

# Weston Partnership

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## Strategic Outline Case (SOC)

31 January 2018  
Version 2.2

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## 1. Executive Summary

The aim of this Strategic Outline Case (SOC) is to establish to what extent there is a sufficiently compelling case demonstrating that the long-standing issues of clinical and financial sustainability of services at Weston Area Health NHS Trust (WAHT) may be addressed through further development of the partnership with University Hospitals Bristol NHS Foundation Trust (UH Bristol).

The SOC describes the drivers and potential benefits for patients, staff and the wider stakeholders of both organisations of greater collaboration between UH Bristol and WAHT, considers the fit with UH Bristol's clinical strategy and the potential clinical and non-clinical benefits and risks of partnership options, and recommends the preferred option of organisational merger by acquisition.

### 1.1 Sustainability challenge for WAHT

Over a number of years it has been increasingly clear that WAHT, as one of the smallest NHS Trusts in England, would not achieve stand-alone Foundation Trust status. In addition, it has continued to experience challenges in maintaining the financial and clinical sustainability of its services. A number of attempts to develop a viable long term plan have failed, most recently in 2014 when an attempt to tender WAHT for acquisition did not complete.

Despite the commitment and hard work of staff, the prolonged periods of uncertainty created by these processes and the continuing deterioration in WAHT's ability to recruit to clinical posts in key service areas with a context of national workforce shortages, have already resulted in temporary service changes. Furthermore, WAHT have identified a number of other services which may present sustainability risks in the short to medium term, which themselves reinforce the recruitment and retention challenge, creating a potential overreliance on temporary staff, substantial costs and care continuity implications.

The WAHT Care Quality Commission (CQC) report published in June 2017 provides a clear rationale for the need for significant pace behind actions to improve service resilience and quality. Weston General Hospital received an overall rating of 'requires improvement' with its urgent and emergency care services rated as 'inadequate', medicine and older people rated as 'requires improvement' and surgery and critical care rated as 'good'.

The report demonstrates that the continued sustainability risk in key clinical services is adversely affecting the quality of care it is possible for staff to provide for patients. The deterioration from the previous inspection, particularly in the areas of emergency care and patient flow, demonstrates that previous attempts to address difficulties, primarily through the recruitment and retention of substantive staff, have been of limited success.

### 1.2 Partnership Working

There are currently well established and strong links between services at WAHT and UH Bristol, with a number of joint service models already in place providing evidence that working collaboratively provides the opportunity to secure local access to quality care for appropriate District General Hospital (DGH) services.

UH Bristol has formal and informal links to WAHT at a number of levels. Service Level Agreements for services provided to WAHT by UH Bristol are in place for consultant medical staff across a number of specialities including laboratory medicine, surgery, cardiology, oncology, paediatrics and dermatology. The most significant are haematology and ophthalmology. There are also established joint clinical leadership models in place, including the UH Bristol Head of Midwifery providing leadership for maternity staff in UH Bristol and in Weston.

UH Bristol has also provided increased support in a number of clinical areas over the past twelve months, notably in paediatrics and oncology. This support ranges from giving clinical advice, to providing medical cover at times of planned or unplanned leave of WAHT Consultants. More recently, gynaecology services are being delivered via a joint model with inpatient gynaecology treatment and care being provided at UH Bristol, and daycase work planned to transfer to Weston, so North Somerset patients currently travelling to Bristol for this service can access it locally in Weston.

Building on the long-standing, positive working relationships which give local people access to a range of services delivered or supported by Bristol and Weston clinicians, both Trust Boards approved a formal interim partnership agreement in May 2017.

This Strategic Outline Case is the culmination of the work developed through this partnership arrangement to outline and evaluate the options to achieve financial and clinical sustainability for services at Weston General Hospital.

### **1.3 The Healthy Weston Programme and the Local Commissioning Context**

In autumn 2017, Bristol, North Somerset and South Gloucester (BNSSG) Clinical Commissioning Groups (CCGs) published '*Healthy Weston; Joining up services for better care in the Weston area*' (Ref 1 ) which provides an outline of the intended commissioning context for the population of North Somerset for the period 2017/18 to 2020/21. This document focusses on the needs of the North Somerset population and sets out the challenge of addressing the issues of financial and clinical sustainability for the region.

It describes an intention to work together in more effective ways and to integrate local services and pathways to tackle the identified health inequalities and better meet the needs of the local population. The three key strands within the vision are:

1. Primary Care (General Practice) working at scale and providing strong system leadership.
2. Stronger, more integrated community services supported by a 'Care Campus' model at the Weston General Hospital (WGH) site.
3. A stronger, more focussed Acute Trust and acute care model at WGH.

The programme is structured around these three key workstreams and WAHT and UH Bristol clinical and non-clinical teams are involved in the joint planning and redesign of the acute care model for WGH.

This SOC is being developed within the context of the Healthy Weston programme and it is the intention that the output of the acute workstream and wider Healthy Weston service

model, will inform the basis upon which any final recommendation, through a Full Business Case (FBC), to move to acquisition would be made.

#### 1.4 Case for Change and Benefits

The key drivers for both organisations to consider merging are as follows (detail in section 4 of SOC):

- Securing the clinical sustainability of appropriate services at WAHT
- Growing demand and population growth, particularly within North Somerset
- The need to optimise use of all available NHS capacity to meet growing demand
- Strategic and operational risks to UH Bristol and to the quality of care for Bristol and North Somerset patients, of failure to support the resilience of services at Weston General Hospital
- The need for financial sustainability through the delivery of productivity, efficiency and affordable service quality
- Supporting the strategic vision of Bristol, North Somerset and South Gloucestershire (BNSSG) Sustainability and Transformation Programme (STP) and delivering the Healthy Weston vision

There is clear strategic alignment between the UH Bristol and WAHT strategies. UH Bristol currently has significant capacity limitations, particularly in the delivery of general and emergency services to the local population, which are placing constraints both on access to general services and UH Bristol's ability to continue to develop its specialist and tertiary portfolio as planned within our strategic intent. Further alignment of Weston and UH Bristol could provide an opportunity to strengthen a joint DGH offer by increasing the critical mass of these services and also by using estate flexibly across the two sites to maximise benefit.

Strategically, the proposal to become a single organisation also provides an opportunity to demonstrate progress towards the stated strategic vision for the STP to move towards a much more integrated health and care system. An organisational merger would specifically progress the key principles agreed by the two Trusts and North Bristol NHS Trust within the Acute Care Collaboration workstream to deliver:

- A collaborative provider model, supported by a single commissioning approach
- Reducing use of the acute hospital bed base
- Using our acute hospital resources to support the wider health and care system

The key strategic benefits expected from the single organisation option are assessed as follows (detail in Section 6):

Domain	Strategic benefits
<b>Operational</b>	Providing a clinically and financially sustainable and viable platform for future services
<b>Clinical</b>	Providing a strengthened workforce with improved flexibility, recruitment and retention
<b>Financial</b>	Achieve economies of scale in corporate services, facilities, functional and clinical areas

The primary benefit to patients and staff will be addressing the operational, safety, quality and access issues highlighted in the recent CQC report and delivering the following:

<b>Key Patient Benefits</b>
Access to a range of local DGH services is retained, for the current and future population of North Somerset
Weston General Hospital has a sustainable future with the scope and opportunity for development
The quality and safety of services will improve through partnering with an outstanding teaching and Foundation Trust
Variation in clinical care and outcomes for patients will be reduced through shared learning and application of best practice models

### 1.5 Key Findings of the Strategic Outline Case (SOC)

The SOC demonstrates that scope exists to deliver a range of benefits to patients and staff and ensure that hospital-based services in Bristol and North Somerset provide high quality care to patients and families which are clinically and financially sustainable.

The SOC also presents an initial financial case, reflecting current and historic financial performance of WAHT, its potential future financial prospects going forward five years as a standalone entity, and the key drivers behind the track record of financial deficits at WAHT and provides an early assessment of the extent to which these can be mitigated under the preferred option, assessing a number of scenarios. These include an assessment of UH Bristol's financial position going forward, taking into consideration the potential net financial benefits of organisational merger.

This initial financial assessment indicates that whilst integration will support mitigation of the WAHT deficit, primarily through workforce and structural changes, the full deficit cannot be resolved within the current service model.

This is due to the infrastructure costs associated with the provision of a full DGH suite of services (including a Type 1 ED service), with a relatively small scale of activity which cannot be provided within funding tariffs on an ongoing basis. This assessment is further supported by evidence from a number of similar sites to Weston across the country.

The assessment of whether this situation can be further mitigated or eliminated will require clarity on the outcomes from the Healthy Weston programme and the associated confirmation of commissioning intentions. The process and timescales for this work will be key to informing the Boards' decision to commence a Full Business Case analysis.

### 1.6 Recommendation

**The Board of UH Bristol is asked to:**

- **Approve** the Strategic Outline Case for organisational merger, through acquisition of WAHT by UH Bristol.
- **Note** that the next stage in the process will be to complete a comprehensive appraisal of the future model of acute care within the context of the 'Healthy Weston' programme and vision. Depending on the outcome of this appraisal process, a full business case (FBC) will be developed. The FBC will be the document upon which

the final decision by the UH Bristol Trust Board and Council of Governors to proceed with any future transaction will be made. Any final decision would also require the approval and support of NHS regulators and the Competition and Markets Authority.

- Note that identification of sufficient resources to support the development of a Full Business Case and, subsequently, to make the transition to a merged organisation effective, will remain under discussion with Regulators.

## 2. Introduction and background

### 2.1 Introduction

This document describes the drivers, options and potential benefits of greater collaboration between University Hospitals Bristol NHS Foundation Trust (UH Bristol) and Weston Area Health NHS Trust (WAHT). The development of this SOC was agreed in a formal partnership agreement between both organisations committing to explore how increasing the level of joint working between the two Trusts could address long-standing issues of clinical and financial sustainability at Weston Area Health NHS Trust.

In May 2017, the Trust Boards of UH Bristol and WAHT signed an Interim Partnership Agreement to work in collaboration to:

- 1. Develop a joint service strategy setting out proposed areas for co-operation and for UH Bristol to provide management support to WAHT with the aim of ensuring sustainable and financially viable services are provided at WAHT alongside securing the ongoing integrity of service provision at UH Bristol; and*
- 2. Progress proposals for a long term arrangement (the "LTA"), which, subject to satisfactory completion of the required business cases, due diligence processes, final Board decisions and regulatory/statutory approvals where required, the Boards of both Trusts agree would involve an organisational merger of the two Trusts (effected by an acquisition of WAHT by UH Bristol).*

This Strategic Outline Case (SOC) considers the options for a long term arrangement and recommends a preferred option for organisational form to support achievement of sustainable and financially viable services at WAHT and secure the ongoing integrity of services at UH Bristol.

In the context of the continued challenges faced by Weston General Hospital and the increasing risk to resilience of some services, it was agreed with the Boards of both organisations and with the Regulator NHS Improvement, to undertake an accelerated business case process, recognising the constraints of time and resource. This SOC therefore also incorporates a limited level of analysis similar to that normally included in an Outline Business Case (OBC).

The recommendation to approve the SOC is based on the findings of this accelerated SOC and supported by an interim Due Diligence (DD) exercise examining the viability of and requirements, for proceeding with a formal transaction.

The next steps in the process will require development of a Full Business Case (FBC). The FBC will be the document upon which the final decision by the UH Bristol Trust Board and Council of Governors to proceed with any future transaction will be made.

The main purpose of the FBC ahead of the organisational merger via acquisition and contract signature is to test that the principles, assumptions and basis for recommending the preferred option at the SOC stage, remain valid and also to further evidence that the preferred option is the optimal course of action to address the issue of WAHT's clinically



non-sustainable and financially non-viable services. Essentially, the FBC allows for a more detailed review of the case for change, opportunities, risks and benefits.

In addition, the FBC will explain in more detail UH Bristol's fundamental requirements both financially and non-financially in order to produce a viable case for the acquisition of WAHT that can be approved by UH Bristol's Board and Council of Governors. UH Bristol's requirements will specify the content and values for negotiation with Commissioners and the Regulator, NHS Improvement. The FBC will also describe in detail the robust management arrangements for pre and post-merger project delivery that will drive the service changes that are required for clinically sustainable service provision at WAHT and ensure that staff are fully engaged in developing a shared vision for the new organisation.

## 2.2 Background

Over the last 10-15 years, it has been increasingly clear that Weston Area Health NHS Trust (WAHT), as one of the smallest NHS Trusts in England, would not achieve stand-alone Foundation Trust status. In addition, it has continued to experience increasing challenges in maintaining the financial and clinical sustainability of its services. A number of attempts to develop a viable long term plan to address this underlying issue have failed, most recently in 2014 when an attempt to tender WAHT for acquisition did not proceed.

In 2012, North Somerset Council, North Somerset Community Partnership and Weston Area Health Trust developed an integrated business plan that set out proposals for an Integrated Care Organisation (ICO) to be the principal provider of acute and community health services, and adult and children's social care services in North Somerset. This did not subsequently proceed. The business plan stated that the financial plan did not demonstrate how services would be delivered within the available resource and that further work would be required to resolve how to deliver long term financial sustainability and financial balance for both the provider and commissioner.

Work undertaken by WAHT prior to 2014 in partnership with North Somerset Clinical Commissioning Group (NSCCG) has demonstrated that WAHT, as a standalone entity, and as an integrated care organisation in partnership with other local health and social care provider organisations, was unable to satisfy the financial requirements necessary to achieve foundation status.

In 2014, WAHT and the local health economy therefore determined that an NHS only transaction process would offer the best and most timely solution for WAHT. In August 2014, WAHT and the Trust Development Authority (TDA) began an open NHS only transaction process to find the most suitable NHS Foundation Trust to acquire WAHT. An Invitation to Participate (ITP) in a process to find "A statutory recipient for the assets and liabilities of WAHT" was issued on 5th August 2014. Expressions of interest were received from UH Bristol, Taunton and Somerset NHS Foundation Trust (TSFT) and Somerset Partnership NHS Foundation Trust. Taunton and Somerset NHS Foundation Trust proceeded to FBC for the proposed acquisition of Weston Area Health NHS Trust but ultimately the acquisition did not proceed. The FBC did not demonstrate a financially sustainable solution.

In late 2015, after the Taunton acquisition was halted, leaders of the local health and social care system came together to form a partnership called the North Somerset Sustainability Board. Its aim was to take a fresh approach to this issue. Instead of looking for a solution that starts with organisational restructure, it has engaged a wide range of local expert clinicians to review the current models of care and service pathways. The North Somerset Sustainability Board initiated a three phase programme to deliver clinically and financially sustainable acute services in North Somerset, within the wider context of a sustainable health and social care system.

**Phase 1:** GE Fynamore was commissioned in early 2016 to complete a review of all the previous assessments of the local system's challenges;

**Phase 2:** The Programme for Sustainable Services developed a set of options/ proposals based on the Fynamore's work to put to the Sustainability Board;

**Phase 3:** The programme moved into a phase of engagement, consultation and implementation.

In February 2017, North Somerset and Somerset Clinical Commissioning Groups (CCG's) engaged the public on 4 option 'ideas' for Weston at the start of its programme phase 3. These were:

1. *change the urgent and emergency care service model overnight from 10pm – 8am*
2. *bring day to day non-complex planned operations back to weston general hospital*
3. *transfer some emergency surgery to other hospitals*
4. *increase the number of beds in the critical care unit on the weston general hospital site*

They also sought views on two enabling strategies, one of which was integrated working within acute care. This was based upon the work of the Acute Care Collaboration (ACC) within the BNSSG STP process which involves the three local hospital Trusts (Weston Area Health NHS Trust, University Hospitals Bristol NHS Foundation Trust and North Bristol NHS Trust (NBT)) as well as community partners. The ACC has agreed the following four objectives to guide its work:

- To ensure the best use of capacity and resources across the three hospitals (staff, facilities etc)
- To develop strong effective clinical pathways (the patient's journey through all necessary health services)
- To develop and support specialist services
- To secure sustainable services at Weston General Hospital

Following a joint Trust Board to Board meeting in January 2017, the Boards of Weston Area Health NHS Trust (WAHT) and University Hospitals Bristol NHS Foundation Trust (UH Bristol) announced on 8 February 2017 that they had agreed to establish a formal partnership arrangement, increasing the level of joint working between the two Trusts to address long-standing issues of unsustainability of clinical services and financially unviable services at Weston General Hospital.

This new collaboration was created in line with the NHS vision of developing networks between smaller and larger Trusts (Ref 2) and reflects the aim of the North Somerset Sustainability programme to build a strong future for Weston General Hospital (Ref 3). It also represents a step-up in acute care collaboration across Bristol North Somerset and South Gloucestershire (BNSSG), reflecting the commitments made within the Sustainability and Transformation Plan (STP) and progress towards the shared medium term objective of developing a BNSSG Integrated Health and Care system (Ref 4).

Building on the long-standing, positive working relationships which give local people access to a range of services delivered or supported by Bristol and Weston clinicians, the two Trust Boards approved a formal interim partnership agreement in May 2017.

This Strategic Outline Case is the culmination of the work developed through this partnership arrangement to outline and evaluate the options to achieve financial and clinical sustainability for services at Weston General Hospital.

In October 2017, BNSSG CCGs published their commissioning context document, *'Healthy Weston – Joining up services for better health care in the Weston Area'*. (Ref 1). This document outlines the context of the current challenges facing the “place” of Weston and the approach to developing the optimal clinical model for future services to inform commissioner decisions. Further detail is provided in section 3.2.2.

The prolonged periods of uncertainty created by the context outlined above have clearly been highly challenging for WAHT staff and undoubtedly have led to a further deterioration in recruitment and retention of clinical staff, underpinning the clinical service viability challenge. There has also been a further deterioration in the quality of emergency services and access for patients, outlined in the recent Care Quality Commission (CQC) report (Ref 5). It is therefore critical that a solution for the future of WAHT services is agreed quickly, so that the quality of services for patients does not further deteriorate and that a period of support and engagement can begin with staff.

### 3. Strategic and Local Context

This section outlines the strategic, national and local context for the Strategic Outline Case.

#### 3.1 National Context

NHS England's (NHSE) Five Year Forward View document published in October 2014 outlines the clear direction for the NHS. The report focuses on models of care and sets out a vision for 2020 intended to close 3 key health, quality and financial "gaps" and ensure that the needs of future patients are addressed in a sustainable way.

The current financial challenge within the NHS is significant, with the 2014 Carter report (Ref 6: Carter Report, 2014) stating how the "*NHS is expected to deliver efficiencies of 2-3%, effectively setting a 10-15% real terms cost reduction target for achievement by April 2021*" (Ref 6). It is of note that the 2-3% relates to annual efficiency savings.

The national response to this position is outlined in the document, *The Next Steps on the NHS Five Year Forward View* (March 2017). This key NHSE document describes how '*pressures on the NHS are greater than they have ever been*', and sets out an expectation that organisations will need to evolve. This SOC is being developed firmly within the strategic context of this national challenge for the NHS.

One of the key vehicles outlined to transform the NHS are changes to the traditional and established organisational forms. There are 13 Vanguards which have been established to review alternative models, including Acute Care Collaboration (ACC), as well as a number of other cross sector models.

In a speech to the Confederation of British Industry in London on the 25<sup>th</sup> September 2015, Simon Stevens (Chief Executive Officer of the NHS) stated that, "*the era of go-it-alone individual hospitals is now being superseded by more integrated care partnerships*" and that, "*our new approach to hospital partnerships will help sustain the viability of local hospitals, share clinical and management expertise across geographies, and drive efficient beyond the walls of individual organisations*" (2015).

In addition, the 2014 Dalton Review, *Examining new options and opportunities for providers of the NHS* identifies five key themes underpinning successful changes to organisational form within the NHS (Ref 7). These can be summarised as:

- One size does not fit all;
- Quicker transformational and transactional change is required;
- Ambitious organisations with a proven track record should be encouraged to expand their reach and have greater impact;
- Overall sustainability of the provider sector is a priority; and
- A dedicated implementation programme is needed to make change happen.

The Five Year Forward View strongly signposts the need for new models of care to respond to the challenges faced by the NHS and that providers will struggle to meet the challenges faced by the NHS without looking outside of traditional organisational boundaries.

The proposal outlined in this SOC will represent the first steps towards developing a more integrated health system in BNSSG.

## 3.2 Regional and Commissioning Context

### 3.2.1 Regional context

Weston Area Health NHS Trust and University Hospitals Bristol NHS Foundation Trust along with a third acute provider, North Bristol NHS Trust, form part of the BNSSG healthcare system. The system is developing a Sustainability and Transformation Plan (STP) designed to address the national drivers outlined above and has also provided the overarching framework for the North Somerset Sustainability Programme and Healthy Weston programme.

“Healthier Together” is the local Sustainability and Transformation Partnership (STP). It covers the three local authority areas of Bristol, North Somerset and South Gloucestershire (BNSSG). 13 local health and care organisations sit on the Healthier Together board, but the partnership goes beyond just these organisations. The views of the public, patients, and voluntary sector form an important role in shaping the future.

There are around 1million people living within BNSSG. Similar to other areas of the UK, the local population is expected to grow significantly in the next few years, with a large increase in people aged over 75. Generally the population enjoys good health and life expectancy is increasing, but this also means there are a greater number of people living with long term conditions – such as diabetes and dementia. There are some significant pockets of deprivation within BNSSG, which in turn results in illness and average life expectancy can vary by about six years because of this.

Local authorities have faced unprecedented levels of funding cuts in recent years, despite increasing demand and this has affected the level of service they can provide to those who need social care and residential care. Funding for the NHS is growing year on year but is very challenged in keeping pace with demand for services. On average, every month our local NHS services overspend by £8m. The STP predicted that if this isn't addressed, BNSSG will be £325m overspent by 2021.

The STP includes three major transformational workstreams:

- Prevention, Early Intervention and Self-Care,
- Integrated Primary and Community Care, and
- Acute Care Collaboration.

The Acute Care Collaboration workstream has established three key principles for the development of effective and high quality acute services in BNSSG. This SOC has been developed in the context of these underpinning principles and with the aim of supporting the system to work towards the delivery of these aims. These principles can be summarised as:

#### ***A collaborative provider model, supported by a single commissioning approach***

- Eliminate variation from best practice for both quality and efficiency.

- Provide services locally where possible, centralised where necessary making best use of available estate and workforce.
- Working together across care pathways so that patients receive right care first time in the most appropriate setting.
- Support primary and community care with a consistent offer from all Trusts.
- Improve patient care across pathways by improving speed and quality of information sharing.

### ***Reducing use of acute hospital bed base***

- Ambulatory care maximised.
- Hospitals including paediatric and acute mental health have bed occupancy that allows efficient flow of patients.
- Best practice in whole hospital flow embedded to include optimal theatre utilisation, avoiding cancellations and flow from acute hospital to mental health settings.
- Efficient outpatient work delivered in a place that patients want, which avoids waste and supports community based case.

### ***Using our acute hospital resources to support the wider health and care system***

- Sharing the acute and mental health hospital facilities, physical assets, clinical skills and staff to support patients to stay out of hospital when possible.
- Using our scale to provide resilience to the health and care system including infrastructure, shared corporate services and workforce development.

The future success and stability of WAHT is a key priority for the BNSSG STP. UH Bristol, as an acute system leader within the STP, accepts a level of responsibility for supporting a sustainable solution for the benefit of residents requiring acute healthcare in North Somerset.

### **3.2.2 Commissioning context**

The BNSSG CCG commissioning context document '*Healthy Weston: Joining up services for better care in the Weston Area*' (Ref 1) focusses on the needs of the North Somerset Population and sets out the challenge of addressing the issues of financial and clinical sustainability for the region. The purpose of the document was to;

1. Set out the needs of the local population, why the current health and care system needs to change and the key priority areas for system transformation.
2. Describe a vision for local services with a specific focus on the 'place' of Weston to improve the way health and care services are delivered to the local population, setting out commissioning requirements for local service transformation.
3. Outline what will be different this time around versus previous unsuccessful attempts to reform the local hospital system, and how the CCG intends to explore new and innovative ways of encouraging greater collaboration across organisational boundaries and systems of care to deliver the necessary changes.

The Commissioning Context document identifies three priority population groups as;

1. Frail and Older People
2. Children, Young People and Pregnant Women
3. Vulnerable Groups (for example people with mental health needs, learning difficulties and those who struggle with drug and alcohol addiction)

It describes an intention to work together in more effective ways and integrating local services and pathways to join-up patient care to tackle the identified health inequalities and better meet the needs of the local population.

The Commissioning Context document outlines the operational and financial challenge facing Weston. Describing the growth in demand, alongside challenges in the recruitment and retention of staff required to sustain clinical services, it outlines the significant financial pressures in the region and within the BNSSG system and the commissioning approach described is set within this context.

It describes three key strands to its vision;

1. Primary Care (General Practice) working at scale and providing strong system leadership.
2. Stronger, more integrated community services supported by a 'Care Campus' model at the WGH site.
3. A stronger, more focussed Acute Trust and acute care model at WGH.

The Healthy Weston Programme was established by BNSSG CCG to progress the delivery of the vision outlined above. The programme has workstreams shaped around the three key themes and UH Bristol and WAHT have been integral to the development of the Integrated Acute Care Model workstream. This workstream includes clinical and non-clinical representatives from UH Bristol and WAHT, along with NBT, community and primary care providers and is focussing on developing a sustainable acute clinical model for Weston. This includes establishing how viability can be improved through maximising the productivity and utilisation of current services as well as developing new clinical models of care to achieve the vision outlined above.

Following the development of these models of care, BNSSG CCG will develop a business case to inform public consultation on the future service model for the population of Weston.

This SOC is being developed within the context of the Healthy Weston programme and its outputs will be fundamental in gaining certainty over the commissioning intentions for acute services for Weston GH and the associated impact on the robustness of the case for organisational merger

### **3.3 Local Context and Current Services**

#### **3.3.1 Comparative Data**

The tables below outline the relative volume and value of services between WAHT and UH Bristol.



**Table 1: Selected Key Comparative Reference Costs Data (WAHT and UH Bristol)**

2015/16 data	UH Bristol	WAHT
Catchment population	450,000	202,000
ED attendances - Type 1	101,000	54,000
Outpatient attendances	690,000	144,000
Inpatient - day cases	42,100	10,500
Inpatient - elective	13,700	1,500
Inpatient - non elective	60,800	15,200
Number of beds	899	270
2016/17 Outturn	£'m	£'m
Turnover	639.0	105.0
Net surplus / (deficit)	16.6	(7.2)
Agency expenditure	11.2	11.7
Agency expenditure - percentage of pay cost	3.0%	15.5%
Cash balance	65.4	1.6
Reference Cost Index	96	104

### 3.3.2 University Hospitals Bristol NHS Foundation Trust (UH Bristol)

University Hospitals Bristol NHS Foundation Trust is one of the country's largest NHS acute Trusts and a major teaching and research centre for the South West of England. As a specialist teaching Trust, it works in partnership with the University of Bristol, the University of the West of England and several other higher education institutions to provide medical, nursing, midwifery and allied health professional education at pre and post-graduate levels. UH Bristol's mission is *to improve the health of the people it serves by delivering exceptional care, teaching and research every day.*

#### 3.3.2.1 Key facts (UH Bristol)

- UH Bristol has over 9,000 staff and offers over 100 different clinical services across nine different sites.
- UH Bristol provides general medical and emergency services to the local population of Central and South Bristol, and a broad range of specialist services across a region that extends from Cornwall to Gloucestershire, into South Wales and beyond.
- UH Bristol is one of the country's largest acute NHS Trusts with a 2017/18 planned income of £657 million.
- UH Bristol provided treatment and care to 72,000 inpatient and day case elective patients, 60,000 non-elective inpatients and saw 126,000 patients in our emergency departments during 2016/17 It also provided approximately 663,000 outpatient appointments.
- With strong links to the University of Bristol and University of West of England, UH Bristol is the major medical research centre in the region, ensuring a focus on continually improving our patient care. These academic links also make UH Bristol the largest centre for medical training in the South West.
- UH Bristol was rated Outstanding by the CQC following an inspection in November 2016.
- As a Foundation Trust, UH Bristol is accountable to the local community and patients. The community and patients are invited to become members of the Trust and currently UH Bristol has 8,500 members.



- University Hospitals Bristol provides regional and tertiary services to a population of circa 5.3 million across the geographically and economically diverse South West region of England;
- 55% of UH Bristol activity is commissioned by CCGs, within 45% commissioning by NHSE Specialised. The split of contract financial value by commissioner for UH Bristol is outlined below;

**Table 2: The split of contract financial value by commissioner for UH Bristol**

<b>Commissioner</b>	<b>% contract financial value</b>
<b>NHS Bristol</b>	30.52%
<b>South West Specialised Commissioning Hub</b>	44.62%
<b>NHS North Somerset</b>	7.87%
<b>NHS South Gloucestershire</b>	5.42%
<b>Other CCG</b>	5.25%
<b>NHSE Other</b>	6.32%

UH Bristol's structure is based on five autonomous Clinical Divisions:

- Medicine and Emergency Care
- Surgical Division
- Women's and Children's Services
- Specialised Services
- Diagnostic and Therapy Services

### **3.3.2.2. UH Bristol Strategy**

The UH Bristol *Vision* is 'for Bristol and our hospitals, to be among the best and safest places in the country to receive care', with the *Strategic Intent* 'to provide excellent local, regional and tertiary services, and maximise the benefit to our patients that comes from providing this range of services'.

The current UH Bristol Trust Strategy - Rising to the Challenge 2020 (Ref 8) states that our key challenge is 'to maintain and develop the quality of our services, whilst managing within the finite available resources, with our focus being on "affordable excellence'. It also clear that UH Bristol operates as part of a wider health and care community and the strategic intent sets out our position with regard to how we will optimise our collective resources to deliver sustainable quality care into the future.

UH Bristol has identified six key strategic priorities for the period 2014 to 2019. These are:

- We will consistently deliver high quality individual care, delivered with compassion;
- We will ensure a safe, friendly and modern environment for our patients and for our staff;
- We will strive to employ the best and help our staff fulfil their potential;
- We will provide leadership to the networks we are part of, for the benefit of the region and the people we serve;

- We will ensure we are financially sustainable to safeguard the quality of our services for the future and that our strategic direction support this goal; and
- We will ensure we are soundly governed and are compliant with the requirements our regulators.

### 3.3.3 Weston Area Health NHS Trust (WAHT)

Weston Area Health NHS Trust was established in April 1991. It is a 270 bedded district general hospital which includes general, acute midwife-led beds and 5 critical care beds. The hospital provides acute emergency services for adults including Emergency department, critical care, medicine and surgery together with supporting diagnostic services. In addition, the site provides a range of planned services including general surgery, urology, orthopaedics, and other planned treatments such as endoscopy, haematology and some cancer care.

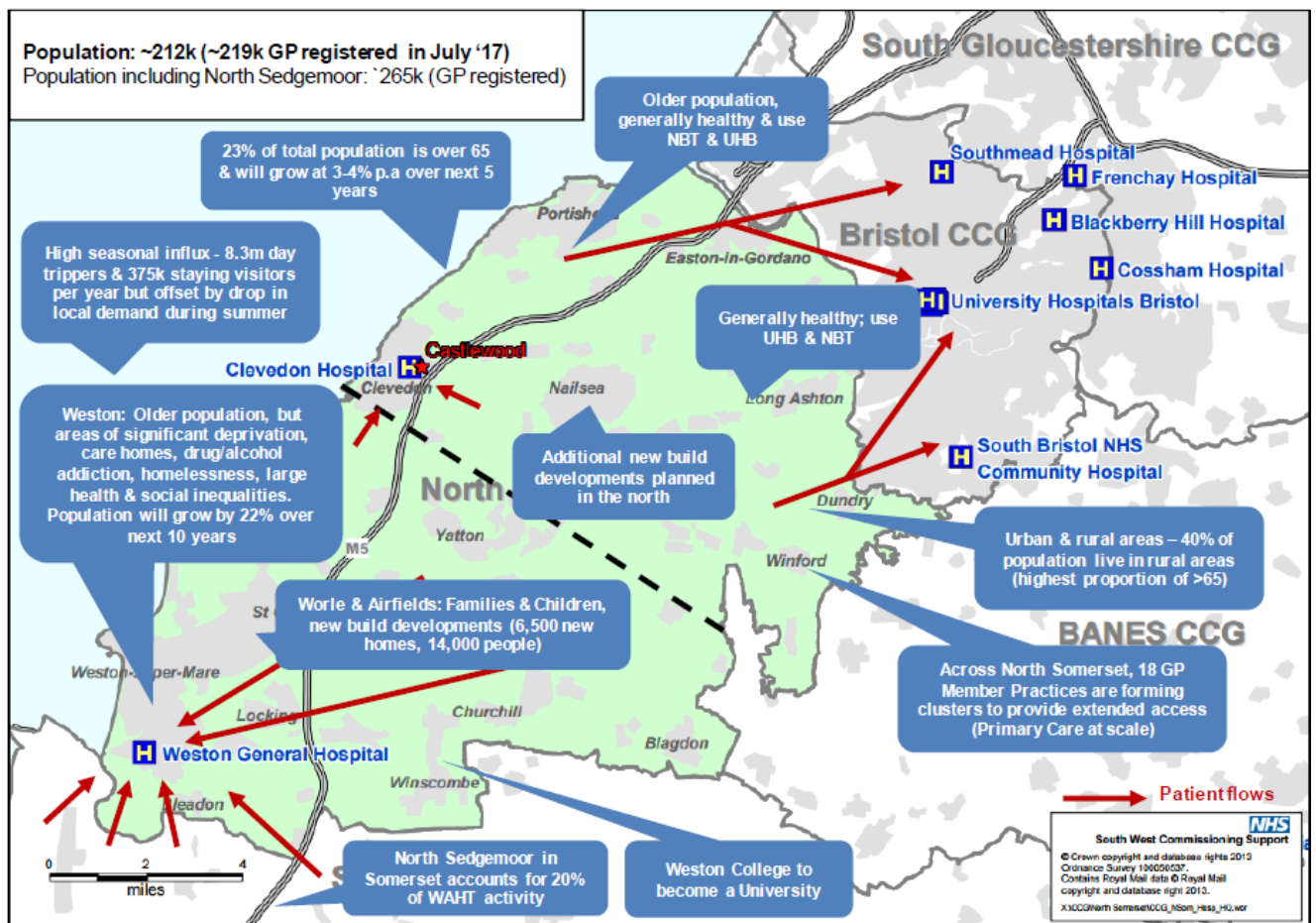
#### 3.3.3.1 Key Facts

- WAHT has been operating a 24 hour emergency department at Weston General Hospital. The unit is busy, seeing circa 54,000 attendances in 2015/16, which is above the average number expected for the size of the hospital and local area. From the 4<sup>th</sup> July 2017 the Emergency Department (ED) at WAHT has instigated a temporary closure of its ED department from 10pm to 8am daily, due to the on-going inability to safely staff the unit during these hours. Since the implementation of the planned overnight closure of ED in Weston, patients have instead been accessing emergency care in alternative local providers, primarily UH Bristol, Taunton and Somerset NHS Foundation Trust and North Bristol NHS Trust. All organisations involved have applied effective partnership working to enact and manage this change, including jointly agreed operational protocols and repatriation policies to ensure patients receive ongoing care as close to home as possible where clinically appropriate, as well as joint structures through which risks can be escalated within the system.
- WAHT provides, in general, non-complex inpatient and day case surgical procedures and outpatient services. In 2016/17, WAHT carried out 10,500 planned day cases, 15,200 non-elective inpatients, and 1,500 elective inpatients, together with 144,000 outpatient attendances. In addition, WAHT currently operates a 5 bedded Critical Care Unit supported by an anaesthetic team. During 2016/17 the maternity unit delivered 190 babies.
- North Somerset Clinical Commissioning Group is WAHT's main commissioner accounting for approximately 73% of WAHT's income from patient care activities, with NHS Somerset accounting for 16% and other patient related income of 11%.
- WAHT works closely with other hospitals in Bristol as part of 'clinical networks' including, for example, cancer, pathology and cardiology.
- WAHT serves a resident population in North Somerset of circa 202,000 people (source: Mid-2014 population estimate: ONS), with over 70% of people living in the four main towns of Weston, Clevedon, Portishead and Nailsea. A further 3.3 million day trippers and 375,000 staying visitors increase this base population each year during the summer period.

- WAHT also provides services to North Sedgemoor which has an estimated population of 48,400 (Mid 2014 GP registered population). The largest town is Bridgewater, followed by Burnham-on-Sea and Highbridge.
- Children's and Young People's Community Health Services including Child and Adolescent Mental Health Services are provided from two children's centres located in Weston-Super-Mare and Clevedon.
- WAHT is managed operationally on a directorate basis. Each directorate is managed by a Directorate Director (Clinical), Directorate Manager (General Management) and supported by an Operational Head of Nursing. All are accountable on a day-to-day basis through the Director of Operations to the Chief Executive for delivery of operational and financial performance. The Directorates do not have the equivalent of UH Bristol's model of Divisional Finance and HR partners in place supporting clinical directorates.

The figure below is taken from the Healthy Weston commissioning context document and provides some key facts about North Somerset and context relevant to the future development of WAHT (Ref 1, p.15)

**Figure 1: North Somerset Key Facts**



### 3.3.3.2 WAHT Strategy

The WAHT Trust vision is 'to work in partnership to provide outstanding healthcare'. The Strategic plan describes a new business model that 'is necessary for WAHT to develop

sustainable and financially viable services for the local population (place) and support North Somerset's provision of sustainable health and wellbeing services'.

There is a significant emphasis in the latest WAHT strategy on the sustainability of services, with partnership working identified as a key factor in achieving this sustainability.

The 2016 WAHT strategy outlines the challenges to the resilience of services, which are summarised in the three points below:

- WAHT faces an ongoing challenge concerning the recruitment of medical staff across a number of key specialities including emergency medicine, potentially placing at risk the clinical safety and sustainability of services provided.
- This has led to an increasing reliance on locum clinical staff and some problems with clinical care standards in a number of areas including Emergency Care for Paediatrics, Community Paediatric and Safeguarding Services, Dermatology and Neurology services. These challenges cannot be met by WAHT working in isolation.
- Current tariffs do not meet the real costs of emergency care at WAHT.

### **3.4 Strategic Rationale for Preferred Option**

UH Bristol and WAHT strategies are broadly compatible and this presents opportunity for the development of a single organisation. The WAHT service strategy clearly asserts their priority to be the development of sustainable clinical services, with a focus on 'core services', defined as emergency care for local patients and all services associated.

UH Bristol strategic priorities are orientated around the further development and expansion of the tertiary and specialist offer, whilst maintaining high quality District General Hospital (DGH) services for the local population. The opportunities these complementary strategic positions offer are further considered in section 4 (Case for Change).

### **3.5 Current Joint Clinical Service Models**

There are currently well established and strong links between services at WAHT and UH Bristol, with a number of joint clinical service models already in place and working well.

UH Bristol has formal and informal links to WAHT. Service Level Agreements for services provided to WAHT by UH Bristol amount to c£1.0m and are largely charges for clinical time for UH Bristol consultant medical staff who deliver services from WAHT across a number of specialities including laboratory medicine, surgery, cardiology, oncology, paediatrics and dermatology. The most significant are haematology and ophthalmology. UH Bristol also has a Service Level Agreement (SLA) for provision of a small number of services by WAHT to UH Bristol.

There are also established joint clinical leadership models in place, including the UH Bristol Head of Midwifery providing professional leadership for maternity staff at UH Bristol and at WAHT.

UH Bristol has also provided increased support in a number of clinical service areas over the past twelve months, most notably in paediatrics and obstetrics & gynaecology. This ranges from clinical advice, to providing medical cover at times of planned or unplanned leave of WAHT Consultants. From July 2017, a new joint model was implemented for gynaecology. This has involved gynaecology inpatient emergency care transferring to UH Bristol, and from October 2017 being replaced in Weston with access to day case surgery for women who are currently having to travel into Bristol. Due to the on-going inability to recruit into consultant posts at WAHT, additional support has also been provided to the clinical haematology service in the form of joint appointments through UH Bristol.

Under the current interim Partnership Agreement, there are opportunities for the development of a new joint clinical services model to further consolidate and extend the established models currently working across both Trusts. This is further outlined in section 7.

### 3.6 Operational Performance and Access

Both Weston Area Health Trust and UH Bristol are challenged in the delivery of regulatory access standards.

In particular, the current lack of resilience in clinical staffing levels is impacting on WAHT's performance against a number of different national access standards, most notably 4-hours and 62-day GP cancer.

The assessment of the impact of WAHT's performance on UH Bristol performance, should the merger proceed, has been undertaken using nationally available data submitted by WAHT (see Appendix 7). Comparing UH Bristol's performance for each quarter of 2016/17 with WAHT performance by simply aggregating WAHT and UH Bristol's performance together for the same periods, suggests that there is potential for a small deterioration in performance against the 62-day GP cancer target, but a more material deterioration for A&E 4-hours, the latter also being impacted by a comparatively worse length of stay for inpatients at WAHT.

#### 3.6.1 4 Hours ED Standard

There are potentially regulatory, financial and clinical risks associated with a worsening 4-hour performance. It is not at present clear the extent to which mitigations can be effected and how quickly this would turn performance around. It should however be noted that performance in both organisations has improved in 2017/18.

**Table2a: A&E 4 Hours**

	UHBristol (RA7)				Weston (RA3)				Combined			
	Under 4 Hours	4+ Hours	Attendances	Performance	Under 4 Hours	4+ Hours	Attendances	Performance	Under 4 Hours	4+ Hours	Attendances	Performance
2016/2017 Q1	29,251	3,482	32,733	89.36%	11,465	2,045	13,510	84.86%	40,716	5,527	46,243	88.05%
2016/2017 Q2	28,506	3,564	32,070	88.89%	11,975	2,590	14,565	82.22%	40,481	6,154	46,635	86.80%
2016/2017 Q3	26,972	6,598	33,570	80.35%	9,293	3,748	13,041	71.26%	36,265	10,346	46,611	77.80%
2016/2017 Q4	25,269	5,726	30,995	81.53%	8,538	3,568	12,106	70.53%	33,807	9,294	43,101	78.44%
2017/2018 Q1	27,788	4,978	32,766	84.81%	12,160	1,716	13,876	87.63%	39,948	6,694	46,642	85.65%
2017/2018 Q2	29,507	2,965	32,472	90.87%	10,349	1,197	11,546	89.63%	39,856	4,162	44,018	90.54%
2017/2018 Q3	30,708	3,937	34,645	88.64%	9,423	1,699	11,122	84.72%	40,131	5,636	45,767	87.69%

### 3.6.2 62-day GP cancer standard

A combined workforce, together with improved pathway models and management, should be sufficient to off-set a small deterioration in 62-day GP cancer standard performance and may even allow an overall improvement in performance above that currently reported by UH Bristol, given UH Bristol's skewed case-mix and the small but measurable impact late referrals from WAHT has.

**Table 2b: 62-day GP cancer**

	UHBristol (RA7)				Weston (RA3)				Combined			
	Non Breaches	Breaches	Total Seen	Performance	Non Breaches	Breaches	Total Seen	Performance	Non Breaches	Breaches	Total Seen	Performance
2016/2017 Q1	196	74	270	72.73%	67	17	84	80.24%	263	90	353	74.50%
2016/2017 Q2	253	63	316	80.19%	66	24	90	73.74%	319	86	405	78.77%
2016/2017 Q3	238	51	289	82.35%	77	20	97	79.38%	315	71	386	81.61%
2016/2017 Q4	247	56	303	81.49%	66	20	86	76.61%	312	76	388	80.41%
2017/2018 Q1	245	66	310	78.87%	71	29	99	71.21%	315	94	409	77.02%
2017/2018 Q2	250	62	311	80.23%	66	25	91	72.93%	316	86	402	78.58%

### 3.6.3. Other standards [6-week wait diagnostic; Referral to Treatment Times (RTT) and 31-day first and subsequent treatment cancer standards]

By simply aggregating WAHT and UH Bristol's performance together for the same periods, a negligible or small positive impact could be achieved in a merged organisation, relative to UH Bristol's own performance on the following indicators

- 2WW cancer
- 31-day first definitive cancer and other 31-day cancer standards
- RTT
- 6-week diagnostics
- Last-minute cancelled operations (LMCs)
- Follow-up to New ratios
- Length of Stay (LOS)
- hospital cancellation rates

There are clearly existing challenges within both Trusts to the delivery of regulatory standards and both WAHT and UH Bristol experience particular operational pressures associated with emergency demand and bed capacity, as well as ability to discharge patients from hospital. It is also apparent however, that there are opportunities in functioning as a single organisation to combine pathways and learning and to maximise use of capacity to potentially improve the combined position.



## 4. Case for Change

This section sets out the case for change to address the long term clinical and financial sustainability issues at WAHT.

### 4.1 Introduction

The key driver of the case for change is the sustained challenge to the clinical and financial sustainability of services at Weston General Hospital, and the adverse impact upon all acute service providers across the BNSSG region.

As outlined in WAHT's 2017/18 Operational Plan, this is driven by the continuing deterioration in the ability to recruit to clinical posts in key areas, which is also driving an increasing challenge in delivering consistently high quality and clinically effective care on an affordable basis. An over reliance on temporary staff to try to address this issue is in turn resulting in substantial and escalating staff pay costs, one of the key factors behind WAHT's recurring financial deficits.

This deteriorating position, with costs escalating and clinical services increasingly being unable to function independently, results in short term unplanned changes to services which can, without the correct capacity and resource planning adversely impact both WAHT and Bristol patients. It may also result in service changes which are not strategically aligned in the longer term. It is clear from the scale of deterioration that doing nothing to address the situation is not an option and moreover, that the pace at which action is taken is also critical to prevent further deterioration of services for patients.

It is apparent from past experience of joint working between UH Bristol and WAHT, that working collaboratively provides the opportunity to secure local access for appropriate DGH services. Clinical leaders from both Trusts participated in clinical expert groups as part of the Phase 2 North Somerset Sustainability Programme. The Programme Board have confirmed the following key factors driving the case for change for the programme and the same factors can be considered as driving this SOC. (Ref 9)

- *The growing demand for services particularly from an increasingly elderly population.*
- *Difficulties in recruiting sufficient medical staff in key clinical areas, leading to a high number of locums and consultant post vacancies. This is resulting in increasing challenges in sustaining viable clinical rotas (necessary to deliver high quality care) in a number of areas.*
- *Reduced numbers of permanent consultants in posts causing issues for medical training. For example: the inability to provide the necessary consultant oversight in the emergency department caused the withdrawal of FY2 doctors from that department, further adding to the pressures of running the department sustainably and maintaining clinical rotas.*
- *Continuing uncertainty over the strategic future of services at the Trust has exacerbated the challenge of recruitment to key posts.*
- *Unless there is a major change in the service delivery and operational model all key emergency and inpatient services will continue to face sustainability challenges, with*

*the loss of a small number of key individuals rapidly leading to a need for immediate action to safeguard service quality.*

- *The North Somerset Sustainability programme has identified that the long term service sustainability depends on substantially greater integration of clinical teams at Weston with those from other BNSSG providers. Attempts to improve sustainability through an “informal partnership” approach, with the aim of joint appointments or ad hoc mutual aid to shore up rotas have not delivered anywhere near enough of an impact to enable a sustainable and robust staffing model in some specialities*
- *Progressing with a long-term collaboration between the Trusts offers the potential to build confidence in the future for Weston General Hospital, improve morale and recruitment and reduce reliance on temporary locum and agency staff.*

## **4.2 Strategic Drivers of Change**

Within the context above, this section summarises the 5 key strategic drivers for a collaborative acute services partnership between UH Bristol and WAHT as follows:

- 4.2.1 Clinical sustainability of services at WGH** - There have been a number of attempts to address the sustainability and resilience of clinical services at WAHT over the past six years, none of which have been fully successful. Some clinical services are no longer sustainable to be delivered locally, with others likely to become unsustainable in the near future without formal collaboration. There is a growing imperative for change at pace.
- 4.2.2 Growing demand /population growth** – all of the partners in the North Somerset Sustainability programme have agreed the need to strengthen the resilience of Weston General Hospital as an important local hospital and a permanent part of the health system which provides appropriate services local people need close to home. The demographic growth over recent years and expected over the next decade underpins this position.
- 4.2.3 Need to optimise use of available NHS capacity to meet growing demand** – nationally and locally there are clear drivers to ensure value for money is secured from all NHS resources. The current configuration and utilisation of clinical capacity is not optimised and opportunities for improvement exist that support the objectives of both Trusts and the BNSSG STP.
- 4.2.4 Strategic and operational risks to UH Bristol and potential impact on quality of care for Bristol and North Somerset patients, of failure to take a leadership role in supporting the resilience of services at Weston General Hospital** – the ability of UH Bristol to fulfil its strategic intentions is impacted on by the strength of service provision across its system partners. Failure to take a lead role in supporting the resilience of services at Weston General Hospital could lead to unplanned operational impact on services at UH Bristol hospitals as well as at WGH, affecting performance and patient experience and constraining UH Bristol’s strategic objective to expand specialist / tertiary services for the wider regional population.



**4.2.5 Financial sustainability - Delivering productivity, efficiency and affordable service quality** – WAHT is financially unsustainable driven largely by the fact it is one of the smallest acute Trust hospitals in England and has struggled with delivery of recurrent savings and the long-term recruitment of doctors in some specialties and delivering services within budget. Both Trusts need to ensure corporate services are delivered as efficiently as possible and opportunities exist through collaboration to secure savings.

**4.2.6 Supporting the strategic vision of STP and delivery of the Healthy Weston vision**– There is both a need and opportunity to demonstrate progress towards the stated strategic vision for the STP for an Integrated Health and Care system and progressing acute care collaboration as a key step in the journey. The March 2017 document, Next Steps on the NHS Five Year Forward View (Ref 10: Next Steps on the NHS Five Year Forward View, March 2017), clearly indicates the aim to, ‘use the next several years to make the biggest national move to integrated care of any major western country’ (Ref 10: p31) and that the development of Accountable Care System (ACS)’ is the vehicle to achieve this. It describes a number of key characteristics of an ACS, including being able to demonstrate how, ‘provider organisations will operate on a horizontally integrated basis, whether virtually or through actual mergers’ (Ref 10: p36).

The Healthy Weston commissioning context document describes the need to establish, *A stronger more focussed Acute Trust and acute care model at WGH*. It describes how this will be achieved by, *‘working in closer collaboration with other Acute Trusts and across BNSSG as part of a wider Acute Trust Network’* (Ref 1, p34). The development of this SOC is a key step in the move towards great integration and collaboration between acute services in BNSSG.

Each of these drivers is considered in more detail below:

#### **4.2.1 Clinical sustainability**

As detailed in section 2.2 and 3.3.2, there are long-standing issues with the clinical effectiveness of some services provided at Weston General Hospital primarily driven by its size which means that it is operating below ‘critical mass’ for a number of its clinical services.

Despite the commitment and hard work of staff, the continuing deterioration in WAHT’s ability to recruit to clinical posts in key service areas has already resulted in temporary service changes, with a number of other services identified by WAHT as at risk of being sustainable in the short to medium term. In addition, an over reliance on temporary staff to try to address the recruitment issues is resulting in substantial and escalating costs as well as an increasing lack of stability, continuity and consistency of care. WAHT identifies the following challenge in its 2017/18 Operational Plan;

*“The recruitment of medical staff in the Trust continues to be the greatest recruitment challenge faced by the Trust and some of these difficulties can be attributed to a UK wide skills shortage for certain positions, e.g. Consultants in Histopathology, Emergency Medicine, Respiratory, Acute and Community Paediatrician. As a result, there are clinical sustainability issues associated with a number of services in the Trust”.*

The North Somerset Sustainability Programme summarised the position in relation to the clinical viability of services in the following statement:

*'The North Somerset health system, together with Weston Area Health Trust has been operating for a number of years now under the label of being unsustainable. This has caused a good deal of concern for patients, staff and the wider public, compounded by the fact that there have been a number of unsuccessful attempts to agree a package of reforms that can deliver a sustainable future for the services provided at Weston General Hospital.'*

The Healthy Weston commissioning document builds on the above analysis and clarifies some specific long standing issues in relation to clinical services which need to be addressed. It outlines these as: (Ref 1. p13);

- *The provision of A&E services is a high profile local issue. We must look carefully at population need to identify the most effective long term solution for local urgent care provision.*
- *The ability to recruit to key clinical specialties; and issues with trainee doctor placements (supervision and satisfaction) are significant challenges, putting service delivery at risk. This is compounded by the continued delay in finding a longer term solution for the sustainability of WGH.*
- *The local Midwife led maternity service at WGH is not chosen by enough women to make it clinically or financially viable in its current form. The number of deliveries is currently ~170 per year, but the minimum level for a clinically appropriate unit of this type is considered to be ~ 500.*
- *There are questions as to whether other services may be more appropriately delivered elsewhere at scale, such as emergency general surgery and Level 3 ICU.*

The WAHT CQC report published in June 2017 provides a clear driver for the need for significant pace behind the actions to improve service resilience at WAHT. Weston General Hospital received an overall rating of 'requires improvement with the urgent and emergency care services rated as "inadequate", medicine and older people as "requires improvement" and surgery and critical care as "good"' (Ref 5).

It was noted that there had been some progress since the previous inspection with surgery and critical care moving from requires improvement to good overall. Medical care also demonstrated improvement with the domains of 'safety' and 'well-led' is now rated as 'requires improvement from inadequate'.

The report outlines how *'the ongoing pressures on the emergency department continued to be reflected in the ratings with safety remaining as inadequate and responsive and well led failing to improve also being rated inadequate. Patient flow had not been sufficiently improved since our last inspection and responsive in medical care was rated as inadequate'*.

The report notes, *'serious concerns that systems or processes to manage patient flow through the hospital were not operating effectively and did not ensure care and treatment was being provided in a safe way for service users'*.

The key findings in the CQC report are summarised below:

- *'We found the trust had been under increasing pressure to manage flow in the hospital for several months and the emergency department was under sustained pressure from an increase in attendances.*
- *There was a lack of support for the emergency department from the wider hospital services and a lack of trust wide ownership around patient flow. This means patients were frequently and consistently not able to access services in a timely way and some patients experienced unacceptable waits for some services.*
- *There was a fragile medical infrastructure in the emergency department with a crucial reliance on locum medical staff at consultant and middle grade positions. However, shortly after our on-site inspection a recent partnership with another local acute trust had secured some input for clinical leadership one day a week.*
- *The corridor area in the emergency department was frequently used when there were more patients than cubicles available. This was not a suitable or safe environment for patients to receive emergency care and treatment and was not fit for purpose.*
- *The trust mortality rate had been higher than the expected level for the recent reporting periods of July 2015 to June 2016. A review of mortality and an associated action plan were in place; however the lack of recorded minutes and actions in specialty mortality review meetings was of concern. It was unclear if learning was shared or action taken as a result of reviews of patient deaths.*
- *Since our previous inspection there had been some changes to the executive team with some people now in permanent roles and others being interim positions. More changes were due in April 2017 with a new medical director and director of operations starting in post. While the current executives worked well together they had been drawn into managing operational pressures in the emergency department on a regular basis. The new executives could lead to further change and approach to a team already under pressure and 'wearing many hats' due to the small trust and less senior roles.*
- *A review of governance had begun to implement change but was immature and lacking in clinical leadership at directorate level to provide robust assurance'.*

The key findings outlined above clearly demonstrate that the continued unsustainability of clinical services is impacting on the quality of care it is possible for staff to provide for patients. The deterioration from the previous inspection, particularly in the areas of emergency care and patient flow demonstrate that previous attempts to address difficulties, particularly in the recruitment and retention of substantive staff, have not been successful. This clearly demonstrates the need for pace behind the delivery of actions to improve the sustainability of these core clinical services.

#### **4.2.2 Growing demand / population growth**

The assumption underpinning this SOC is that Weston-Super-Mare is too large to exist without a district general hospital and too far from Taunton and Bristol for its population to be

expected to travel there routinely. The North Somerset Programme for Sustainable Services Phase 2: Part A report, December 2016 asserts that; *'all stakeholders agree that the Weston General Hospital forms a key part of the BNSSG system, and that it is essential it continues to provide a broad range of emergency and elective care services to the local population'* (Ref 9: p.16).

The Healthy Weston Programme commissioning context document (Ref 1, p17) identifies significant predicted growth for the North Somerset population, along with notable existing health inequalities. It summarises the key challenges from a North Somerset population perspective as;

- *The long-term projections based on ONS data suggest the population of North Somerset (and North Sedgemoor) will increase over the next decade at an annual rate of 1% across all age groups. These figures take into account planned housing developments, and are the same figures used by North Somerset Council's Planning Department.*
- *However, estimates obtained from Hampshire Council's small area population forecast service, which takes into account housing development, suggests growth in the Weston locality in the 10-year period from 2014-2024 will be 22% (i.e. 2.2% per year on average), compared to background growth across the whole of North Somerset of 13%.*
- *The largest increase in population over the next ten years is set to be in the 75-84 age group (50% vs. 36% in England), followed by the over 85s (~46% vs. 42% in England).*
- *In respect of the younger age groups, the population is projected to rise in the 0-14 age group by ~12% (vs. ~8% in England), which equates to an additional ~4,000 children in total within the next 10 years.*
- *Life expectancy varies considerably across North Somerset. WsM Central Ward has the lowest life expectancy, where the respective figures are 67.5 years for males and 76 years for females. Conversely, Clevedon Yeo has the highest life expectancy for both males and females, at 86.1 years and 92.5 years respectively. A gap in male life expectancy therefore between these wards of 18.6 years; the equivalent gap for females in this example is 16.5 years.*
- *The main causes of the gap in life expectancy are circulatory diseases (such as coronary heart disease (CHD) and stroke), cancers and respiratory disease (COPD).*
- *Using data from Public Health England, it is estimated that 46% of male deaths and 36% of female deaths in the most deprived areas were considered 'excess'; in other words, these deaths would not have occurred if all areas in North Somerset had the same mortality profile as the least deprived areas. Standardised Mortality Ratios range from 57% in Clevedon Yeo to 161% in Central Ward – much better and much worse than England respectively.*
- *The leading causes of premature mortality in North Somerset are circulatory diseases, respiratory diseases (COPD), cancer and liver disease. These are also the leading causes of premature mortality and years of life lost in North Sedgemoor.*

- *The potential years of life lost from treatment amenable cancers, i.e. cancers that could possibly be prevented through early detection and treatment (including breast, colorectal and skin cancer) in North Somerset, have been increasing and are above national figures. Treatment amenable cancers are now the primary cause of years of life lost from amenable causes in North Somerset, representing more than a third of total years of life lost.*
- *Across North Somerset, the leading causes of disability adjusted life years (DALY) lost are cancer (neoplasms), mental health and behavioural disorders, musculoskeletal conditions and cardiovascular disease.*
- *Compared with 2015, it is estimated that by 2030 in North Somerset, there will be over 1,700 more people living with CHD; around 750 more people will have had a stroke; over 10,000 more people will be living with hypertension; 6,000 more people will have diabetes; and around 6,000 people will be living with COPD.*

#### **4.2.3. Need to optimise use of available NHS capacity to meet growing demand**

The BNSSG STP analysis as referenced in section 3.2, confirms the commitment of acute providers to maximise use of collective hospital resources alongside a broader STP vision of reducing demand through greater focus on prevention, early intervention and self-care and enhanced primary and community services.

UH Bristol and WAHT both currently operate at high levels of bed occupancy. Both Trusts need to improve patient flows across the system as there are substantial capacity pressures on the hospitals leading, for example, to elective operations being cancelled because of emergency patients occupying acute hospital beds.

The WAHT 2017/18 Operational Plan indicates under-utilisation of theatres and opportunities to reduce length of stay to reduce bed occupancy. This presents an important opportunity to enhance overall viability through increasing elective care provision at the Trust. The WAHT plan also demonstrates that operating at 95% occupancy, provides potential to release circa 17 beds within medicine (6,205 bed days) and 13 beds within surgery (4,745 bed days). This could enable anticipated demographic growth to be managed within existing capacity and deliver further growth within elective surgery.

UH Bristol theatre capacity is constrained by limitations in physical expansion options. Potential flexible use of estate across both organisations could enable redistribution of services, maximise productivity and support UH Bristol to develop its specialist portfolio. Complementary to this would be the critical mass of the larger single organisation supporting the resilience of core services at WAHT. The opportunity to maximise capacity by effectively planning utilisation across both organisations could offer operational and strategic opportunities.

#### **4.2.4 Strategic and operational risks to UH Bristol and potential impact on quality of care for Bristol and North Somerset patients, of failure to take a leadership role in supporting the resilience of services at Weston General Hospital**

There is significant strategic and operational risk to UH Bristol of a continuing deterioration in services at WAHT and failure to take a leadership role to seek to resolve a long-term plan for the resilience of WAHT. Examples such as the temporary closure of WAHT ED overnight from the 4<sup>th</sup> of July and the need for clinical support in areas such as gynaecology,

cardiology and oncology, leading to short term arrangements, including joint appointments to clinical posts, demonstrate the fragility of some services. There is potential risk of the unplanned transfer of patients and activity to UH Bristol in circumstances where UH Bristol would not have had the opportunity to jointly plan the most appropriate clinical pathways with WAHT and would not have had the opportunity to make required plans for capacity, both in terms of workforce and physical space.

A recent example of this is the lung cancer pathway, where WAHT patients have been diverted for oncological treatment to the Bristol Haematology and Oncology Centre (BHOC) at short notice due to the inability of services to be maintained at WAHT. This has resulted in a loss of access to local services for North Somerset patients and has also placed unplanned pressure on the BHOC, potentially compromising access to services for existing patients. Continuation of these types of circumstances in other services could result in a suboptimal solution for North Somerset patients, but also could potentially deteriorate services for Bristol patients and significantly impact on UH Bristol's operating and strategic plans.

There is strategic alignment between the UH Bristol and WAHT strategies. The UH Bristol Strategic Intent is to; *provide excellent local, regional and tertiary services, and maximise the benefit to our patients that comes from providing this range of services (2014)*. UH Bristol currently has significant capacity limitations, particularly in the delivery of general and emergency services to the local population. These capacity limitations are placing constraints both on access to general services and UH Bristol's ability to continue to develop its specialist and tertiary portfolio.

Further alignment of WAHT and UH Bristol could provide an opportunity to strengthen the overall DGH offer by increasing the critical mass of these services and also using estate flexibly across the two sites to maximise benefit.

It would also offer the ability to take a level of control, not only over the risk of unplanned deterioration of WAHT services and the subsequent operational impact, but also to influence the future shaping of health and social care services within BNSSG, to the ongoing benefit of the organisation, as well as the system. The future of UH Bristol is increasingly dependent on the broader health and social care system operating well. Given the current strength of the UH Bristol position within the system, the opportunity to take a role in leading the resolution of one of the key challenges to financial and clinical sustainability, would be to the strategic benefit of both the STP, UH Bristol and WAHT.

The closer collaboration also presents a tangible opportunity for UH Bristol to extend its strategic approach to transformation and innovation beyond the organisation. Innovation and ambition is a key characteristic of the organisation and one that was recognised in the recent CQC Outstanding rating. Closer collaboration not only presents the opportunity of learning to enable WAHT to access the approach and expertise that has demonstrated success at UH Bristol, but also provides a platform for innovation for both organisations to develop and evaluate new delivery models, particularly around more integrated out of hospital care to the benefit of both patient populations.

#### 4.2.5 Financial sustainability - Delivering productivity, efficiency and affordable service quality

WAHT has reported financial deficits since 2008 in the range of -5% to -8% of turnover ranging from £4.7m in 2010/11 to £8.9m in 2016/17 excluding external revenue support and sustainability & transformation funding. The financial deficits have grown in recent years largely due to the poor delivery of recurrent savings and workforce recruitment and retention difficulties which have resulted in excessive and increasing agency expenditure to maintain services.

The financial position of WAHT is such that it cannot live within its means with the current service configuration and provision. The financial track record of the Trust indicates that a structural deficit exists under the current National Tariff arrangements and so the Trust is unable to live within its means on a recurrent basis despite securing additional support subsidies of £3.3m in 2016/17 and 2017/18 for specific services. The history of financial deficits has resulted in the Trust having a very weak balance sheet, poor liquidity and very limited cash to meet its financial obligations. The planned deficit for 2017/18 continues the recent trend of financial deficits and further weakens the Trust's financial standing.

Every year since 2010, the Trust has relied on cash support in a variety of forms from the Department of Health (DoH). More recently, the Trust has secured its cash support with short term and long term loans provided by the DoH. For example, the Trust's 2017/18 initial planned deficit of £6.0m is supported in cash terms with a commensurate increase in loan financing which is yet to be formally agreed. It should be noted that the DoH loans incur interest charges and the loan principal must be repaid at some point in the future.

The fundamental driver of the case for change underpinning this SOC is that WAHT is clinically non-sustainable and financially non-viable due to its small scale and physical location for the services currently provided. The underlying financial deficit of the Trust is further compounded by ongoing staff recruitment and retention difficulties which has resulted in rapidly escalating and extremely high agency staff expenditure. The Trust incurred agency expenditure of £11.7m in 2016/17. This position represents 20% of all expenditure on pay and an increase of 180% on 2015/16.

The financial case for change for the benefit of taxpayers and patients is overwhelming and there are clear opportunities to make inroads into the current position, with the high level opportunities identified at this initial stage of the SOC summarised as:

- Reduction in reliance on high cost staffing solution in medical and nursing posts through use of UH Bristol brand to improve recruitment.
- Consolidation of corporate services across both sites.
- Standardisation of operational processes and terms and conditions across organisations.
- Improved productivity and use of physical assets to improve utilisation and throughput of activity on both sites.



- Development of new longer term clinical models, building on existing partnership arrangements and utilising the new opportunity of a greater critical mass of services to realise longer term clinically and financially sustainable clinical services.

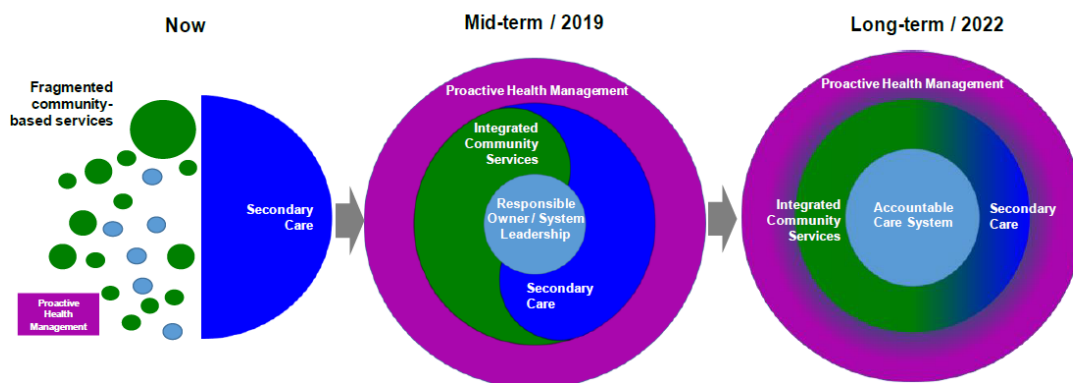
#### 4.2.6 Supporting the strategic vision of STP and the delivery of Healthy Weston vision

A key strand of the UH Bristol strategy is that; *'We will provide leadership to the networks we are part of, for the benefit of the region and the people we service'*. Closer collaboration with WAHT presents an opportunity for UH Bristol to demonstrate this leadership within BNSSG, making a clear statement that UH Bristol is not only an ambitious and outward looking organisation but is also prepared to step above its single organisational perspective to take a level of responsibility for the quality and sustainability of health services for patients not only in Bristol but across BNSSG.

This would not only reinforce UH Bristol position as a strong and influential partner within BNSSG and capitalise on the reputation gained to date as an outstanding organisation with a history of delivery but strategically, proceeding with the preferred option would also be a step on the journey for BNSSG towards the development of an Integrated Health and Care system, a key national and local priority.

The development of new and fully integrated care models is a key aim of the Healthy Weston programme. The figure below, taken from the document illustrates at a high level the proposed shift from fragmented services to a model of greater integration across secondary care, community and primary care and proactive health management and ultimately the development of an Integrated Health and Care system; (Ref 1, p33).

**Figure 2: Development of an Integrated Health and Care system**





## 5. Options Formulation and Appraisal

### 5.1 Options Appraisal Process

The aim of options appraisal is to identify the preferred option for the partnership model of acute care collaboration between UH Bristol and WAHT.

The assessment of options has been undertaken in the context of a significant number of reviews and business cases over the past 10 years (discussed in section 3 above) seeking to identify a package of reforms that can deliver a sustainable future for the services provided at Weston General Hospital and the more recent development of a vision for the BNSSG STP footprint.

These include the following key contextual reviews:

- 2012 - Proposals for an ICO
- 2014 - WAHT acquisition on an “As Is” basis and subsequent Taunton business case
- Late 2015 - North Somerset Programme for Sustainable Services
- April 2016 The Finnamore report - Meta-analysis of 9 previous reports
- 2016 - BNSSG STP

The STP long term vision describes aspirations to work towards an Integrated Health and Care system model, with support for incremental progress towards this vision through a number of horizontal integrations, such as three CCGs into single commissioner and acute care collaboration models.

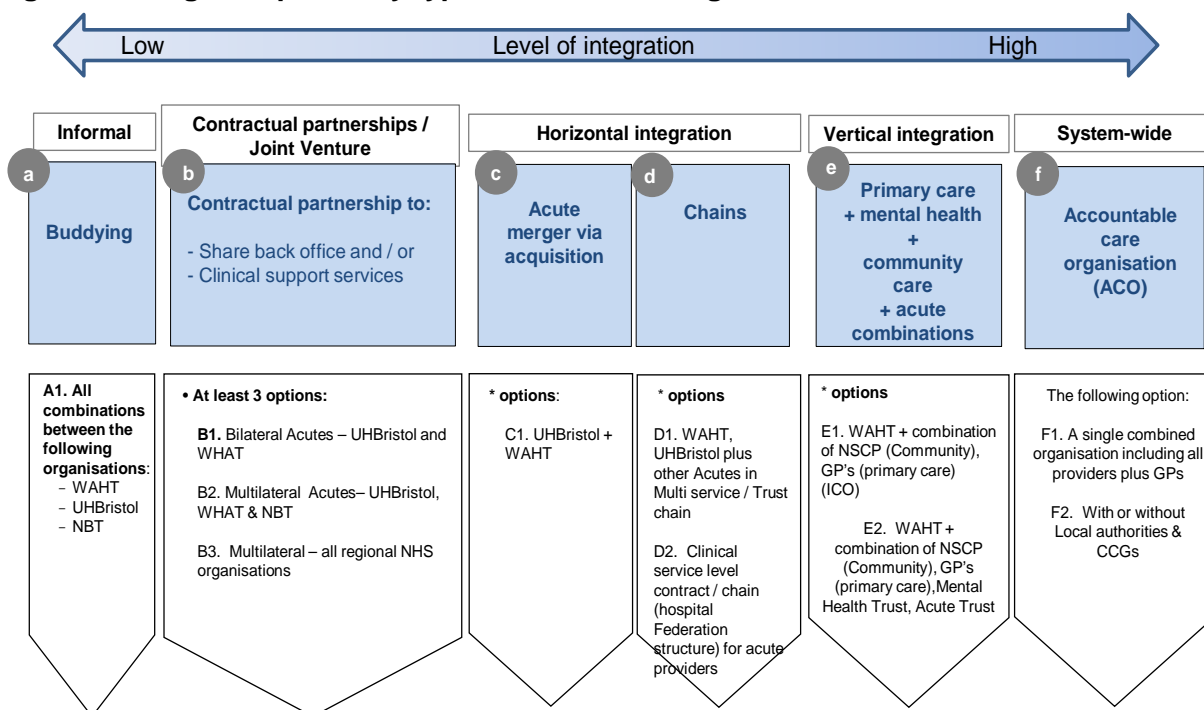
The case for change set out above in section 4, describes the imperative for action at pace to prevent further deterioration in sustainability of services at WAHT that in turn, would impact on the integrity and performance of the wider acute system. This context supports identification and assessment of the long list of options below.

### 5.2 Long list formulation and options appraisal process

During the development of the strategic outline case, a long list of options were identified as a possible means to addressing the objectives and challenges of the local health economy referred to in section 1 and 2. The Dalton Review (Ref 7) also informed the possible range of options for organisational form changes across the local health economy.

Figure 3 below sets out the long list of options considered by type and level of integration.

**Figure 3: Long list options by type and level of integration**



Given the scale of the clinical and financial challenges in our local health economy, successive reviews agree that significant transformational change is required to address the system wide financial challenges and improve the pattern and provision of care for the population of North Somerset.

### 5.2.1 The long list: inclusions and exclusions

The long list has appraised a wide range of possible options. Each of these options was considered against their ability to address the factors of **pace and deliverability**, and with reference to the previous reconfiguration context and future STP intentions.

The table below summarises the inclusions, exclusions and possible option (s) for next stage:

**Table 3: Summary of long list findings by type, model and option**

Type	Models	Options	Long list finding
Informal	<b>A. Buddying</b>	A1. All combinations between the following organisations: - WAHT - UH Bristol - NBT	A1. Discounted – because considered inadequate to achieve pace and deliverability required i.e. attempts to improve sustainability through an “informal partnership” approach, with the aim of joint appointments or ad hoc mutual aid to shore up rotas have not delivered sufficient impact to enable a sustainable and robust staffing model in some specialities.
Contractual Partnership / joint venture	<b>B. Contractual partnerships</b>	<b>B1.</b> Bilateral Acutes – UHBristol and WAHT  <b>B2.</b> Multilateral	<b>B1 Possible –to support either a clinical and / or corporate shared service model or a one Board, two organisation model</b>

Type	Models	Options	Long list finding
		Acutes– UH Bristol, WAHT & NBT  B3. Multilateral – all regional NHS organisations	B2 and B3 – Discounted at this stage because inadequate to achieve pace and deliverability required. Increased acute hospital collaboration across the region is active as are other forms of closer organisational collaboration under the STP process. These are considered medium to long term options.
Horizontal integration	<b>C Acute merger via acquisition</b>	C1. UH Bristol + WAHT	<b>C1 Possible – because has the potential to achieve pace and deliverability required</b>
Horizontal integration	<b>D. Hospital Chains</b>	D1. WAHT, UH Bristol plus other Acutes in Multi service / Trust chain  D2. Clinical service level contract / chain (hospital Federation structure) for acute providers	D1& D2. – Discounted at this stage because inadequate to achieve pace and deliverability required. Increased acute hospital collaboration across the region is active as are other forms of closer organisational collaboration under the STP process. These are considered medium to long term options.
Vertical integration	<b>E. Integrated care Organisation models  Primary care + mental health or community care + acute combination</b>	E1. WAHT + combination of NSCP (Community), GP's (primary care) (ICO)  E2. WAHT + combination of NSCP (Community), GP's (primary care), Mental Health Trust, Acute Trust	E1 and E2 – Discounted at this stage because inadequate to achieve pace and deliverability required. Increased acute hospital collaboration across the region is active as are other forms of closer organisational collaboration under the STP process. These are considered medium to long term options. Further work to clarify the commissioning context and consult with the public on new models of care under the Healthy Weston programme will inform the added value from increased organisational integration vs integrated services delivery models that drive increased integration (vertical and horizontal) without organisational change
System wide	<b>Integrated Health and Care system</b>	F1. A single combined organisation including all providers plus GPs  F2. With or without Local authorities & CCGs	F1 and F2 – Discounted at this stage because inadequate to achieve pace and deliverability required. Increased acute hospital collaboration across the region is active as are other forms of closer organisational collaboration under the STP process. These are considered medium to long term options. Further work required through the Healthy Weston programme to clarify the commissioning context and consult with the public on new models of care to drive increased integration (vertical and horizontal)

### 5.3 Short-listing: Critical success factors (CSF's) (financial and non-financial assessment criteria) formulation

The UH Bristol and WAHT Partnership Management Board approved the short list for options appraisal and associated critical success factors (CSF).

The critical success factors are based on UH Bristol business case appraisal criteria, adjusted to reflect the nature of the proposed business case. In addition, the adopted criteria take due notice of:

- The North Somerset Sustainability Programme success criteria
- A Guide to Investment Appraisal in the Public Sector - Extract from Capital Investment Manual and requirements of HM Treasury's Green Book 2015 (Ref 11)
- Taunton FBC 2014: Critical Success Factors for the acquisition
- NHS Improvement advice
- Learning from evaluation criteria used in range of other NHS transactions

These CSFs have been used to evaluate the short listed options.

**Table 4: Critical Success Factors**

<b>1. Strategic Alignment</b> - Must align to organisational priorities & BNSSG Sustainability and Transformation Plan
<b>2. Deliverability and clinical sustainability</b> - Must have scope to enable delivery of improvement and be acceptable to patients and stakeholders
<b>3. Financial Sustainability</b> - Must have the scope to live within its means on a recurrent basis
<b>4. Affordability</b> - Must be affordable, making the best use of public funds
<b>5. Pace</b> - The extent to which the option enables UH Bristol to effect significant change within a short timeframe to mitigate risk of further deterioration in service sustainability at WAHT impacting adversely on patients and the wider system

The evaluation was undertaken in accordance with how well each option met the critical success factors. The goal was to seek the option (s) that best balance the costs in relation to the benefits and risks.

#### 5.3.1 Options Short List

The 'preferred' and 'possible' options identified above in long listing have been carried forward for further appraisal and evaluation. All the options that were discounted have been excluded at this stage. On the basis of this analysis, the recommended short list for further appraisal / business case development is as follows:

**Table 5: Short list for further appraisal**

Option	Option description	Categorisation	Via
1.	<b>Do nothing</b>	Partnership model	Interim Partnership Agreement (until. 31.03.18)
2.	<b>Shared services</b> <ul style="list-style-type: none"> <li>• specific clinical services</li> <li>• Specific Corporate functions</li> </ul>	Partnership model	Bi-lateral Contractual Partnership arrangement (medium term)
3.	<b>Two boards, one executive team and one “operational” organisation</b>	Single management model	Bi-lateral Contractual Partnership arrangement (medium term)
4.	<b>One merged organisation</b> (through Acquisition)	horizontal integration	Single organisation

### 5.3.2 Critical Success Factors

The Partnership Management Board agreed the following high level critical success factors, to be used to frame the options appraisal process:

Against the CSF's a number of sub areas and questions were developed to support the appraisal process:

**Table 6: Critical Success Factors and sub areas**

Critical Success Factors	Areas	Questions to consider
<b>1. Strategic alignment - Must align to organisational priorities &amp; BNSSG Sustainability and Transformation Plan (Quality)</b>	1.1 Aligned with organisational strategy	1.1.1. Does the option align with the BNSSG STP key priorities and vision for future service model / Integrated health and care system?[1]
		1.1.2. Does the option align with the Trust's strategic priorities?
	1.2 Impact on organisational reputation	1.1.3. How will option impact on organisational reputation?
	1.3 Political acceptability	1.1.4. Assessment of attractiveness of the approach to the partners in a “local political sense”
<b>2. Deliverability and clinical sustainability -Must have scope to enable delivery of improvement and be acceptable to patients and stakeholders</b>	2.1 Impact on performance	2.1.1. To what extent does the option provide scope to address the current operational sustainability issues at WAHT and at minimum sustain performance at UH Bristol?
		2.1.2. To what extent does the option meet commissioning plans?
	2.2 Market and Demand	2.1.3. To what extent does the option impact on the relative market positions of both Trusts?
		2.1.4. How practical is it to implement? – (the organisation's ability to adapt, introduce, support and manage the
2.3 Deliverability		

Critical Success Factors	Areas	Questions to consider
		required level of change, including the management of associated risks and the need for supporting skills)
		2.1.5. Will the proposed model be acceptable to clinical stakeholders?
	2.4 Access to Care	2.1.6. To what extent does the option impact upon timely access to services?
	2.5 Impact on Workforce	2.1.7. To what extent does the option impact positively upon recruitment and retention?
	2.6 Quality of Patient Care	2.1.8. To what extent does the option support deliver of high-quality patient care and address safety and quality concerns?
		2.1.9. To what extent does the option create the conditions to address regulatory risks?
2.1.10. To what extent does the option create the conditions to achieve all key quality and safety targets, National Outcomes, Framework operational targets, NHS Constitution commitments, CQC Outcomes standards and appropriate National / Professional standards?		
<b>3. Financial Sustainability - Must have the scope to live within its means on a recurrent basis</b>	3.1 Financially sustainable - recurrent expenditure within recurrent income	3.1.1. Continue high quality services within the financial envelope
		3.1.2. Ensure long term financial viability of any new provider forms
		3.1.3. Significant financial savings through synergies and better use of physical capacity
<b>4. Affordability - Must be affordable, making the best use of public funds</b>	4.1 Affordable - cost of the transaction, which may require capital expenditure and one-off revenue costs?	4.1.1. The cost of investment must not be excessive relative to the financial benefits
		4.1.2. The payback period should be reasonable
		4.1.3. Must consider what/whether central funding will be available within the Local health community
<b>5. Pace - The extent to which the option enables UH Bristol to effect significant change within a short timeframe to mitigate risk of further deterioration in service sustainability at WAHT impacting adversely on patients and the wider system</b>	5.1 Pace of implementation	5.1.1. The extent to which the option enables UH Bristol to effect significant change from a final decision to merge

### 5.3.3. Weighting

The Partnership Management Board agreed weightings for the assessment criteria, set out in the table below, with quality and finance equally weighted.

**Table 7: Score Weighting**

	Critical Success Factors (CSF's)	Weighting / 100
Quality	Strategic Alignment	10
Quality	Deliverability and clinical sustainability	20
Quality	Pace	20
		<b>Quality – 50/100</b>
Finance	Affordability	15
Finance	Financial Sustainability	35
		<b>Finance - 50/100</b>
		<b>Total - 100/100</b>

### 5.3.4. Scoring

Appraisers allocated up to 100 points to each of the 4 options based upon how well each meets the CSF's. Scores were collated and any significant variation between scorers was discussed and recorded. The weights and scores are then multiplied to provide a total average weighted score for each option. The options were then ranked in terms of meeting the appraisal CSF's and the preferred option is identified on the basis of the highest score.

Options were appraised by representatives from both Trusts.

### 5.3.5 Appraisal Group Membership

The Partnership Management Board agreed the weightings for the assessment criteria with quality and finance equally weighted. The Appraisal group membership was as follows:

- Executive Director Strategy & Transformation (UH Bristol)
- Executive Director of Strategic Development (WAHT)
- Medical Director (WAHT)
- Clinical Lead for Strategy and Productivity (UH Bristol)
- Associate Director of Strategy and Business Planning (UH Bristol)
- Associate Director of Finance (UH Bristol)

Observer: Head of Delivery & Improvement (NHSI) South West - South Region

Facilitator: Project Manager (UH Bristol)

### 5.3.6 Options appraisal exercise outcome

The outcome of the options appraisal exercise is summarised as follows:

**Table 8: Summary Scoring Matrix**

Scoring sheet (Options Appraisal) - 27th June SUMMARY	Maximum Score Possible for each question	Maximum Weighting possible for each question	Option 1	Option 2	Option 3	Option 4
			Do Nothing	Shared Services	1 Executive	Merger
Critical Success Factors (CSFs)			Av. Weighted score	Av. Weighted score	Av. Weighted score	Av. Weighted score
1. <b>Strategic Alignment</b> - Must align to organisational priorities & BNSSG Sustainability and Transformation Plan	100	10%	1.7	4.0	5.8	7.8
2. <b>Deliverability and clinical sustainability</b> - Must have scope to enable delivery of improvement and be acceptable to patients and stakeholders	100	20%	4.3	8.3	11.8	15.7
3. <b>Financial Sustainability</b> - Must have the scope to live within its means on a recurrent basis	100	35%	3.2	9.6	17.2	24.5
4. <b>Affordability</b> - Must be affordable, making the best use of public funds	100	15%	12.5	9.9	7.5	5.6
5. <b>Pace</b> - The extent to which the option enables UHBristol to effect significant change from 1st April 2018 to mitigate risk of further deterioration in service sustainability at WAHT impacting adversely on wider system	100	20%	2.2	6.7	11.5	16.3
<b>TOTALS</b>	<b>500</b>	<b>100%</b>	<b>23.9</b>	<b>38.5</b>	<b>53.8</b>	<b>70.0</b>
<b>Final Ranking (where a rank of 1 most meets the CSFs)</b>			<b>4</b>	<b>3</b>	<b>2</b>	<b>1</b>

The short listing exercise identified organisational merger via acquisition as the most likely option to achieve the required critical success factors. The following points were made by the members of the appraisal group in the closing session:

- The degree of option desirability increased in even steps from do nothing through to organisational merger.
- If this case proceeds to FBC, a fuller benefits and risks appraisal exercise will be required as this was not undertaken at SOC stage.
- The WAHT members of the appraisal group reported their satisfaction with the appraisal process and confirmed that they felt their voice was fully heard in the process.
- The NHSI representative confirmed agreement with and support for with the appraisal process and the disciplined way in which the exercise was undertaken.



## 6. Benefits and risks of the preferred option

### 6.1 Benefits and risks

This section sets out the benefits that the recommended option will bring to patients, staff, and the wider NHS; particularly through making services more sustainable and hence safer whilst continuing to offer local access.

It also considers the risks of closer collaboration through an organisational merger and the issues that will require further examination during the FBC stage to establish the robustness of mitigations.

A systematic appraisal of the relative expected benefits from each of the 4 shortlisted options has not been undertaken at this stage. More information on the preliminary analysis of financial benefits and risks can also be found in section 9 'Financial Plan'.

The prime benefits expected from the combined Trust option may be summarised as follows:

**Table 9: Expected Strategic Benefits**

	<b>Strategic benefits</b>
<b>Operational</b>	Providing a clinically and financially sustainable and viable platform for future services
<b>Clinical</b>	Providing a strengthened workforce with improved flexibility, recruitment and retention
<b>Financial</b>	Achieves economies of scale in corporate services, facilities, functional and clinical areas

### 6.2 Benefits

There are expected benefits to both Trusts of closer integration as set out in the table below:

**Table 10: General Expected Benefits**

<b>Benefits</b>	<b>WAHT</b>	<b>UH Bristol</b>
<b>Critical mass</b> – increasing the resilience of WAHT as an organisation through being part of a larger organisation	✓	
<b>Recruitment and retention</b> – providing a strengthened workforce with improved flexibility, recruitment and retention through maximising opportunity of UH Bristol's reputation and brand.	✓	
<b>Pace and impact</b> – the preferred option enables alignment of ways of working and benefit to changes to clinical models at pace, as part of a single organisation.	✓	✓
<b>Clinical alignment and reduction in variation</b> – Realising benefits of alignment of clinical services and opportunities to reduce variation, improve productivity and to reduce operational and quality risks currently associated with some services.	✓	✓
<b>Addressing in a controlled manner</b> the current known risks to the resilience of acute clinical services across Bristol and North	✓	✓

<b>Benefits</b>	<b>WAHT</b>	<b>UH Bristol</b>
Somerset.		
Enabling the wider health system to protect its future services for the benefits of patients, by <b>improving the financial sustainability of acute services</b> in North Somerset	✓	✓
<b>Supporting staff</b> to access a greater range of training and development, education, training and research opportunities across a wider organisation	✓	✓
<b>Sharing learning</b> across both organisations <b>to improve access to and quality</b> of clinical services for patients	✓	✓
Greater scope to <b>make best use of the combined available capacity and buildings</b> in order to deliver our service goals	✓	✓
<b>Corporate synergies</b> – realising efficiencies in shared corporate services	✓	✓

### 6.3 Benefits to Patients and Staff

The primary benefit to patients and staff will be addressing the operational, safety, quality and access issues highlighted in the recent CQC report. The main benefits of a WAHT organisational merger with UH Bristol are expected to be as follows:

**Table 11: Expected Patient and Staff Benefits**

<b>Key Patient and Staff Benefits</b>
Access to a range of local DGH services is retained, for the current and future population of North Somerset
Weston General Hospital has a sustainable future with the scope and opportunity for development of a range of services for patients
The quality and safety of services will improve through partnering with an outstanding teaching and research-oriented Trust
Variation in clinical care and outcomes for patients will be reduced through shared learning and application of best practice models

A key part of the FBC process will be to undertake benefits analysis in more detail to establish a robust benefits portfolio and benefits realisation plan and process.

In developing a FBC, learning will be taken from the evidence about mergers across healthcare organisations. This learning will be applied to support effective management of the risks to proceeding with the transaction. A summary of the most recent evidence is included in Appendix 9.

### 6.4 Risks and issues

This section discusses the key risks to delivering the preferred option; focussing upon how the identified risks will be managed as the organisations progress through the business case planning process, to implementation of the preferred option, including risks to delivering its stated benefits.

Section 10 describes in more detail the proposed programme approach to risk management.

## 6.5 Key risks to delivering the preferred option

The key risks that could present to delivering on the preferred option of organisational merger via acquisition are set out below:

**Table 12: Key risks to delivering the preferred option**

<b>No.</b>	<b>Area</b>	<b>Key risks identified</b>	<b>Mitigations</b>
1.	Financial	The organisational merger by acquisition is not financially viable and therefore compromises the UH Bristol Strategic and Operational Plan	To be assessed in detail through the FBC process.
2.	Regulatory	The Competition and Markets Authority (CMA) rules that there are significant competition and choice issues that require full review	Process to manage is set out in section 8.
3.	Project Management	Capacity to mobilise and deliver the required project outputs are not fully in place, supported by robust governance and a fully funded resource plan.	External support for resourcing an effective Programme Management Office (PMO) will be sought
4.	Workforce	The Staff consultation and TUPE transfer process timetable is not deliverable within the required timescale	Effective planning and dedicated resource within PMO to deliver process (see 11.3.3)
5.	Public Engagement	Public concern regarding an organisational merger proposal adversely affects the timetable and / or the preferred option	Effective communication and engagement plans developed and managed
6.	Operational	UH Bristol business as usual activities and performance are adversely affected by management attention turned to the acquisition project	Dedicated senior resources required within PMO. Regular assessment of impact by Trust Senior Team
7.	Operational	WAHT services deteriorate ahead of the planned transaction date, resulting in UH Bristol requirement to support services in an unplanned way with adverse impact on existing services	Partnership management Board (PMB) to identify emergent risks and take key actions across system partners to mitigate.
8.	Commissioning	the outcomes of the Healthy Weston commissioning process are not compatible with a viable transaction	– UH Bristol and WAHT providing lead roles within the HW process and ensuring

No.	Area	Key risks identified	Mitigations
			<p>interdependencies between the overall population service model and the acute service model are identified.</p> <ul style="list-style-type: none"> <li>- External capacity commenced January 2018 under direction of PMB to develop and test viability of acute service model within HW context.</li> </ul>

The controls and mitigations will be further developed as a priority during development of the FBC.

## 7. Joint Clinical Services Strategy

### 7.1 Introduction

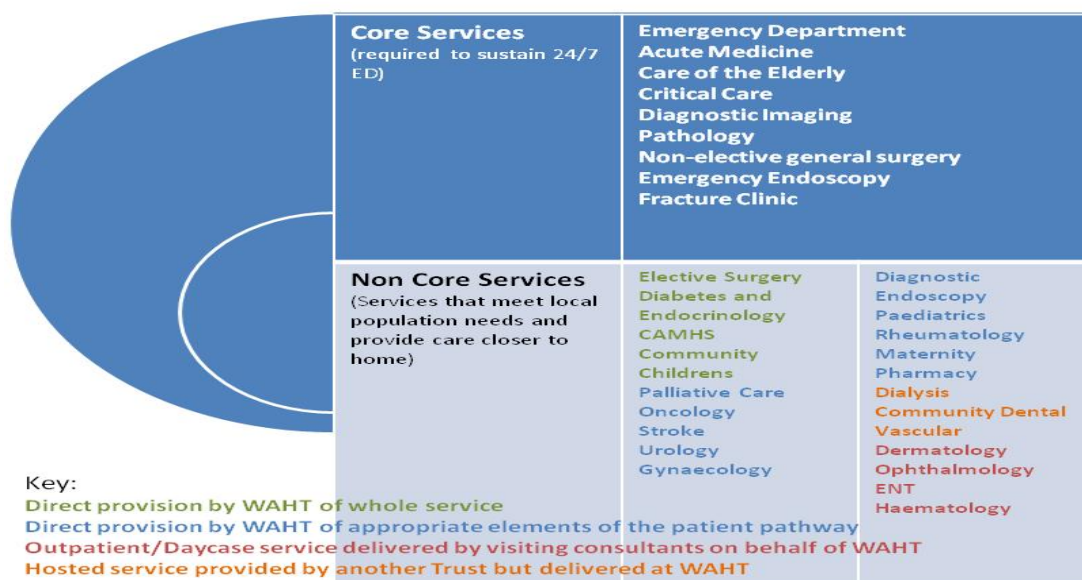
This section outlines the current UH Bristol and WAHT Clinical Strategies, highlighting the alignment and compatibility of the current approaches of the two organisations. It also provides an outline of the emerging approach to developing a joint clinical services strategy.

The current UH Bristol and WAHT partnership arrangement has identified that there is clear scope for the partnership to optimise and standardise clinically driven pathways around the patient and reduce clinical variation. Whilst work to develop some areas of collaborative clinical pathways is being undertaken within the BNSSG STP, there are a number of local priority areas of work where the degree of risk to resilience of services merit solutions being developed at pace between WAHT and UH Bristol.

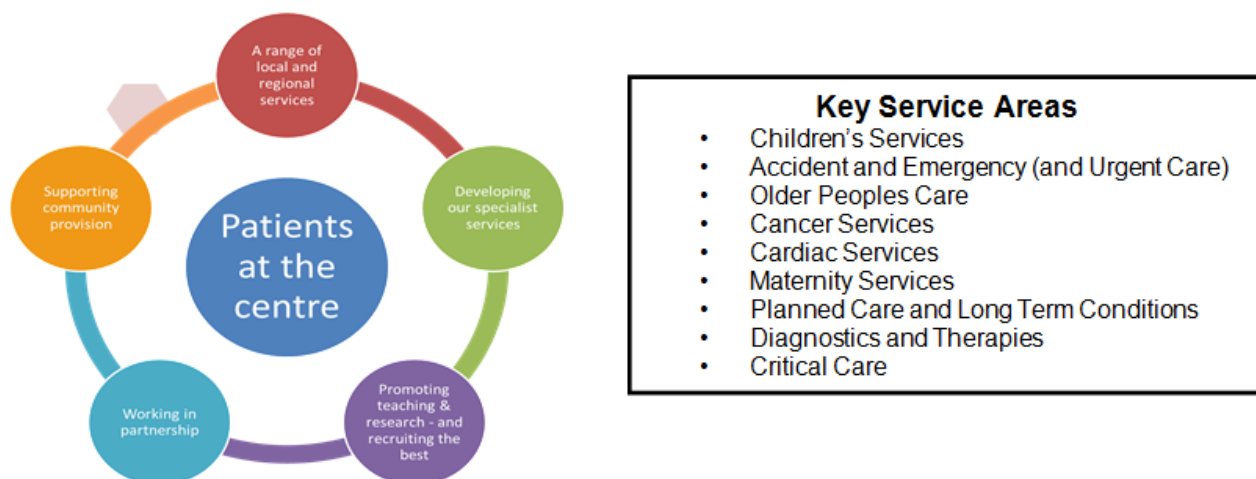
### 7.2 Current Alignment in Clinical Strategies

There is alignment between the existing clinical strategies at WAHT and UH Bristol. The key priorities relating to clinical services outlined in both organisational strategies are outlined below.

**Figure 4: WAHT Clinical Model**



**Figure 5: UH Bristol Clinical Model**



WAHT summarises the core clinical services at WAHT as those associated with the delivery of urgent care services for the local population. UH Bristol describes the delivery of a range of local and regional services, but also a clear strategic intent to continue to develop UH Bristol's specialist service portfolio. There are synergies between both organisations clinical strategies which could present opportunities in the development of future models of care. The preferred option outlined in this SOC presents the opportunity to accelerate the benefits of a combined clinical strategy.

### **7.3 The Development of a Future Vision for Clinical Services**

The working principle through this SOC is that the clinical model developed as part of the proposed preferred option will be based on the commissioning intentions developing through the Healthy Weston Programme which states the ongoing need for a district general hospital for the population of North Somerset.

Prior to publication of the Healthy Weston commissioning context, the primary vehicle for the development of this clinical model had been through the North Somerset Sustainability Process, which also stated in its December 2016 Phase 2 report that, *'All stakeholders agree that Weston General Hospital forms a key part of the BNSSG system, and that it is essential it continues to provide a broad range of emergency and elective services to the local population'*.

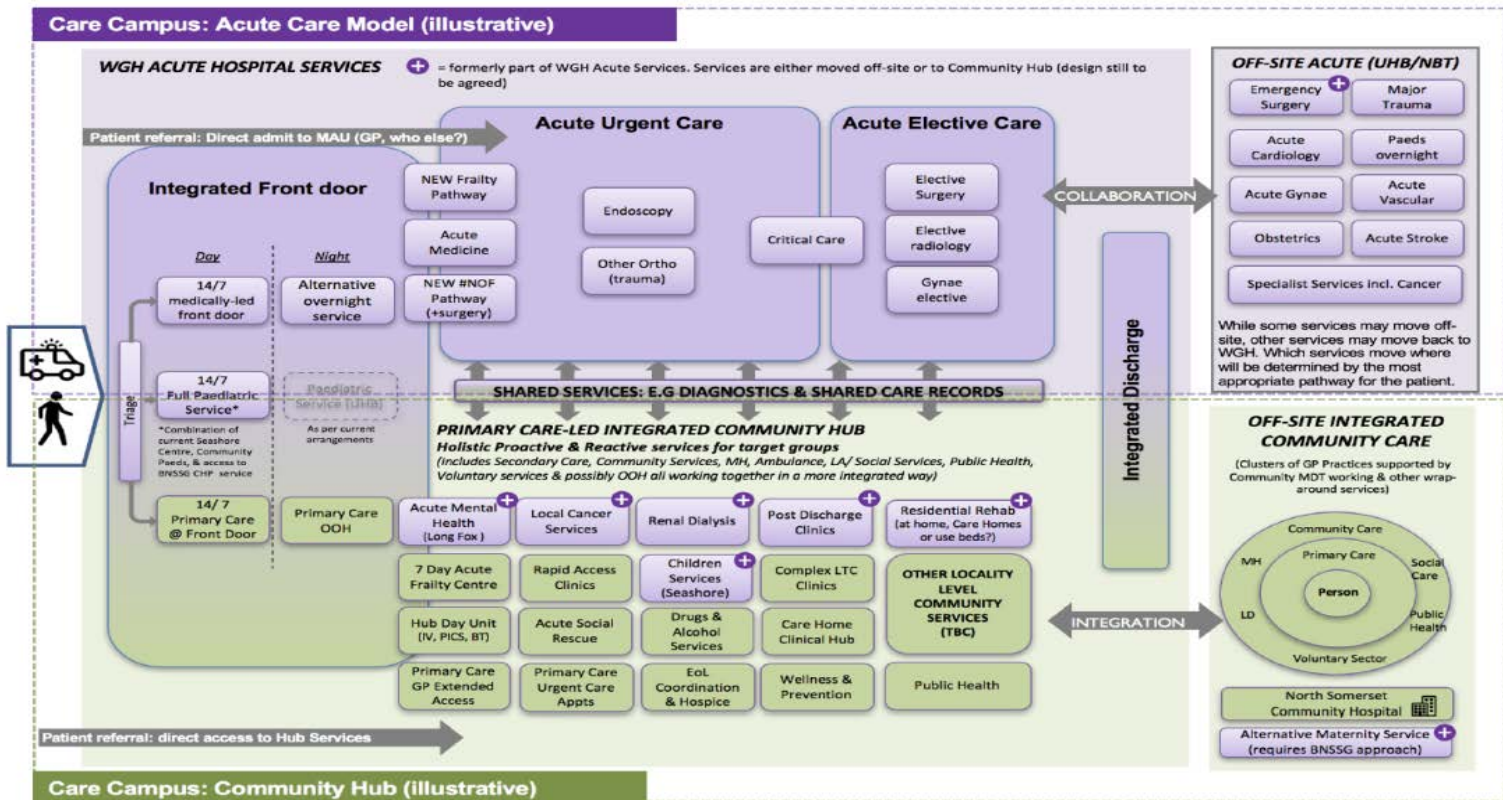
The Healthy Weston programme is taking a more system wide approach to the future development of services for WAHT and the North Somerset population, building on the work completed within the North Somerset Sustainability Programme.

The proposal described through the Healthy Weston programme, is to move towards the delivery of care through an Integrated Care Campus model.

An illustration of how this could function is outlined in the Healthy Weston document (Ref 1, pg 39) and the work of the Healthy Weston programme is to establish the basis upon which this proposed high level model could effectively function to deliver the overall aims of the programme.



Figure 6: Care Campus: Acute Care Model



In order to implement this model successfully, the document describes how. 'WAHT needs to redefine the role of WGH within the BNSSG landscape and we must collectively take this opportunity to address long-standing issues of clinical and financial sustainability for a number of different services' (Ref 1, p. 45).

The Healthy Weston commissioning context also establishes a set of key design principles for a new acute care model (outlined in full in Appendix 8). The core themes of these are integration in key areas such as urgent care and paediatrics and also with primary and community care, using the opportunities presented in Weston to develop centres of excellence in areas such as frailty and elective care and greater and more effective collaboration across Acute Trusts.

The organisational alignment between UH Bristol and WAHT would clearly provide a platform to accelerate the successful integration of clinical services and partnership models to deliver this vision. More detailed work is however required to assess the level of service change and the associated impact on clinical sustainability and financial viability that this model could bring.

This transformation work involved may present direct opportunities for UH Bristol, not only to support the development and delivery of high quality and sustainable services at WAHT, but also to develop innovative models from which learning can be translated back to UH Bristol, for the benefit of the organisation and Bristol patients.

Full delivery of a vision for WAHT services to create a fully sustainable model is clearly a longer term piece of work, which will develop over the next three to five years. The next step is for the Healthy Weston process to conclude the detailed analysis of the options for future services to inform the development of a pre-consultation business case to be progressed by the BNSSG CCGs. The output from this process will inform the basis upon which any final recommendation, through a Full Business Case (FBC), to move to acquisition would be made.

## 8. Competition considerations

### 8.1 Competition

Mergers can benefit patients by helping providers improve the efficiency and quality of their services. At the same time, choice and competition also have an important role in encouraging providers to deliver better services. The merger review process allows for both the competition effects and the benefits of mergers to be taken into account in order to determine what is in the overall best interests of patients. NHSI and the CMA work together to ensure that the interests of patients are always at the heart of the merger review process.

### 8.2 NHS Improvement's role with regard to Competition

NHS Improvement's role is to provide expert advice and guidance on the regulatory framework governing transactions in the NHS; and assess merger benefits and provide expert advice on benefits to the CMA. NHS Improvement would be the regulator of any merged UH Bristol - WAHT organisation.

### 8.3 Competition and Markets Authority (CMA)

The CMA is the UK's primary competition and consumer authority. It is an "independent non-ministerial government department with responsibility for carrying out investigations into mergers, markets and the regulated industries and enforcing competition and consumer law."

### 8.4 The Process

There are three phases to the CMA evaluation:

- **Pre-notification,**
- **Phase 1,**
- **Phase 2** (only needed if the evidence supplied at phase 1 is not sufficient to eliminate any competition concerns).

**8.4.1 Pre-notification** has no time limit but is an opportunity to liaise informally with regulators and the CMA to provide data analysis, mitigating factors and patient benefits that are considered what their data analysis may suggest is an area of concern. It is a two way dialogue that is an opportunity to prepare sufficiently well that a phase 2 referral is not required.

Once a merger has been formally notified to the CMA by NHSI, the review process is as follows:

**8.4.2 Phase 1:** (Lasts up to 40 working days). As part of a phase 1 review, the CMA must decide whether there is a realistic prospect that the merger will result in a substantial lessening of competition and have an adverse effect on patients and/or commissioners by significantly reducing their choice of provider, and consider NHSI's expert advice on the benefits of the merger.

If the CMA believes that the merger will not result in a realistic prospect of a substantial lessening of competition, or if the benefits of the merger outweigh any lessening of



competition, it will not refer the merger for a Phase 2 review and that would conclude the CMA's review of the merger.

If a merger is not cleared at Phase 1, the review progresses to Phase 2.

**8.4.3 Phase 2:** (Limited to 24 weeks). In Phase 2, the CMA conducts a detailed assessment and must decide whether the merger is reviewable and whether it is expected to result in a substantial lessening of competition.

As part of their process to understand if competition issues exist with collaborative working, the CMA will undertake a service by service analysis of emergency and elective work and where GP's refer patients to.

### **8.5 Data Analysis**

Work has already commenced with NHS Improvement's Competition and Co-operation Department, which has been acting as an advisor to the collaboration project to help understand the likely level of interest from CMA in the proposed organisational merger.

The CMA will consider as part of pre-notification and phase 1, whether the merger reduces patient choice and competition. Should it be necessary, there will be an opportunity to provide evidence to the CMA to support the case in terms of patient benefits of the proposed organisational merger, and measures that we might put in place to ensure that patients would not be disadvantaged by a reduction in choice.

The NHSI (Competitions and Markets Team) have undertaken an economic analysis based upon the CMA's methodology for identifying potentially problematic overlaps. This establishes a case for whether or not the proposed transaction meets the CMA thresholds for formal stage 1 review.

The Trust has received the NHSI (CMA team) report for review and approval. This will then be sent to the CMA for their consideration and next steps agreed.

### **8.6 Competition - next steps**

If the CMA conclude that proposed transaction does not require a stage 1 review, then no further action is required.

Should the CMA identify the requirement for a stage 1 submission, then the NHSI economic analysis report will form part of this submission, together with a detailed analysis of the benefits case. Typically it can take 4 – 6 weeks to prepare the detailed submission and then a further 40 working days for the CMA to complete their stage 1 review.

If a Phase 2 review should subsequently be required, this will have a significant impact on the transaction and implementation timetable (up to 24 week process). An FBC decision cannot be ratified without CMA approval.

## 9. Financial Appraisal and Resources Plan

### 9.1 Introduction

The Financial Appraisal section of the SOC outlines the current and historic financial performance of WAHT and looks at its future financial prospects going forward five years as a standalone entity. It also describes the key drivers behind the track record of financial deficits at WAHT and provides an early assessment of the extent to which these could be mitigated under the preferred option. The financial case also outlines the financial track record of UH Bristol and provides an assessment of UH Bristol's financial position going forward taking into consideration the potential net financial benefits of a merger through acquisition and the effect on the viability of a combined organisation.

To support assessment of the case for merger at this stage, all of the analysis is based on 2018/19 as an indicative base year for a merged organisation (year one). The analysis is also based on an "as is" service model at WAHT, resulting in identification of the requirement for financial support to ensure that the financial performance and financial standing of the combined organisation is not unduly diluted and that the combined organisation has the ability to be financially viable and deliver the assessed benefits.

The financial appraisal is described in detail in Appendix 5. It should be noted that this was based on information available earlier in the 2017/18 financial year. The comprehensive appraisal to be completed on a future acute service model within the Healthy Weston programme will update this assessment and include a comprehensive productivity review. This will be used in the FBC financial case.

In summary, the financial appraisal at this stage describes a structural net deficit, after initial assessed mitigations, of £9.7 million at WAHT due to the provision of a Type 1 Emergency Department and the full suite of DGH services operating from a relatively remote location twenty-five miles from Bristol and Taunton. There is little likelihood of this requirement being affordable going forward within the context of a significant current overspend by the CCG for the North Somerset population (Ref 1). The FBC will further assess the impact and potential mitigation of the need for such support resulting from the development of a new acute service model developed within the Healthy Weston process.

In addition, the financial appraisal identifies that a viable merger proposition would require a non-recurrent public dividend cash (PDC) injection of £32.4 million to address WAHT's historic debt, alongside a PDC capital investment of £7 million in year one of a combined organisation, to replace and integrate WAHT's and UH Bristol's wider information technology. A requirement for £5 million non-recurrent investment to secure the resources needed to effectively deliver a combined organisation and ensure a successful transition is also identified.

The need for and level of financial support will be reassessed in the FBC.

## **10. Execution Plan**

### **10.1 Introduction**

It is important that the ability of both organisations to effectively take forward the preferred option is demonstrated. This section sets out plans to ensure that sufficient resources and management structures are in place to achieve this and produce a full business case which will set out the detailed arrangements required to successfully deliver the organisational merger through acquisition.

A summary of the high level milestone plan for the transaction execution period is included below. A detailed implementation blueprint and plan will be developed during the FBC phase and will set out what will be delivered through this programme structure.

The following section also sets out in high level terms a proposed governance structure post-merger and what the focus would be for day 1 of the merged organisation. A priority activity following approval of the SOC will be to work up the post transaction implementation plan (PTIP) in detail. This will include key milestones, interdependencies and risks to the smooth transition to a new organisation from day 1. It will also focus on realising the clinical and non-clinical benefits through improvement plans for year 1, alongside a clear implementation plan for how services would be developed and changed over time in line with the commissioning decisions made within the Healthy Weston programme and following commissioner-led consultation, if required. Investment in these activities has been evidenced to be critical to the success of merger acquisitions nationally.

A key priority of the process must be the safe integration of operational services across both sites. In addition the Trust needs to ensure that performance is monitored as part of the benefits realisation strategy through the transition and integration period.

High quality communication and engagement with staff, patients and the public will be fundamental throughout the implementation of the transaction. A developed communications and engagement plan will be in place to shape with staff the new organisation's brand and to develop joint and consistent staff ownership of culture and values. This is addressed in section 11.

### **10.2 Programme Management and Governance arrangements**

#### **10.2.1 Programme management**

The process to manage the organisational merger will become an integral part of the UH Bristol transformation programme, which comprises a portfolio of projects for the delivery of the Trust's strategic priorities.

#### **10.2.2 Programme management arrangements**

Developing a FBC (phase 2) will require a dedicated project team supplemented with significant additional dedicated resource to deliver the more detailed outputs required. For example, there will need to be significant focus on staff and public engagement, and an implementation plan developed to cover each and every corporate and clinical service across both organisations, together with work to ensure that the necessary assurance is in place to support regulatory review and approval at each stage. Feedback from other similar NHS transactions is that it is imperative that there is dedicated project / programme management and implementation planning resource to support this work.

It is proposed therefore that a dedicated Programme Management Office (PMO) is established, accountable to a newly formed Transition Programme Board to coordinate and track each work stream's progress. Prince 2 methodology will primarily be used.

Links to other programmes of work that impact upon this proposed organisational merger will be established, with formal memorandum of understanding (MoU) developed where required to provide clarity of role, purpose and areas of collaboration, and to ensure alignment in goals and vision.

### 10.2.3 Programme plan and implementation timeline

The following table presents the key stages and milestones within a transaction execution plan and reflects NHS Improvement *Transactions Guidance for Trust's undertaking transactions, including mergers and acquisitions*. Specific timescales will be set following Board approval of the SOC and subsequent consideration of the outcome from the comprehensive appraisal of the future model of acute care within the context of the 'Healthy Weston' programme and vision.

**Table 34: Draft Project Plan and Milestones**

<b>DRAFT PROJECT PLAN</b>
<b>Phase 1 - Following SOC approval</b>
<b>NHSI SOC Review process</b>
Regional NHS Improvement team reviews SOC and provides formal feedback
<b>Comprehensive appraisal of the future model of acute care within the context of the 'Healthy Weston' programme and vision</b>
<b>MILESTONE REVIEW – proceed to FBC</b>
<b>Phase 2 - Full business Case</b>
Phase 2 project team resources assembled
Full Business Case (FBC) production process
Full Due diligence undertaken by UH Bristol
FBC brought forward for approval by WAHT and UH Bristol Trust Boards
<b>Regulatory approval process (post FBC approval)</b>
FBC approved by WAHT and UH Bristol Trust Boards
NHS Improvement - transaction assurance process
Board to Board Meeting with NHSI to discuss transaction risk rating
NHS Improvement issue a Transaction Risk Rating
Both Trust boards confirm the acquisition is to proceed
UH Bristol Board of Governors formal vote and approval of transaction application
Joint application is made to NHSI and Secretary of State (SoS) containing application and outcome of Governors vote
Secretary of State approves the transaction (letter)
NHSI issues Statutory Order allowing organisational merger by acquisition
<b>Workforce (TUPE transfer process)</b>
TUPE Transfer process
Consultation period (staff and staff side representatives)

<b>DRAFT PROJECT PLAN</b>
Notice of transfer (letter to WAHT staff confirming transfer of employment from WAHT to UH Bristol)
WAHT staff transfer employment
<b>CMA indicative timeline</b>
NHSI Report and Analysis sent to the CMA for review
CMA holds meeting with UH Bristol to discuss findings and provides a steer on requirement or not for stage 1 submission
<u>If stage 1 submission required then:</u>
Preliminary case prepared by UH Bristol with NHSI (4 – 6 week process depending upon resources)
Stage 1 submission made to CMA (40 working day process once accepted by CMA)
<u>If stage 2 submission required,</u> the above timescales will require to be extended
Stage 2 case prepared by UH Bristol with NHSI (4 – 6 week process depending upon resources)
Stage 2 submission made to CMA (up to 120 working days process once accepted by CMA)

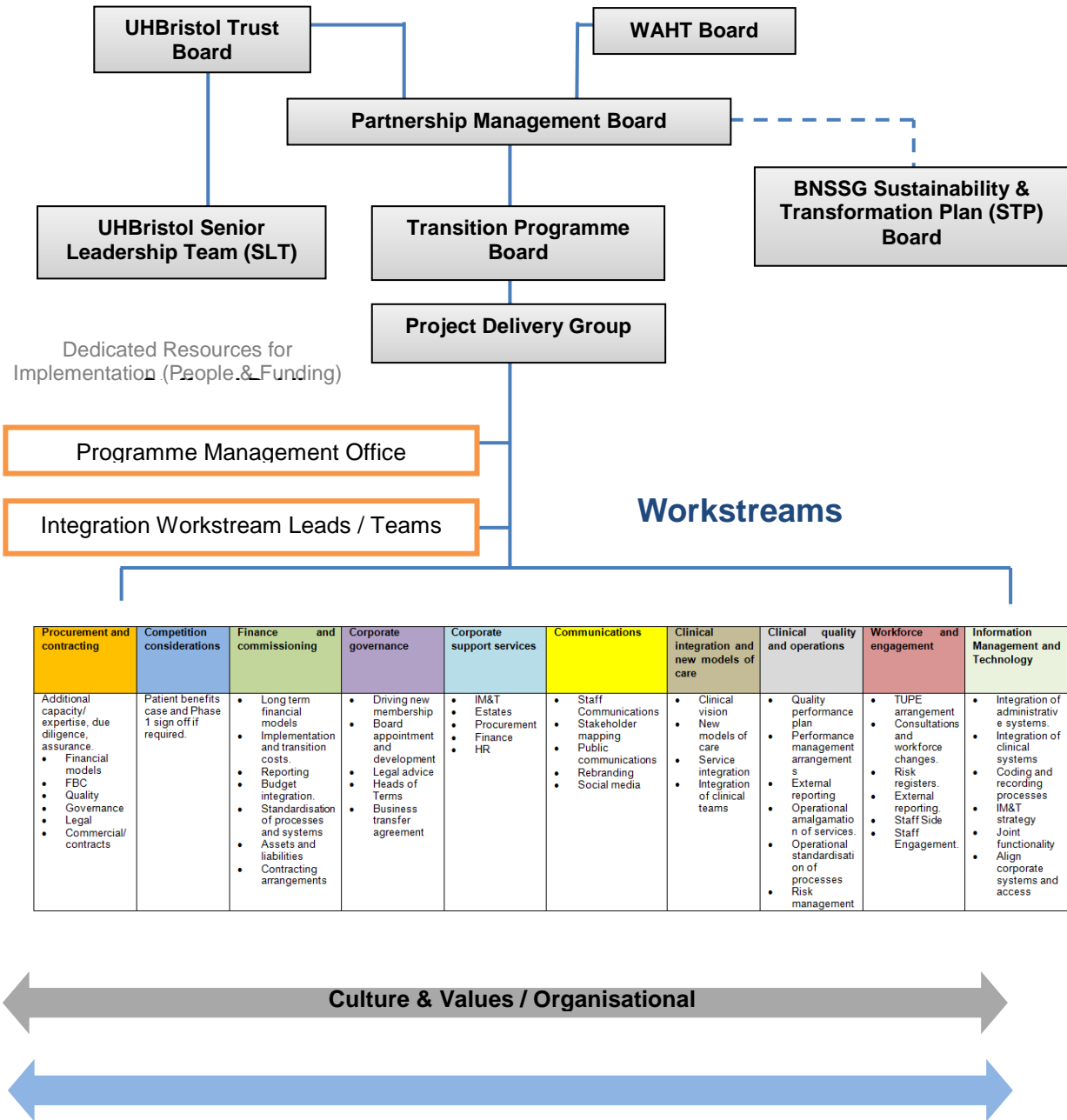
#### 10.2.4 Transition Programme Board

The current Weston Partnership Steering Group will be replaced with a Transition Programme Board with overall responsibility for delivery of the programme's desired outcomes. The following diagram sets out the reporting arrangements:

#### 10.2.5 Programme reporting structure

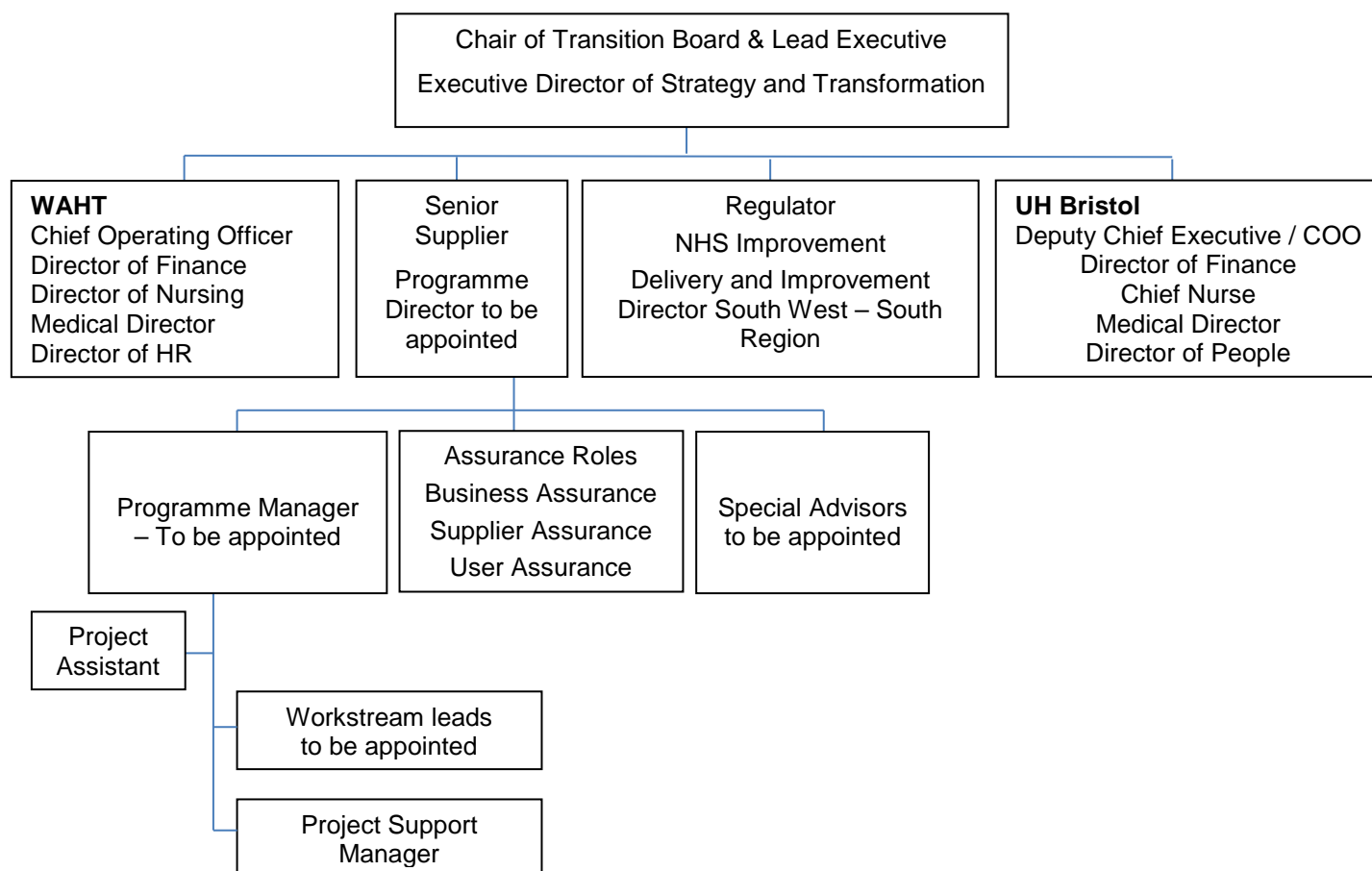
The reporting organisation and the reporting structure for the programme are as follows:

**Figure 7: Programme Reporting Structure**



All reviews of successful acquisitions identify the skills and expertise of the programme team as critical for transaction success. The indicative Transition Board and supporting PMO lead roles are outlined below:

**Figure 8: Transition Board responsibilities**



### 10.2.6 Workstream arrangements

A workstream approach will be taken to support the delivery of the FBC and process to acquisition. It will also be critical to driving achievement of the expected benefits for patients and staff and translating the change to a new organisation into the future new business as usual.

The work programme for each workstream will be determined by the key deliverables within the project plan. The work programme will be specified in detailed work packages. Each workstream will have a nominated chair who will have dedicated time for leadership and management activities. In consultation with the Programme Director and Programme Manager, the workstream chair will assemble the team required to deliver the workstream programme. This will be a combination of in house staff and external advisors. The workstream chair will be a member of the Delivery Group and will be accountable to the Programme Director for delivery.

Within the first 100 days following the transaction, the Trust will need to ensure delivery against key aims of the transaction and to ensure staff are fully engaged with the process, as well as ensuring clinical services continue to be delivered effectively.

The following workstreams will be established and the priorities for day 1, month 1 and first 100 days will be clearly established for each as part of the FBC.

- Procurement and contracting
- Competition considerations

- Finance and commissioning
- Corporate governance
- Corporate support services
- Communications
- Clinical integration and new models of care
- Clinical quality and operations
- Workforce and engagement
- IM&T

### **10.2.7 Resource Plan**

The Financial appraisal section sets out the financial envelope for the expected transaction costs of an organisational merger. This includes costs of special advisors, legal and other advisory fees.

The Trust believes that the project has the best chance of success, and uses public funds most efficiently, if programme resources are predominantly drawn from within the current UH Bristol and WAHT staffing capacity and expertise. This approach will require posts to be backfilled to release staff from business as usual duties and additional in house project management training.

The risk of adverse impact upon business-as-usual activities is considerable and is assessed within the benefits and risks section.

### **10.2.8 Use of special advisers**

In phase 1, the Trust has used in house resources (except for an interim project manager) and not special advisors to prepare the strategic outline case and interim due diligence.

External project consultation and advice has been provided by NHSI. This consists of advice on transactions, mergers and the acquisition process, together with regulatory requirements. The NHSI Competition and Markets team has also provided advice and guidance on the requirements to submit a stage 1 CMA review.

The requirement for external special advisors is stated in the NHSI guidance on mergers and acquisitions, and the resource requirement has formed part of the Trust's financial case for non-recurrent financial support.

Special advisers will be appointed and used in a timely and cost-effective manner in accordance with the Treasury Guidance: 'Use of Special Advisers' (Ref 11).

A full resource plan is being developed and will reflect this requirement.

## **10.3 Outline arrangements for change and contract management**

A procurement and contract workstream will be established which will be responsible for all contractual and procurement aspects of the transaction. This workstream will be supported by specialist acquisition and merger legal advisors.

Following a decision to proceed to FBC, the current Interim Partnership Agreement will be updated and a Transition Board will be established in line with the project requirements for acquisition. The timing for the Transition Board and PMO will be dependent on the



identification of appropriate resources and associated funding being secured, as well as the timeline for commissioning decisions to be progressed within the HW programme. These two factors are key milestones in the transaction critical path.

#### **10.4 Outline arrangements for benefits realisation**

The expected high level benefits of the proposed organisational merger by acquisition were set out earlier in the case (section 6).

In order to ensure a clear focus on realising these benefits, a benefits realisation strategy will be developed through the FBC phase to form a central part of the overall integration plan.

The costs of realising the benefits will be assessed as part of the implementation planning process and built into the FBC submission.

As implementation proceeds, the forecast benefits will be cross-referenced with work stream project plans, risk management plans and the corporate vision and objectives to which each benefit relates.

The potential benefits will be identified and quantified using the following processes:

- Development of SOC identified benefits,
- Discussion through the work streams, with Transition Board oversight,
- Work with members of the programme management team and external advisers,
- Undertaking a benefit and metric identification and mapping exercise.

The benefits realisation plan will sit under the benefits strategy and will contain:

- A schedule detailing when each benefit or group of benefits will be realised,
- The identification of appropriate milestones when a programme benefit review could be undertaken,
- The details of any handover activities, beyond the mere implementation of a deliverable or output, to sustain the process of benefits realisation after the programme is closed.

The benefits realisation plan will be used to track the delivery of benefits across the programme. It will be owned initially by the PMO but over time it is intended to integrate this into the routine business management processes of the combined Trust.

#### **10.5 Outline arrangements for risk management**

The risks to achieving a preferred option for collaboration that is jointly agreed by both Trust Boards have been identified, documented, and tracked throughout the development of the SOC. These risks and mitigations have been reviewed by the Partnership Management Board.

The identified risks to delivering the preferred option, and realising the stated benefits were covered in the Benefits and Risks (section 6).

Risk assessment is a fundamental management tool and forms part of the governance and decision making process at all levels of this organisation. The risk register is a risk management tool whereby identified risks are described, scored, controls identified, mitigating actions planned and a narrative review is recorded.

The identification and accurate reporting of risks is embedded into the UH Bristol staff culture at all levels, along with an understanding that risks reported will be acted upon appropriately by those in more senior positions. This will be vital throughout any collaborative work, in order to ensure day to day performance on quality, finance and operational performance does not slip, and in order to support the integration processes of merging the two organisations.

Following approval, the programme will continue to adopt sound and tested risk management processes based on both Trusts' risk management policies to allow the Transition Board to understand the programme risks and put in place mitigation measures to manage those risks.

### **10.6 Quality assurance**

Quality assurance and control are key disciplines of successful projects. For this project, details of quality assurance control will be included in each group of tasks leading to a completed element of the project or work package. Aspects of quality will be assessed using the following approaches:

- Peer review,
- Internal audit assessment,
- Board approval,
- OGC Gateway Review.

### **10.7 Outline arrangements for post project evaluation**

During the FBC phase, arrangements will be established for post implementation review (PIR) and project evaluation reviews (PER) in accordance with best practice.

### **10.8 Post Transaction Implementation Plan (PTIP)**

The PTIP is a key document alongside the FBC that sets out details of the post-transaction organisation after it has completed all activities necessary for consolidation. It is also a document that is scrutinised as part of the NHSI assurance and risk rating process post FBC approval for all significant transactions.

The intention is to develop outline integration plans which will account for the Organisational Development, staff consultation and cultural aspects of the organisational change, as well as the technical. These will be developed and driven via the workstreams identified above.

The learning from the case studies undertaken in the Aldwych Partners Report (Ref 13), regarding the importance of post-merger planning and clinical involvement and leadership of these plans will be used to support this process ensuring an early focus on delivering a single organisational culture.

## 10.9 Governance of the Merged Organisation

Initial plans for the new organisation governance below Board level have been considered but require development within an FBC.

With regard to Clinical Services, during the initial post-merger stabilisation period and to ensure effective management of risk, WAHT clinical services would be operated in a similar way as a Division of UH Bristol led on site by a Divisional Director and Clinical Chair, supported by a Head of Nursing, HR and Finance Partner.

This Divisional team would be supported by a dedicated Transition Team whose responsibility it would be to lead on delivery of the transformation programme.

With regard to the Corporate and Support Services of both organisations, these could be integrated from day 1. This is considered practicable and enables the early delivery of shared services benefits.

The detailed planning for the successful organisational merger will ensure clear accountability for the delivery of the business as usual activity in the interim. An accountability and responsibility matrix will be developed to provide organisational and individual role certainty.

The Resources plan being developed includes the staffing requirement for the year 1 post-merger stabilisation period.

In general, achieving a successful organisational merger and a stable financial and operational future requires early and detailed planning. The actions required to achieve a smooth transition to the new organisation on Day 1 must be clear, in order to have effective control of the combined organisation, and become a fully integrated organisation as quickly as possible.

Underpinning all implementation plans will be an emphasis on developing a single, consolidated, centralised structure and a single set of systems, processes and policies. The development of the PTIP will be done in an inclusive manner that ensures that all workstream leads own and deliver these plans as part of their day-to-day activities.

Performance across all domains during the organisational merger must be sustained, so there needs to be an early focus on developing a shared understanding of the performance and activity at service line level. Identifying and addressing differences in organisational culture will also be key component. An early focus will also be developing a comprehensive organisational development approach as part of the pre-merger process.

This is further addressed in the section below.

## **11. Communication and Engagement**

### **11.1 Introduction**

This section considers the communication and engagement strategy and approach that will be undertaken during the next phase of the project (full business case development and work through to organisational merger).

This section considers:

- Communications,
- Staff Engagement,
- Stakeholder Engagement and Involvement.

### **11.2 Communications Strategy Aims and Objectives**

The Joint Partnership Management board approved the Communications Strategic Aims and Objectives, as part of the communications and engagement plan. These are summarised as follows:

#### **11.2.1 The aim of Strategic communications**

To provide communications and engagement support to all identified audiences on behalf of the programme in its development of the potential merger that:

- Builds understanding and support for change and closer working between the two Trusts for the benefit of patients,
- Builds confidence in plans for more closer working between the two Trusts,
- Supports the development of a common vision, values and culture for closer working,
- Enables staff of both organisations to shape and become advocates of the closer working or new organisation,
- Maintains and improves the reputation of UH Bristol, WAHT and ultimately, the new organisation.

In order to achieve this, communications and engagement will:

- Provide open, robust and effective communication and engagement,
- Ensure communication and engagement from both Trusts is joined up, consistent, credible, timely and well co-ordinated,
- Be sufficiently resourced and deliverable, using existing channels whenever possible; ensuring value for money and appropriate use of public funds at all times,
- Ensure communication on potential organisational merger, Healthy Weston and the Sustainability and Transformation Partnership external stakeholder processes are aligned,
- Support formal consultation with staff on any changes that may affect them as required.

### 11.2.2 Communications and engagement – governance arrangements

A communications and engagement work stream will be established to oversee the development of the strategy set out above and ensure it delivers against the timelines and key milestones. This group will also oversee coordination of plans with the wider health economy and will include leads from the following organisations:

- UH Bristol,
- WAHT,
- Bristol, North Somerset and South Gloucestershire CCGs,
- North Bristol NHS Trust,
- NHS Improvement,
- Healthier Together [formerly STP].

To ensure coordination of plans with the wider health economy, links would be established with leads from the following organisations through the existing STP infrastructure:

- Taunton and Somerset NHS Foundation Trust,
- South Western Ambulance Service,
- Bristol Community Health,
- Avon and Wiltshire Mental Health Partnership,
- Bristol City Council,
- North Somerset Council,
- NHS England.

### 11.2.3 Communications and Engagement Approach

The approach for communications and engagement to support this project will use milestones within the project to differentiate specific phases of communications and engagement activity.

To support every phase of work there will be a detailed communications and engagement plan that sets out what needs to be achieved during that phase of the project, the key messages, methods of communication and engagement, and the activity that will be put in place. It will explain the context of this work and its relationship with other cross-organisational work such as the STP.

For each phase of work, stakeholder analysis will provide insight into which audiences need particular focus and the methods of communication and engagement that will be used. The plan to support each phase will include:

- Stakeholder analysis,
- Key messages,
- Methods of communication and engagement (including internal communication channels, methods of engagement, media relations, briefings etc.),
- Timetable of activity,
- Methods of evaluation.

The communications and engagement plan to support this work will address the communications and engagement needs of these audiences, putting in place appropriate communication and engagement opportunities and methods.

#### **11.2.4 Key messages**

Key messages for each phase of the project will be developed and will be set out in the communication and engagement plan. In each case they will:

- Set out how far the project has progressed, what has been done and what still needs to be done,
- Put the project in context by explaining its relationship to other relevant work, for example Healthy Weston
- Set out clearly the benefits of partnership working,
- Set out clearly the opportunities for engagement and involvement.

The communications and engagement plan for each phase of the project will consider tailoring the key messages for each audience, in line with the stakeholder analysis, where appropriate.

### **11.3 HR Strategy**

#### **11.3.1 Key Principles**

The challenges inherent in enacting organisational change are fully appreciated by both organisations and in order to address these issues effectively the following principles will be adopted;

- All affected staff will be supported throughout the change process and will have the opportunity to seek clarity, responsibility and recognition for what they do.
- All affected staff will be fully consulted regarding changes however, the process will also be mindful of the need to move quickly to ensure we minimise disruption and uncertainty for staff and continue to deliver high quality services for patients
- All reasonable steps will be taken to minimise redundancies to ensure that key valuable skills and experience across staff groups are not lost to the organisations.
- Any process required to appoint to posts as a result of the merger will be fair and transparent and will seek to match individuals' skills and ability with available posts.
- All appointment and selection processes will be fair and transparent and will comply with equal opportunities best practice and legislation.
- A partnership approach will be taken with trade unions throughout the transition, which will involve views of Staff Side being considered and taken into account within the change process, as well as Staff Side representatives being kept informed and involved throughout.

#### **11.3.2 Staff communication and engagement**

The key communication objective is to involve stakeholders in the progress of the merger process, highlight the benefits to both Trusts, allay concerns from internal and external stakeholders and present a clear vision for the new organisation.

A key element of successfully integrating the two organisations will be the communication and engagement with staff across both organisations. It is particularly acknowledged that there has been a prolonged period of uncertainty and difficulty for staff and WAHT and there is need to gain the confidence of staff in the benefits of the merger in order to secure their engagement. It will also be important to secure the confidence of staff at UH Bristol that there are benefits to both organisations and in particular, that the stability and success of UH Bristol will not be compromised by the transition and conversely that working together as organisation, could present potential opportunity to improve services for patients of both Trusts.

A full communications and engagement approach will be developed to deliver the above and the importance of getting this right will not be underestimated, both in terms of the overall short and long term success of the programme and also on the individual staff involved.

One of the communications and engagement aims is to support the development of a common vision, values and culture for closer working between UH Bristol and WAHT that enables staff of both organisations to shape and become advocates of the benefits of working together.

### **11.3.3 Establishing the New Organisation through Transfer of Undertakings of Employment (TUPE)**

When a new organisation is created, there is a requirement for communication and consultation to support a smooth Transfer of Undertakings (Protection of Employment) (TUPE) of WAHT staff.

The effect of the TUPE Regulations is to preserve the employment and terms and conditions of those employees who are transferred to a new employer when a transfer takes place.

Both employers will have a duty to inform and consult appropriate representatives of their employees who may be affected by the transfer, however, the engagement would be led by WAHT as the transferor and UH Bristol as the transferee.

To effect a smooth TUPE transfer of WAHT staff, both organisations will need to undergo a period of information exchange and meaningful consultation with both staff and trade unions, prior to an effective transfer date and in accordance with both the TUPE Regulations and internal policy requirements.

The stages of this process following a decision to proceed will include.

- A pre-consultation process including briefing meetings at WAHT with all staff groups.
- A formal consultation process over a minimum two month period, followed by consideration of the consultation feedback.
- Finalisation of the transfer proposal  
Providing transferring staff with three months' notice of transfer prior to the transfer date.

Prior to the consultation stage, a proposal document will be written detailing the transfer proposal, special measures and the transfer timetable. The proposal document will be consulted upon with both staff and representative Trade Unions at collective consultation



meetings. Feedback would be received and considered at the end of the consultation period. A final proposal document will then be prepared, approved through existing governance arrangements and published.

Full details of the transfer mechanism will be provided in the Full Business Case.

#### **11.4 Outline public communication and engagement approach**

UH Bristol has a strong patient centred culture and sees public engagement and involvement as essential in developing services for the communities it serves.

This section considers the communication and engagement approach that will be undertaken during the next phase of the project to Full Business Case including the principles which will underpin post-acquisition activities.

In summary, a public communication and engagement process will be developed and delivered which runs in parallel with developing plans by BNSSG CCGs to consult on clinical commissioning options within Healthy Weston.

From a technical perspective, Section 56A of the Health and Social Care Act 2012 provides for a Foundation Trust to acquire an NHS Trust or another Foundation Trust. It is a tried and tested and legally certain transaction route. There is no requirement in section 56A for a public consultation prior to undertaking the merger through acquisition. Notwithstanding, and central to our approach, is the recognition of the value of effective public engagement. From the outset, UH Bristol and WAHT will develop processes and take actions that establish and develop effective relationships with community stakeholders building a climate of shared value, trust and transparency that will define future interactions. This includes those required to fulfil statutory and regulatory duties, specifically the involvement of patients and the public, under section 242 (duty to involve) of the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012).

UH Bristol and WAHT will work pro-actively with North Somerset Healthwatch to advise on the planning and delivery of public participation activities, including a focus on ensuring engagement with seldom heard groups and providing assurances that we are listening and responding to the views of patients, carers and stakeholders. This will integrate with the Healthy Weston communication and engagement processes which also targets the engagement of three priority population groups including Frail and Older People; Children, Young People and Pregnant Women; Vulnerable Groups (for example people with mental health needs, learning difficulties and those who struggle with drug and alcohol addiction).

UH Bristol and WAHT recognise the complexity of current developments in the local health economy and that parallel public participation exercises can be seen as duplication and result in confusion amongst the local community. We will work with partners to join up conversations and ensure that engagement activities and any subsequent consultation activities are co-ordinated. In addition we will establish and communicate clear objectives for public participation exercises ensuring a shared understanding of expectations.

Our commitment to best practice and to assisting stakeholders to participate fully in this and any future consultation and involvement processes will be achieved by adopting the



'Consultation Charter Principles' from the Consultation Institute (Ref 14). This will include applying consistent and appropriate methods of engagement with an emphasis on inclusive dialogue and consensus building. Activities may include:

- Targeted activities with patient interest groups though, for example "The For All Healthy Living Company",
- Healthwatch led meetings,
- Social media and on-line engagement activities,
- Public information events,
- Public meetings.

#### **11.4.1 Resources and Budgets**

We recognise that a commitment to public communication and engagement, subsequent consultations and other involvement activities requires resourcing.

An assessment of the resources required to undertake effective public communication and engagement will include:

- Anticipated cost for planning, delivering and evaluation activities. This may include commissioning third party organisations such as Healthwatch to undertake work and costs incurred for translation and interpreting,
- The anticipated capacity required in terms of people.

#### **11.4.2 Stakeholder engagement Post-merger**

Communications post-merger will remain key to the success of the project and so a detailed communications strategy, with similar focus on the stakeholders in previous phases, will need to be put in place during the immediate post-merger stages.

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5.	CQC Inspection Report (WAHT), Care Quality Commission, June 2017	2.2
6.	Lord Carter Review, April 2014	3.1
7.	Dalton review: options for providers of NHS care, Department of Health, January 2015	3.1
8.	Rising to the challenge - our 2020 vision, UH Bristol	3.3.2.2
9.	North Somerset Programme for Sustainable Services, Phase 2, December 2016	4.1
10.	Next Steps for the Five Year Forward View, NHS England, March 2017	4.2.6
11.	Public Sector Business Cases - Using the Five Case Model -Green Book Supplementary Guidance, HM Treasury, 2015	5.3
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	September 2015	
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14.	<a href="https://www.consultationinstitute.org/">https://www.consultationinstitute.org/</a> - 2010	11.3

#### Appendix 4: Glossary of Terms

Abbreviation	Full Title
A&E	Accident & Emergency
ACC	Acute Care Collaboration
AHP	Allied Health Professionals
BHOC	Bristol Haematology and Oncology Centre
BNSSG	Bristol North Somerset and South Gloucestershire
CQC	Care Quality Commission
CCG	Clinical Commissioning Group
CMA	Competition and Markets Authority
CSF	Critical Success Factors
DoH	Department of Health
DGH	District General Hospital
DD	Due Diligence
ED	Emergency Department
EPR	Electronic Patient Record
FBC	Full Business Case
ICO	Integrated Care Organisation
ITFF	Independent Trust Financing Facility
ITP	Invitation to Participate
KPI	Key Performance Indicators
LMCs	Last-minute cancelled operations
LOS	Length of Stay
LTA	Long Term Arrangement
LTFM	Long Term Financial Model
MFFD	Medically Fit For Discharge
MoU	Memorandum of Understanding
NPSA	National Patient Safety Agency
NBT	North Bristol NHS Trust
NHSE	NHS England
NHSI	NHS Improvement
NSCCG	North Somerset Clinical Commissioning Group
OBC	Outline Business Case
PIR	Post Implementation Review
PTIP	Post Transaction Implementation Plan
PMO	Programme Management Office
PER	Project Evaluation Reviews
PDC	Public Dividend Capital
RTT	Referral to Treatment Times
SoS	Secretary of State
SLT	Senior Leadership Team
SLA	Service Level Agreement
SOC	Strategic Outline Case
S&T	Sustainability & Transformation (Funding)

<b>Abbreviation</b>	<b>Full Title</b>
STP	Sustainability and Transformation Plan
TSFT	Taunton and Somerset NHS Foundation Trust
TDA	Trust Development Authority
TUPE	Transfer of Undertakings (Protection of Employment)
UH Bristol	University Hospitals Bristol NHS Foundation Trust
VTE	Venous Thrombo-Embolicism
WAHT	Weston Area Health NHS Trust

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## APPENDIX 5: Financial Appraisal Analysis

This section provides the detail for the financial appraisal analysis reference in section 9 of the SOC. The analysis is based on information available earlier in the 2017/18 financial year and on an “as is” service model at WAHT, resulting in identification of the requirement for financial support to ensure the financial performance and financial standing of UH Bristol is not unduly diluted through an organisational merger and that the merged organisation has the ability to be financially viable and deliver the assessed benefits.

The comprehensive appraisal to be completed on a future acute service model within the Healthy Weston programme will update this assessment and include a comprehensive productivity review. This will be used in the FBC financial case.

### 9.2 Summary

#### 9.2.1 Scenarios

There are a large number of variables included in the various scenarios – most based on estimates but with these estimates being backed up by experience and realism. Therefore, the scenarios can be relied upon with some confidence. The scenarios can be described in two ways:

- WAHT impact only,
- Combined UH Bristol / WAHT impact with and without financial support.

#### 9.2.2 WAHT impact

The WAHT impact scenarios can be shown in table 13 below:

**Table 13: WAHT impact**

	2017/18		2021/22		
	Plan	UHB View	Do Nothing	With mitigations without financial support	With mitigations, with financial support
<b>Statement of Comprehensive Income (SoCI) £'million</b>					
Operating income from patient care activities	92.4	89.3	93.2	92.9	92.9
Operating income from patient care activities - income support	3.3	3.3	0.0	0.0	9.7
Other operating income - project costs	0.0	0.0	0.0	0.0	0.0
Other operating income - transitional support	0.0	0.0	0.0	0.0	0.0
Other operating income excluding STF	7.9	7.9	6.6	6.6	6.6
Sustainability & Transformation Funding (STF)	3.1	0.5	3.1	3.1	3.1
<b>Total income</b>	<b>106.7</b>	<b>100.9</b>	<b>102.9</b>	<b>102.6</b>	<b>112.3</b>
Operating expenses	(111.0)	(114.5)	(114.4)	(110.7)	(111.2)
<b>Net operating surplus / (deficit)</b>	<b>(4.3)</b>	<b>(13.5)</b>	<b>(11.5)</b>	<b>(8.1)</b>	<b>1.1</b>
Net financing costs	(1.9)	(1.9)	(1.9)	(1.6)	(1.1)
<b>Net surplus / (deficit) for period excluding technicals</b>	<b>(6.0)</b>	<b>(15.2)</b>	<b>(13.4)</b>	<b>(9.7)</b>	<b>0.0</b>
<b>Statement of Financial Position (SoFP) £'million</b>					
<b>Net current assets/(liabilities)</b>	<b>(5.3)</b>	<b>(4.9)</b>	<b>(5.0)</b>	<b>6.8</b>	<b>0.0</b>
Non current liabilities - existing DH loan	(17.9)	(17.9)	(45.8)	(45.8)	0.0
Non current liabilities - new DH loan to fund future year deficit	0.0	(9.6)	(50.3)	(50.3)	0.0
<b>Total liabilities</b>	<b>(23.3)</b>	<b>(32.4)</b>	<b>(101.1)</b>	<b>(89.3)</b>	<b>0.0</b>

It can be seen that the WAHT position is likely to deteriorate substantially as a result of an increased net I&E deficit to c£13.4 million per year in the period to 2021/22. This results in total liabilities of £23.3 million as at 31<sup>st</sup> March 2018 increasing to total liabilities of £101.1 million as at 31<sup>st</sup> March 2022, an increase of £77.8 million. This would result in an increased requirement for matching loan funding of £101.1 million. The interest rate impact has not been included in this assessment but with current short term loan rates, raising this would result in a further significant deterioration.

In addition, the WAHT underlying position assumes that national efficiency savings are met each year from 2018/19. Given the actual delivery record of the past few years this assumption is probably not realistic. Hence if, for example, a 2.0% national efficiency requirement plus 0.5% for unavoidable cost pressures is in place and only 1% recurrent savings are delivered, (the actual performance has been well below this in the past few years), the do nothing deficit would build as follows as shown in table 14 below:

**Table 14: Adjusted net surplus / deficit including savings risk**

Statement of Comprehensive Income (SoCI) £'million	2018/19	2019/20	2020/21	2021/22
<b>Net surplus / (deficit) excluding technicals</b>	<b>(13.4)</b>	<b>(13.4)</b>	<b>(13.4)</b>	<b>(13.4)</b>
Impact of further savings shortfall	(1.5)	(3.0)	(4.5)	(6.0)
<b>Adjusted Net surplus / (deficit) including savings risk</b>	<b>(14.9)</b>	<b>(16.4)</b>	<b>(17.9)</b>	<b>(19.4)</b>
<b>Statement of Financial Position (SoFP) £'million</b>				
<b>Total liabilities - total existing and new</b>	<b>(51.0)</b>	<b>(69.3)</b>	<b>(87.7)</b>	<b>(101.1)</b>
Impact of further savings shortfall	(1.5)	(4.5)	(9.0)	(15.0)
<b>Adjusted total liabilities - total existing and new</b>	<b>(52.5)</b>	<b>(73.8)</b>	<b>(96.7)</b>	<b>(116.1)</b>

As the issue of scale and size are the biggest factor preventing delivery of efficiency savings at WAHT this adjusted scenario is therefore highly likely. Hence the scale of deficit and cash shortfalls would become unsustainable

### 9.2.3 Combined Organisation impact

The combined organisation impact (assuming the UH Bristol component is unchanged) with financial support results in a surplus of £13.0 million and total liabilities of £76.5 million i.e. an undiluted position for UH Bristol.

The combined organisation impact shown on the next page as table 18 (assuming the UH Bristol component is unchanged) but without financial support, the UH Bristol position is diluted to a net I&E surplus of £3.3 million and total liabilities of £171.7 million (a deterioration of £95.2 million). This is not a sustainable position. For a combined entity with turnover of £782.9 million in 2018/19 (indicative year one of a combined organisation), a planned surplus of c2% of turnover or c£15.7 million is required. This ensures a reasonable level of working capital is available to meet the ongoing revenue costs of staff and suppliers, capital investment requirements and provide a degree of financial resilience going forward.

For the combined organisation, the distinction for consideration is simply the impact upon UH Bristol either with or without financial support. The position is summarised in table 15 below.



**Table 15: Combined Trust with and without financial support**

	Combined Trust 2018/19		Combined Trust 2019/20		Combined Trust 2020/21		Combined Trust 2021/22	
	With support	Without support	With support	Without support	With support	Without support	With support	Without support
<b>Statement of Comprehensive Income (SoCI) £'million</b>								
Operating income from patient care activities	659.1	659.1	663.9	663.9	664.4	664.4	664.9	664.9
Operating income from patient care activities - subsidy	9.7	0.0	9.7	0.0	9.7	0.0	9.7	0.0
Other operating income - project costs	2.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0
Other operating income - transitional support	3.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Other operating income excluding STF	92.7	92.7	96.8	96.8	98.9	98.9	101.2	101.2
Sustainability & Transformation Funding (STF)	16.4	16.4	16.4	16.4	16.4	16.4	16.4	16.4
<b>Total income</b>	<b>782.9</b>	<b>768.2</b>	<b>787.8</b>	<b>777.1</b>	<b>789.4</b>	<b>779.7</b>	<b>792.2</b>	<b>782.5</b>
Operating expenses	(757.8)	(757.2)	(763.3)	(762.8)	(765.1)	(764.5)	(765.9)	(765.3)
<b>Net operating surplus / (deficit)</b>	<b>25.1</b>	<b>11.0</b>	<b>24.5</b>	<b>14.3</b>	<b>24.3</b>	<b>15.2</b>	<b>26.3</b>	<b>17.2</b>
Net financing costs	(13.8)	(14.4)	(14.4)	(14.9)	(14.5)	(15.1)	(14.7)	(15.3)
<b>Net surplus / (deficit) for year</b>	<b>11.3</b>	<b>(3.4)</b>	<b>10.1</b>	<b>(0.6)</b>	<b>9.8</b>	<b>0.1</b>	<b>11.6</b>	<b>1.9</b>
Excluding Technicals	1.7	1.7	2.9	2.9	3.2	3.2	1.5	1.5
<b>Net surplus / (deficit) for year excluding technicals</b>	<b>13.0</b>	<b>(1.7)</b>	<b>13.0</b>	<b>2.3</b>	<b>13.0</b>	<b>3.3</b>	<b>13.0</b>	<b>3.3</b>
<b>Statement of Financial Position (SoFP) £'million</b>								
<b>Net current assets/(liabilities)</b>	<b>21.1</b>	<b>12.3</b>	<b>10.0</b>	<b>3.8</b>	<b>9.4</b>	<b>6.8</b>	<b>4.0</b>	<b>5.0</b>
Non current liabilities - existing DH loan	(77.3)	(113.1)	(82.1)	(122.9)	(81.3)	(127.1)	(80.5)	(126.3)
Non current liabilities - new DH loan to fund future year deficit	0.0	(10.2)	0.0	(23.5)	0.0	(36.9)	0.0	(50.3)
<b>Sub total liabilities - total existing and new</b>	<b>(56.2)</b>	<b>(111.0)</b>	<b>(72.1)</b>	<b>(142.6)</b>	<b>(71.9)</b>	<b>(157.2)</b>	<b>(76.5)</b>	<b>(171.7)</b>

**Table 16: The deterioration from the 'with support' to the 'without support' position is accounted for as follows:**

Surplus / (Deficit) excluding technicals	Combined Trust 2018/19	Combined Trust 2019/20	Combined Trust 2020/21	Combined Trust 2021/22
<b>Net surplus / (deficit) for year - with financial support</b>	<b>13.0</b>	<b>13.0</b>	<b>13.0</b>	<b>13.0</b>
Remove recurrent revenue income support	(9.7)	(9.7)	(9.7)	(9.7)
Remove non-recurrent income funding for project costs	(2.0)	(1.0)	0.0	0.0
Remove non-recurrent income funding for transitional costs	(3.0)	0.0	0.0	0.0
<b>Subtotal - financial support</b>	<b>(14.7)</b>	<b>(10.7)</b>	<b>(9.7)</b>	<b>(9.7)</b>
<b>Net surplus / (deficit) for year - without financial support</b>	<b>(1.7)</b>	<b>2.3</b>	<b>3.3</b>	<b>3.3</b>

## 9.2.4 Conclusion

It is clear that based on the “as is” service position of WAHT, that financial support which takes the combined organisation through to 2021/22 (indicative year 4) is required to make the proposal to merge WAHT with UH Bristol, viable financially.

The potential to mitigate this requirement for financial support needs to be developed in an FBC reflecting the opportunities for both planned productivity and efficiency benefits from an organisational merger and from the impact of a new acute service model for WGH alongside an integrated “care campus”.

## 9.3 WAHT’s historic financial track record

### 9.3.1 Net income and expenditure deficit

In 2008/9, WAHT reported a net deficit of £16.8 million. Since this time, whilst the Trust had showed some signs of financial recovery, WAHT also received additional financial support as additional non-recurring revenue funding that was classified as other operating revenue as follows: £7.4 million in 2010/11; £9.2million in 2011/12; and £6.6 million in 2012/13. Nil non-recurring support was received in 2013/14. However, Public Dividend Capital (PDC) cash support of £5.0 million was received in 2013/14 to address cash flow difficulties resulting from the 2013/14 reported deficit of £5.1 million.

WAHT's net income and expenditure deficit excluding non-recurring revenue support and Sustainability & Transformation (S&T) funding ranges from a net deficit of £4.7 million in 2010/11 to a net deficit of £8.9 million in 2016/17. The historic net deficit is in the range of -5% to -8% of turnover. A summary of recent financial performance is provided in table 17 below:

**Table 17: WAHT historic financial performance**

WAHT's historic net I&E position and cash support	2010/11 £'m	2011/12 £'m	2012/13 £'m	2013/14 £'m	2014/15 £'m	2015/16 £'m	2016/17 £'m
Turnover	93.3	95.3	96.7	96.8	100.4	98.5	105.6
<b>Reported net surplus/(deficit)</b>	<b>2.7</b>	<b>3.5</b>	<b>1.3</b>	<b>(5.1)</b>	<b>(3.9)</b>	<b>(7.0)</b>	<b>(7.2)</b>
Less Revenue support	(7.4)	(9.2)	(6.6)	0.0	0.0	0.0	0.0
Less S&T Funding	0.0	0.0	0.0	0.0	0.0	0.0	(1.8)
<b>Adjusted net surplus/(deficit)</b>	<b>(4.7)</b>	<b>(5.7)</b>	<b>(5.3)</b>	<b>(5.1)</b>	<b>(3.9)</b>	<b>(7.0)</b>	<b>(8.9)</b>
<b>Loan and PDC cash support</b>							
Loans	0.0	0.0	0.0	0.0	0.0	7.7	4.2
PDC	0.0	0.0	0.0	5.0	5.1	1.8	0.0
<b>Total loan and PDC cash support</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>5.0</b>	<b>5.1</b>	<b>9.5</b>	<b>4.2</b>

This shows a deteriorating position over the past few years with 2017/18 accelerating this further (see section 9.4).

### 9.3.2 Savings delivery

WAHT has a consistent pattern of substantial under-delivery against the annual savings requirement particularly the delivery of recurrent savings. This provides a legacy of undelivered savings each year that simply rolls over into the following year resulting in an ever-increasing cumulative underlying deficit. For example, in 2016/17, WAHT delivered recurrent savings of £0.5 million against a target of £4.1 million. This is attributed to the small scale of services making efficiency savings difficult to identify and deliver.

### 9.3.3 Statement of Financial Position (Balance Sheet), cashflow and liquidity

WAHT has a weak balance sheet with net current liabilities of £12.9m as at 31<sup>st</sup> March 2017. Liquidity is a major concern with liquidity of minus 48 days. This position is the result of historic deficits since 2013/14 despite a PDC cash injection of £5.0 million in that year. Since this time, WAHT has managed its cash position with short term and long-term loans provided by the Department of Health (DoH).

It is clear that WAHT is unable to meet its ongoing obligations without recourse to cash loans. For example, the Trust is funding the 2017/18 planned net deficit of £6.0 million with a further extension of loan funding from the DoH. This highlights the Trust's inability to generate sufficient cash from ongoing trading and is a serious concern. Nonetheless, going concern was adopted by the Trust for completion of the 2016/17 annual accounts that were subsequently audited by Grant Thornton UK LLP.

### 9.3.4 Financial Summary – WAHT's historic financial track record

The financial summary below in table 18 provides the three primary financial statements: Statement of Comprehensive Income (net income & expenditure position); the Statement of Financial Position (balance sheet) and a Cash flow Statement relating to the three most recent financial years.

**Table 18: WAHT's historic financial performance**

<b>Statement of Comprehensive Income (SoCI) £'million</b>	<b>2014/15</b>	<b>2015/16</b>	<b>2016/17</b>
Operating income from patient care activities	90.7	89.0	95.7
Other operating income excluding STF	9.7	9.5	8.1
Sustainability & Transformation Funding (STF)	0.0	0.0	1.8
<b>Total income</b>	<b>100.4</b>	<b>98.5</b>	<b>105.6</b>
Operating expenses - pay	(67.8)	(68.4)	(75.7)
Operating expenses - non-pay	(35.1)	(35.7)	(35.3)
<b>Net operating surplus / (deficit)</b>	<b>(2.6)</b>	<b>(5.6)</b>	<b>(5.4)</b>
Net financing costs	(1.9)	(1.9)	(1.9)
<b>Net surplus / (deficit) for year</b>	<b>(4.4)</b>	<b>(7.5)</b>	<b>(7.3)</b>
Remove capital donations/grants I&E impact	0.6	0.5	0.1
<b>Net surplus / (deficit) for period excluding technicals</b>	<b>(3.9)</b>	<b>(7.0)</b>	<b>(7.2)</b>
<b>Operating surplus/(deficit) Margin %</b>	<b>-3%</b>	<b>-6%</b>	<b>-5%</b>
<b>Net I&amp;E Margin %</b>	<b>-4%</b>	<b>-7%</b>	<b>-7%</b>
<b>Statement of Financial Position (SoFP) £'million</b>	<b>2014/15</b>	<b>2015/16</b>	<b>2016/17</b>
Non current assets	66.9	69.7	72.3
Current assets excluding cash	4.2	4.4	5.4
Cash and cash equivalents	3.0	3.9	1.6
Current liabilities	(9.8)	(10.3)	(19.9)
<b>Net current assets/(liabilities)</b>	<b>(2.6)</b>	<b>(2.1)</b>	<b>(12.9)</b>
Non current liabilities - DH Loan	0.0	(7.7)	(4.2)
<b>Sub - total (liabilities)</b>	<b>(2.6)</b>	<b>(9.8)</b>	<b>(17.1)</b>
Non current liabilities - Provisions	(0.2)	(0.4)	(0.4)
<b>Total net assets employed</b>	<b>64.1</b>	<b>59.5</b>	<b>54.9</b>
<b>Statement of Cashflow (SoCF) £'million</b>	<b>2014/15</b>	<b>2015/16</b>	<b>2016/17</b>
<b>Opening cash b/fwd</b>	<b>0.8</b>	<b>3.0</b>	<b>3.9</b>
Net cash generated from / (used in) operations	2.6	(1.4)	(1.5)
Capital cash (outflow)/inflow	(3.5)	(5.4)	(3.6)
Other	0.0	0.0	0.0
Net PDC (outflow)/inflow	3.2	(0.1)	(1.2)
Loans received from DH	0.0	7.7	4.2
Loans repaid to DH	0.0	(0.0)	0.0
Interest paid to DH	0.0	(0.0)	(0.1)
Sub-total net cash (outflow)/inflow	2.3	0.8	(2.2)
<b>Closing cash c/fwd</b>	<b>3.0</b>	<b>3.9</b>	<b>1.6</b>

WAHT's financial track record of year on year net income and expenditure deficits and the consequential requirement for external cash support has not been successfully resolved for more than a decade. It is universally accepted that WAHT is currently financially non-viable due to its small-scale provision of District General Hospital (DGH) services and difficulties faced with staff recruitment and retention.

After a phase of relative stability over the period of 2010/11 to 2013/14 with net deficits excluding support at c£5.0 million, the financial position has significantly deteriorated in 2015/16 and 2016/17 with the recent (2017/18) run rate deficit accelerating (once S&T funding is adjusted for). There is little prospect of this trend recovering under current arrangements.

## 9.4 WAHT's underlying financial position

The following section describes UH Bristol's assessments of the WAHT 2017/18 Operational Plan as submitted to NHS Improvement and the forecast underlying position going forward as the do nothing option. (**NB:** based on assessment early in 2017/18 to provide indicative financial scenarios of options to merge).

### 9.4.1 Income and Expenditure

WAHT submitted a revised 2017/18 Operational Plan to NHS Improvement on 12<sup>th</sup> April 2017 and was subsequently approved by the WAHT Board on 2<sup>nd</sup> May 2017. The 2017/18 plan is a net income and expenditure deficit of £6.0 million in line with the control total required by NHS Improvement. However, it should be noted that the control total for 2018/19 has not been agreed. Key factors underpinning the delivery of the planned deficit are: planned savings of £4.5 million and the full receipt of S&T funding of £3.1 million.

UH Bristol has reviewed WAHT's 2017/18 Operational Plan and have assessed the likely 2017/18 outturn deficit at £15.2 million, a deterioration of £9.2 million. The deterioration is due to a range of factors including:

£million

- (2.8) Temporary closure of the Emergency Depart. from 4<sup>th</sup> July 2017 (currently under review);
- (2.6) Loss of S&T funding from Q2 (due to failure to meet control total - core & performance);
- (2.4) Savings shortfall;
- (0.5) Removal of assumed agency nursing reduction per Safer Staffing review (double count);
- (0.5) 25% removal of a repatriation margin/contribution for Orthopaedic activity;
- (0.4) Imposition of national core fines due to the loss of S&T funding.
- (9.2) Total – increase in WAHT deficit

UH Bristol's assessment of WAHT's underlying or recurrent net deficit in 2018/19 is £13.4 million. For simplicity and in the absence of WAHT developing and maintaining a Long Term Financial Model (LTFM), UH Bristol has modelled financial deficits until 2021/22 using this figure as the base position. However, this presents a considerable risk as WAHT's track record of recurrent savings delivery is poor. A recurrent savings under-delivery of c£1.5 million in each year from 2018/19 would accumulate resulting in a further deterioration of £6.0m by 2021/22 and a potential deficit of £19.4 million.

A summary of WAHT's 2017/18 Operational Plan and the projected financial position without merger is summarised in table 19 below as the "Do Nothing" scenario:

**Table 19: WAHT's 2017/18 operational plan and financial performance "Do Nothing" scenario**

<b>Statement of Comprehensive Income (SoCI) £'million</b>	<b>2017/18</b>	<b>2018/19</b>	<b>2019/20</b>	<b>2020/21</b>	<b>2021/22</b>
Operating income from patient care activities	89.3	93.2	93.2	93.2	93.2
Operating income from patient care activities - subsidy	3.3	0.0	0.0	0.0	0.0
Other operating income excluding STF	7.9	6.6	6.6	6.6	6.6
Sustainability & Transformation Funding (STF)	0.5	3.1	3.1	3.1	3.1
<b>Total income</b>	<b>100.9</b>	<b>102.9</b>	<b>102.9</b>	<b>102.9</b>	<b>102.9</b>
Operating expenses - pay	(77.1)	(76.4)	(76.4)	(76.4)	(76.4)
Operating expenses - non-pay	(37.3)	(38.3)	(38.3)	(38.3)	(38.3)
<b>Net operating surplus / (deficit)</b>	<b>(13.5)</b>	<b>(11.8)</b>	<b>(11.8)</b>	<b>(11.8)</b>	<b>(11.8)</b>
Net financing costs	(1.9)	(1.8)	(1.8)	(1.8)	(1.8)
<b>Net surplus / (deficit)</b>	<b>(15.3)</b>	<b>(13.5)</b>	<b>(13.5)</b>	<b>(13.5)</b>	<b>(13.5)</b>
Remove capital donations/grants I&E impact	0.1	0.1	0.1	0.1	0.1
<b>Net surplus / (deficit) excluding technicals</b>	<b>(15.2)</b>	<b>(13.4)</b>	<b>(13.4)</b>	<b>(13.4)</b>	<b>(13.4)</b>
<i>Risk of deterioration from recurrent savings under-delivery</i>		(1.5)	(1.5)	(1.5)	(1.5)
<i>Cumulative</i>		(1.5)	(3.0)	(4.5)	(6.0)
<b>Net surplus / (deficit) including savings risk</b>		<b>(14.9)</b>	<b>(16.4)</b>	<b>(17.9)</b>	<b>(19.4)</b>
<b>Operating surplus/(deficit) Margin %</b>	<b>-13.8%</b>	<b>-11.4%</b>	<b>-11.4%</b>	<b>-11.4%</b>	<b>-11.4%</b>
<b>Net I&amp;E Margin %</b>	<b>-15.6%</b>	<b>-13.0%</b>	<b>-13.0%</b>	<b>-13.0%</b>	<b>-13.0%</b>

The assessed impact of the temporary closure of WAHT's Emergency Department overnight is included in the £15.2 million estimated deficit for 2017/18 at £2.75 million (based on information provided by WAHT).

It should be noted that, for simplicity at this stage, values included in the Statement of Comprehensive income are rolled forward on a flat cash basis from 2018/19 and therefore exclude inflation.

#### 9.4.2 Savings delivery

The delivery of recurrent savings is a significant issue for WAHT. Savings plans provided by WAHT have been reviewed and risk assessed by the Trust. The risk assessed savings forecast is £2.2 million against a target of £4.5 million, a shortfall of £2.3 million. Plans to deliver recurrent savings of £2.4 million to meet the National Tariff requirement of 2.0% plus an additional 0.4% for local cost pressures have been identified but UH Bristol's risk assessment indicates likely recurrent savings delivery of only £1.0 million. UH Bristol's current assessment suggests non-recurring savings of £1.3 million are likely. Recurrent savings plans for an additional 2% or £2.1 million required to deliver the planned deficit of £6.0 million have not been identified by WAHT.

With national efficiency requirements of 2% pa expected over the medium term this pattern of delivery will continue to grow the WAHT underlying deficit.

#### 9.4.3 Statement of Financial Position (Balance Sheet), cashflow and liquidity

UH Bristol's assessment of the WAHT's forecast 2017/18 outturn deficit of £15.2 million further weakens the balance sheet with projected total liabilities of £32.4 million by 31<sup>st</sup> March 2018 meaning further cash advances or loans will need to be obtained from the DoH. This includes a long-term loan of £4.2 million with the DoH. WAHT's planned net deficit of £6.0 million currently assumes a commensurate increase in loan funding.

UH Bristol's assessment of the underlying net deficit at WAHT of £13.4 million per year from 2018/19 until 2021/22 would result in the requirement for further revenue cash support of £53.6 million bringing the total cash support required up to £86.0 million plus the £15.0m IT Capital loan assumed i.e. £101.1m total liabilities. The do nothing option presents an unsustainable prospect.

A summary of WAHT's Statement of Financial Position and Statement of Cashflow is provided in the table 20 below:

**Table 20: WAHT Statement of financial position and statement of cashflow**

<b>Statement of Financial Position (SoFP) £'million</b>	<b>2017/18</b>	<b>2018/19</b>	<b>2019/20</b>	<b>2020/21</b>	<b>2021/22</b>
Non current assets	70.8	75.8	80.6	85.5	85.3
Current assets excluding cash	4.9	4.5	4.5	4.5	4.5
Cash and cash equivalents	1.6	1.6	1.6	1.6	1.6
Current liabilities	(11.4)	(11.2)	(11.2)	(11.2)	(11.1)
<b>Net current assets/(liabilities)</b>	<b>(4.9)</b>	<b>(5.1)</b>	<b>(5.1)</b>	<b>(5.0)</b>	<b>(5.0)</b>
Non current liabilities - existing DH loan per WAHT plan	(17.9)	(35.8)	(40.8)	(45.8)	(45.8)
Non current liabilities - new DH loan to fund future year deficit	(9.6)	(10.1)	(23.5)	(36.9)	(50.3)
<b>Sub total liabilities - total existing and new</b>	<b>(32.4)</b>	<b>(51.0)</b>	<b>(69.3)</b>	<b>(87.7)</b>	<b>(101.1)</b>
Non current liabilities - Provisions	(0.4)	(0.4)	(0.4)	(0.4)	(0.4)
<b>Total net assets employed</b>	<b>38.0</b>	<b>24.5</b>	<b>10.9</b>	<b>(2.6)</b>	<b>(16.2)</b>
<b>Statement of Cashflow (SoCF) £'million</b>	<b>2017/18</b>	<b>2018/19</b>	<b>2019/20</b>	<b>2020/21</b>	<b>2021/22</b>
<b>Opening cash b/fwd</b>	<b>1.6</b>	<b>1.6</b>	<b>1.6</b>	<b>1.6</b>	<b>1.6</b>
Net cash generated from / (used in) operations	(9.9)	(7.6)	(8.1)	(8.1)	(8.1)
Capital cash (outflow)/inflow	(4.5)	(8.9)	(8.5)	(8.5)	(3.5)
Other	0.0	0.0	0.0	0.0	0.0
Net PDC (outflow)/inflow	(1.0)	(1.2)	(1.2)	(1.2)	(1.2)
Loans received from DH - Existing	6.0	25.6	5.0	5.0	0.0
Loans received from DH - New to fund future year deficit	9.6	0.5	13.4	13.4	13.4
Loans repaid to DH	0.0	(7.7)	0.0	0.0	0.0
Interest paid to DH	(0.3)	(0.6)	(0.6)	(0.6)	(0.6)
Sub-total net cash (outflow)/inflow	(0.0)	(0.0)	0.1	0.0	(0.0)
<b>Closing cash c/fwd</b>	<b>1.6</b>	<b>1.6</b>	<b>1.6</b>	<b>1.6</b>	<b>1.6</b>

## 9.5 UH Bristol's historic and planned financial performance

The following section describes UH Bristol's financial track record and financial outlook over the period to 2021/22.

### 9.5.1 Income and expenditure

UH Bristol has an excellent record of financial delivery. 2016/17 was the UH Bristol's fourteenth year of delivering financial surpluses. UH Bristol ended the 2016/17 financial year with a net surplus of £16.6 million. UH Bristol submitted its revised 2017/18 Operational Plan to NHS Improvement on 30<sup>th</sup> March 2017 following its acceptance of NHS Improvement's control total net surplus of £13.0 million including S&T funding of £13.3 million.

It should be noted that the control total for 2018/19 has not been agreed. The delivery of the planned net surplus in 2017/18 is a prerequisite to the Trust's plans for further essential capital investment in its estate. The Trust has set aside Phase 5 capital funding of £18.0 million to further develop and enhance UH Bristol's clinical services. UH Bristol is clear that



the rewards for delivering the 2017/18 planned surplus are high and the key factors necessary to deliver it are of paramount importance. Therefore, continued focus on, and discipline regarding the delivery of Divisional Operating Plans will be vital going forward.

UH Bristol's financial outlook builds on the Trust's financial track record. In line with the Trust's Financial Strategy net surpluses are planned at approximately 2% of total income. A planned net income and expenditure surplus of £13.0 million is assumed over the period to 2021/22. A summary of UH Bristol's planned financial performance is provided below in table 21:

**Table 21: Planned financial performance**

<b>Statement of Comprehensive Income (SoCI) £'million</b>	<b>2017/18</b>	<b>2018/19</b>	<b>2019/20</b>	<b>2020/21</b>	<b>2021/22</b>
Operating income from patient care activities	557.7	566.2	571.0	571.5	572.0
Other operating income excluding STF	86.7	86.0	90.1	92.2	94.6
Sustainability & Transformation Funding (STF)	13.3	13.3	13.3	13.3	13.3
<b>Total income</b>	<b>657.7</b>	<b>665.6</b>	<b>674.5</b>	<b>677.1</b>	<b>679.9</b>
Operating expenses - pay	(378.6)	(384.8)	(385.1)	(386.6)	(387.8)
Operating expenses - non-pay	(256.9)	(256.7)	(266.0)	(267.2)	(266.9)
<b>Net operating surplus / (deficit)</b>	<b>22.2</b>	<b>24.1</b>	<b>23.4</b>	<b>23.3</b>	<b>25.2</b>
Net financing costs	(12.1)	(12.6)	(13.1)	(13.3)	(13.5)
<b>Net surplus / (deficit) for year</b>	<b>10.1</b>	<b>11.5</b>	<b>10.3</b>	<b>10.0</b>	<b>11.7</b>
Remove capital donations/grants I&E impact/Impairments/reversals	2.9	1.5	2.7	3.1	1.3
<b>Net surplus / (deficit) for period excluding technicals</b>	<b>13.0</b>	<b>13.0</b>	<b>13.0</b>	<b>13.0</b>	<b>13.0</b>
<b>Operating surplus/(deficit) Margin %</b>	<b>3.4%</b>	<b>3.6%</b>	<b>3.5%</b>	<b>3.4%</b>	<b>3.7%</b>
<b>Net I&amp;E Margin %</b>	<b>2.0%</b>	<b>2.0%</b>	<b>1.9%</b>	<b>1.9%</b>	<b>1.9%</b>

### 9.5.2 Savings delivery

UH Bristol has a reasonably good track of delivering recurrent savings. In 2016/17, UH Bristol delivered savings of £13.2 million against a target of £17.4 million. For 2017/18, the Trust has a low and deliverable savings requirement at 2.5% or £11.9 million due to its low relative cost base (Reference Cost Index of 96) for a large tertiary, teaching and research hospital. Savings plans of £11.3 million have been identified leaving a shortfall of £0.6 million. In recognition of the low saving requirement and UH Bristol's track record, the Trust expects full delivery of the savings target in 2017/18.

### 9.5.3 Statement of Financial Position (Balance Sheet), cashflow and liquidity

UH Bristol has a strong balance sheet with net current assets of £35.3 million as at 31<sup>st</sup> March 2018. The position contrasts significantly with WAHT's balance sheet and is the result of net income and expenditure surpluses achieved over the previous fourteen years. UH Bristol also has long term loan finance of £76.2 million as at 31<sup>st</sup> March 2018 which supported the Trust's capital investment plans over the past decade.

Going forward, the Trust maintains good liquidity with cash balances in excess of £40 million over the period to 2021/22 after planned capital investment of £200 million. The Trust has secured additional loan funding of £19 million in principle with the Independent Trust Financing Facility (ITFF) for the Trust's Multi-Storey Car Park scheme. The Trust's liquidity rating is 1 until 2018/19 and 2 from 2019/20 onwards due to capital expenditure.

UH Bristol's strong historic financial track record and sound financial planning presents the required financial foundations that are necessary to secure the stability and long term financial sustainability of any integration with WAHT.



A summary of UH Bristol's Statement of Financial Position and Statement of Cashflow is provided in table 22 below:

**Table 22: UH Bristol's statement of financial position and statement of cashflow**

<b>Statement of Financial Position (SoFP) £'million</b>	<b>2017/18</b>	<b>2018/19</b>	<b>2019/20</b>	<b>2020/21</b>	<b>2021/22</b>
Non current assets	413.5	448.0	484.8	494.3	510.4
Current assets excluding cash	38.6	38.6	38.0	38.0	38.0
Cash and cash equivalents	66.8	51.4	47.9	46.0	40.5
Current liabilities	(70.0)	(69.3)	(76.7)	(75.5)	(75.5)
<b>Net current assets/(liabilities)</b>	<b>35.3</b>	<b>20.6</b>	<b>9.3</b>	<b>8.6</b>	<b>3.0</b>
Non current liabilities - DH Loan	(70.4)	(77.3)	(82.1)	(81.3)	(80.6)
<b>Sub total (liabilities)</b>	<b>(35.1)</b>	<b>(56.8)</b>	<b>(72.8)</b>	<b>(72.8)</b>	<b>(77.6)</b>
Non current liabilities - Provisions / Other	(4.4)	(4.1)	(3.7)	(3.3)	(2.9)
<b>Total net assets employed</b>	<b>374.0</b>	<b>387.1</b>	<b>408.2</b>	<b>418.2</b>	<b>429.9</b>
<b>Statement of Cashflow (SoCF) £'million</b>	<b>2017/18</b>	<b>2018/19</b>	<b>2019/20</b>	<b>2020/21</b>	<b>2021/22</b>
<b>Opening cash b/fwd</b>	65.4	66.8	51.4	47.9	46.0
Net cash generated from / (used in) operations	51.7	49.2	49.2	48.5	48.8
Capital cash (outflow)/inflow	(35.8)	(60.2)	(40.4)	(30.0)	(33.9)
Net PDC (outflow)/inflow	(5.4)	(8.4)	(8.7)	(10.8)	(11.2)
Loans received	0.0	12.8	6.2	0.0	0.0
Loans repaid	(5.8)	(5.8)	(6.6)	(6.6)	(6.6)
Net Interest paid/received	(2.9)	(2.6)	(2.8)	(2.5)	(2.3)
Capital element of finance lease	(0.3)	(0.3)	(0.4)	(0.4)	(0.4)
Sub-total net cash (outflow)/inflow	1.3	(15.4)	(3.5)	(1.9)	(5.6)
<b>Closing cash c/fwd</b>	<b>66.8</b>	<b>51.4</b>	<b>47.9</b>	<b>46.0</b>	<b>40.5</b>

## 9.6 Impact of WAHT upon Combined Organisation

This section describes the potential dilutive effect of WAHT in a combined organisation. This simple consolidation of section 9.4 and 9.5 provides the baseline financial position.

### 9.6.1 Income and expenditure

The consolidated position is shown notionally from 2017/18 with a likely net forecast deficit of £2.2 million (UH Bristol £13 million surplus and WAHT £15.2 million deficit). This position is £9.2 million adrift of the combined control total net surplus of £7.0 million (i.e. UH Bristol's control total net surplus of £13.0 million plus WAHT's control total net deficit of £6.0 million).

The consolidated position combining UH Bristol and WAHT's 2018/19 planned net income and expenditure position's results in a combined entity with a planned net deficit of £0.4 million. This position is £18.4 million adrift of the combined (proposed but not agreed) individual Trust control total net surplus of £18.0 million (£24.0m net surplus for UH Bristol and a £6.0 million net deficit for WAHT).

The combined net deficit position is entirely due to WAHT's underlying net deficit of £13.4m which exceeds UH Bristol's planned net surplus of £13.0 million. For a combined entity with turnover of £768.5m, a planned surplus of c2% of turnover or c£15.0 million is required to ensure a reasonable level of working capital is available to meet the ongoing revenue costs of staff and suppliers, capital investment requirements and provide a degree of financial resilience going forward.

The dilutive effect of WAHT in a combined organisation is significant and does not meet the requirements of UH Bristol's Financial Strategy going forward and in particular would necessitate the cancellation of the UH Bristol's Phase 5 capital programme over the period.

A summary of the impact of an organisational merger with WAHT upon UH Bristol's financial performance is provided below in table 23:

**Table 23: impact of WAHT in a combined organisation**

<b>Statement of Comprehensive Income (SoCI) £'million</b>	<b>2017/18</b>	<b>2018/19</b>	<b>2019/20</b>	<b>2020/21</b>	<b>2021/22</b>
Operating income from patient care activities	647.0	659.4	664.2	664.7	665.2
Operating income from patient care activities - subsidy	3.3	0.0	0.0	0.0	0.0
Other operating income excluding STF	94.6	92.7	96.8	98.9	101.2
Sustainability & Transformation Funding (STF)	13.8	16.4	16.4	16.4	16.4
<b>Total income</b>	<b>758.6</b>	<b>768.5</b>	<b>777.4</b>	<b>780.0</b>	<b>782.8</b>
Operating expenses - pay	(455.6)	(461.2)	(461.5)	(463.0)	(464.2)
Operating expenses - non-pay	(294.3)	(295.0)	(304.2)	(305.4)	(305.2)
<b>Net operating surplus / (deficit)</b>	<b>8.7</b>	<b>12.3</b>	<b>11.6</b>	<b>11.5</b>	<b>13.5</b>
Net financing costs	(14.0)	(14.4)	(14.9)	(15.1)	(15.3)
<b>Net surplus / (deficit)</b>	<b>(5.2)</b>	<b>(2.1)</b>	<b>(3.2)</b>	<b>(3.6)</b>	<b>(1.8)</b>
Remove capital donations/grants I&E impact/Impairments/reversals	3.0	1.7	2.9	3.2	1.4
<b>Net surplus / (deficit) excluding technical</b>	<b>(2.2)</b>	<b>(0.4)</b>	<b>(0.4)</b>	<b>(0.4)</b>	<b>(0.4)</b>
<b>Operating surplus/(deficit) Margin %</b>	<b>1.2%</b>	<b>1.6%</b>	<b>1.5%</b>	<b>1.5%</b>	<b>1.7%</b>
<b>Net I&amp;E Margin %</b>	<b>-0.3%</b>	<b>-0.1%</b>	<b>-0.1%</b>	<b>0.0%</b>	<b>0.0%</b>

### 9.6.2 Savings delivery

The combined savings requirement in 2018/19 is £16.4 million or 2.5% with 2.0% anticipated for National Tariff efficiency which all NHS Trusts are subject to plus 0.5% for cost pressures. The key concern is WAHT's historically very low level of recurrent savings delivery at £0.5 million in 2016/17 and £0.8 million in 2015/16. UH Bristol cannot support this low level of recurrent delivery and a full understanding of the reasons behind such a poor savings delivery record will require to be explored in the FBC process.

### 9.6.3 Statement of Financial Position (Balance Sheet), cashflow and liquidity

The combined Balance Sheet presents a weak position with total liabilities of £67.5 million as at 31<sup>st</sup> March 2018 falling to £178.6 million by 31<sup>st</sup> March 2022. Again, the combined position is entirely due the impact of WAHT's very weak and deteriorating balance sheet. The dilutive effect of WAHT in a combined organisation is significant and results in a combined entity with very limited liquidity going forward to meet its ongoing revenue commitments without external cash support. External cash support using loan finance would be required at £178.6 million.

This position is not financially sustainable and would require one-off reductions in capital investment in the short term and thus significantly impact on UH Bristol's Phase 5 capital investment plans. This measure, however, would be short lived and would not address the underlying drivers of the very weak balance sheet. The combined entity would not be financially sustainable and is highlighted by the combined entity's liquidity metric of 4, the lowest rating, over the period.

UH Bristol's strong historic financial track record and sound financial planning presents the required financial foundations and stability that are necessary in order to secure stability and long term financial sustainability of WAHT but this must be maintained post-merger to avoid key clinical services not being compromised going forward.

A summary of the potential impact of WAHT in a combined organisation is provided in table 24 below:

**Table 24: the potential impact of WAHT in a combined organisation**

<b>Statement of Financial Position (SoFP) £'million</b>	<b>2017/18</b>	<b>2018/19</b>	<b>2019/20</b>	<b>2020/21</b>	<b>2021/22</b>
Non current assets	484.3	523.8	565.4	579.8	595.6
Current assets excluding cash	43.5	43.1	42.6	42.6	42.6
Cash and cash equivalents	68.3	52.9	49.5	47.7	42.1
Current liabilities	(81.4)	(80.6)	(87.9)	(86.7)	(86.7)
<b>Net current assets/(liabilities)</b>	<b>30.4</b>	<b>15.4</b>	<b>4.2</b>	<b>3.5</b>	<b>(2.0)</b>
Non current liabilities - DH Loan	(88.4)	(113.1)	(122.9)	(127.1)	(126.3)
Non current liabilities - new DH loan to fund future year deficit	(9.6)	(10.1)	(23.5)	(36.9)	(50.3)
<b>Sub total - (liabilities)</b>	<b>(67.5)</b>	<b>(107.8)</b>	<b>(142.1)</b>	<b>(160.5)</b>	<b>(178.6)</b>
Non current liabilities - Provisions / Other	(4.8)	(4.4)	(4.1)	(3.7)	(3.3)
<b>Total net assets employed</b>	<b>412.0</b>	<b>411.5</b>	<b>419.2</b>	<b>415.6</b>	<b>413.7</b>
<b>Statement of Cashflow (SoCF) £'million</b>	<b>2017/18</b>	<b>2018/19</b>	<b>2019/20</b>	<b>2020/21</b>	<b>2021/22</b>
<b>Opening cash b/fwd</b>	67.0	68.3	52.9	49.5	47.7
Net cash generated from / (used in) operations	41.8	41.5	41.1	40.3	40.7
Capital cash (outflow)/inflow	(40.3)	(69.1)	(48.9)	(38.5)	(37.4)
Other	0.0	0.0	0.0	0.0	0.0
Net PDC (outflow)/inflow	(6.4)	(9.6)	(9.9)	(12.0)	(12.4)
Loans received from DH - Existing	6.0	38.3	11.2	5.0	0.0
Loans received from DH - New to fund future year deficit	9.6	0.5	13.4	13.4	13.4
Loans repaid	(5.8)	(13.5)	(6.6)	(6.6)	(6.6)
Net Interest paid/received	(3.2)	(3.2)	(3.4)	(3.1)	(2.9)
Capital element of finance lease	(0.3)	(0.3)	(0.4)	(0.4)	(0.4)
Sub-total net cash (outflow)/inflow	1.3	(15.4)	(3.4)	(1.8)	(5.6)
<b>Closing cash c/fwd</b>	<b>68.3</b>	<b>52.9</b>	<b>49.5</b>	<b>47.7</b>	<b>42.1</b>

## 9.7 The financial mitigations and costs of the combined organisation

### 9.7.1 Financial mitigations - Summary

UH Bristol has undertaken a high level assessment of the financial mitigations available to a combined entity using 1<sup>st</sup> April 2018 as indicative year one scenario. It should be noted that the assessment has been informed by an interim financial Due Diligence (DD) and is predicated on an “as is” basis for services currently provided by WAHT. Any financial mitigations or costs arising from any potential redesign or reconfiguration of clinical services are not provided in this financial assessment but would feature in the Full Business Case (FBC) should the transaction proceed beyond the SOC stage.

Potential financial mitigations of £5.0 million with £2.0 million deliverable in 2018/19 (indicative year one of the acquisition) and £3.0 million in 2019/20 (indicative year two) have been identified. This is deemed to be a realistic assessment. However, a comprehensive productivity review and full financial DD may highlight further opportunity for financial savings in due course or it could demonstrate that these savings are not deliverable for a variety of reasons.

### 9.7.2 Financial mitigations – Savings from medical staffing expenditure

An assessment of medical staffing expenditure has revealed significant medical agency expenditure of £6.5 million in 2016/17 primarily due to excessive medical staffing vacancies. UH Bristol estimates it can help to address the issue of medical staffing recruitment under

the UH Bristol branding and potentially reduce agency expenditure by £0.5 million in year one of a merged organisation and a further £1.5 million in year two.

This assessment assumes that the level of medical staffing vacancies reported by WAHT during the interim financial DD is appropriate - no assessment has been made in relation to clinical activity volumes, rota requirements or job plans.

### **9.7.3 Financial mitigations – Savings from nursing agency savings**

Reported nursing agency expenditure was £4.5 million in 2016/17 primarily due to very high levels of registered nursing vacancies. UH Bristol estimates it would have a negligible impact on nursing recruitment under the UH Bristol branding as the issue of nursing recruitment is not isolated to WAHT and is faced by all NHS Trusts. However, the interim financial DD has identified opportunities for reducing agency expenditure through improved rostering and financial controls. UH Bristol has assessed the financial opportunity as £0.5 million in year one and a further £0.5 million in year two. Again, this assessment assumes that the level of nursing vacancies reported by WAHT and reviewed during the interim financial DD is accurate.

### **9.7.4 Financial mitigations – Savings from corporate overheads**

UH Bristol has undertaken an assessment of the possible savings primarily arising from efficiencies in corporate overheads across both Trusts. Savings of £2.0 million have been notionally identified. This would need to be tested in the FBC.

### **9.7.5 Financial costs – Nursing staffing levels**

The interim financial DD and non-financial DD has identified a potential requirement for further investment in registered nursing staffing levels at WAHT to bring the position into line with UH Bristol ratios. The investment would be required recurrently from year one at a cost of £1.0 million per year.

This investment is required to ensure consistency of nursing staffing across both sites and assumes that the current volume of beds and the reported acuity at WAHT is appropriate. The quality issues described in the Care Quality Commission's (CQC) latest inspection report, higher than expected level of mortality and key concerns relating to hospital acquired pressure ulcer etc. identified in the non-financial DD would be addressed through this investment. Further costs may be identified as part of a full financial DD and included in the FBC.

### **9.7.6 Financial costs – Impact of joined spells**

This issue relates to inpatient transfers between UH Bristol and WAHT. Currently, inpatients that are transferred between both sites for care are recorded as separate "spells" of activity with each Trust recording a date of admission and a date of discharge. This results in two inpatient "spells", one at each site. Post-merger, such transfers would take place within one Trust only meaning a single inpatient or joined "spell" would be recorded. The impact of lost income due to joined spells has been assessed at £0.3 million per year based on a detailed analysis of both Trusts' patient datasets.

### 9.7.7 Financial mitigations and costs – summary

The potential financial mitigations are summarised in table 25 below. These financial mitigations are partly offset by the potential requirement to invest in nursing levels at £1.0 million and the impact of joined spells at £0.3 million. The total net financial mitigation identified is therefore £0.7 million in year one and £3.7 million in year two. Further scope for mitigations may become available following a comprehensive productivity appraisal and a full financial DD and non-financial DD.

**Table 25: Net financial mitigations and costs of the merger**

<b>Financial mitigations £'million</b>	<b>2018/19</b>	<b>2019/20</b>
<b>Financial Costs</b>		
Joined spells estimated loss of income	(0.3)	(0.3)
Nursing staffing levels levelling up	(1.0)	(1.0)
<b>Sub total - financial costs</b>	<b>(1.3)</b>	<b>(1.3)</b>
<b>Financial mitigations identified</b>		
Corporate overhead savings	1.0	2.0
Savings from medical staff premium costs	0.5	2.0
Nursing agency savings	0.5	1.0
<b>Sub total - financial mitigations</b>	<b>2.0</b>	<b>5.0</b>
<b>Total - net financial mitigations</b>	<b>0.7</b>	<b>3.7</b>

## 9.8 The Resources Plan

### 9.8.1 Project Costs

An initial assessment of the non-recurrent project costs directly associated with delivering a successful organisational merger acquisition is estimated at £3.0 million. The sum includes estimates relating to project management, governance and delivery. Specific pre- and post-merger transaction costs relating to the external professional legal and financial fees relating to a full financial DD and non-financial DD diligence exercise are also included.

Provision has also been made for clinical lead roles, operational management roles and supporting Finance and Human Resources roles. Pre-merger costs are estimated at £2.0 million and post-merger costs are estimated at £1.0 million. A summary of the estimated project costs are provided in the summary below.

These are estimates only and further intelligence from other mergers is being sought. The total estimate of £3.0 million is, however, in the order of costs quoted from other transactions and the evidence demonstrates that successful mergers require dedicated input to ensure that clinical and non-clinical benefits are delivered and staff are supported and engaged during the transition period.

### 9.8.2 Transitional Workforce Costs

Non-recurrent costs are estimated at £2.0 million with £1.0 million assumed in year one and £1.0 million assumed in year two. Transitional workforce costs primarily relate to the delivery of corporate overhead savings. A further detailed assessment could be provided at a full financial DD and non-financial DD stage and detailed in an FBC. Every effort will be made to avoid redundancy costs by redeployment and natural wastage.

### 9.8.3 Summary

The Resources Plan totals £5.0 million shown below in table 26. Estimated expenditure of £2.0 million per year is assumed in the year of acquisition and year one, with £1.0 million assumed in year two.

**Table 26: Summary of the non-recurrent costs**

Project costs £'million	2017/18	2018/19	2019/20
Project costs – pre merger	(2.0)	0.0	0.0
Project costs – post merger	0.0	(1.0)	0.0
Transitional workforce costs	0.0	(1.0)	(1.0)
<b>Total</b>	<b>(2.0)</b>	<b>(2.0)</b>	<b>(1.0)</b>

## 9.9 Combined organisation position post-merger including financial mitigations and the Resources Plan

This section describes the consolidated position including the potential net financial mitigations of £3.7 million described in section 9.7 and the Resources Plan costs of £5.0 million described in section 9.8. The combined position represents the position without external financial support.

### 9.9.1 Income and expenditure

The consolidated position is shown from 2017/18 to illustrate the financial impact of the transaction in notional terms pre-merger. The 2017/18 forecast net deficit increases by £2.0 million to £4.2 million compared with the “do nothing” position. The deterioration is due to unfunded pre-merger project costs of £2.0 million. The combined net control total surplus of £7.0 million would be missed by £11.2 million.

The indicative year 1 planned net income and expenditure position deteriorates by £1.3 million to a net deficit of £1.7 million. The deterioration is due to unfunded post-merger project costs and transitional workforce costs of £1.0 million each offset by net financial mitigations of £0.7 million.

The Year 2 planned net deficit improves by £2.7 million to a net surplus of £2.3 million compared with the “do nothing” position. This is due to the full impact of the net financial mitigations of £3.7 million offset by £1.0 million for transitional workforce costs.

From Year 3, the planned net deficit improves by the full net financial mitigations of £3.7 million to a net surplus of £3.3 million. Nil project costs are anticipated in 2020/21. The position is summarised in the table 27 below:



**Table 27: Combined net (deficit) / surplus – no financial support**

Combined net (deficit) / surplus £'million	2017/18	2018/19	2019/20	2020/21
<b>Net (deficit) – do nothing</b>	<b>(2.2)</b>	<b>(0.4)</b>	<b>(0.4)</b>	<b>(0.4)</b>
Unfunded pre-merger project costs	(2.0)	0.0	0.0	0.0
Unfunded post-merger costs	0.0	(1.0)	0.0	0.0
Unfunded post-merger transitional workforce costs	0.0	(1.0)	(1.0)	0.0
Net financial mitigations	0.0	0.7	3.7	3.7
Subtotal – net (cost) / benefit	(2.0)	(1.3)	2.7	3.7
<b>Net (deficit) / surplus do nothing</b>	<b>(4.2)</b>	<b>(1.7)</b>	<b>2.3</b>	<b>3.3</b>
UH Bristol control total	13.0	24.0	TBC	TBC
WAHT control total	(6.0)	(6.0)	TBC	TBC
<b>Combined control total</b>	<b>7.0</b>	<b>18.0</b>	<b>TBC</b>	<b>TBC</b>
<b>Adverse position against combined control total</b>	<b>(11.2)</b>	<b>(19.7)</b>	<b>TBC</b>	<b>TBC</b>

The effect of consolidating the WAHT position including the phased £5.0 million Resources Plan and the net financial mitigations of £3.7 million result in a marginally improved net income and expenditure performance with a planned net surplus of £2.3m in year 2 and £3.3 million from year 3.

For a combined entity with turnover of £768.2m in year 1, a planned surplus of c2% of turnover or c£15.0 million is required to ensure a reasonable level of working capital is available to meet the ongoing revenue costs of staff and suppliers, capital investment requirements and provide a degree of financial resilience going forward.

The position without financial support significantly impacts on the combined organisation and does not meet the requirements of UH Bristol's Financial Strategy going forward and in particular would necessitate the cancellation of the UH Bristol's Phase 5 capital programme over the period. This is summarised in table 28 below:

**Table 28: Statement of Comprehensive Income (SoCI)**

Statement of Comprehensive Income (SoCI) £'million	2017/18	2018/19	2019/20	2020/21	2021/22
Operating income from patient care activities	646.9	659.1	663.9	664.4	664.9
Operating income from patient care activities - subsidy	3.3	0.0	0.0	0.0	0.0
Other operating income excluding STF	94.6	92.7	96.8	98.9	101.2
Sustainability & Transformation Funding (STF)	13.8	16.4	16.4	16.4	16.4
<b>Total income</b>	<b>758.6</b>	<b>768.2</b>	<b>777.1</b>	<b>779.7</b>	<b>782.5</b>
Operating expenses - pay	(455.7)	(460.8)	(458.5)	(460.0)	(461.2)
Operating expenses - non-pay	(296.2)	(296.4)	(304.2)	(304.4)	(304.2)
<b>Net operating surplus / (deficit)</b>	<b>6.7</b>	<b>11.0</b>	<b>14.3</b>	<b>15.2</b>	<b>17.2</b>
Net financing costs	(14.0)	(14.4)	(14.9)	(15.1)	(15.3)
<b>Net surplus / (deficit) for year</b>	<b>(7.2)</b>	<b>(3.4)</b>	<b>(0.5)</b>	<b>0.1</b>	<b>1.9</b>
Remove capital donations/grants I&E impact/Impairments/reversals	3.0	1.7	2.9	3.2	1.5
<b>Net surplus / (deficit) for period excluding technical</b>	<b>(4.2)</b>	<b>(1.7)</b>	<b>2.3</b>	<b>3.3</b>	<b>3.3</b>
<b>Operating surplus/(deficit) Margin %</b>	<b>0.9%</b>	<b>1.4%</b>	<b>1.8%</b>	<b>2.0%</b>	<b>2.2%</b>
<b>Net I&amp;E Margin %</b>	<b>-0.6%</b>	<b>-0.2%</b>	<b>0.3%</b>	<b>0.4%</b>	<b>0.4%</b>

### 9.9.2 Savings delivery

The combined savings requirement in Year 1 is £16.4 million or 2.5%, 0.5% for cost pressures in addition to the assumed efficiency requirement within National Tariff. The key concern is WAHT's historically very low level of recurrent savings delivery at £0.5 million in 2016/17 and £0.8 million in 2015/16.



### 9.9.3 Statement of Financial Position (Balance Sheet), cashflow and liquidity

The combined balance sheet continues to present a weak position with total liabilities of £69.4 million as at 31<sup>st</sup> March 2018 increasing to £171.7 million by 31<sup>st</sup> March 2022 (indicative year 4). Again, the combined position is primarily due the impact of WAHT's very weak and deteriorating balance sheet. The dilutive effect of WAHT in a combined organisation is significant and results in a combined entity with very limited liquidity going forward to meet its ongoing revenue commitments without external cash support.

The position is not financially sustainable and would require one-off reductions in capital investment in the short term and thus significantly impact on UH Bristol's Phase 5 capital investment plans. This measure, however, would be short lived and would not address the underlying drivers of the very weak balance sheet. The combined entity would not be financially sustainable.

A summary of the impact of WAHT in a combined organisation including financial mitigations is provided below in table 29:

**Table 29: Combined organisation financial position post-merger including financial mitigations**

<b>Statement of Financial Position (SoFP) £'million</b>	<b>2017/18</b>	<b>2018/19</b>	<b>2019/20</b>	<b>2020/21</b>	<b>2021/22</b>
Non current assets	484.3	523.8	565.4	579.8	595.6
Current assets excluding cash	43.5	43.1	42.6	42.6	42.6
Cash and cash equivalents	66.5	49.8	49.1	50.9	49.1
Current liabilities	(81.4)	(80.6)	(87.9)	(86.7)	(86.7)
<b>Net current assets/(liabilities)</b>	<b>28.6</b>	<b>12.3</b>	<b>3.8</b>	<b>6.8</b>	<b>5.0</b>
Non current liabilities - existing DH Loan	(88.4)	(113.1)	(122.9)	(127.1)	(126.3)
Non current liabilities - new DH Loan to fund future deficit	(9.6)	(10.1)	(23.5)	(36.9)	(50.3)
<b>Sub total (liabilities) - existing &amp; new</b>	<b>(69.4)</b>	<b>(110.9)</b>	<b>(142.6)</b>	<b>(157.2)</b>	<b>(171.7)</b>
Non current liabilities - Provisions / other	(4.8)	(4.4)	(4.1)	(3.7)	(3.3)
<b>Total net assets employed</b>	<b>410.2</b>	<b>408.4</b>	<b>418.7</b>	<b>418.8</b>	<b>420.7</b>
<b>Statement of Cashflow (SoCF) £'million</b>	<b>2017/18</b>	<b>2018/19</b>	<b>2019/20</b>	<b>2020/21</b>	<b>2021/22</b>
<b>Opening cash b/fwd</b>	67.0	66.5	49.8	49.1	50.9
Net cash generated from / (used in) operations	39.9	40.2	43.8	44.0	44.4
Capital cash (outflow)/inflow	(40.3)	(69.1)	(48.9)	(38.5)	(37.4)
Other	0.0	0.0	0.0	0.0	0.0
Net PDC (outflow)/inflow	(6.4)	(9.6)	(9.9)	(12.0)	(12.4)
Loans received	6.0	38.3	11.2	5.0	0.0
Loans received from DH - New to fund future year deficit	9.6	0.5	13.4	13.4	13.4
Loans repaid	(5.8)	(13.5)	(6.6)	(6.6)	(6.6)
Net Interest paid/received	(3.2)	(3.2)	(3.4)	(3.1)	(2.9)
Capital element of finance lease	(0.3)	(0.3)	(0.4)	(0.4)	(0.4)
Sub-total net cash (outflow)/inflow	(0.6)	(16.7)	(0.7)	1.9	(1.9)
<b>Closing cash c/fwd</b>	<b>66.5</b>	<b>49.8</b>	<b>49.1</b>	<b>50.9</b>	<b>49.1</b>

### 9.10 The financial support required for a viable acquisition

This section describes the level of financial support currently assessed as required for a viable merger. In addition to the requirement to renegotiate the Year 1 Control Total for a combined entity, the level of financial support required is to mitigate the dilutive impact of WAHT in a combined organisation as described in section 12.6. The financial support considers a number of elements: the underlying structural deficit at WAHT; the very weak balance sheet; and the costs identified in the Resources Plan.

The requirement for this support is predicated on analysis and assessment of an “as is” service model at WAHT, and is necessary in this context, to ensure the merged organisation has the ability to be financially viable and deliver the assessed benefits.

The comprehensive appraisal to be completed on a future acute service model within the Healthy Weston programme will update this assessment and include a comprehensive productivity review. This will be used in the FBC financial analysis which will further assess the impact and potential mitigation of the need for such support.

### 9.10.1 Recurrent income support

Following the interim financial DD, UH Bristol has assessed WAHT’s underlying or recurring net financial deficit at £13.4 million in 2017/18. For year 1 (of a combined organisation), the position reduces to a recurrent deficit of £12.7 million including the net financial mitigations of £0.7 million. From year 2, the full impact of the net financial mitigations are realised at £3.7 million hence the recurrent deficit reduces by a further £3.0 million to £9.7 million.

The residual position of £9.7 million represents UH Bristol’s assessment of the structural net deficit at WAHT due to the small scale of full District General Hospital (DGH) suite of services including a type 1 Emergency Department twenty-five miles from Bristol and Taunton. All indications are that whilst the WAHT deficit can be mitigated by £3.7 million, the structural net deficit cannot be resolved as this level of infrastructure cannot be provided “as is”, within National Tariff on an ongoing basis.

The interim financial DD identified that WAHT currently receives a recurrent support of £3.3 million:

£million

- 1.3 For Emergency Department excess costs;
- 1.1 For a “Medically Fit For Discharge” (MFFD) ward;
- 0.7 For critical care; and
- 0.2 For haematology and oncology services.
- 3.3 Total – existing recurrent income support

Assuming the existing support of £3.3 million is confirmed and therefore remains in place; this can be offset against WAHT’s structural deficit of £9.7 million leaving a residual structural deficit of £6.4 million. This residual structural deficit would need to be met with new recurrent support of £6.4 million from year 1. This assessment will be reassessed in the analysis associated with the development of a new service model resulting from the Healthy Weston process.

### 9.10.2 Non-recurrent transitional income support

UH Bristol has assessed WAHT’s underlying or recurring net financial deficit at £13.4 million in 2017/18. For Year 1, the position reduces to a recurrent deficit of £12.7 million. Section 9.10.1 describes the requirement for a new recurrent subsidy of £6.4 million in addition to the current support of £3.3 million from Year 1, a total of £9.7 million. This position leaves a gap of £3.0 million in Year 2 hence a requirement for transitional, non-recurrent support of £3.0 million in order to bridge the gap.

### **9.10.3 Cash (Public Dividend Capital) injection – Balance Sheet**

UH Bristol has reviewed WAHT's audited balance sheet as at 31<sup>st</sup> March 2017. The audited position reports net current liabilities of £12.9 million and a long term loan with the DoH of £4.2 million, a total liabilities position of £17.1 million. WAHT's approved 2017/18 Operational Plan net deficit of £6.2 million including technical items as submitted to NHS Improvement would increase the total liabilities position to £23.2 million as at 31<sup>st</sup> March 2018.

UH Bristol's assessment of WAHT's 2017/18 net deficit is £15.2 million excluding technical items, an increased deficit of £9.2 million. The increased deficit of £9.2 million would therefore increase the total liabilities position from £23.2 million to £32.4 million as at 31<sup>st</sup> March 2018.

WAHT's very weak balance sheet containing total liabilities of £32.4 million is the result of cumulative deficits incurred without revenue income support since 2013/14. Liabilities on this scale would eliminate UH Bristol's balance sheet strength accumulated from UH Bristol's excellent financial track record over the previous fourteen years. Therefore, a viable merger proposition would require a non-recurrent PDC cash injection of £32.4 million that effectively writes-off WAHT's historic debt.

### **9.10.4 Cash (Public Dividend Capital) injection – Capital investment**

WAHT's 2017/18 Operational Plan submitted to NHS Improvement included the requirement for PDC of £15.0 million over three years until 2019/20 for capital investment in Information Technology hardware and software including the replacement of WAHT's Electronic Patient Record (EPR). UH Bristol's assessment requires PDC cash for capital investment of £7.0 million in Year 1 to secure the replacement of WAHT's EPR and to replace and integrate WAHT's wider Information Technology provision with UH Bristol's. This investment is considerably lower than that required for WAHT under the do nothing scenario as a standalone organisation.

### **9.10.5 Summary position**

The financial support necessary for a viable merger based on an "as is" service model is shown below in table 30:

**Table 30: Financial support required for a viable merger:**

<b>Non-recurrent support funding:</b>	<b>£'m</b>	<b>Comment</b>
Cash (PDC) injection	28.2	Write-off of WAHT's historic debt
Cash (PDC) injection	4.2	Repayment of existing long term loan with DoH
Subtotal - Cash (PDC) injection	32.4	
Cash (PDC) for capital investment in IT	7.0	Cash funding required for IT integration
<b>Total - PDC Funding</b>	<b>39.4</b>	
Revenue funding i.e. income to pay for:		
Resources Plan - project costs	3.0	Next stage costs of acquisition e.g. professional fees
Resources Plan - redundancies / restructuring costs	2.0	Initial estimate - subject to confirmation at FBC stage
Transitional support	3.0	Over and above recurrent income (existing support) in year 1 of acquisition
<b>Total - non-recurrent income support</b>	<b>8.0</b>	
Recurrent support funding:		
Recurrent income - existing support	3.3	Required to cover structural net deficit at WAHT
Recurrent income - new support	6.4	
<b>Total - recurring income support</b>	<b>9.7</b>	

It should be noted it is assumed that the full receipt of S&T funding of £16.4 million is made available throughout the period from Year 1 to Year 3. The comprehensive appraisal to be completed on a future acute service model within the Healthy Weston programme will update this assessment for support and will include a comprehensive productivity review. This will be used in the FBC financial analysis which will further assess the impact and potential mitigation of the need for such support.

### 9.11 Combined organisation position post-merger including financial support

This section describes the consolidated position including the net financial mitigations of £3.7 million described in section 9.7, the Resources Plan costs of £5.0 million described in section 9.8 and the financial support required for a viable transaction detailed in section 9.10.

### 9.12 Income and expenditure

The consolidated position is shown from 2017/18 to illustrate in the financial impact of the transaction in notional terms pre-merger. The notional 2017/18 forecast net deficit of £2.2 million returns to the “do nothing” position as a result of additional non recurring funding in support of project costs of £2.0 million in 2017/18. The combined net control total surplus of £7.0 million would be missed by £9.2 million and would require a re-negotiated control total for the combined entity to ensure the full receipt of S&T funding in 2017/18.

The Year 1 planned net income and expenditure is restored to the combined organisation planned surplus of £13.0 million. This position includes a permanent subsidy of £9.7 million, a further £2.0 million for non-recurrent project costs and £3.0m non-recurrent transitional support funding. S&T funding of £16.4 million is also assumed on the basis that a revised 2018/19 control total can be agreed at £13.0 million. The position is summarised in table 31 below:

**Table 31: Combined net surplus / (deficit) including financial support**

Combined net (deficit) / surplus - including financial support £'million	2017/18	2018/19	2019/20	2020/21
<b>Net (deficit) - do nothing</b>	<b>(2.2)</b>	<b>(0.4)</b>	<b>(0.4)</b>	<b>(0.4)</b>
Unfunded pre-acquisition project costs	(2.0)	0.0	0.0	0.0
Unfunded post-acquisition project costs	0.0	(1.0)	0.0	0.0
Unfunded post-acquisition redundancy costs	0.0	(1.0)	(1.0)	0.0
Net financial mitigations	0.0	0.7	3.7	3.7
<b>Subtotal - net (cost) / benefit</b>	<b>(2.0)</b>	<b>(1.3)</b>	<b>2.7</b>	<b>3.7</b>
Funding for pre-acquisition project costs	2.0	0.0	0.0	0.0
Funding for post-acquisition project costs	0.0	1.0	0.0	0.0
Funding for post-acquisition redundancy costs	0.0	1.0	1.0	0.0
Transitional funding	0.0	3.0	0.0	0.0
Recurrent subsidy	0.0	9.7	9.7	9.7
<b>Subtotal - net funding</b>	<b>2.0</b>	<b>14.7</b>	<b>10.7</b>	<b>9.7</b>
<b>Net (deficit)/surplus - UH Bristol undiluted</b>	<b>(2.2)</b>	<b>13.0</b>	<b>13.0</b>	<b>13.0</b>
UH Bristol control total	13.0	24.0	TBC	TBC
WAHT control total	(6.0)	(6.0)	TBC	TBC
<b>Combined control total</b>	<b>7.0</b>	<b>18.0</b>	<b>TBC</b>	<b>TBC</b>
<b>Adverse position against combined control total</b>	<b>(9.2)</b>	<b>(5.0)</b>	<b>TBC</b>	<b>TBC</b>

The combined organisation position post-merger including the financial support is summarised in table 32 below:

**Table 32: Combined organisation position with financial support**

Statement of Comprehensive Income (SoCI) £'million	2017/18	2018/19	2019/20	2020/21	2021/22
Operating income from patient care activities	647.0	659.1	663.9	664.4	664.9
Operating income from patient care activities - subsidy	3.3	9.7	9.7	9.7	9.7
Other operating income - project costs	2.0	2.0	1.0	0.0	0.0
Other operating income - transitional support	0.0	3.0	0.0	0.0	0.0
Other operating income excluding STF	94.6	92.7	96.8	98.9	101.2
Sustainability & Transformation Funding (STF)	13.8	16.4	16.4	16.4	16.4
<b>Total income</b>	<b>760.6</b>	<b>782.9</b>	<b>787.8</b>	<b>789.4</b>	<b>792.2</b>
Operating expenses - pay	(455.7)	(460.8)	(458.5)	(460.0)	(461.2)
Operating expenses - non-pay	(296.1)	(297.0)	(304.8)	(305.0)	(304.7)
<b>Net operating surplus / (deficit)</b>	<b>8.8</b>	<b>25.1</b>	<b>24.5</b>	<b>24.3</b>	<b>26.3</b>
Net financing costs	(14.0)	(13.8)	(14.3)	(14.5)	(14.7)
<b>Net surplus / (deficit) for year</b>	<b>(5.1)</b>	<b>11.3</b>	<b>10.1</b>	<b>9.8</b>	<b>11.6</b>
Remove capital donations/grants I&E impact/Impairments/reversals	3.0	1.7	2.9	3.2	1.5
<b>Net surplus / (deficit) for period excluding technical</b>	<b>(2.2)</b>	<b>13.0</b>	<b>13.0</b>	<b>13.0</b>	<b>13.0</b>

The effect of consolidating the WAHT position after the inclusion of the £5.0 million Resources Plan, the £3.0 million transitional support and the net recurrent support funding of £9.7 million, a total of £17.7 million, presents an undiluted income and expenditure position for UH Bristol post-merger.

However, it should be noted that whilst UH Bristol's planned net surplus of £13.0 million remains unaffected it is c£2.0 million short of the c£15.0 million or c2% of turnover required in line with UH Bristol's financial strategy.

### 9.13 Savings requirement

The key concern is WAHT's historically very low level of recurrent savings delivery. As mentioned previously, UH Bristol cannot support this low level of recurrent delivery and a full understanding of the reasons behind such a poor savings delivery record will need to be understood in due course following a full financial DD exercise. This scenario assumes the combined organisation will be able to deliver national efficiency savings hence the WAHT component is a risk.

### 9.14 Statement of Financial Position (Balance Sheet), cashflow and liquidity

The combined balance sheet presents a stronger position with forecast total liabilities as at 31<sup>st</sup> March 2022 (Year 4) reducing by £95.2 million from £171.7 million without financial support to £76.5 million with financial support. The combined entity is forecast to remain in a net current asset position of £4.0 million as at Year 4. The dilutive effect of WAHT in a combined organisation is mitigated with financial support and provides sufficient liquidity going to meet its ongoing revenue commitments without external cash support. The position is financially sustainable going forward.

A summary of the impact of WAHT in a combined organisation including financial support is provided below in table 33:

**Table 33: impact of WAHT in a combined organisation including financial support**

<b>Statement of Financial Position (SoFP) £'million</b>	<b>2017/18</b>	<b>2018/19</b>	<b>2019/20</b>	<b>2020/21</b>	<b>2021/22</b>
Non current assets	484.3	524.2	560.7	569.9	585.7
Current assets excluding cash	43.5	43.1	42.6	42.6	42.6
Cash and cash equivalents	58.9	58.6	55.3	53.6	48.1
Current liabilities	(81.4)	(80.6)	(87.9)	(86.7)	(86.7)
<b>Net current assets/(liabilities)</b>	<b>21.0</b>	<b>21.1</b>	<b>10.0</b>	<b>9.4</b>	<b>4.0</b>
Non current liabilities - DH Loan	(88.4)	(77.3)	(82.1)	(81.3)	(80.6)
<b>Sub-total (liabilities)</b>	<b>(67.4)</b>	<b>(56.3)</b>	<b>(72.1)</b>	<b>(71.9)</b>	<b>(76.5)</b>
Non current liabilities - Provisions / Other	(4.8)	(4.4)	(4.1)	(3.7)	(3.3)
<b>Total net assets employed</b>	<b>412.2</b>	<b>463.5</b>	<b>484.5</b>	<b>494.3</b>	<b>505.9</b>
<b>Statement of Cashflow (SoCF) £'million</b>	<b>2017/18</b>	<b>2018/19</b>	<b>2019/20</b>	<b>2020/21</b>	<b>2021/22</b>
<b>Opening cash b/fwd</b>	67.0	58.9	58.6	55.3	53.6
Net cash generated from / (used in) operations	41.9	54.4	54.0	53.3	53.6
Capital cash (outflow)/inflow	(40.3)	(70.5)	(43.9)	(33.5)	(37.4)
Net PDC (outflow)/inflow	(6.4)	29.8	(9.9)	(12.0)	(12.4)
Loans received	6.0	12.8	6.2	0.0	0.0
Loans repaid	(5.8)	(23.8)	(6.6)	(6.6)	(6.6)
Net Interest paid/received	(3.2)	(2.6)	(2.8)	(2.5)	(2.3)
Capital element of finance lease	(0.3)	(0.3)	(0.4)	(0.4)	(0.4)
Sub-total net cash (outflow)/inflow	(8.2)	(0.3)	(3.3)	(1.7)	(5.5)
<b>Closing cash c/fwd</b>	<b>58.9</b>	<b>58.6</b>	<b>55.3</b>	<b>53.6</b>	<b>48.1</b>

### 9.15 Sensitivity Analysis

As the values at the SOC stage are mainly estimates with many being subject to significant uncertainty, a sensitivity analysis has not been undertaken at this stage. This will be introduced in the FBC.

### 9.16 Conclusion

The financial appraisal describes the financial support required for a viable merger that does not unduly dilute the financial performance and financial standing of a combined organisation. It describes the level of financial support currently assessed as required for a

viable merger predicated on analysis and assessment of an “as is” service model at WAHT

The financial support presents a significant investment but the worst case scenario remains ‘do nothing’.

The comprehensive appraisal to be completed on a future acute service model within the Healthy Weston programme will update this assessment and include a comprehensive productivity review. This will be used in the FBC financial analysis which will further assess the impact and potential mitigation of the need for such support.



## Appendix 6: Equality Impact Assessment (EIA) SCREENING TOOL

Name of the Document: **Weston Partnership Strategic Outline Case (SOC)**

The main purpose of the document is to consider the strategic outline case for long term arrangements between WAHT and UH Bristol.

This paper considers options for different organisational forms including organisational merger by acquisition of WAHT by UH Bristol. This option would entail UH Bristol taking ownership of the WAHT, including transfer of staff to UH Bristol's contracts of employment.

At this stage, the proposed option does not include changes to roles and responsibilities of staff or clinical services changes. Should these be proposed in the future, separate EIA's will be completed as part of a consultation process for each individual proposal.

The standard UH Bristol EAI screening tool has been used to test the preferred option.

Both organisations are NHS employers and subject to national terms and conditions and common regulatory frameworks.

Who is it likely to have an impact on?

In global terms it will affect the following groups: Staff / Patients / Visitors / Carers

Could the document/proposal have a significant <b>negative</b> impact on equality in relation to each of these characteristics?	YES	NO	Please explain why, and what evidence supports this assessment.
<b>Age</b> (including younger and older people)		No	Simply by changing organisational ownership and transferring employment from one NHS organisation to another does not negatively impact upon these groups. For patients, visitors or carers there are no clinical pathway changes proposed in this document that would have a negative impact.
<b>Disability</b> (including physical and sensory impairments, learning disabilities, mental health)		No	
<b>Gender reassignment</b>		No	
<b>Pregnancy and maternity</b>		No	
<b>Race</b> (includes ethnicity as well as gypsy travelers)		No	
<b>Religion and belief</b> (includes non-belief)		No	
<b>Sex</b> (male and female)		No	
<b>Sexual Orientation</b> (lesbian,		No	

Could the document/proposal have a significant <b>negative</b> impact on equality in relation to each of these characteristics?	YES	NO	Please explain why, and what evidence supports this assessment.
gay, bisexual, other)			
<b>Groups at risk of stigma</b> or social exclusion (e.g. offenders, homeless people)		No	
<b>Human Rights</b> (particularly rights to privacy, dignity, liberty and non-degrading treatment)		No	

Will the document create any problems or barriers to any community or group? NO  
 Will any group be excluded because of this document? NO  
 Will the document result in discrimination against any group? NO

If the answer to any of these questions is YES, you must complete a full Equality Impact Assessment (Form B).

Could the document/proposal have a significant <b>positive</b> impact on inclusion by reducing inequalities?	YES	NO	If yes, please explain why, and what evidence supports this assessment.
Will it promote equal opportunities for people from all groups?		No	
Will it help to get rid of discrimination?		No	
Will it help to get rid of harassment?		No	
Will it promote good relations between people from all groups?		No	
Will it promote and protect human rights?		No	

On the basis of the information / evidence so far, do you believe that the document will have a positive or negative impact on equality? - NIL IMPACT.

Is a full equality impact assessment required? NO

Date assessment completed: 20<sup>th</sup> July 2017

Person completing the assessment: Rob Gittins, Programme Manager; Sarah Nadin, Associate Director of Strategic and Business Planning

Person responsible for the document: Paula Clarke, Executive Director of Strategy and Transformation

## Appendix 7: 2016-2017 Key Performance Indicator comparative Analysis (UH Bristol and WAHT)

<b>62-day GP cancer</b>									
		<b>Table 1: Quarter 1 2016/17</b>		<b>Table 2: Quarter 2 2016/17</b>		<b>Table 3: Quarter 3 2016/17</b>		<b>Table 4: Quarter 4 2016/17</b>	
		<b>Non Breaches</b>	<b>Breaches</b>	<b>Total Seen</b>	<b>%</b>	<b>Non Breaches</b>	<b>Breaches</b>	<b>Total Seen</b>	<b>%</b>
UH Bristol		196.0	73.5	269.5	72.7%	253.0	62.5	315.5	80.2%
Weston		67.0	16.5	83.5	80.2%	66.0	23.5	89.5	73.7%
Combined		263.0	90.0	353.0	74.5%	319.0	86.0	405.0	78.8%
<b>62-day Screening cancer</b>									
		<b>Table 5: Quarter 1 2016/17</b>		<b>Table 6: Quarter 2 2016/17</b>		<b>Table 7: Quarter 3 2016/17</b>		<b>Table 8: Quarter 4 2016/17</b>	
		<b>Non Breaches</b>	<b>Breaches</b>	<b>Total Seen</b>	<b>%</b>	<b>Non Breaches</b>	<b>Breaches</b>	<b>Total Seen</b>	<b>%</b>
UH Bristol		8.5	9.5	18.0	47.2%	7.5	6.0	13.5	55.6%
Weston		1.0	0.0	1.0	100%	0.5	0.0	0.5	100.0%
Combined		9.5	9.5	19.0	50.0%	8.0	6.0	14.0	57.1%
<b>31-day First Definitive</b>									
		<b>Table 9: Quarter 1 2016/17</b>		<b>Table 10: Quarter 2 2016/17</b>		<b>Table 11: Quarter 3 2016/17</b>		<b>Table 12: Quarter 4 2016/17</b>	
		<b>Non Breaches</b>	<b>Breaches</b>	<b>Total Seen</b>	<b>%</b>	<b>Non Breaches</b>	<b>Breaches</b>	<b>Total Seen</b>	<b>%</b>
UH Bristol		628	34	662	94.9%	685	17	702	97.6%
Weston		113	1	114	99.1%	137	1	138	99.3%
Combined		741.0	35.0	776.0	95.5%	822.0	18.0	840.0	97.9%
<b>2-Week Wait</b>									
		<b>Quarter 1 2016/17</b>		<b>Quarter 2 2016/17</b>		<b>Quarter 3 2016/17</b>		<b>Quarter 4 2016/17</b>	
		<b>Non Breaches</b>	<b>Breaches</b>	<b>Total Seen</b>	<b>%</b>	<b>Non Breaches</b>	<b>Breaches</b>	<b>Total Seen</b>	<b>%</b>
UH Bristol		3,192	196	3,388	94.2%	3,097	213	3,310	93.6%
Weston		1,315	60	1,375	95.6%	1,043	66	1,109	94.0%
Combined		4,507.0	256.0	4,763	94.6%	4,140.0	279.0	4,419.0	93.7%
		<b>Non Breaches</b>	<b>Breaches</b>	<b>Total Seen</b>	<b>%</b>	<b>Non Breaches</b>	<b>Breaches</b>	<b>Total Seen</b>	<b>%</b>
UH Bristol		3,186	151	3,337	95.5%	3,344	142	3,486	95.9%
Weston		1,240	80	1,320	93.9%	1,099	228	1,327	82.8%
Combined		4,426.0	231.0	4,657.0	95.0%	4,443.0	370.0	4,813.0	92.3%

### A&E 4-hours

Table 13: Quarter 1 2016/17

	Non Breaches	Breaches	Total Seen	%
UH Bristol	29,251	3,482	32,733	89.4%
Weston	11,465	2,045	13,510	84.9%
Combined	40,716	5,527	46,243	88.0%

Table 14: Quarter 2 2016/17

	Non Breaches	Breaches	Total Seen	%
UH Bristol	28,506	3,564	32,070	88.9%
Weston	11,975	2,590	14,565	82.2%
Combined	40,481.0	6,154.0	46,635.0	86.8%

Table 15: Quarter 3 2016/17

	Non Breaches	Breaches	Total Seen	%
UH Bristol	26,972	6,598	33,570	80.3%
Weston	9,293	3,748	13,041	71.3%
Combined	36,265.0	10,346.0	46,611.0	77.8%

Table 16: Quarter 4 2016/17

	Non Breaches	Breaches	Total Seen	%
UH Bristol	25,269	5,726	30,995	81.5%
Weston	8,538	3,568	12,106	70.5%
Combined	33,807.0	9,294.0	43,101.0	78.4%

### RTT

Table 17: Quarter 1 2016/17

	Total Under 18 Weeks	Total Pathways	Percentage Under 18 Weeks
UH Bristol	92,460	100,135	92.3%
Weston	15,822	17,173	92.1%
Combined	108,282	117,308	92.3%

Table 18: Quarter 2 2016/17

	Total Under 18 Weeks	Total Pathways	Percentage Under 18 Weeks
UH Bristol	94,111	103,460	91.0%
Weston	16,748	17,639	94.9%
Combined	110,859	121,099	91.5%

Table 19: Quarter 3 2016/17

	Total Under 18 Weeks	Total Pathways	Percentage Under 18 Weeks
UH Bristol	95,119	103,653	91.8%
Weston	17,740	19,018	93.3%
Combined	112,859	122,671	92.0%

Table 20: Quarter 4 2016/17

	Total Under 18 Weeks	Total Pathways	Percentage Under 18 Weeks
UH Bristol	95,523	104,090	91.8%
Weston	16,583	17,607	94.2%
Combined	112,106	121,697	92.1%

### Diagnostics

Table 21: Quarter 1 2016/17

	Waiting Under 6 Weeks	Total Waiting List Size	Percentage Under 6 Weeks
UH Bristol	24,137	24,711	97.7%
Weston	6,832	6,876	99.4%
Combined	30,969	31,587	98.0%

Table 22: Quarter 2 2016/17

	Waiting Under 6 Weeks	Total Waiting List Size	Percentage Under 6 Weeks
UH Bristol	23,701	24,645	96.2%
Weston	6,616	6,706	98.7%
Combined	30,317	31,351	96.7%

Table 23: Quarter 3 2016/17

	Waiting Under 6 Weeks	Total Waiting List Size	Percentage Under 6 Weeks
UH Bristol	23,625	23,929	98.7%
Weston	6,249	6,253	99.9%
Combined	29,874	30,182	99.0%

Table 24: Quarter 4 2016/17

	Waiting Under 6 Weeks	Total Waiting List Size	Percentage Under 6 Weeks
UH Bristol	24,630	24,985	98.6%
Weston	5,735	5,737	100.0%
Combined	30,365	30,722	98.8%

### Last minute cancelled operations

Table 25: Quarter 1 2016/17

Last Minute Cancelled Operations	Elective Admissions	LMC Rate
UH Bristol	18,071	1.01%
Weston	3,699	1.35%
Combined	21,770	1.07%

Table 26: Quarter 2 2016/17

Last Minute Cancelled Operations	Elective Admissions	LMC Rate
UH Bristol	18,990	0.70%
Weston	3,759	0.82%
Combined	22,749	0.72%

Table 27: Quarter 3 2016/17

Last Minute Cancelled Operations	Elective Admissions	LMC Rate
UH Bristol	18,399	1.02%
Weston	3,711	1.51%
Combined	22,110	1.10%

Table 28: Quarter 4 2016/17

Last Minute Cancelled Operations	Elective Admissions	LMC Rate
UH Bristol	18,931	1.22%
Weston	3,772	1.03%
Combined	22,703	1.19%

### Length of Stay

Table 29: Quarter 1 2016/17

Total Beddays	Total Spells	Average LOS
UH Bristol	19,765	3.69
Weston	4,276	5.07
Combined	24,041	3.94

Table 30: Quarter 2 2016/17

Total Beddays	Total Spells	Average LOS
UH Bristol	19,782	3.65
Weston	4,310	5.19
Combined	24,092	3.93

Table 31: Quarter 3 2016/17

Total Beddays	Total Spells	Average LOS
UH Bristol	20,087	3.73
Weston	4,099	5.78
Combined	24,186	4.08

Table 32: Quarter 4 2016/17

Total Beddays	Total Spells	Average LOS
UH Bristol	19,277	3.96
Weston	3,879	6.32
Combined	23,156	4.35

### Outpatient efficiency measures

Table 33: DNA rates 2016/17

Attendances	DNAs	DNA rate
UH Bristol	55,066	7.3%
Weston	9,504	6.0%
Combined	64,570	7.6%

Table 34: Follow-up rates 2016/17

Follow-up Attendances	New Attendances	Follow-up ratio
UH Bristol	215,978	2.26
Weston	51,340	1.88
Combined	267,318	2.19

Table 35: Hospital cancellation rates 2016/17

Appointments	Hosp cancellations	Cancellation rate
UH Bristol	119,575	11.8%
Weston	28,737	13.4%
Combined	148,312	12.1%

## Appendix 8 Key Design Principles for a new Acute Care Model

- Quality is the overriding consideration for the new model that we are developing, including the ability to routinely and sustainably meet relevant national safety, staffing and clinical standards.
- The WGH site operating as a clinically and financially sustainable 'Care Campus' model that brings together in one place the best of the Acute Trust with the best of primary care, community services, mental health, social services, the ambulance service, the local authority and the voluntary sector to support the creation of an integrated primary care led Community Hub working in close alignment with a new Acute Care Model.
- An Integrated Urgent Care Front Door service to effectively meet the urgent and emergency care needs of the local and visitor populations, acknowledging that more complex and life threatening conditions may be better treated elsewhere in the system.
- An Integrated Community and Acute Children's Paediatric service, that works closely with the new urgent care service model. Consider partnership options with other children's healthcare providers to improve service resilience and the potential to recruit scarce specialist staff.
- WGH operating as a recognised 'centre of excellence' for the effective treatment of frailty, including the development of new pathways – for example, a specific integrated acute and community frailty pathway.
- Integrated working with primary and community care services to help proactively manage frail and older patients and help them stay healthy and out-of-hospital for as long as possible. Frail and older patients who do need to be admitted to an acute hospital need are able to go home as soon as possible and that patients' experience of rehabilitation services both in and out of hospital is as seamless as possible.
- WGH operating as a recognised regional centre for NHS elective care, with a co-ordinated strategy to encourage more local people to choose it for their routine and non-complex elective care.
- Integrated services for patients by working jointly with local primary care and community colleagues, for example through joint LTC clinics in the community and / or the Community Hub, telemedicine / advice, and encouraging community services to routinely walk wards to "pull" patients through to discharge.
- The ability to use IT to appropriately share patient data and records, thereby improving co-ordination and efficiency of patient care.
- Integrated working with mental health services, including substance and alcohol misuse services, to ensure a joined-up service for vulnerable groups.
- Greater collaboration across Acute Trusts – working under the guidance of the Acute Care Collaboration workstream of the STP and further enabled by greater partnership working between UHB and WAHT and collaboration with NBT.

## Appendix 9 Learning from the evidence: the challenges to realising the desired benefits from organisational mergers

A multi-site Trust is the most common organisational form for larger organisations in the NHS. This is where, through a series of transactions, mostly contiguous; one provider owns and operates a number of hospital facilities in close geographical proximity. Dalton (Ref 7) identifies the potential for 'infrastructure, clinical, and corporate synergies that can be realised through the merger or acquisition of neighbouring or nearby organisations'. He also goes on to say that 'as this model involves full change of management control to the acquiring organisation or the newly formed Trust Board of the merged organisation, there are considerable opportunities to standardise practices'.

There is however, considerable evidence in the literature that the expected benefits of merger are often overstated and often not fully realised. The Kings Fund (Ref 12) state for example that the 'widespread belief in the benefits of achieving 'critical mass'... is not supported by the available evidence'. Neither is sufficient 'recognition given to the disadvantages of creating larger, more complex organisations with conflicting cultures or business models'.

In 2016, Monitor commissioned Aldwych Partners (Ref 13) to produce a report called 'Benefits from mergers: lessons from recent NHS transactions'. This report identifies the benefits to patients and commissioners that were realised by NHS Trusts following the six case study mergers; discusses the extent to which these mergers facilitated the realisation of these benefits; and identifies factors common to those Trusts that experienced success in realising merger benefits (see below).

The report does not seek to balance the costs and benefits that arose in the six merger case studies. It carried out a more limited consideration of the post-merger benefits that were achieved. Given this approach, 'the report may come across as more positive about NHS mergers than may be the case in other studies. However, care should be taken in reading this report to remember that it does not seek to review each of these transactions as a whole'.

### **Key summary findings (Aldwych Partners Report 2016)**

- In the six case studies, we have identified efficiencies and service delivery improvements that were realised after each merger; the extent of these benefits varies across the case studies. Savings in corporate overheads and clinical support services of around 1-3% of a merged Trusts turnover were generally realised relatively quickly post-merger,
- Service delivery improvements were also made by each Trust post-merger, and were frequently accompanied by further cost savings. A variety of post-merger initiatives led to service improvements, including consolidating services onto fewer sites where larger numbers of patients are treated, improvements in treatment processes, and investment in estate and infrastructure,
- Service improvements generally took longer to realise than savings from the rationalisation of corporate overheads and clinical support services (e.g. at least 2-3 years compared with 12 months). This was due to the greater complexity of these.