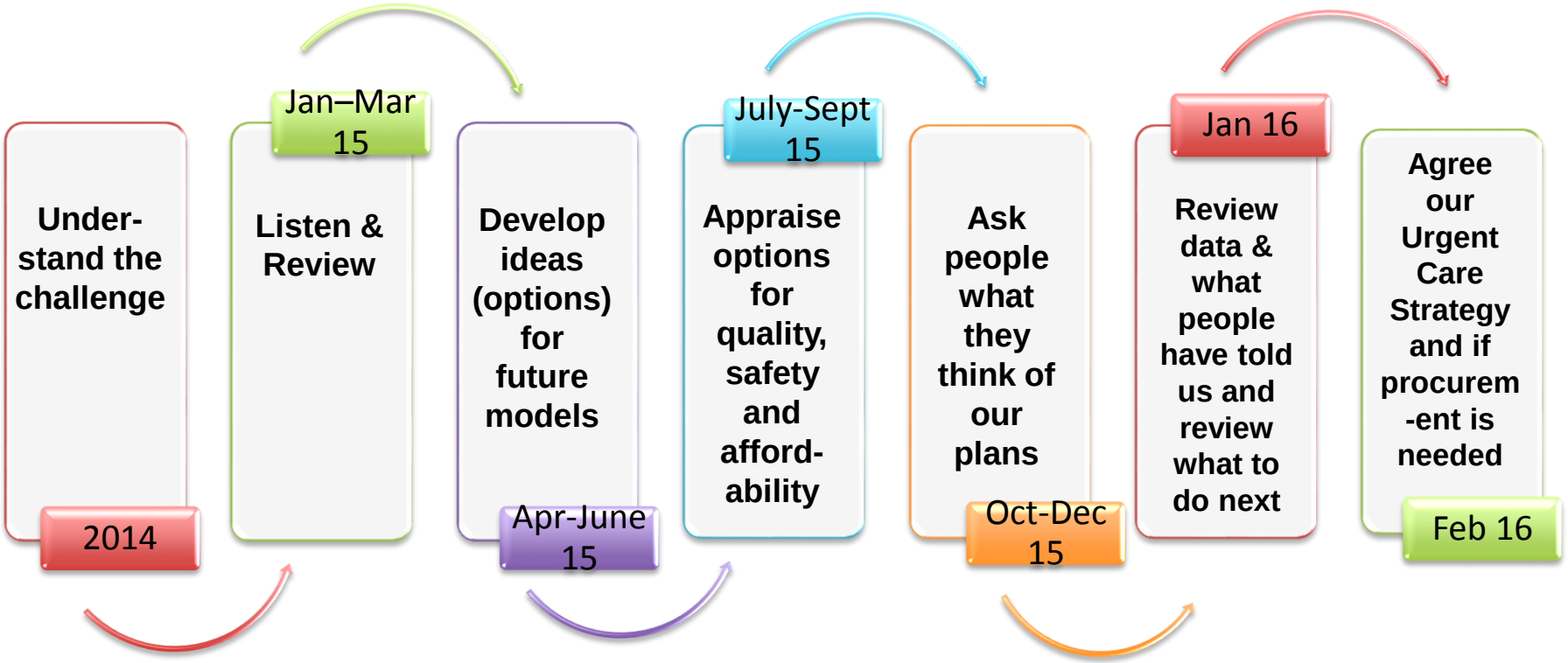
Listening exercise recommendations

In co-designing the urgent and emergency care system for the future we need to consider patient feedback:

- Improve access at a primary care level
- Make the best use of existing local health centres
- Inform patients of what services to use and when
- Invest in technology to meet the changing needs of patients.

The urgent and emergency care programme



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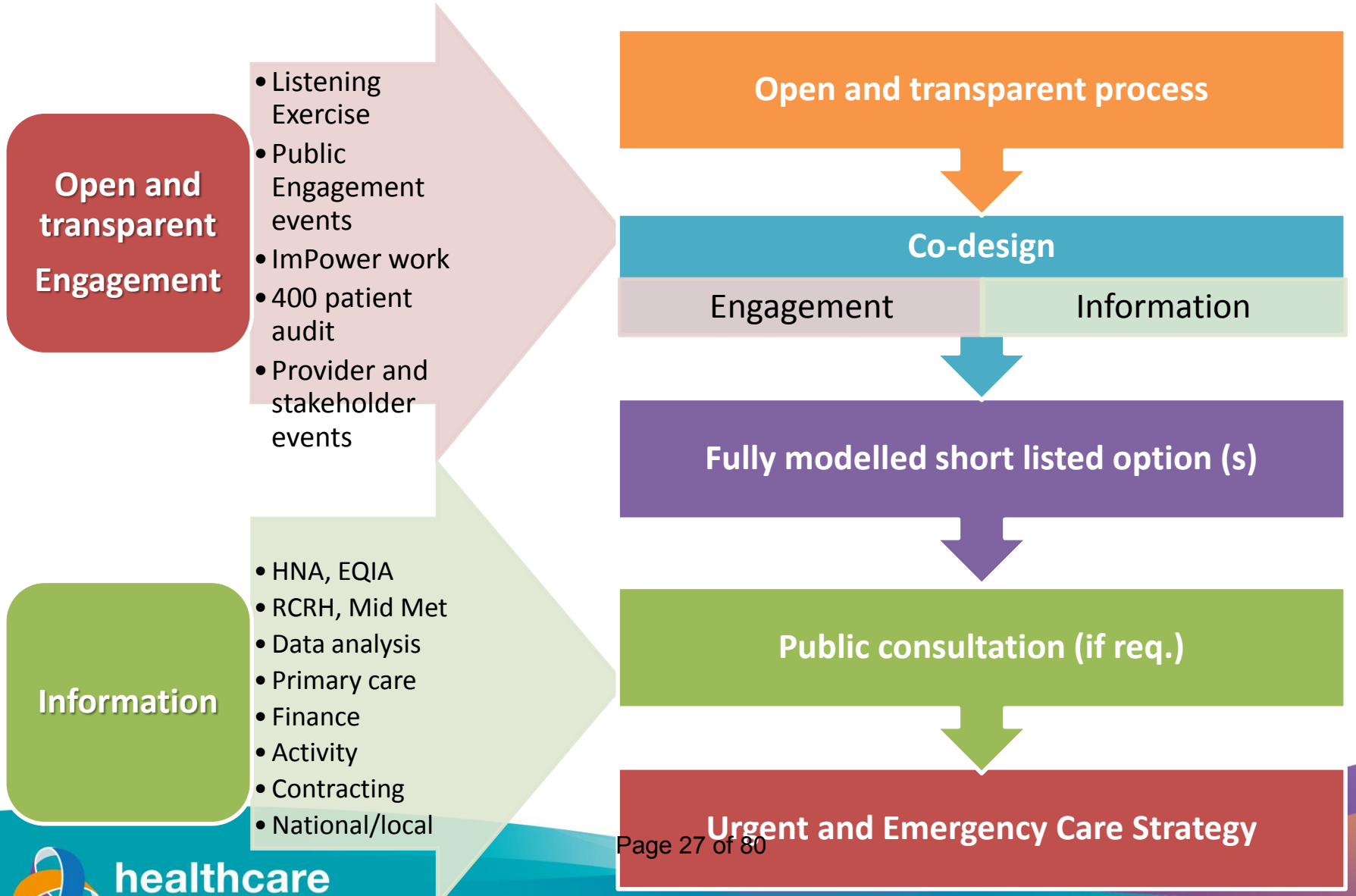
A new approach: co-design



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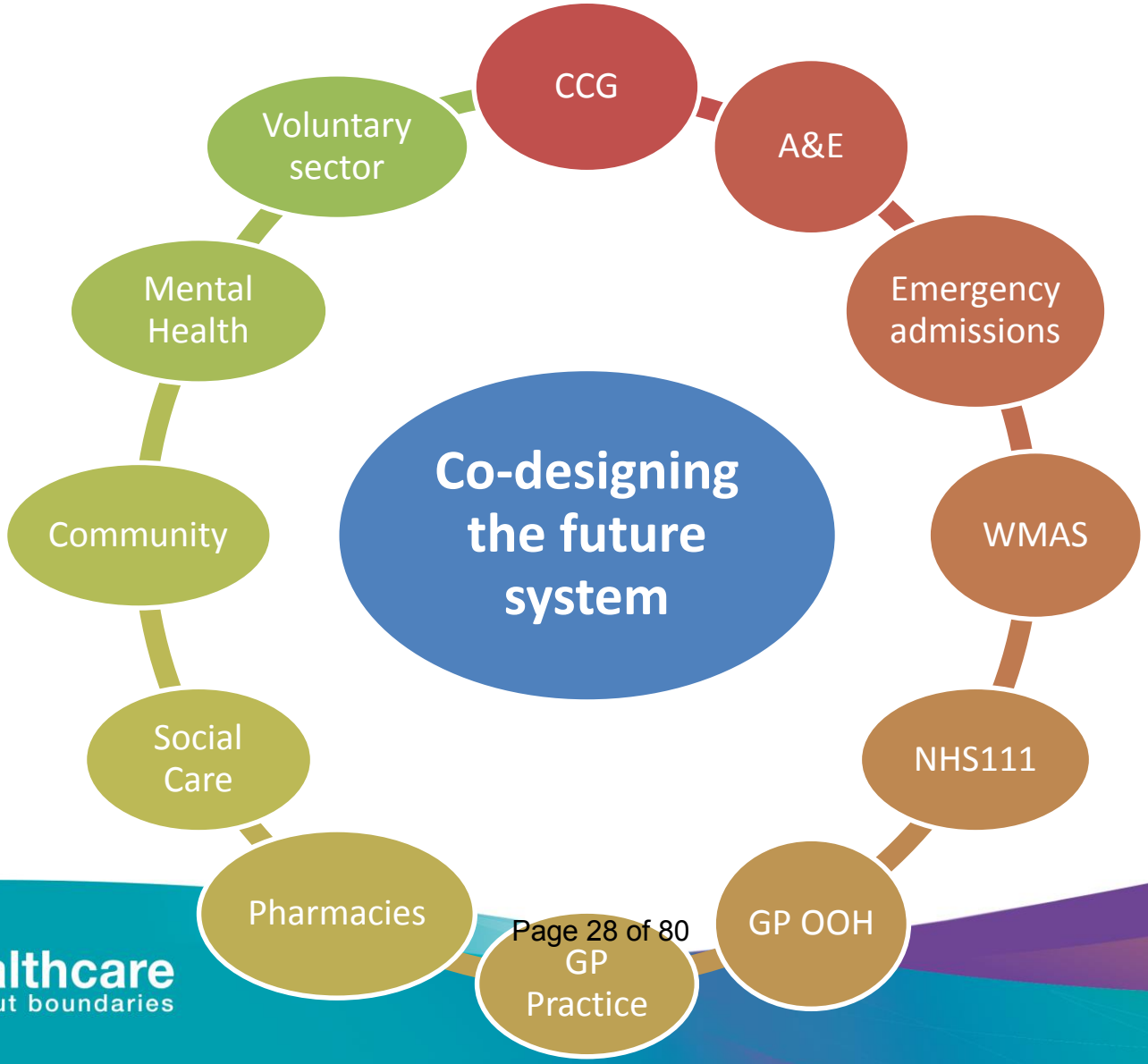
Co-designing the urgent and emergency care system



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Co-design event

- Co-design planning event held 22/04/15
- Co-design event 30 June 2015
- Brings together providers, partners, voluntary sector to discuss:
  - **A joint definition of urgent and emergency care** - clarity on what the system defines as urgent and emergency care as this may not be mirrored by our patients – also any difference between perceived and actual need
  - **Fixed points** - what are the fixed points in the system? Each partner organisation to describe this for themselves. The event will aim to reach collaborative agreement on what fixed points already exist and an understanding of the consequence(s), if these change e.g. Midland Met Hospital.

Next steps

- We are continuing to feedback the findings of the listening exercise and keep people informed
- Co-design event to develop a future urgent and emergency model
- Develop the five year Urgent and Emergency Care Strategy
- This work will inform our approach to engagement; if significant change is needed we will want to engage people on any proposals (potentially autumn 2015)

Recommendations

Committee members are asked to:

- Note the contents of the report
- Indicate any timescales for future updates to be presented to the Committee.

Questions?

Joint Health Overview and Scrutiny Panel

1 July 2015

Update on the urgent cardiology, emergency surgery and trauma assessment proposed reconfigurations

This paper provides an update to the Joint Overview and Scrutiny Committee on the urgent cardiology, emergency surgery and trauma assessment reconfiguration programme, being carried out by NHS Sandwell and West Birmingham Clinical Commissioning Group and Sandwell and West Birmingham Hospitals NHS Trust. The paper outlines the outcomes of the listening exercise, programme findings and recommendations.

1. Programme overview

1.1 Right Care Right Here

For over 10 years health and social care partners have worked together under the Right Care Right Here partnership to achieve major transformational change. The partnership is committed to improving people's health and the quality of health and social care services provided to them, by:

- Expanding the provision of services in community settings, bringing appropriate elements of care closer to home
- Ensuring that people have the opportunity to benefit from healthier lifestyles
- Ensuring that services are extensively redesigned to meet the needs of the local population
- Delivering Midland Met Hospital, a new specialist acute hospital in Smethwick by 2018.

1.2 Continued improvements to quality service proposals

NHS Sandwell and West Birmingham Hospitals NHS Trust and Sandwell and West Birmingham CCG are continually working to improve the quality of care for local patients. This involves reviewing the latest best practice, technologies and listening to patients to identify improvements. Two key specialities have so far been identified as needing transformation prior to the opening of Midland Met Hospital:

- Interventional cardiology
- Emergency surgery and trauma assessment.

Best practice shows that these services need to become specialist centres, which are able to deliver:

- Timely access to treatment
- Skilled care from specialist teams
- Quality and consistent care across both Sandwell and West Birmingham
- Consultant-led services 24 hours a day seven days a week.

In December 2014 the CCG Governing Body and Joint Overview and Scrutiny Committee approved the launch of a listening exercise to seek public and patient views on proposals to:

- Locate urgent cardiology services at City Hospital
- Locate emergency surgery and trauma assessment services at Sandwell Hospital, alongside the inpatient wards which are already based at Sandwell Hospital.

These proposals would be interim solutions, until the new Midland Met Hospital opens in autumn 2018. Outpatient services would still be based at both hospitals and at Rowley Regis Hospital.

The listening exercise was carried out between 12 January and 20 March 2015.

2. Clinical case for change

2.1 Urgent cardiology

When the Midland Met Hospital opens in 2018, all cardiology inpatients and interventional procedures including primary percutaneous coronary intervention (PPCI) and percutaneous coronary intervention (PCI) treatment for patients having a heart attack or at high risk of one (using specialist cardiac catheterisation laboratories) will be located on one site.

Currently cardiology inpatients and interventional procedures (including specialist cardiac catheterisation laboratories) are provided 24/7 on two sites, Birmingham City Hospital and Sandwell General Hospital. This means there are two cardiology departments (one at Sandwell and one at City Hospital), with the team of specialist doctors and nurses required to work across two sites.

Urgent cardiology hospital services are made up of two key areas:

- Cardiac catheterisation laboratories- specialist theatres where patients receive treatment. Cardiology departments need two of these laboratories and these are currently split across the two hospitals, which is not ideal
- Coronary care unit- cardiology wards for patients to receive specialist care and treatment.

Currently Sandwell and West Birmingham Hospitals NHS Trust, which runs the two hospitals, is recognised as a specialist cardiology centre. This is important for Sandwell and West Birmingham, which we know has a higher than average coronary heart disease rate and related deaths. We can only keep this specialist status if we continue to meet the expected national standards. To do this we need to adapt, by bringing services onto one site before 2018.

2.1.1 Cardiac catheterisation laboratory capacity and resilience

Each hospital has one cardiac catheterisation laboratory with a contingency plan that, if one is not operational (for example, requiring repairs), patients requiring emergency procedures are transferred to the other hospital. This further disrupts the elective sessions for planned interventional treatment. There is an urgent need to replace the cardiac catheterisation laboratory facility at City Hospital (last replaced in 2002), which has reached the end of its life and to link this investment to improve patient safety and patient flow. The Sandwell cardiac catheterisation laboratory is also due for replacement and is experiencing an increasing number of breakdowns. The proposal now is to replace both laboratories but on the same site.

The tables below summarise access times for PPCI and PCI. In relation to PPCI, the percentage of patients being treated within door-to-balloon target times has reduced slightly over the last couple of years particularly for patients presenting at City Hospital. This is primarily due to issues with the age of the catheterisation laboratory at City Hospital and the related frequency of breakdowns.

Sandwell and West Birmingham Hospitals Trust PPCI Data 2013/14 (April 13-end of March 14)

	PPCI	% Door to Balloon < 90 mins	% Call to Balloon < 150 mins
City	104	75%	84%*
Sandwell	115	90%	91%**
Trust	219	83%	88%

*11 patients self- presented

** 18 patients self-presented

Source: Trust MINAP data

With regard to PCI, the current door to angiogram time remains a concern on both sites but especially at City Hospital. This is partly due to each site only having one catheterisation laboratory, with delays occurring to PCI and other non-emergency work as a result of PPCI cases. It is also a result of the age of the catheterisation laboratory at City Hospital with breakdowns resulting in cancellations of PCI cases at City and transfer of PPCI cases from City impacting on PCI waits at Sandwell Hospital.

Table 3: SWBH PCI Data – excluding PPCI - 2013/14 (April 13-end of March 14)

	PCI	% Door to Angio. < 96 hours
City	361	73%
Sandwell	282	89%
Trust	643	80%

Source: Trust MINAP data

***2.1.2 The NHS Standard Contract for Cardiology*:** PPCI – NHS England 2013 and the national British Cardiac Intervention Society (BCIS) guidance require a minimum of 400 PCI cases and two cardiac catheterisation laboratories per centre. Whilst Sandwell and West Birmingham Hospitals NHS Trust currently meets these standards on a trust basis, the service consolidated on a single site would be in a better position to meet the standards on an ongoing basis.

2.1.3 Maintaining specialist services: A loss of PPCI services from the trust would have a significant negative impact on the provision of all cardiac services. In addition it would result in the local population having to travel further for at least the emergency interventional cardiology service and possibly a wider range of cardiology services. Other Black Country acute cardiology providers have reconfigured services so that all PPCI is delivered at New Cross Hospital (in order to achieve a critical mass of activity) and so for the Sandwell population, the nearest alternative provider would be New Cross Hospital in Wolverhampton. This would potentially create capacity issues for other providers.

2.1.4 Independent clinical review: This was also endorsed by the Royal College of Physicians, which the trust commissioned to undertake a cardiology service review (24-26 September 2014). This service review looked at a wide range of aspects of cardiology but the *report of the invited service review to Sandwell and West Birmingham Hospitals NHS Trust* made the following comments in relation to the proposed reconfiguration:

"The new hospital and an interim reconfiguration at City Hospital should be good for patients both in terms of service delivery and safety, and although travel seems to be an issue for some patients we believe the potential improvements in quality and sustainability of the services delivered outweigh these concerns."

(Royal College of Physicians, 2015, pg 18)

2.1.5 Benefits of moving services to one site:

a) Improves treatment times for patients who have a ST segment Elevation Myocardial Infarction (STEMI) (which is a type of heart attack), improving direct access to specialist cardiac catheterisation laboratories
b) Develops an infrastructure consistent with the NHS Standard Contract for Cardiology: PPCI – NHS England 2013 and fulfils national British Cardiac Intervention Society (BCIS) guidance of a minimum of 400 PCI cases and two cardiac catheterisation laboratories per centre
c) Improves access times for non-STEMI patients (who require urgent PCI treatment)
d) Improves consistency in practice (reducing current variation across multiple sites)
e) Ensures recruitment and retention of specialist staff
f) Supports the future development of interventional procedures (utilising latest technologies and best practice).

It is important to note that cardiology outpatient clinics will continue to be provided at both hospitals, as well as at Rowley Regis Hospital. This is in line with the Right Care Right Here principles of bringing care closer to home.

In developing the proposal a number of options were explored including continuing with the current two hospital model and locating the service at Sandwell Hospital. After a review it was felt that the existing two site model would not address the drivers for change. The Sandwell Hospital option was not considered feasible as locating two cardiac catheterisation laboratories at Sandwell Hospital, in close proximity to each other, and the Coronary Care Unit (CCU) would not be possible without:

- Relocating both cardiac catheterisation laboratories and the CCU to another location in the hospital requiring major refurbishment /new build and displacement of another service along with moving the service further away from the emergency department and blue light ambulance entrance or
- Placing the second cardiac catheterisation laboratory in another location away from the existing one and the CCU.

2.1.6 Future activity proposals

Emergency department and acute medical unit at City Hospital: During 2013/14 the trust undertook 862 percutaneous procedures of which 219 were PPCI with 115 of these PPCI being at Sandwell Hospital. In the proposed pathway these patients would be treated at City. The majority arrived by ambulance and so in the new pathway West Midlands Ambulance Service (WMAS) would take patients with ST elevation directly to City Hospital. The ambulance service would pre-alert the cardiology team at City of any patient with ST elevation. The Cardiology team would meet the patient at the emergency department ambulance entrance on arrival for a rapid initial assessment and then if PPCI is appropriate, accompany the patient and ambulance crew directly to the cardiac cath lab suite. The volume of patients with symptoms of heart attack presenting at City emergency

department by ambulance will increase but the new pathway will mean they are rapidly assessed by the cardiology team and those with STEMI appropriate for PPCI taken directly to the cardiac catheterisation laboratory without further assessment or treatment in emergency department. Patients not found on rapid initial assessment to be appropriate for PPCI would be transferred directly to emergency department for further assessment and onward referral to the most appropriate clinical team. If 50% false positives are assumed and therefore these patients then need further assessment or treatment in emergency department and/or the acute medical unit this is only likely to equate to an additional 50-60 patients a year and so is within the capacity of City emergency department and acute medical unit. This will be at a time that a greater number of surgical and trauma patients are redirected to Sandwell Hospital rather than City.

Patients who self present at Sandwell emergency department and on examination are found to have ST elevation will be transferred by blue light WMAS ambulance to City Hospital with a pre-alert to the Cardiology team who will meet the patient on arrival.

Patients with other chest pain would still present at Sandwell Hospital and be assessed in the emergency department there. If appropriate these patients would be referred to the Acute Medical Unit (AMU) at Sandwell under the care of a Consultant in Acute Medicine. If the patient was assessed as having a cardiac condition they would be seen by a cardiology consultant. Where appropriate for the patient's condition the patient would remain at Sandwell under the Consultant in Acute Medicine but with review and advice from the cardiology team. If the patient's condition required admission under a Cardiologist and treatment in coronary care or in the cardiac catheterisation laboratory (e.g. PCI, pacemaker, device) they would be transferred by the trust's patient transport service (with appropriate escort) to the cardiology service at City Hospital. It is estimated that this may result in around a further 300- 400 patient transfers a year.

2.1.7 Why do services need to be at City Hospital?

After working with clinical specialists we propose that cardiology services should be based at City Hospital. There are a number of reasons for this:

- ***Direct access*** - ambulance crews will have direct access to the cardiology services at City Hospital, avoiding the need for them to be admitted to the emergency department first. It is also possible for the new cardiac catheterisation laboratory unit to stay closer to the cardiology wards, emergency department and ambulance entrance
- ***Safety*** - there is enough room for a second laboratory to be installed which would also be close to the first
- ***Achievable***- as an interim option, City Hospital requires less refurbishment for the service to be delivered. It will cause the least disruption to other services and represents better value for money. This means we can deliver better care for patients sooner.

There will still be facilities for initial assessment; monitoring and short inpatient stays for non-heart attack cardiology patients at Sandwell Hospital. This would take place in the acute medical unit at Sandwell Hospital. Specialist cardiology doctors will be present on the Sandwell site to review/provide advice and minor treatment to these patients on a daily basis and will also arrange appropriate transfer to the specialist cardiology unit at City Hospital if appropriate.

2.2 Emergency surgery and trauma assessment

2.2.1 Current model

The trust previously identified the need to consolidate its inpatient surgery, trauma and orthopaedic services on one site ahead of opening the new Midland Met Hospital. This centred on a need to ensure that the trust's surgical specialties were large enough to be able to continue to develop high quality patient services whilst continuing to provide appropriate support to the trust's two accident and emergency departments in the management of emergency patients. Public consultation on the proposed changes *Shaping Hospital Services for the Future,* took place between November 2006 and end of March 2007.

In 2007, an Independent Review Panel endorsed the trust's proposals and recommended that emergency surgery and orthopaedics trauma should be provided at a single acute surgical centre. The reconfiguration was implemented in 2009.

The current service model is:

- General surgery and trauma and orthopaedic inpatient wards are all located at Sandwell Hospital
- Ophthalmology, urology, ear nose throat, breast surgery and gynaecology inpatient wards are all located at City Hospital
- The trust's current surgical assessment model consists of two separate surgical assessment units (SAU), one based at City Hospital and one at Sandwell Hospital. Patients requiring a longer hospital stay are transferred from the SAU to the appropriate inpatient specialist ward.

Subsequent to this, a number of other service reconfigurations have taken place within Birmingham and as a result, all vascular surgery emergency services are concentrated at the Queen Elizabeth Hospital Birmingham along with the major trauma centre, with ambulances taking patients meeting the criteria for these services directly to the Queen Elizabeth Hospital. This has reduced the volume, and therefore critical mass, of patients requiring immediate surgery who present to the trust overall but, in particular, the volume to each site.

The SAU model on both sites has been regularly monitored and there is evidence of inconsistencies between sites. The timing and frequency of consultant review of patients on the SAU at City Hospital can be longer if the on call consultant for City Hospital is required to support the emergency consultant at Sandwell Hospital at peak times of emergency activity. Transfer times from the SAU at City Hospital to the inpatient wards at Sandwell Hospital, and therefore at times to surgery, can also take longer because of the need to transfer the patient across the site and balancing this with, as far as possible, not transferring the patient overnight in order not to disrupt the patient's sleep. Use of agency nursing staff can also be high on both SAUs. Consolidation of assessment services on one site would allow concentration of staffing resources for a larger group of patients, which would facilitate delivery of improved, consistent care pathways (including access to diagnostics) and concentration of expertise leading to more frequent consultant review and decision-making about patients on SAU and quicker transfer from SAU to an inpatient ward if required.

Concentration of the service on one site is also expected to make it more attractive to staff, assisting with recruitment and retention of specialist staff and reducing reliance on agency staff. The national reduction in middle grade training posts in surgery also makes sustaining two resident middle grade rotas difficult without increased use of locums.

The Right Care Right Here partnership recognises that continuing to work across two sites is resulting in delays for patients getting the assessment and treatment they need. The current two site model is therefore not considered equitable or sustainable until the opening of the Midland Met Hospital.

2.2.2 Proposed change

The proposals are seeking to transfer the nursing expertise onto a single site and expand the scale of care at Sandwell Hospital. This reflects the growth in demand at Sandwell for complex surgery, which makes supporting a dual site model more difficult than seven years ago, despite investments in staffing including consultant numbers.

It is important to note that all major trauma cases are already taken directly or transferred to the major trauma centre at the Queen Elizabeth Hospital (QEH). Both emergency departments in the trust currently have trauma unit status, where immediate treatment may be given prior to safe onward transfer to the major trauma centre. As a result, the number of major trauma cases presenting directly to City or Sandwell emergency departments are relatively small and so maintaining the required experience and expertise on both sites is increasingly difficult.

The challenges in summary are:

- A lack of timely access to senior clinical input , which is dependent on how often they are asked to assess patients in two emergency departments at both City and Sandwell hospitals
- Inability to meet required staffing levels (middle grade doctors) 52 weeks a year, as surgical trainee numbers reduce nationally
- Reliance on agency nursing to staff the SAU and other surgical wards, with the general surgical ward at City Hospital isolated from the wider specialty bed base.

2.2.3 Future model

The Trust is proposing to create a single surgical assessment unit, based on the Sandwell Hospital site alongside inpatient services.

Sandwell and West Birmingham Hospitals NHS Trust's proposed surgery and trauma service configuration

Sandwell Hospital	City Hospital
24/7 emergency department (ED) with trauma unit status- transfer surgical patients to SAU. Major trauma transferred to major trauma centre (QEH) as per trauma network criteria	24/7 ED transfer surgical patients to SAU at Sandwell. Major trauma transferred to major trauma centre (QEH) as per trauma network criteria
24/7 SAU (chairs and trolleys) with a maximum 24 hour length of stay before discharge or transfer to an inpatient bed	No SAU
Gynaecology, ear nose throat (ENT), urology, breast and plastic surgery, emergency referrals transfer to City Hospital specialty wards	ENT, urology, gynaecology, breast and plastic surgery inpatient beds
Trauma and orthopaedic (T&O) inpatient beds	
General surgery inpatient beds	

Female patients with abdominal pain, who are pregnant or have vaginal bleeding, would be referred to gynaecology at City Hospital and transferred to the EGAU as appropriate	24/7 emergency gynaecology assessment unit (EGAU)
Revised head injury pathway including patients without bone damage or intracranial bleeding referred to acute medicine on site and other patients referred to critical care or T&O depending on clinical need	Head injury patients without bone damage or intracranial bleeding referred to acute medicine on site and other patients referred to critical care (on site) or T&O (and transferred to Sandwell Hospital) depending on clinical need
Critical care	Critical care
Surgical and T&O day case procedures including 'patch and plan' surgery	Surgical and T&O day case procedures including 'patch and plan' surgery
Surgical and T&O outpatients including fracture clinic	Surgical and T&O outpatients including fracture clinic

This new service model enables:

- A critical mass of expertise and an increase in clinical expert control over assessment and admission process with consolidation of imaging service and dedicated imaging capacity
- Rapid multidisciplinary assessment/diagnosis within six hours
- The majority of patients to be seen/have a working diagnosis and be admitted/transferred or discharged within 12 hours of arrival to the surgical assessment unit; a small number of patients may require a stay of up to 24 hours maximum according to clinical need as defined by the specialist
- Ambulance patients with surgical or trauma conditions to be taken directly to Sandwell's emergency department with the exception of women with abdominal pain, who are known to be pregnant or reporting vaginal bleeding, who will be taken directly to City Hospital's emergency department to be assessed by gynaecology in the first instance
- GP emergency referrals to general surgery, trauma and orthopaedics to be directed to Sandwell Hospital's SAU with a timed appointment. GP emergency referrals to gynaecology, urology and ENT to be directed to the appropriate ward at City Hospital. GP emergency referrals are made through a telephone call from the GP to the appropriate clinical team
- Self- presenting patients to the City Hospital's emergency department with a surgical condition or trauma will be seen at City and transferred to Sandwell Hospital's emergency department or SAU if surgical or trauma specialist assessment is required.

2.2.4 Future activity proposals

Based on the number of surgical admissions to SAU at City Hospital from the emergency department at City Hospital, this equates to 1,323 trauma and orthopaedic patients and 1,677 general surgical patients. These patients would need to be either diverted by West Midlands Ambulance Service or transferred across to Sandwell Hospital SAU (approximately 3,000 patients per year).

Of those 3000 patients approximately:

- 60% arrive by ambulance (around 1,800 patients per year)
- 40% (around 1,200 patients per year) would self- present and therefore require transfer across to the SAU at Sandwell. For the majority of those patients who self-present this is likely to be managed by the Hospital Trust's internal transport

- A percentage of the self- presenters between 10-25% (120-300 patients) may require West Midlands Ambulance Service paramedic transfer.

2.2.5 What are the benefits of working on one site?

Locating the assessment services onto the Sandwell Hospital site, alongside inpatient care, would further improve care, by:

- ***Maintaining clinical knowledge***; clinicians and staff would be treating enough patients to maintain their skills
- ***Recruit and maintain skilled staff***; working on one site would be more attractive to clinicians and staff, and will help us be less reliant on agency staff
- ***Timely access to assessment and treatment***; patients would have a rapid assessment as all members of the emergency team are now working together on one site
- ***Consolidated capacity*;** locating the surgical assessment unit on one site allows greater flexibility to meet peaks in demand
- ***Faster access for GP referrals;*** patients can be given a timed appointment for urgent referrals direct to the surgical assessment unit from their GP.

3. Equality Impact Assessment key findings

The programme undertook an Equality Impact Assessment (EQIA), which identified the proposed service changes as potentially impacting on:

- Patients at risk of cardiovascular disease
- Older people
- Sandwell and West Birmingham has higher levels of deprivation, which highlights that increased travel costs could have an impact
- People with pre-existing disabilities particularly in terms of understanding the new service model and reasons for this in terms of travel times and ease for relatives
- Race: ethnic groups who may be more prone to cardiovascular disease and associated conditions, including some black and minority ethnic groups (South Asian men are 50% more likely to have a heart attack or angina, diabetes prevalence is five times higher amongst Bangladeshi and Pakistani population groups, young south Asian men are at high relative risk of coronary heart disease at a younger age
- Carers: possible impact on time and travel costs
- Some pregnant women with abdominal pain may require a transfer between sites after initial assessment to rule out gynaecology pathology before referral to general surgeons.

The findings of the Equality Impact Assessment were used to target key groups within the listening exercise.

If the recommendations are approved, the following mitigating actions will be taken in response to the EQIA findings:

- Monitoring of service provision to ensure appropriate engagement and access to information and language services
- Pre-Post intervention quality of life measures
- Monitoring of service provision to ensure equitable access, experience and outcomes
- Monitor patient/carer experience
- Monitoring of service provision to ensure equitable access and outcomes for all groups

- Travel and transport analysis undertaken to support decision-making
- Post-implementation EQIA will be carried out to monitor impact of changes.

The potential impact on travel times and ease for relatives is recognised but the benefits to patients, in terms of quicker treatment times for emergencies, shorter stays in hospital and the improved skills of specialist staff treating a critical mass of patients, mitigate this impact. The implementation phase will be monitored closely especially for the areas outlined above to ensure that any impact is highlighted in real-time and acted upon.

4. Travel analysis

A key theme arising from the engagement activity has been the impact on travel both from the perspective of ambulance journey times and from the perspective of visitor travel times. The programme has undertaken several areas of work around these issues:

4.1 West Midlands Ambulance Service (WMAS)

For both urgent cardiology, emergency surgery and trauma pathways all patients requiring emergency assessment and admission either through a 999 call or transfer between sites would be transferred via a 'blue light' pathway.

Chest pain patients with an ST elevation on an electrocardiogram or ECG (STEMI) (a type of heart attack) will be taken by ambulance directly to City Hospital. Following discussions with WMAS, there may be a very small impact for Sandwell residents whose nearest location for emergency interventional cardiology post- reconfiguration would be New Cross Hospital. It is estimated that about 2% of patients within the Sandwell Hospital catchment area having a STEMI heart attack would be taken by ambulance to New Cross Hospital (as the nearest hospital offering PPCI) rather than City Hospital. This should have minimal impact on the trust's catchment area and the commissioned boundary for WMAS pathways would remain the same.

All other patients having a STEMI heart attack will be taken by ambulance to City Hospital as, for all other areas of the trust's catchment population, City Hospital will be the closest location and the impact on blue light ambulance journey times would be minimal. The additional number of redirections from the Sandwell Hospital catchment area is estimated to be circa 120 cases per year, with an additional 60 hours of work for WMAS.

Both City and Sandwell hospitals currently have trauma unit status. In the proposed new service model only Sandwell would have trauma unit status and City Hospital would become a local emergency hospital. As a result, any trauma patients in the City Hospital catchment area, meeting trauma unit criteria at the scene, would be taken by ambulance to Sandwell Hospital as would any trauma case with a strong likelihood of surgery being required. Currently some redirection to Sandwell Hospital already takes place for patients with a strongly suspected fractured neck of femur injury. The additional redirection is estimated to be around 120 cases per year, with an additional 60 hours of work.

For general surgery cases, the main patient category from the City Hospital catchment area that would need redirection to Sandwell Hospital would be patients with abdominal pain. The current 'worst case scenario' is circa 1,800 cases per year. Further work is required to clarify the pathways.

This flow of patients will be closely monitored throughout the implementation phase to ensure that any greater catchment loss (or catchment increase) or adverse impact on WMAS is identified early and acted upon in real-time.

Throughout the programme the team have worked closely with West Midlands Ambulance Service to seek assurance that patients can continue to be transferred and treated within the recommended times. To support the West Midlands Ambulance Service, the Clinical Commissioning Group Governing Body will be considering additional funding to support the change in activity, until the Midland Met Hospital opens.

The Hospital Trust and West Midlands Ambulance Service already have experience in ensuring patients are transferred to single sites, through the stroke reconfiguration. As a result, both organisations are confident that patients can be seen within the recommended times.

4.2 Public transport

The programme commissioned an analysis of public transport (PT) accessibility to the Sandwell and City hospital sites. Accessibility is defined as the extent to which individuals and households can access everyday services such as healthcare. The modes of public transport considered included: rail, metro and bus. Car ownership is an important consideration in accessibility studies because where there is a level of car ownership much lower than average, then good public transport opportunities need to exist in order for people to access education, employment, local facilities and health services.

Setting an optimum travel time of 30 minutes or less for access to main hospitals is supported by the accessibility statistics (taken from National Travel Survey data) reported by the Department for Transport in 2014. The report provides information on the services available to local communities by public transport/walking, cycling and car modes. For each destination type (employment, primary schools, secondary schools, further education, GPs, hospitals, food stores, town centres) statistics have been produced showing the percentage of the population that can reach the nearest location providing that service within specific time thresholds. The time thresholds vary depending on the type of destination.

In relation to access to hospitals, the percentage of households able to access them within 30 minutes by each mode is shown below:

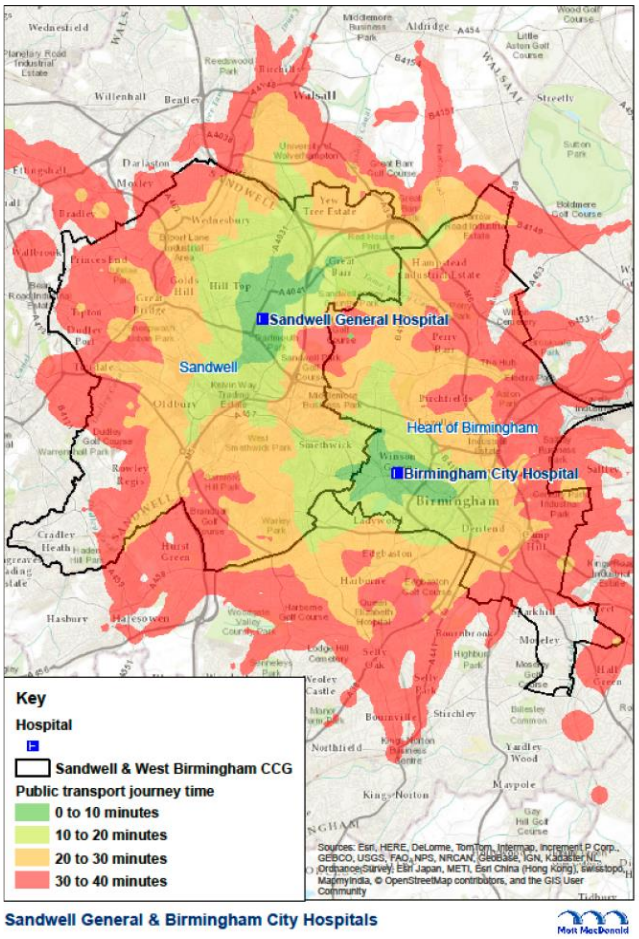
- Public transport / walking: 66%
- Cycle: 79%
- Car: 99%

The percentages suggest that the level of service (accessibility) achievable by private car should also be achieved for public transport users. This should therefore be a consideration for transport and healthcare providers in relation to the location of healthcare services.

Sandwell has traditionally had a low level of car ownership compared to the West Midlands and country-wide averages. The former Heart of Birmingham PCT area (HoB) average is relatively high compared with the West Midlands and Sandwell averages because it is an area of mostly high deprivation. Some areas in Sandwell also have car ownership levels that are around the average for HoB. Although this situation, particularly in HoB, suggests that accessibility could be relatively poor, the availability of a large number of high frequency public transport services could mean that access to education, employment, local facilities and health services can prove otherwise, assuming that all public services and other facilities are available / located within 30 minutes' travel time.

Public transport routes and times are therefore important for our local population both in terms of attending hospitals for planned (elective) care and for visiting people in hospitals. A journey time of less than 30 minutes by public transport to a main hospital is the accepted standard (West Midlands Local Transport Plan *WMLTP* - 2006-11) and in the National Travel Survey data reported by the Department for Transport - 2014).

The analysis showed (see map), when reviewing the public transport accessibility of Sandwell Hospital and City Hospital together, that the majority of the Sandwell and West Birmingham population can access either hospital in a public transport journey time of 30 minutes or less.



Sandwell and West Birmingham Public Transport Accessibility Map

Overall the Sandwell and West Birmingham area generally experiences positive public transport journey times to all hospital sites. However, there are areas along the periphery of the CCG boundary that are not able to achieve this same level of accessibility. This primarily affects Cradley Heath, Tipton, Perry Bar, Camp Hill and Moseley. It is important to note that the areas of Sparkhill and Moseley are not able to reach either City Hospital or Sandwell Hospital within a 30 minute journey time. These populations currently primarily access the Queen Elizabeth Hospital or Heartlands Hospital and are likely to continue to do so.

Retaining outpatient clinics at both City and Sandwell hospital sites would help to ensure local access for many patients. Most emergency patients with heart conditions arrive at hospital by ambulance and so the main impact in relation to longer public transport times would be on the visitors of Sandwell patients who are on the cardiology wards at City Hospital. Many of these patients would only be in hospital for a short period of time. The trust is exploring options to provide assistance to visitors in these circumstances such as some form of bus service between the City and Sandwell hospital sites that visitors can use at key times.

5. Communications and engagement

A comprehensive Communications and Engagement Plan was developed, which enabled the programme to engage all its stakeholders in the listening exercise and to undertake targeted engagement with key groups including seldom heard groups.

The approach was driven by a number of key principles, including that the engagement process was objective, sincere, stands up to scrutiny and complies with best practice and legislation.

5.1 Communication and engagement channels

A range of communication channels were used to ensure that effective communications with different stakeholders took place. Examples included:

- The Internet - websites
- Internal communications – existing staff, clinician and member channels
- Social media – Twitter
- The media – local newspapers, radio
- External communications – stakeholder bulletins and a listening document used to ensure that all our stakeholders had the opportunity to read and understand the proposals being talked about.

In respect of our approach to engagement, it is helpful to see different levels of involvement as a continuum from just giving information to full 'meaningful' involvement.

- ***Giving information*** - documentation, media, social media
- ***Obtaining information*** - semi-structured interviews, self-completed questionnaires, telephone interviews, face-to-face interviews, open surgeries and radio interviews
- ***Forums for debate*** - public meetings, focus groups, attendance at local forums.

5.2 Feedback from the listening exercise

A ten week listening exercise was conducted from 12 January to 20 March 2015 to ensure that patients and stakeholders were effectively engaged and the CCG and trust board could reach the right decision for their local population regarding the proposed reconfiguration of urgent cardiology services and emergency general surgery and trauma assessment.

At least 17,810 people were reached through electronic/ postal mailings and the distribution of materials within local communities. Discussions took place at 74 engagement activities with approximately 1,274 attendees.

179 survey responses were received and further anecdotal feedback was captured during wider discussions at the various meetings attended.

Feedback revealed:

- Mixed levels of awareness in relation to the Right Care Right Here programme, but more people had some level of awareness
- In relation to understanding the need for change, 64% agreed that change was needed
- Single site working was supported by three quarters of survey respondents, predominantly based on faster access to treatment, a belief that the changes would lead to better outcomes for patients and the benefits of more concentrated expertise. However, some concerns were raised around increased distances for some patients according to where they live and potential travel delays
- Agreement with the proposed venues for each service was rated on a scale of 1-5:
    - In terms of locating urgent cardiology at City Hospital, 64% gave a positive score
    - In terms of locating emergency surgery and trauma assessment at Sandwell Hospital, 69% gave a positive score.

    However, additional comments through the survey and engagement activities revealed concerns raised by many, largely around increased distances and journey times for some relatives and visitors and the impact on the patient (in other words chances of survival for cardiology patients).

    Despite survey scores, the comments seemed to suggest a general preference for services to be at the nearest hospital. Traffic congestion around City Hospital and the impact on patient choice were also frequent concerns.

- When we asked how we could support people through these proposed changes, the strongest theme by far for both services was about communication and information, mentioned in 68% of comments for urgent cardiology and 82% of comments for emergency surgery and trauma assessment. People want to be kept informed in an honest and transparent manner.

  Transport issues were also raised for both proposals, either relating to journey time or transport routes for visitors, and these were mentioned by around 16% of respondents.

  Smaller percentages stressed the need for patients and relatives to be listened to and also talked about costs both for parking and travel (by public transport, taxi and car), which will be more expensive for some who have further distances to travel.

- When respondents were asked to rank five criteria in relation to their importance, the top two included:

    - Treatment by expert clinicians
    - Direct (faster access) to specialist teams.

The feedback has been used to shape the key performance indicators to ensure that the service change demonstrates improvement in access to specialist treatment. The programme team will work closely with West Midlands Ambulance Service to ensure there are no delays or adverse impacts on journey times. We have also used the feedback to ensure that communication and engagement remains a key focus during the implementation phase and that it shapes the implementation plan.

5.3 Listening exercise recommendations

The following section describes the recommendations following the listening exercise: priority should be given to:

1. Working closely with WMAS to ensure there are no delays or adverse impacts on journey times, particularly for those living on the border of the catchment area, and also ensuring that capacity will meet demand
2. Working with transport providers of hospital to hospital transfers to ensure that there are no delays or adverse impacts on journey times and also to ensure that capacity will meet demand
3. Working with public transport providers to ensure that there is good accessibility to both Sandwell and City hospital sites
4. Using the feedback to help shape the key performance indicators (measures) that should be put in place to ensure that the proposed service changes can demonstrate improvements in access to specialist treatment and patient outcomes
5. Keeping all participants, stakeholders, patients and the general public informed by:
    - Sharing the outcome of the listening exercise and/ or copies of the report
    - Sharing the final decision taken as to whether the proposals will be implemented, and all factors considered as part of the decision- making process
    - Ensuring that if the proposals are implemented, engagement remains a key focus during the implementation phase and feedback is provided on any further improvements that are implemented as a direct result of engagement, including the listening exercise.

- Ensuring that if the proposals are implemented, services are monitored regularly to measure the success of the service change, and that the findings are communicated.

6. Programme assurance

Benefits and key performance indicators have been developed for both proposals in partnership with clinical, programme, equality, public health and patient representatives. The metrics have also taken into account the feedback from the listening exercise. These metrics have been presented to NHS England's Quality and Surveillance Group to seek assurance on the proposed reconfigurations. NHS England's Quality and Surveillance Group endorsed the proposals with a recommendation to inform the British Cardiac Intervention Society.

7. Financial considerations

The trust has carried out a detailed analysis of the financial resource required to support the selection of the viable models and this has supported the quality recommendations. It is important to note that the cost of service change will be supported by the national Payment by Result Tariff.

The impact of the redirection of ambulances on West Midlands Ambulance Service would need to be funded by the CCG at a cost of £25,200 per annum for urgent cardiology and trauma until the Midland Met Hospital opens. Changes to activity flows would be monitored on a monthly basis.

For general surgery cases, the main patient category from within the City Hospital catchment area that would need redirection to Sandwell Hospital is patients with abdominal pain. The current 'worst case scenario' is circa 1,800 cases per year. Further work is required to clarify pathways. The impact on WMAS for the redirection of emergency surgery patients could lead to an impact of £189,000.

8. Next steps

The programme findings and recommendations are being taken to the CCG's Governing Body on 1 July and the Hospital Trust's Board on 2 July for approval, subject to approval by the Joint Health Overview and Scrutiny Committee.

If the recommendations are approved, clinicians and staff will be working to implement the changes by:

- A single site interventional cardiology model at City Hospital with an implementation date of early August 2015
- A single site emergency surgery and trauma assessment model at Sandwell Hospital, alongside the inpatient beds, with an implementation date of Autumn 2015 (tbc.)

A detailed implementation plan has been developed, working with clinicians and West Midlands Ambulance Service, to support the safe transfer of services. The trust is keen to implement the changes for cardiology in August 2015, to align with the new intake of clinicians.

Throughout the implementation patients and the public will be kept informed of the changes.

9. Conclusion

This paper has provided an update on the listening exercise and programme recommendations to reconfigure:

- A single site interventional cardiology model at City Hospital with an implementation date of early August 2015
- A single site emergency surgery and trauma assessment model at Sandwell Hospital, alongside the inpatient beds, with an implementation date of Autumn 2015 (tbc.)

These reconfigurations are required ahead of the opening of the Midland Met Hospital in order to ensure safe, high quality care and a sustainable service. In both services the proposals will further improve care by:

- ***Maintaining clinical knowledge***; clinicians and staff would be treating enough patients to maintain their skills
- ***Recruit and maintain skilled staff***; working on one site would be more attractive to clinicians and staff, and would help us be less reliant on agency staff
- ***Timely access to assessment and treatment***; patients would have a rapid assessment and start of treatment as all members of the emergency team would work together on one site
- ***Consolidated capacity*;** locating specialist capacity on one site in other words, the Surgical Assessment Unit (SAU) at Sandwell Hospital and the cardiac catheterisation laboratories at City Hospital would allow greater flexibility to meet peaks in demand.

Feedback from the listening exercise demonstrates that the local population understands the reasons for change and supports single site working. Predominantly their reasoning was based on faster access to treatment and a belief that the changes would lead to better outcomes for patients and the benefits of more concentrated expertise. Some concerns were, however, raised around increased distances for some patients and visitors, according to where they live and potential travel delays. For visitors, a key issue is public transport routes as our local population has lower than average car ownership and the Equality Impact Assessment demonstrated higher than average levels of deprivation in the population. The trust will continue to explore options for supporting visitor travel arrangements. The EQIA also identified the ethnic diversity of our population and the need to monitor any adverse impacts resulting from the proposed changes on this section of the population. It also identified the potential for the emergency surgery assessment reconfiguration to impact on pregnant women but the agreed pathways for women with abdominal pain and who are pregnant should reduce any adverse impact by directing these women to City Hospital for an initial assessment by the gynaecology or obstetric team.

Further work is required to finalise the detailed implementation plan for emergency surgery and trauma assessment especially around transport for transfers between sites and implementation dates, which are likely to be in autumn 2015 for emergency surgery and possibly earlier (August) for trauma assessment.

10. Recommendations

After considering the clinical case for change, feedback from the listening exercise and the travel analysis, the Joint Health Overview and Scrutiny Committee is asked to endorse the recommendations to reconfigure :

- Single site interventional cardiology service at City Hospital with an implementation date of early August 2015
- Single site emergency surgery and trauma assessment service at Sandwell Hospital with a likely implementation date in the autumn of 2015.

11. Paper presented by:

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Right Care Right Here

Delivering better care for patients in Sandwell and West Birmingham

- Urgent cardiology services
- Emergency surgery and trauma assessment

Why are we reviewing services?

National best practice shows:

- Specialist emergency and hospital services are best provided in fewer but bigger centres to deliver the best patient care
- Services should be located on one site (specialist centres) to deliver:
  - Faster access to treatment
  - Skilled care from specialist teams (with a minimum number of patients)
  - Consultant led services 24 hours a day, 7 days a week

We can deliver better care for patients

Why are we reviewing services?

Midland Met Hospital

- Opens in 2018
- Brings together hospital services onto one site
- We need to prepare for the new hospital, by:
  - Gradually bringing services together on one site
  - Managing a smooth transition

We don’t want to wait three years to improve quality

Right Care Right Here

- 10 year partnership
- Local health and social care organisations
- Committed to improving people's health and the quality of health and social care services by:
  - Delivering a new specialist acute hospital in Smethwick
  - Care closer to home- greater provision of services in the community
  - Ensuring people have the opportunity to benefit from healthier lifestyles
  - Ensuring that services are extensively redesigned to meet the needs of the local population

Our journey so far

- 2006 public consultation
- £150million invested in new first class facilities
- New health centres developed
- More services provided in the community
- 2011 improved maternity services
- 2013 improved stroke services- located at Sandwell Hospital

Still to come

- Wednesbury health centre
- Langley Rood End health centre
- 2018 Midland Met Hospital opens
- Sandwell Hospital intermediate care beds

For over 10 years health and social care organisations have worked together as the Right Care Right Here partnership

Right Care Right Here

Our vision for 2018

What do cardiology services look like now?

- Provided 24/7 at both Sandwell and City hospitals
- Teams work across two sites
- Currently a specialist cardiology centre

Cardiology services need:

- **Two cardiac laboratories-** (these are currently split across two hospitals, which is not ideal)
- **Coronary care unit-** specialist cardiology wards

Our cardiology laboratories are experiencing increased breakdowns- and need to be replaced

Proposed changes

- Locating services for heart attack patients at City Hospital. This means:
  - 2 new cardiac laboratories located next to each other
  - Coronary Care Unit

- All patients requiring treatment in a cardiac laboratory or on coronary care unit (whether as an emergency or planned) will receive this at City Hospital

- Sandwell Hospital would no longer have a cardiac laboratory or coronary care unit. Some patients with heart conditions not requiring a cardiac laboratory or coronary care unit will still be cared for at Sandwell Hospital and be seen there by a consultant cardiologist

We want to locate urgent cardiology services at City Hospital

What are the benefits of working on one site?

- **Faster access to treatment;**
  Ambulance crews are able to take patients direct to the cardiology team
  Increased cover- specialists are no longer working on two sites
- **Delivering better quality care;**
  Clinicians are treating more patients- which helps **maintain their skills**
  Senior cardiology doctors can be on site 24/7
- **Fewer cancelled appointments;**
  New **state of the art laboratories** will mean fewer breakdowns- with less cancelled appointments for non-emergencies
- **Continuity of care**;
  Reduced transfers between hospitals for patients, if a laboratory breaks down
- **Investing in the latest technologies and treatment;**
  Reduced duplication of equipment and costs
- **Recruit and retain the best staff;**
  One site working is more attractive to staff

Why locate services at City Hospital?

- **Direct access-** ambulance crews can directly access the cardiac services- avoiding the need for patients to spend time in the emergency department
- **Direct access and safety -** the two laboratories can be located next to each other, near to the cardiology wards and emergency department
- **Achievable**-
  - City Hospital needs less refurbishment
  - We can change services with less disruption for other emergency patients. This is not easily achievable at Sandwell Hospital

Clinicians are supportive of the changes

Right Care Right Here

A small number of patients may go to **Sandwell A&E** with chest pains:

- They will be assessed and quickly transferred to City Hospital by ambulance
- The specialist team will be expecting the patient
- This will ensure patients are still treated within the recommended 120 minutes

We already have experience of transferring emergency cases between hospitals- stroke services

Cardiology services remaining on Sandwell Hospital

- Daily ward rounds
- Dedicated beds in the Acute Medical Unit (less urgent cases)
- ECG
- Follow up appointments for pacemakers
- Full range of outpatient services

Outpatient services

will also continue at:

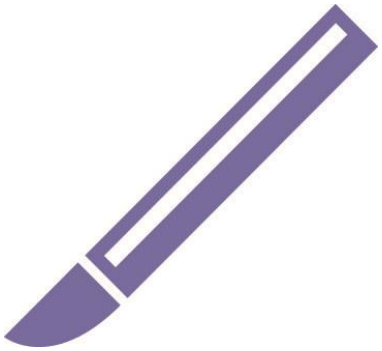
- City Hospital
- Rowley Regis Hospital

What do emergency surgery and trauma services look like now?

- **Initial diagnosis and treatment** of emergency patients with general surgical and trauma conditions
- If you need an emergency operation or longer stay in hospital you are transferred to Sandwell Hospital
- **General Surgery and Trauma and Orthopaedic inpatient services** (wards) were moved to Sandwell Hospital in 2009
- This was recommended by **an Independent Review Panel** in 2007

The most serious trauma cases are taken by ambulance to the Major Trauma Centre at Queen Elizabeth Hospital

Proposed changes



- Locating assessment services for emergency patients with general surgery or trauma conditions at Sandwell Hospital.
  - 24/7 on site specialist medical teams
  - A Surgical Assessment Unit (SAU)

- Ambulances will take patients, likely to require general surgery or trauma treatment (e.g. abdominal pain and serious broken bones) to Sandwell Hospital

- Any patients who take themselves to City Hospital Emergency Department will be assessed and if appropriate will then be transferred by ambulance to Sandwell Hospital

- Some patients with less serious conditions may receive initial treatment from the ED team at City Hospital and then be given an appointment to come back for further specialist treatment

The most serious trauma cases will still be taken by ambulance to the Major Trauma Centre at Queen Elizabeth Hospital

What are the benefits of working on one site?

Faster access to ultrasound scans
Working on one site will enable us to have dedicated slots for radiology

Recruit and maintain skilled staff
Working on one site will be more attractive to clinicians and staff- we can be less reliant on agency staff

Timely access to assessment and treatment
All members of the emergency team are on one site- meaning faster treatment for patients

Faster access for GP referrals
Patients can be given a timed appointment by their GP for urgent referrals

Right Care Right Here

- On average around nine patients a day will need to transfer from City Emergency Department to Sandwell Hospital for emergency surgery
- Patients will be stabilised in City ED and then transferred to SAU or a ward at Sandwell
- Many patients do not need emergency surgery, and can be given an appointment for urgent planned surgery (usually within a week)
- Outpatient clinics will still be provided at both hospitals

We already have experience of transferring emergency cases between hospitals- stroke services

Gynaecology services

- Women with suspected gynaecology or pregnancy conditions will be taken by ambulance to City Hospital
- If after assessment a gynaecology condition is discounted, they will be transferred to Sandwell Hospital for treatment under the general surgery team

Equality impact assessment

- Patients at risk of **cardiovascular disease**
- **Older people**
- Area has higher levels of **deprivation**- impact of increased travel costs
- People with **pre-existing disabilities**
- **Ethnic groups** who may be more prone to cardiovascular disease and associated conditions, including some black and minority ethnic groups (South Asian men are 50% more likely to have a heart attack or angina, diabetes prevalence is five times higher amongst Bangladeshi and Pakistani population groups, young south Asian men at high relative risk of CHD at a younger age)
- **Carers**: possible impact on time and travel costs
- Some **pregnant women** with abdominal pain may require a transfer between sites after initial assessment to rule out gynaecology pathology before referral to general surgeons.

Travel analysis

West Midlands Ambulance Service

- Working closely with the Ambulance Service throughout the programme
- The service has confirmed they can support the change in activity levels between sites (subject to funding)
- Additional funding is being reviewed by the CCG to support the proposed activity changes
- The flow of patients will be closely monitored throughout the implementation phase
- Emergency patients who phone 999 will be taken directly to the right hospital
- If a patient self-presents processes will be put in place to ensure they are transferred quickly (via the Ambulance Service for emergencies)

We already have experience in transferring patients- through the previous stroke reconfiguration

Travel analysis

Public transport

- A key theme throughout the listening exercise
- Optimum travel time of 30 minutes or less for access to main hospitals
- The majority of the Sandwell and West Birmingham population can access either hospital in a public transport journey time of 30 minutes or less
- We recognise that areas on the CCG boundary that are not able to achieve this same level of accessibility (Cradley Heath, Tipton, Perry Bar, Camp Hill and Moseley)
- Sparkhill and Moseley are not able to reach either hospital within a 30 minute journey time (however currently primarily access the Queen Elizabeth Hospital or Heartlands Hospital and are likely to continue to do so)

Travel analysis

- Most emergency patients with heart conditions arrive at hospital by ambulance and so the main impact in relation to longer public transport times would be on the visitors
- The trust is exploring options to provide assistance to visitors in these circumstances such as some form of bus service between the City and Sandwell hospital sites that visitors can use at key times.
- After the first few days patients can be transferred back to their nearest hospital to recover
- A communication plan is being developed to ensure patients know where to go
- Retaining outpatient clinics at both City and Sandwell hospital sites would help to ensure local access for many patients

Listening exercise activity

- A 10 week listening exercise was conducted from 12 January - 20 March 2015
- At least 17,810 people were reached through electronic/ postal mailings and the distribution of materials within local communities
- Discussions took place at 74 engagement activities with approximately1,274 attendees
- 179 survey responses were received and further anecdotal feedback was captured during wider discussions

We will be feeding back the listening exercise findings over the next few months

Listening exercise key messages

- **64% agreed that change was needed**
- **Single site working was supported** by three quarters of respondents
- Concerns were raised around **increased distances** for some patients and **potential travel times** and congestion around City Hospital
- Despite survey scores, the comments suggested a general preference for services to be at the **nearest hospital**
- Impact on **patient choice** was also a frequent concern
- **Communication and information** was important to patients
- Smaller percentages stressed the need to **listen to patients and relatives** and also talked about costs both for parking and travel (by public transport, taxi and car)
- Respondents said that the most important factors were:
  - **Treatment by expert clinicians**
  - **Direct (faster access) to specialist teams**.

Listening exercise recommendations

- Working closely with **West Midlands Ambulance Service** to ensure there are no delays or adverse impacts on journey times
- Working with **transport providers** of hospital to hospital transfers
- Working with **public transport providers** to ensure good accessibility to both Sandwell and City hospital sites
- Using the feedback to help shape the **key performance indicators** (measures)
- Keeping all participants, stakeholders, patients and the general public informed:
  - Sharing the outcome of the listening exercise
  - Sharing the final decision taken
  - Ensuring that if the proposals are implemented, **engagement remains a key focus during implementation**
  - Ensuring that if the proposals are implemented, **services are monitored regularly**

Next steps

Recommendations to be reviewed by:

- CCG Governing Body 1 July
- Hospital Trust Board 2 July
- Joint Health Overview and Scrutiny Committee 1 July

Proposed implementation

If approved, proposed implementation would take place:

- Urgent cardiology model at City Hospital in early **August 2015** (to align with new clinicians starting)
- Emergency surgery and trauma assessment model at Sandwell Hospital alongside the inpatient beds in **Autumn 2015 (tbc.)**

Communication and engagement

Communication and engagement will be essential throughout implementation to ensure patients are informed of the changes

Right Care Right Here

THE END

Sandwell and West Birmingham
Clinical Commissioning Group

Update on the Procurement of End of Life Care Services across Sandwell and West Birmingham CCG

A report for the Joint Health Overview and Scrutiny Committee for Sandwell & West Birmingham

July 1. 2015

Update on the Procurement of End of Life Care Services

1. Introduction

In March 2014 the Sandwell and West Birmingham CCG Governing Body supported a proposal to use a Social Impact Bond (SIB) to fund the development of a Coordination Hub and Urgent Response team for End of Life Care (EOLC). Launched by the Government, Social Impact Bonds (SIBs) are considered a catalyst for the development of innovative delivery models and transfer risk to socially motivated investors often from charitable foundations. It was recognised that utilising a SIB could provide a range of benefits to commissioners and service users, i.e.

- Provide organisations with the flexibility to bring in new systems, innovative approaches and management expertise
- Provide rigorous data analysis and on-going project monitoring to ensure that the service is always focused on delivering improved outcomes for patients, and ensure the CCG only pays if these are achieved

2.0 Background.

Working in collaboration with Marie Curie Cancer Care, Social Finance, (DH appointed partners) and Bevan Brittan the project team developed a proposal for a new finance and contracting model with 2 defined elements being funded through the proposed SIB. Rigorous data analysis was undertaken by Social Finance which indicated a level of outcome targets which was considered achievable and financially viable for investors. The CCG also applied to the Big Lottery Fund/Cabinet Office for a level of funding to support delivery the outcomes.

To ensure confidence in the data, an internal analysis was undertaken to confirm the metric developed by Social Finance remained appropriate. This exercise resulted in significant changes to the metric as it was felt that the activity would in fact be less than that originally estimated, making the margins much tighter.

3.0. Procurement Process

Following extensive market engagement with a wide range of stakeholders, potential investors and intermediaries (organisations liaising between investors and providers

/ commissioners) it quickly became clear that the investor and intermediary market was very limited for this type of investment. Further engagement was undertaken, on a one to one basis with a range of intermediaries, to promote interest and encourage engagement with provider partners.

The procurement process began in August 2014. A prequalification questionnaire (PQQ) was issued and resulted in 2 returns both of which met the criteria. An Invitation to Tender (ITT) was then issued to both. This process closed on January 22. 2015.

One shortlisted bidder did not return a bid as they felt that there would need to be detailed negotiation around the financial metric, and to submit a return without this would result in a non-compliant bid. The second bidder returned a bid. However on review it evaluated as non-compliant. The bidder's rationale for this variance was based on disagreement around the baseline activity described in the revised metric. Furthermore they proposed negotiation to resolve the issues around the metric.

The CCG were therefore in a position where they did not have a compliant bid to take forward. A number of alternative options were considered by the Governing Body.

4.0 Options

In line with procurement rules the following options were considered by the CCG Governing Body.

Option 1

The first option was to continue with the procurement, despite the fact that a non-compliant bid had been received. This approach would have required the CCG to enter into negotiation with the second bidder in order to arrive at an arrangement which was mutually beneficial. Despite the fact that this would be likely to have delivered a solution which would work well for the CCG, it also carried a heightened risk of legal challenge. The initial Official Journal of the European Union (OJEU) notice stated that the CCG would not accept variant bids – this would have given any aggrieved party a sound basis on which to challenge. For this reason it was considered that taking this option would carry a very high risk of legal challenge.

Continuing with the tender submitted by the second bidder was therefore not recommended.

Option 2

A further option was to roll back the procurement to the stage of close of PQQ. The tender documents could then be re-issued to the 2 bidders and the competitive dialogue procedure adopted. This would have given both parties who were initially invited to tender the opportunity to negotiate with the CCG – an outcome which both providers had indicated that they would find beneficial. There were a few issues identified with this approach. Firstly, it is not strictly in line with what the CCG are permitted to do. The OJEU notice stated that the CCG would be carrying out a restricted procurement process. Changing the process at this point in the procurement could have led to a risk of challenge from another party who indicated that they would have been interested in submitting a PQQ, but suggested timescales were not sufficient for them to secure an investment partner. There was therefore a possibility that there could be a challenge from them (or another party who had not identified themselves) if the procurement were to be rolled back and the process changed. The basis of their argument was likely to have been that had they known that a competitive dialogue process was to be run, they would have had more time to firm up any conversations with investors, and that on this basis they would have submitted a PQQ. They could therefore argue that they had been unfairly excluded from the process.

In addition to the above, this option would have required much extra resource and up to an extra 6 months may have been required. Competitive Dialogue is particularly resource intensive and would also put extra pressure on the budget for this procurement. The combination of extra resource required and risk of legal challenge made it difficult to recommend this option.

Option 3

Thirdly, was to cancel the procurement as it stood. The main risk here surrounded not taking the single remaining bid through. However, as the bid was essentially non-compliant, the risk was deemed to be very limited.

In agreeing to cancel the existing procurement, a number of options were available which were largely dependent on whether or not the CCG wished to continue the SIB. It was apparent from the work undertaken to date that the use of a SIB was restricting the market, (the number of intermediaries able to support the setup of a SIB was very limited). If the CCG wished to continue with a SIB and be completely compliant, the process would be to re-run the PQQ and then go out to tender again on the basis of a competitive dialogue. It was estimated that this would take a minimum of 9 months or longer to complete.

If the CCG decided that the SIB was not the correct way to proceed, it made sense to combine the procurement for the Hub and Urgent Response Team, (group 1 services) with the tender for the remaining non acute EOLC services, (group 3 services) which was being procured concurrently. Given the need for providers to work together on such a provision, it was likely that the number of competing bids would be reduced making it possible to use the open tender process which allowed for a shorter timeline. It was thought that the process could be completed in between 6 and 8 months.

The Governing Body were asked to make a decision regarding the viability of continuing to secure a SIB to support implementation of the new model for EOLC. The options presented highlighted the associated risks and challenges including the obstacles to overcome in agreeing a financial metric that was both viable and acceptable to all parties.

The Governing Body were also presented with the costs associated with proceeding without a SIB if the CCG was to fully implement the desired model of care. This was estimated at £758,537.

4.0 Governing Body Decision February 2015

Having reviewed the available options the Governing Body agreed to:-

- Discontinue further work on securing a Social Impact Bond
- Cancel procurement process for group 1 services
- Cancel procurement process for group 3 services
- Commence a procurement process for merged group 1 and 3 services.
- Agree to fund the shortfall

The project team therefore proceeded to develop a new service specification and contracting framework. They also engaged with the provider market to inform them of the changes and contracting options.

4.0 Current Position

An open procurement process commenced in March 2015. A market engagement event was held where stakeholders raised concern around the time made available to prepare their bids under the new contracting arrangements. In response to this an additional 6 weeks was made available.

The Invitation to Tender was published in March and closed on July 1. It is anticipated that, subject to the submission of viable bids being received, the contract will be awarded by the end of September 2015 and the new service will commence in January 2016.