AGENDA ITEM 9

OVERVIEW AND SCRUTINY BOARD

2 August 2016

Developing Urgent Care Services
Making Health Simple
- Final Report

PURPOSE OF THE REPORT

1. To present the information received during the Committee's involvement with the South Tees Clinical Commissioning Group's (CCG) development of urgent care services and the Making Health Simple consultation.

MEMBERSHIP OF THE COMMITTEE

2. The membership of the Committee was as detailed below:
   Councillors Dryden (Chair), J Walker, (Vice-Chair) Goddard (Vice Chair) Biswas, Rooney, Lawton, Holyoake, O'Brien, Turner and Watts

   The membership of the Committee from 10 June 2016 is as follows
   Councillors Goddard (Chair), O'Brien (Vice Chair), Dryden (Vice Chair) Holyoake, Turner, Watts, Lawton, McGee, D Rooney and J Walker,

METHODS OF INVESTIGATION

3. Members of the Joint Committee met formally between 16 July 2015 and 10 June 2016 to discuss and receive evidence relating to the proposals and a detailed record of the information discussed at those meetings is available from the Middlesbrough Council website.

4. A brief summary of the methods of investigation is outlined below:
   a. Detailed presentations by senior officers and members of the Governing Body from the South Tees Clinical Commissioning Group (CCG) supplemented by verbal evidence.

   b. Round table discussion with a wide range of organisations including Redcar and Cleveland Council, NHS England, Healthwatch Middlesbrough, South Tees Hospitals NHS Foundation Trust, Cleveland Local Medical Committee, Durham, Darlington, Tees Local Professional Network (Pharmacy), North East Ambulance Service, Public Health in Middlesbrough and Redcar & Cleveland Councils and North of England Commissioning Support Unit.

   c. Desk top research by the Scrutiny Support Officer.

SETTING THE SCENE

5. NHS bodies or providers of NHS health services have a legal duty to consult about the way the NHS is operating and about any proposed substantial developments or variations in the provision of health services in the area. Any 'substantial' variations or changes to NHS provision should be subject to a formal consultation. Where a proposal covers more than one local authority area, such as this one, legislation requires that the respective local authorities appoint a joint health scrutiny committee. As the proposals covered facilities within Middlesbrough and Redcar and Cleveland Council the matter was dealt with through the South Tees Health Scrutiny Joint Committee.

THE COMMITTEE'S FINDINGS

6. The committee were informed by the South Tees CCG in July 2015 about the Case for Change with regard to Urgent Care. At that meeting Members were told about the current services and the national and local drivers for change.

7. Urgent Care was described as *'the range of health services available to people who need urgent advice, diagnosis and treatment quickly and unexpectedly for needs that are not considered life threating'*

8. A national report 'Transforming Urgent and Emergency Care in England Review: End of Phase 1 Report, High Quality Care for All, now and for future generations' identified how the current system was under 'intense, growing and unsustainable pressure' which is driven by rising demand from a population getting older, a confusing and inconsistent array of services outside hospital and high public trust in the A&E brand. It made a number of recommendations including working towards a 7 day NHS service. NHS England also produced further directions on the improvements that needed to be implemented to the 111 service which had to be adopted by CCGs.

9. The CCG then outlined the process it was about to embark on, beginning with the publication of the case for change, then discussions and feedback (pre-consultation) and then potentially the development of options. This would then lead to pre consultation, then depending on the options developed this could lead to post consultation engagement and then the decision by the CCG which would then be implemented. There was to be consultation with staff, patients, the public and the scrutiny committee throughout the review.

10. It was anticipated at the time that over 1,000 people would be consulted through planned consultation work, including an online survey.

11. The committee then met on 13 October and received information on the results of the pre-engagement survey that had been completed. Over July and August 2015, 1,013 people gave their views on urgent care services across the South Tees area. Targeted engagement had taken place through a voluntary sector partner who was able to increase access to minority, marginalised and disadvantages groups and communities. This included young people, unemployed, people with disabilities, carers, people with mental health needs and people of different faiths.

12. Street surveys had been conducted, 175 across Redcar and Cleveland and 175 in Middlesbrough. Surveys were also distributed to a variety of sources and were available on-line. The CCG also held listening events and discussion groups. A stakeholder workshop was held in October and members of the South Tees Health Scrutiny Joint Committee were invited to attend.

13. From the pre-consultation engagement the CCG found the following

    a. People find the system confusing.
    b. Most people try and care for themselves before accessing services.
    c. When they do access a service, most people prefer to see a GP.
    d. A lot of people were not aware of NHS 111, but the majority of people who had accessed it said it was a positive experience, although people were concerned about the number of questions asked by call handlers and the delays this could cause.
    e. The majority of people reported having a positive experience of using the walk-in centres.
    f. The majority of people thought it was important to see the right health professional, in the right place at the right time.
    g. The majority of people said that A&E should only be used by patients who have a life threatening condition.
    h. People think it is important that their health records be shared between services.

14. The committee were reminded of the key drivers for change and the adoption of the national vision locally. In its current form the urgent care system was described as unsustainable. The South Tees area has the second highest rate for admissions not usually requiring hospital admission. The out of hours and walk-in centre contracts have come to an end, providing the CCG with the opportunity to review the current service and make appropriate changes.

15. The committee discussed the urgent care service entry points, to ascertain the reasons why the public find the current system confusing.

16. The points of entry are as follows:
    a. Supported self-care
    b. Pharmacies
    c. NHS 111 – provides advice and signposting
    d. GP in hours (46 practices)
    e. GP out of hours (booked via NHS111 and including home visits)
    f. Minor Injuries – walk in in appointments based at Redcar Primary Care Hospital with x ray access 8-6 weekdays and 9-4 weekends and James Cook University Hospital
    g. Walk-in centres at Eston Grange and North Ormesby
    h. Accident and Emergency – James Cook University Hospital

17. The above have a variety of opening times and the committee recognised that the public could have difficulty understanding differences between what each service provides as GPs, minor injury services and walk in centres all provide assessment and treatments for minor ailments. It was found that most people were best educated about which service to use at the time they accessed the system. The thinking, at that time, was that could some services be brought together and standardised where possible,

therefore eliminating the need for patients to understand the difference between services.

Duplication in the System

18. The committee heard that there has been national debate about the future of walk-in centres, some commissioners have closed walk in centres, choosing to replace them with urgent care centres, some co-located in A&E, others have changed the way in which walk- in centres operate. 68% of the patients using the 2 walk-in centres were referred back to their own GP, adding to the duplication both for the patient and the system.

19. The committee were reminded about the national shortage of GPs, numbers have not risen since 2009. For South Tees the number of GPs in relation to the population is below the England averages. The duplication, as detailed above, also puts pressure on the scarce workforce resource. This also presents challenges for James Cook University Hospital in relation to the emergency medicine workforce, exacerbated by national pressures around delivering care over 7 days a week.

20. A&E departments are undertaking care which could be delivered by primary care – 44% of South Tees A&E attendances were discharged without any further follow-up and most people are discharged within 2 hours. Minor injuries and minor ailments are provided by a number of services outside of A&E but people are not necessarily aware of them, choosing to attend A&E as the first option in the absence of knowledge of the system. The challenge to the CCG was how to address duplication without adversely affecting access.

Costs

21. Members were told that the cost of providing urgent care provision is high. Changes in demographics, particularly the growing elderly population, is driving up the overall cost of healthcare. The CCG must make the best use of tax payer's money and potential economies of scale had been identified by matching capacity and demand, removing duplication in the system, improved integration and better education of patients around self-care.

22. Patients will be advised to contact 111 when

    a. They need medical help fast, but it's not a 999 emergency.
    b. They don't know who to contact for medical help.
    c. They think they need to go to A&E or another NHS urgent care service.
    d. They need to make an appointment with an urgent care service.
    e. They require health information or reassurance about how to care for themselves or what to do next.

23. Following the standards set out by NHS England for the improvements to the 111 service proposed developments will see: access to patients records through the Summary Care Record, the call handler will have the ability to make an electronic referral into a service which best meets the patient's needs, face to face or telephone consultation appointment being made, where appropriate, (this will include access to mental health crisis teams, mental health teams and specialist clinicians) and an appointment with a GP or GP out of hours service will also be able to be made.

24. A directory of service will also be available, the search tool will provide access to locally commissioned services, especially those designed to support care in the community (e.g. the falls team)

25. Members had concerns about the other national telephone numbers that had not worked; there was a perception that they had been driven by targets and a lack of understanding about local services.

26. Members were also concerned about the effect the national shortage of GPs would have on the move to 7 day working. The committee was informed that the GPs would come together and work in hubs to ensure that they cover populations of about 30,000.

27. The committee then met on 17 November and received a short recap of the information received to date, including the case for change, details of the public engagement, the national guidance and context including the 111 service and 7 day GP working and how the existing contracts are ending in March 2017.

The Vanguard Programme

28. There are a number of funding pilots taking place across General Practice – using the Prime Minister's Access Fund. One such scheme in this area is the South Tees STAR[1] scheme bid will cover integrated hubs to extend GP access, integrated with the current NHS 111 service, and will look at triage through the NHS 111.

29. The Vanguard Programme is a nationally funded initiative and the 111 model would sit within this programme and would be completed on a regional basis where advantages could be taken of shared learning.

Development of Proposed Urgent Care System Scenarios

30. Discussions had been held with stakeholders to identify potential ways forward. They had been asked to develop criterion for a good model of care. A number of areas were considered including patient experience, finance, access to the right services and workforce capacity. Information from the stakeholder meetings was used to identify a consensus and protocols were developed to measure against each scenario. There were no GPs present at those meetings owing to the conflict of interest.

31. The scenarios that scored highly were:
    a. The development/enhancement of the NHS 111 model.
    b. Extended opening hours for GP surgeries from 8am to 8pm, 7 days per week delivered around populations of 30,000, replacing existing walk-in centres.
    c. Aligning the out of hours period (to include home visits and appointment booking) to the new GP in hours arrangements, with further exploration of where and how many sites appointments could be delivered from.
    d. A GP presence at front of house in A&E.
    e. The potential for two minor injury units, one in James cook and one based in Redcar which has x-ray and GP cover with opening times which correspond to demand: or one 24/7 minor injury unit at James Cook Hospital.

[1] This stands for the South Tees Access and Response scheme. This scheme is operated by the 46 GP practices across South Tees and provides access to GP services between 6.30pm and 9.30 pm Monday to Friday and 8am to 8pm Saturday and Sunday.

32. The scenarios were then progressed to modelling, with various teams looking at aspects such as activity flow and finances.

33. The committee were told that there were a small number of patients accessing the walk-in centres and an even smaller amount from Hartlepool. It was agreed to keep the respective Councils informed of the developments here, they are sent copies of the Committee's papers and are invited to attend the meetings.

34. Following all the information received Members agreed that the proposals constituted a substantial variation and that they should be subject to formal consultation with the committee. As a result the committee then met on 18 December to receive the final options and the formal consultation and engagement plan.

35. The CCG outlined how they had developed the name from Developing an Urgent Care Strategy to Making Health Simple, Right Place First Time. The development of the final scenarios had been informed by best practice, national guidance, key stakeholders and feedback from the public engagement programme. The CCG had worked with partners to develop, refine and weight appraisal criteria (which included GPs, the patient and public advisory group and local councillors). Healthwatch had also acted as a critical friend throughout the process. The first appraisal criteria was used to score each scenario using a five stage process resulting in the six highest scoring scenarios progressing to financial appraisal.

Financial Appraisal

36. The financial appraisal for each of the scenarios was based on high level staff costings only, the optimum affordable solutions included:
    a. Allowing for a small contingency to absorb unquantifiable costs to date.
    b. Further work-up of the activity flows is required to both the GP elements of the pathway and the combined centres offering out of hours and a high level of service delivery.
    c. The work will take place alongside the consultation process timelines to inform further clarity and better understating of the scenarios. The CCG will incorporate both the flow of activity and the potential size and location of the GP hubs into the modelling.

37. There were 3 scenarios put forward for consultation by the CCG

6 extended hours GP centres 6pm – 8pm Weekdays 8am – 8pm weekends	GP working in front of house A&E	GP Out of Hours reduced 8pm-8am 7 days a week	GP led minor injuries unit with x-ray James Cook open 24/7 Redcar open 8am – 9.30pm

4 extended hours GP centres 6pm – 8pm weekdays 8am – 9.30pm weekends	GP working in front of house A&E	GP Out of Hours reduced 9.30pm – 8am 7 days a week	GP led minor injuries unit with x-ray James Cook open 24/7 Redcar open 8am – 9.30pm

This option (above) is the option preferred by the CCG

8 extended hours	GP Out of Hours	GP led minor injuries

GP centres 6pm-8pm weekdays 8am-8pm weekends	reduced 8pm – 8am 7 days a week	unit with x-ray James Cook open 24/7 Redcar open 8am – 9.30pm

38. The committee were told that the aim of the new model was to encourage patients to seek advice and signpost them to the most appropriate service through NHS 111, simplifying the system and enabling the patient to attend the right place first time. It supported primary care and local GP practices in offering enhanced accessibility over 7 days negating the need for walk-in centres, avoiding duplication and increasing affordability in the system.

39. The model was more responsive to actual patient need and greatest demand, combining GP in and out of hours as well as minor injury services, with access to diagnostics. Members were told that a two site model reflected current demand, however as demand reduces in the evenings, a single site approach overnight would ensure optimisation of quality, safety and affordability.

40. The committee agreed that the locations of the hubs were very important. As they had not been determined yet it was felt that issues such as travel distance, parking, noise and safety implications would all play a considerable role and it was felt suitable and workable locations needed to be identified.

41. Members discussed the CCGs proposed consultation arrangements. In addition to discussions with the CCG it was proposed that the Committee would hold additional meetings, in parallel with the consultation timetable, to seek alternative views.

42. Further meetings will be arranged to hear progress on the consultation by the CCG and to receive independent evidence from other stakeholders.

Stakeholder Meeting – 7 March

43. The committee held a meeting on 7 March to invite a range of stakeholders to come and discuss the impact of the proposals on their service. Those that attended/provided information were
    a. Cleveland Local Medical Committee (CLMC)
    b. Healthwatch Tees
    c. Durham, Darlington, Tees Local Professional Network (Pharmacy)
    d. South Tees Hospitals Foundation Trust (STHFT)
    e. NHS England
    f. North East Ambulance Service (NEAS)
    g. Teesside University
    h. Social Care – Redcar and Cleveland Council
    i. Public Health

44. There was a general agreement that the current urgent care system was confusing. Healthwatch had been involved in the consultation process acting as a ‘critical friend’ agreed that was feeling they had heard from the general public.

45. The STHFT had some concerns about the impact of the proposals on the A&E department. The committee were told that some modelling had taken place and the results had shown that there would be a fairly minimal impact. The STHFT have stated that the A&E department could expect about 20,000 extra patients attending the

department. They advocated that there would need to be a clearly planned information campaign and that extra alternative provision would need to be in place to deal with the demand before the walk-in centres are closed.

46. The STHFT very much welcomed the increased provision of GP services in the evening and at weekends.

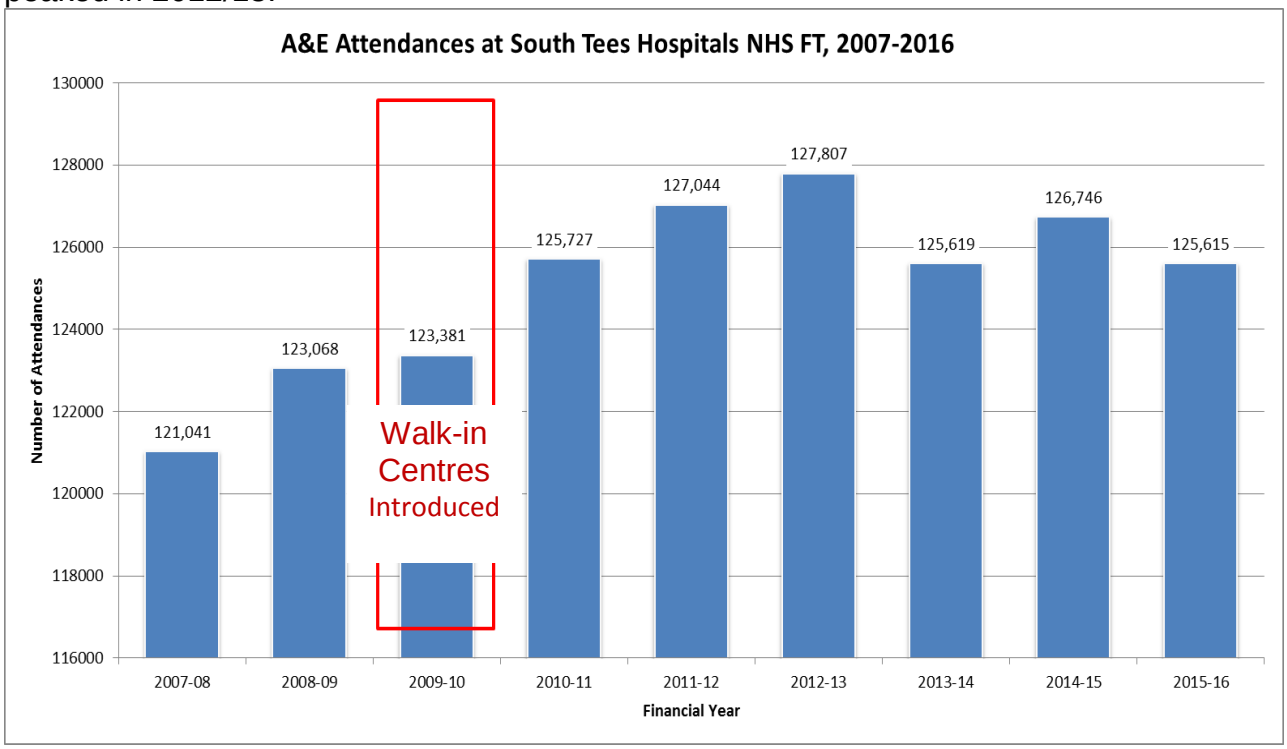
47. There was some support for the location of a GP in A&E and some members thought that it was unnecessary. There was varying evidence around the country and although there was a mixture of success in other areas, there was nothing to suggest that this would not work in South Tees. The committee agreed that it was crucial to have a clear indication of the GPs role from the outset. The CCG outlined that recent data modelled for South Tees showed that approximately 15-18% of primary care attendances at A&E could have been dealt with by a GP.

48. The Royal College of Emergency Medicine believes that primary care facilities should be provided adjacent to emergency departments, with a robust streaming mechanism in place to deal with patients as they arrive. Discussions were taking place to determine the best way to achieve this and how it could be timed to accommodate the overall changes being planned.

49. The CCG provided some statistics about the impact the introduction of the walk in centres had had on emergency admissions and A&E attendances.

Table 1 - A&E attendances over time

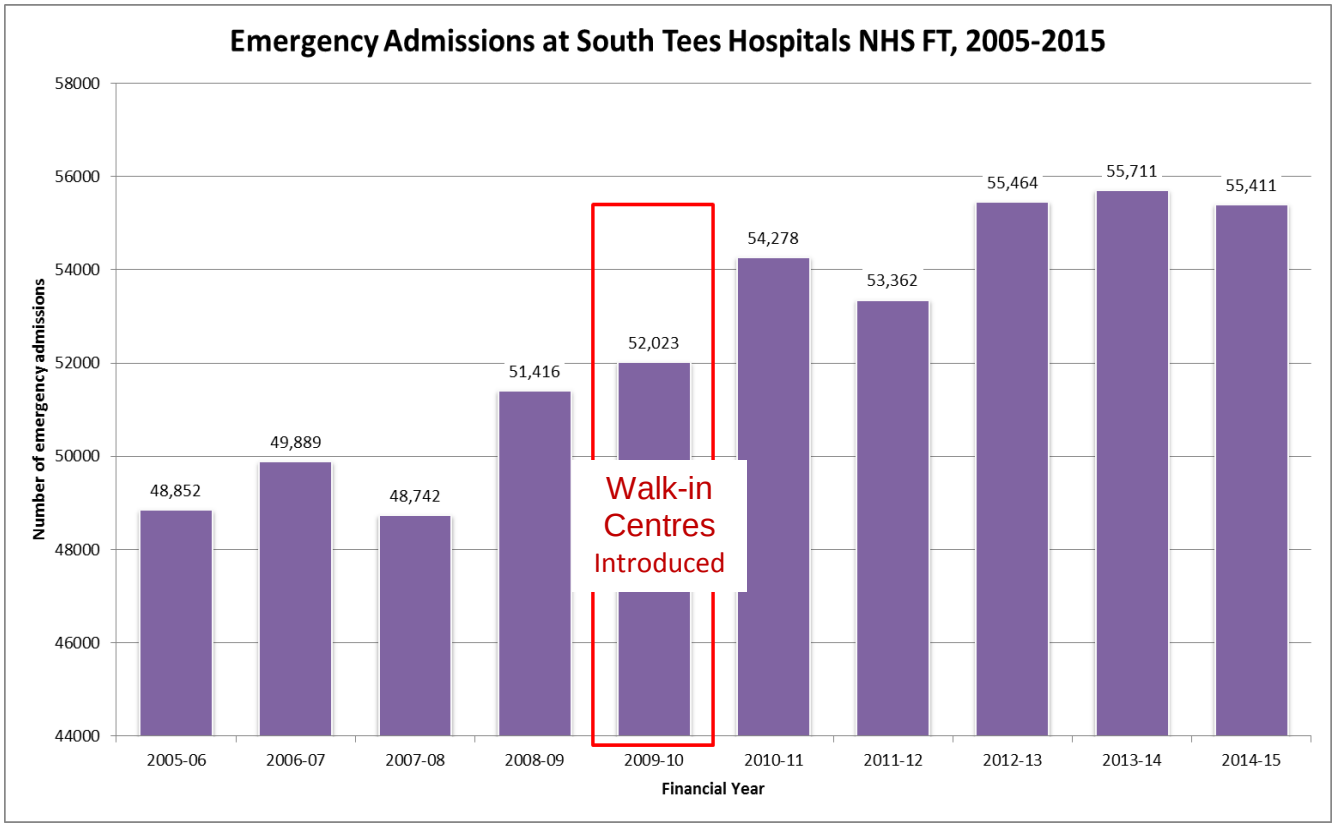
This graph shows **all** (includes STCCG and other CCGs) A&E attendances at James Cook University Hospital from 2007 to March 2016.. As the graph shows, A&E attendances peaked in 2012/13.



Source: National Weekly SITREPs from local NECSU reporting.

Table 2. Emergency admissions over time (includes all CCGs)

The below graph shows that the introduction of Walk-in Centres in 2009 did not result in a reduction in emergency admissions. Similarly to A&E attendances, emergency admissions rose steadily until 2012-13, then remained at similar levels.



Source: Hospital Episodes Statistics at HSCIC.gov

Evidence regarding GPs located in A&E

50. This section contains additional information requested by the Committee on the national picture relating to the effect of GPs being located in A&E. There wasn't a great deal of evidence to support either side at this point in time. However information from the CCG and a desk top exercise is included here.

51. The Royal College of Emergency Medicine alongside Urgent Health UK (a federation of Social Enterprise unscheduled Primary and Community Care) made the case for the immediate co-location of out-of-hours urgent and emergency primary care services with Accident and Emergency departments.

52. Recent research by the Royal College of Emergency Medicine has confirmed that around 15 to 20% of patients attending A&E departments could be more effectively treated by other healthcare professionals such as out-of-hours primary care practitioners, community pharmacists and mental health teams. They believed that those primary care skills should be brought in to A&E departments. They argued that after many years of trying to discourage people from attending A&E departments with less serious conditions it has proved that 'diversion' schemes to be both costly and completely ineffective. Patients continue to come to a place that they know and trust. Therefore, the argued, that there should be provision of a service within A&E departments that matched the need of the patients who attended rather than

constantly and unsuccessfully trying to change patients' behaviour at a time of personal crisis.

53. In a joint statement from the Royal College of Emergency Medicine and the Royal College of General Practitioners they stated that the colleges understood that the most cost-effective form of care was general practice and that investing in general practice services – in and out of hours – and making those services more integrated would alleviate pressures across the health services, including Emergency Departments.

54. In the NHS's 5 Year Forward View (5YFV) it outlined the benefits of having co-located urgent care/primary care services within emergency departments for the following reasons:

- They have a useful role in managing people with minor illnesses to avoid emergency department crowding and that it may only be appropriate to focus on treating less serious injuries
- Where there is a single co-located model of urgent/primary care models within an emergency department there should be shared governance and a single 'front-door'.

55. There are 4 models which were outlined in a Guide to Good Practice that had been developed by the Emergency Care Intensive Support Team. The models detailed how co-locating primary care into an emergency department could work, along with the associated advantages and disadvantages.

56. In 2015, over a four week period, a GP led triage service was put in place at the A&E department of St George's Hospital in South London. The hospital's A&E department is 'among the busiest in the world'. The aim was to re-direct 15 or more patients per day and often they ended up doing 25-30. This resulted in freeing up potentially 2-3 A&E doctors per day. Of those patients who were re-directed, 56% went to see their usual GP and 44% to out of hours GP services/other GP services/Dentist. All were given a same day appointment, co-ordinated by an administrator with many booked in to see a GP within a few hours which is often sooner than they would have been seen by and A&E doctor.

57. The skillset of GPs is regarded as unique, they are able to see patients, take histories, understand their narratives and unify all of that to make a diagnosis within a very short space of time. Following the South London experience it was argued that if this service was rolled out across all A&Es it would fulfil a very important role. It would ease waiting times and provide patients with better care.

58. In the Netherlands, all patients have to see a GP before going to A&E and Monitor, the organisation that regulates health services in England, were carrying out reviews of acute service line models in other countries to help inform thinking. In the Netherlands, GPs are often the gatekeepers for emergency care. A&E attendances are about 120 a year per 1,000 people, compared with 278 in England. (Although to some extent the lower attendances could be driven by the financial incentives that patients face in the Dutch system).

59. A policy paper by the Royal College of Emergency Medicine in 2015 sets out thirteen recommendations to address profound pressures in urgent and emergency care

services. There are two recommendations relating to having a GP at the front of house in A&E.

- Every emergency department should have a co-located primary care out-of-hours facility. It is not appropriate for accident and emergency to be regarded as 'anything and everything' or for the emergency department to be 'everyone's default'. It is unreasonable to expect patients to determine whether their symptoms reflect serious illness or more minor conditions. Co-location enables patients to be streamed following a triage assessment.
- Having senior decision-makers at the front door of the hospital should be normal practice. It is the most reliable way to deliver safe, effective and efficient care.

60. In March 2010 the Department of Health commissioned a Primary Care Foundation to carry out a study across England of the different models of primary care operating within or alongside emergency departments. Analysis found that
    - A GP working in the emergency department may result in lower admissions and less tests being undertaken.
    - Re-direct away from the emergency department has led to variable results regarding future attendances and the assessments of the safety of this intervention have also revealed variable results.
    - Educational interventions have not been shown to change attendance patterns.

61. The conclusion of the report is that there may be benefits of systems of joint working between primary and emergency car but at that moment in time there was no evidence base.

Other examples of GPs in A&E

62. In a report by the Sheffield Teaching Hospitals NHS Foundation Trust and the Sheffield General Practitioner Collaborative, it documented a triage pilot programme in March 2010. Unfortunately the scheme was not as successful as had been hoped. It had been anticipated that 80 patients per week could be triaged from the ED to general practice, but in reality the average sent per week was closer to 36. A number of factors contributed to this: the physical distance between the Emergency Department and the GP; the variance in the practice of triage nurses, the workload of the GP which led to the closure of the service at busy times and the perceived differences in the acceptance criteria between the Emergency Department and the GP for patients to be treated.

63. The initial pilot ran for 4 weeks. However there were difficulties in securing GPs to fill all of the shifts, particularly during the half term school holiday period which coincided with the last week of the pilot.

64. GP feedback noted that there were a proportion of the sessions where GPs felt underutilised. The consistency of GP availability throughout the pilot was a concern and feedback regarding individual sessions was very subjective and dependent on the GP carrying out the role. The GP collaborative (GPC) feedback highlighted their concern for the availability of GPs from the outset.

65. The overall evaluation of the pilot gave the opportunity to evaluate the pool of patients flowing though the ED. Actual 'primary care' cases amounted to 19%.

Communications between the GPC and the ED were improved. However it was difficult to correlate 4 hour target achievement with the presence of a GP in triage. However anecdotally, staff in the ED felt that patient flow was easier at weekends, when a GP was present.

66. From the Trust's perspective, it had been beneficial to have primary care input in the ED. The closer the provision the more effective it has been, and to that end any future plans would be best incorporating such a stream in or adjacent to the ED. The future success of any model of integration would be dependent on the availability of suitable primary care clinical staff.

67. The CLMC discussed how the proposed changes included an element of booking into daytime GP services (through either A&E or the 111 service). They highlighted how the proposals held an assumption that booking through the 111 was universally supported by GP practices and in their view this was not the case. There were concerns about the appropriateness of the appointment which would be dependent on the triage process (a process which was yet to be decided). It was also highlighted that daytime GP services are working to capacity and some would not be able to 'soak up' any further work, even if this was accompanied by extra funding.

68. The CLMC outlined that the GP workforce is stretched, and on Tees there are high levels of expected retirement, with major recruitment difficulties (known to be the worst nationally). Despite this being a priority of the current Government there was a concern that the move to 7 day GP access is possible or safe.

69. The CLMC saw access benefits of the proposals for people living in Redcar and Cleveland, particularly those in East Cleveland, would have a reduced travelling time to the proposed new hub.

70. It was acknowledged that people attending walk-in centres didn't not see their own GP, however the new hubs would not be operated by the patient's own GP but they would have access to people's medical records, which was felt to be an improvement on the current system. However the CLMC have expressed concerns that GP practices are not compelled to share or provide full access to medical records and its unlikely that they would.

71. The committee learnt that one of the biggest pressures facing the system was the number of frail and elderly patients and those with multiple medical conditions. The main option in the out-of-hours period was to call 111 which often resulted in attendance at A&E. In such circumstances it was difficult for safe decisions to be make, particularly in respect of cases of dementia and multiple conditions and therefore hospital admittance was most likely. Mention was made of the impact on the STAR scheme and that the proposals would offer a foundation to fee up some GPs into the late evening to managed this and avoid unnecessary hospital admittance. As a result of the STAR scheme it was explained that there had been 5,000 fewer attendances at the walk in centre at North Ormesby which could be attributable to the various changes that had been initiated by the scheme.

Discussion regarding the Workforce

72. The committee were concerned about the pressure that this could create for the existing workforce; recruitment, especially to vacant GP posts is difficult however in the Government have published the General Practice Forward View in April 2016

which is designed to contain specific and funded steps on investment, workforce, workload infrastructure and care redesign in primary care. Details of the implications of this announcement are awaited.

73. The committee discussed the link with Adult Social Care and it was agreed that the care home sector needed to be properly supported. It was felt that the additional access and extended hours would be of benefit to both the social care teams and to the care homes, particularly in terms of enhancing primary care and community care support. Again reference was made to the STAR scheme in achieving this. The Adult Social Care representative from Redcar & Cleveland explained that it was important to balance the extended opening with the number of hubs and the operation of the hubs until 2130hrs felt the most appropriate. Work was on-going to extend social work within the hospital, aligning with the discharge pathway work also being undertaken by the hospital.

Transport Issues

74. The committee had concerns about the location of the hubs and the access people in some of the South Tees locations would have, they agreed that good transport links for patients would be imperative. Members questioned the work that had been carried out to ensure public transport will be accessible to the GP centres especially in the early evening. A response to the question can be found below.

Additional Questions

75. As a result of the meeting Members had a number of questions which they put to the CCG, their response is as follows

Location	Does the location of the services, especially the GP extended hours, ensure equitable access across South Tees?
	Absolutely, this was a key component of the public consultation; asking people where they thought the CCG should site future GP hubs in order to facilitate best coverage across the whole of South Tees. In addition the CCG has carried out more detailed activity modelling which takes into account geographical location and areas of highest deprivation in order to try and predict where patients are most likely to migrate to as part of the new model.
Accessibility	How accessible will the GP centres be in terms of location, car parking, and public transport? What work has been carried out to ensure that public transport will be accessible to the GP centres, especially in the early evening?
	In order to support the final decision making process, the CCG has carried out an estates/premises appraisal to determine the best facilities from which to deliver the new extended GP hubs. A criteria has been developed. In order to gather information about accessibility of each of the potential premises, the CCG commissioned an independent 'Green Travel Plan' which examined: • Drive time catchment area

	• On-site parking –level (including the number of ambulance bays) and cost • Off-site parking – the level, availability and cost • Pedestrian catchment • Pedestrian facilities (footpaths, safety to walk on site) • Cycle catchment • Public Transport services bus (this included accessibility by bus not only for the neighbouring areas but also across the whole of South Tees) and rail where appropriate • Public transport facilities –bus shelters and other such infrastructure
	If the option of a GP being located within James Cook Hospital's A&E Department is chosen, how accessible will that be for people across the South Tees area, where will people who arrive in cars park and will they be expected to pay?
	The concept of a GP in A&E is intended to educate those individuals currently using A&E inappropriately. This section of the population are already accessing A&E and making their own way to the department (including paying for parking, public transport etc.).
Resources – Personnel	We know that there is a shortage of GPs both nationally and in the South Tees area. In the Tees area there are high levels of expected retirement and there are recruitment difficulties. The proposals are heavily reliant on there being enough GPs to meet the demand and to cover the proposed extended opening hours, what work has been carried out to ensure that there will be enough doctors and health care professionals (both now and in the future) to ensure that cover is provided as stated in the consultation documents?
	The CCG has carried out a workforce review as part of the redesign of urgent care services. This review describes national and local strategies aimed at freeing up valuable GP time by enhancing the whole primary care workforce rather than merely focusing on 'growing' more doctors. The CCG's local and regional commissioning strategies support this approach. However, in acknowledgement of the local ageing GP workforce, the review also describes a number of local and national initiatives to increase the number of doctors entering and being retained within primary care in the long term. In the newly published; General Practice: Forward View, April 2016, NHS England pledges investment and support over the next five years to practices and in particular, aims to double the rate of growth in the primary care medical workforce in the next five years – with an extra 5,000 doctors working in general practice supported by an increase in nurses, pharmacists, physician associates, mental health workers and others. The proposed new model, although requiring more primary care capacity, is likely to contribute to the sustainability of the current workforce, reducing current duplication and encouraging GP practices and other urgent care providers to work together to

	provide workforce efficiencies. Improvements to NHS 111 are expected to divert demand away from primary care and emergency care services, ensuring that patients are signposted to the most appropriate place first time and seen by the most appropriate professional. There are no major concerns over the supply of suitably competent staff to deliver the CCG's proposed new model of care with the exception of increased radiography capacity required for MIU in Redcar. There is a national shortage of radiographers, however, South Tees Foundation Trust are working closely with Teesside University and have informed the CCG that they are confident that they will be able to recruit staff this year from their graduate scheme. There is an acknowledged lack of sophisticated workforce information for primary care which is being addressed, however following a market engagement event, local providers gave a positive response to being able to have and attract the necessary workforce required to deliver future models. In addition South Tees GPs via the STAR scheme are also currently delivering extended hours across two centres and a GP working in A & E in parallel with services which will be replaced and reduced in the new model, freeing up existing workforce. In May 2015, STAR were reporting 37 GP's and 32 nurse practitioners signed up to delivering the service and feel confident that they would be able to deliver from more sites than they are now. In addition there is an acknowledgement that the service will not just rely on the GP workforce but will be made up of a multidisciplinary team in order to best meet the needs of patients.
	There is an expectation that as a result of the proposals more patients will attend A&E, can the committee be assured that clearly planned and alternative provision will be put in place to deal with the demand before the current walk in centres are closed?
	All modelling work undertaken by the CCG to date is based on worst case scenario which has been informed by examples of system changes that have happened elsewhere. However, none of those examples included alternative provision to an A&E attendance being made available in primary care (indeed the most relevant examples encouraged attendance at A&E) and therefore the CCG believes that the impact is likely to be lower than modelled. Any additional attendances to A & E would primarily be for those individuals who have a minor ailment; walk-in centres are predominantly for those with such conditions who can be managed quickly and effectively if required, supported by a potential new model of a GP in A & E signposting patients to more appropriate services.

	Given the recent breakdown of the management of Marske Medical Centre which resulted in emergency action by a group of GPs to maintain service at the Centre, how will this affect the ability of GPs to provide the additional services proposed?
	There is no impact on the plans for extended hours hubs.
	Given the pressures on a diminishing number of GPs to maintain their present service to patients and also move to provide the STAR system, how will the GPs be able to provide additional resources to man the front of A & E Dept. at James Cook Hospital?
	The STAR scheme is currently providing both the extended opening pilot (from Middlesbrough and Redcar) and the current GP in A&E pilot. There are sufficient GPs to provide both services.
Resources – Finance	There is no additional funding to accompany these proposals. Is there a danger that with some GP surgeries that are currently running at full capacity they will not be able to 'soak up' any further work?
	The hubs will provide an additional 4000 appointments per month enabling patients who are currently seen in-hours to book appointments into the evening and on weekends. This level of additional capacity exceeds any shift from walk-in-centres.
	GP practices are free to run their own appointment systems, will all GP practices required to take part in the booking system proposed as part of the improvements to the 111 system? The CCG is currently working with all practices as part of the regional Urgent and Emergency Care Vanguard programme to gain agreement and sign-up for practices to allow NHS 111 to make bookings into practices, in addition all practices will be able to book patients into the out of hours slots within the hubs- this will not be dependent on one single GP practice IT system.
	What plans are going to be put in place to ensure fully collaborative working between commissioners to ensure an integrated urgent care system, notably pharmacy provision, dental care and primary care?

	The CCG is working closely with NHS England (NHSE) and Local Authority Public Health Teams to ensure our commissioning action supports integrated working and provision of services. The CCG has recently taken on full delegated commissioning responsibility for Primary Care and this is also supporting closer working with NHSE in areas such as pharmacy and dental care. In addition the CCG has made good progress in working with the LPC (Local Pharmaceutical Committee) and the LOC (Local Optometry Committee) to progress a number of support schemes intended to reduce system pressures.
	What plans are being put in place to promote self-management, self-care and empowering people to take responsibility for their health?
	This is something that South Tees are working on jointly with other CCGs from across the system on promoting. In particular, the Vanguard Programme is currently developing more information for parents with young children (high users of urgent care services) in various formats including an electronic application to support self-care. A key challenge is in ensuring that the underpinning support services are in place right across the region in order to ensure that any communications, engagement or education is meaningful and relevant to all parts of the population. The CCG is also working closely with colleagues in Local Authority Public Health Teams to understand how to better promote these messages with key groups.

Results of the Consultation – Meeting on 10 June 2016

76. The committee were informed about the results of the public consultation. An independent report had been prepared which contained information regarding the planning and development of the consultation and the analysis of the feedback. The consultation period ran for 12 weeks from 11 January 2016 to 1 April 2016. It attracted 1,925 survey responses and public and community group meetings had enabled the public to provide informal feedback (outside of the questionnaire). Groundwork North East (GWNE) (a voluntary sector partner) had been involved to assist in reaching a diverse range of respondents. There had abeen a targeted engagement of minority and marginalised groups and communities. A total of 136 groups and communities were involved in the engagement. GWNE had facilitated 55 group discussions with 616 participants and 505 surveys were completed through the GWNE sessions. Thus ensuring that people who may not always have had the opportunity to take part could have an influence on developing health services.

77. The consultation was subject to a mid-term review by the Consultation Institute who stated that the volume of qualitative engagement was commendable. The survey responses were independently analysed by Proportion Marketing Ltd.

78. The committee were reminded of all of the different ways the public were made aware that the consultation was taking place, including information in print and broadcast

media, digital media, social media, stakeholder briefings, door to door leaflet drop and through advertising and marketing.

79. The committee were shown the distribution of survey responses and the demographics of the age groups taking part.

Feedback on the proposals

80. The majority of respondents (53.7%) favoured Option 2. When asked to allocate the extended hours GP centres on the whole respondents allocated the centres to reflect the population across the four areas, with Area 1 receiving the highest allocation in all 3 options.

81. The majority of the public responses (54%) agreed that the proposals would reduce confusion and provide a seamless service for patients.

82. The dominant themes that emerged from the survey were GP access (18.1%), the consultation process itself (9.6%), communication (8.9%), there was support and opposition to place a GP at the front of A&E attracting 7.8% of comments. However the majority thought it was a good idea and would relieve A&E pressure. Travel and transport was involved in 5.4% of comments.

83. In addition the dominant themes from the consultation meetings were: the location of the extended hours GP centres, NHS 111 service, GP access, workforce, travel and transport.

84. In conclusion the majority of the public agree that change is necessary, the proposals reflect the feedback from the pre-consultation engagement and that the proposals will provide the best urgent care services to meet the needs of the South Tees population both now and in the future.

Work undertaken following the consultation

85. The CCG had been undertaking a series of work since the close of the consultation. This had included activity modelling, an estates review, A&E modelling with the Trust, a workforce review and an assessment of the implications of the General Practice Forward View. The General Practice Forward Review, did however, contain some initiatives which were already happening in South Tees.

86. In discussing the concerns that Members had about the workforce and the recruitment difficulties, the CCG outlined that last year 50% of GP training places had been unfilled. This year 100% of the training places had been taken up. Whilst this could not be treated as a trend as yet, it was seen as positive news for the future, the key however being to ensure that the qualified doctors stayed in the area.

87. The CCG were aware about the importance of access, including bus routes, car parking, ambulance bays and pedestrian access and taking the feedback from the public the CCG have prepared a travel plan/report. The report considers each location which has been identified for a potential hub and looks at drive time catchment areas, populations, off/onsite parking availability, cycling and pedestrian catchment areas, public transport accessibility, services and facilities. The travel plan provided each property with a score and an overall rank which has been added to the stage 3 estate review.

88. The CCG have spoken to all GP practices and had identified 16 potential sites for the hub using the criteria they had developed which took into account a number of specific criteria within the following headings: access; capacity; finance; minimum standard, and service design.

89. The Committee were told how many frail and elderly patients are presenting at A&E who haven't been seen by a GP. Therefore talks have been taking place between the CCG and its partners, including the STHFT, about the GP frailty unit which is a multi-disciplinary team including social care, geriatrics and therapies as a way forward in assisting with this issue.

CONCLUSIONS

90. Following receipt of the evidence, the committee concluded that:

a. Members agreed that the Committee had every opportunity to challenge the information that had been presented by the CCG before, during and after the consultation.

b. Members supported the general direction of travel, recognising that both nationally and locally the pressures on the health and social care systems mean that no change is not an option. The changes were part of the wider political will and initiatives that are being implemented nationally. Whilst supporting the proposals the Committee agreed that there was still some work to do to achieve the primary aim, which is to 'make it simple' for the public.

c. Throughout the course of the pre-consultation and consultation Members had a number of areas of concern that echoed the comments that came out of the consultation process, which were as follows:

Location/Accessibility

i. Members were very concerned about the unintended consequences of the proposals and the effect that the closure of the walk-in centres may have in adding to the current pressures on numbers attending A&E at James Cook University Hospital. The Committee sought assurances that clearly planned and alternative provision must be put in place to deal with the demand before the walk in centres were closed.
ii. There was some support from Members for a GP in A&E, others thought it would be confusing, and the Committee agreed that there needed to be a clear message given to the public that A&E isn't for minor complaints.
iii. Members did have serious concerns about the public's access to venues and in particular the accessibility of the GP centres in terms of their location, the availability of parking and the provision of public transport, especially out of hours and from the more rural locations.
iv. Members agreed that the location of the hubs was vital and that the location of the services should be equitable across the South Tees area. Members were especially interested in the detailed activity modelling that have been undertaken to predict where patients were most likely to migrate to.

Resources - Personnel

v. Members had concerns over the GP workforce, in an area where there are known GP shortages, where it was difficult to attract GPs and where older GPs were due to retire. Members were concerned that there would be a burden on GPs to cover more hours.
vi. Anecdotal evidence given at the panel outlined how some people still face difficulties getting to see their own GP.

Resources – Finance

vii. At the time the review commenced, pre the General Practice Forward View announcement, the Committee were concerned that there was no additional funding to accompany the proposals and that there was a danger that some GP practices were currently running at full capacity and would not be able to 'soak up' any further work.
viii. With regards to the improvements to the 111 service Members had concerns about the freedom GP practices had to run their own appointment systems and if GP practices would be required to take part in the proposed booking system.
ix. Members were also keen to see fully collaborative working between commissioners to ensure an integrated urgent care system, notably pharmacy, dental care and primary care. The Committee also recognised the importance of joint working with Public Health to promote prevention and self-care.
x. The Committee obviously want to see improvements which will result in better outcomes and reduced health inequalities for people who use the service and will therefore be asking the CCG to keep in regular contact with the Committee through the implementation of the proposals and beyond.

91. In consultation with the Chair and Vice Chair, it was agreed that the comments of Cllr A Watts be included as an appendix to this report and as such can be found at Appendix 1.

RECOMMENDATIONS

92. The Committee made the following recommendations:

a) That the CCG return to the committee to inform Members on a number of issues, including:
   - How the proposals will be implemented
   - What the services will look like
   - Where the locations of the extended hours GP practices will be (and how those locations were determined)
   - Further details on the Travel Plan
   - The implications and implementation of the General Practice Forward View.

b) In addition to a) above, that, post implementation, the CCG return to the committee on an annual basis to provide information and analysis to enable the Committee to

monitor the effects of the proposals and specifically the siting of a GP in front of house in A&E.

c) That clearly planned and alternative provision must be put in place to deal with the demand across the South Tees before the walk-in centres are closed.

d) That when the changes to the urgent care system are put in place that this is well publicised and clear communication is given to the public so they understand what service are available and when and how they access them.

e) As a result of work that Middlesbrough's Health Scrutiny Panel had been involved in on cancer screening, the Committee would like to recommend that the availability of screening services should be included in the services provided by the extended hours GP hubs.

Date: 15 June 2016

Contact: Elise Pout, Scrutiny Support Officer,
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BACKGROUND PAPERS

The following background papers were consulted or referred to in the preparation of this report:

(a) The minutes of the South Tees Health Scrutiny Joint Committee of 16 July 2015, 13 October 2015, 17 November 2015, 18 December 2015, 7 March 2016 and 10 June 2016.

Response from Cllr Anne Watts, Redcar and Cleveland Councillor and Member of the South Tees Health Scrutiny Joint Committee

PUBLIC CONSULTATION REPORT

Making Health Simple – Right Place, Right Time

There are 2 systems in crisis – GP Practices & A&E Depts. Add in the closure of 2 Walk-in Centres and you have the ingredients for chaos. You then spend a large amount of money holding a Public Consultation in which the phrasing of the questions lead to the answer the CCG wanted. The CCG even told participants which was their favoured option Option 2 which was for 4 extended hours GP centres/hubs with GPs also working at front of A&E at JCUH and GP led MIU with x-ray at JCUH open 24/7 and at RPCH open 8am to 9.30pm – see attached sheet.

The number of residents consulted was only 2,100 throughout Middlesbrough and Redcar & Cleveland. That is only 1% of the population but 52% of those giving a preference voted for Option 2 (see attached sheet for participation per area) The next step considered suitable premises (16) and a Travel Plan. For East Cleveland the list of prospective sites for the hubs includes one centre in Guisborough, Brotton Hospital and one in Skelton. There are no proposals for anywhere East of Skelton. Cllr Sheila Hollyoak believed that Skelton was within easy reach for residents in Loftus and beyond. We were told that the GPs in Loftus were not interested in participating??? A Final decision on the future of these Health proposals will be made on the 6th July 2017.

In the results of the Consultation we were told the GPs are in favour of these proposals but Cleveland Local Medical Committee expressed strong concerns as to what the proposals will mean to GP Practices and they also state they have mixed views about GPs in A&E Depts as this is not an appropriate access point for minor and routine services. My own GP, who has been a major instigator in the STAR system says that he is not in favour of GPs at front of house in JCUH. He is also very concerned at the additional pressure on GPs by the closure of the 2 Walk-in Centres. The author of the Consultation Report said that people are now happy about the closure of these Units.

Over the last 12mths I have raised my personal concerns about the 111 Service which I believe is not fit for purpose. I have been told that my experiences are not typical. In the Consultation 10% of participants also expressed mainly negative concerns about this Service. The facilitators then influenced participants' given views by explaining that the Ambulance Service runs 111. Does this matter?

The results mention my name in explanation for arranging a second consultation in Guisborough. What they fail to mention is that I raised the issue as, up to 1 week prior to the session, there was no publicity in the 2 GP's Practices, at Sunnyfield House or even at the Parish Hall where the event was to be held.

I am also concerned that the area East of Guisborough to Loftus (postcodes TS12-3, TS12-2 and TS13-4) were either significantly underrepresented or just underrepresented. This is an area of isolation, deprivation, poor transport links and which had no Public events held

as part of this survey. The survey also showed that the majority of participants did not have a long-term illness or disability, although there appears to now be some confusion over this point. It would appear that it is the fit and responsible section of the population who have participated and their views will do little to influence those who abuse the A&E facilities. WE are now told that the people in Loftus should have responded to the survey and if they did not, it is they who lose out.

This Consultation was brought about following a National Report 'Transforming Urgent & Emergency Care in England: Review' which identified how the current system was "under intense, growing and unsustainable pressure.' Locally we have been made aware of bed-blocking, mainly the elderly and long-term sick who have nowhere else to go, and ambulances lining up outside A&E. The general public tend to look at what they feel is best for them and this is having more time with their GP and easier appmts. To make decisions on A&E dependant on putting increased pressure on GPs is, to quote from the original Review, 'intense, growing and unsustainable.'

I would suggest that taking up the suggestion from South Tees Hospital's own response; a GP led Frailty Assessment Unit alongside extending the STAR system within GP Practices would do more to alleviate the difficulties than the implementation of a complicated and confusing structure proposed by the CCG.