NHS Dartford, Gravesham and Swanley

Clinical Commissioning Group

Urgent and Emergency Care

The Case for Change and Proposed Clinical Model of Care

Report prepared for:	Kent County Council [KCC] Health Overview and Scrutiny Committee [HOSC] 14 July 2017
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1. Introduction

1.1 A report on the urgent and emergency care programme was presented to the Committee in January 2017. Within this report Dartford, Gravesham and Swanley Clinical Commissioning Group (DGS CCG) and NHS Swale Clinical Commissioning Group (Swale CCG) proposed to present the case for change and proposed clinical models to the Committee in March 2017.

1.2 Following three listening events held across DGS and Swale CCG areas in February 2017, the CCGs identified that additional time was required to compile the case for change, and to refine the proposed clinical model options before passing through internal governance processes.

1.3 Further to the urgent care update presented to the Committee in January 2017, this report has been prepared by DGS CCG to present the Committee with the urgent and emergency care review case for change, and to present the potential urgent and emergency care model options based on a review and consideration of national requirements, feedback gained from engagement events held with GPs, a 'whole system' event that took place in November 2016 and a listening event held with the public in February 2017, as well as resource and financial considerations.

1.4 The model options include the re-procurement of NHS111 services, supported by an enhanced Integrated Clinical Advice Service (ICAS) with improved system interoperability, and the re-procurement of GP out-of-hours services.

1.5 The DGS model option includes the centralisation of walk-in services to form an Urgent Care Centre at the Gravesham Community Hospital site, and the re-design of services based at Fleet Healthcare Campus. This re-design may include increased general practice and extended primary care access to 8pm Monday to Friday, and 8.30am to 1pm on Saturdays, as well as health and wellbeing hub services.

1.6 On the advice of the Consultation Institute, and in order to ascertain the level of engagement or consultation required, the CCG conducted a Community Impact Assessment in June 2017 by talking to a range of local stakeholders including local politicians, GP practice staff as well as local people and patients. Feedback was sought regarding the key elements of the urgent care proposals, and particularly the proposed move of the Walk in Centre at the Whitehorse Surgery in Northfleet, to Gravesham Community Hospital which is 1.3 miles away. There appeared to be minimal appetite for a more formal consultation process, especially as most stakeholders broadly supported the proposals. Based on the findings of the Community Impact Assessment, the CCG proposes to conduct a full range of engagement activities between August 2017 and October 2017, using a variety of channels and methods to ensure the local people are fully informed and appropriately engaged. This will include an online survey, and at least three events – one for providers and key stakeholders to work up draft specifications for services, another with GPs (PLT) to build on the specification, and a third one with patients and public to test the specification and refine before going out to tender.

1.7 The Committee is asked to consider the case for change and the potential model options to determine if the Committee considers the proposals to be a substantial variation and if a period of formal consultation with the Committee is required.

2. The Development of the Case for Change and the Proposed Model of Care

2.1. The case for change and the emergent clinical model of care are based upon nationally mandated changes, as well as on the feedback received from local clinical and operational leaders, patients and the public gained at various engagement and listening events.

2.2. All engagement activities undertaken thus far have asked for attendees to give their views of local, urgent and emergency care models, rather than solely on the urgent and emergency care element. The CCG recognises that the outcome of any review will need to complement other transformational programmes (e.g. GP Forward View, and the Sustainability and Transformation Plan) and therefore cannot be considered in isolation. Part of urgent care is currently delivered within primary care (e.g. same day urgent GP appointments and 2, 4 and 6 hour GP dispositions from NHS111), and the future direction of travel is seeing more primary care services supporting Emergency Departments (ED) by identifying patients who can be most appropriately seen and treated within primary care. Feedback gained at these events that relate to local care plans and the primary care strategy have been considered in the design and refinement of the urgent and emergency care model described below.

2.3. The engagement events undertaken that have helped shape the case for change and emergent model of care are as follows:

2.3.1. **February - May 2015: DGS and Swale CCGs Patient and Clinician Reference Groups** to identify a potential solution (e.g. hub and spoke model).

2.3.2. **November 2016: GP Engagement Event.** 32 of the CCG's 34 practices were represented by 48 GPs as well as other members of multi-disciplinary team. Attendees were asked: (i) for their opinions on urgent care using an extract from recent BMA GP survey, (ii) to consider the ways in which extended hours might be provided in primary care (including working with the GP Federation), (ii) to vote on whether they wished to work collaboratively with other GPs to provide area specific extended access, and (iii) to review proposed models for local, urgent and emergency care. A summary of the feedback received is attached in ***Appendix A.***

2.3.3. **November 2016: DGS and Swale CCGs Urgent and Emergency Care Whole Systems Event** which saw over 80 attendees from across health and social care in North Kent. The event brought together patient representatives, voluntary sector organisations, hospital clinicians, GPs, out-of-hours providers, community staff and commissioners to collaborate and discuss possible future models of care in DGS and Swale CCG areas. Presentations and workshop sessions allowed the delegates to work together to tackle

issues and focus on improving patient access, promoting appropriate health services and breaking down organisational barriers to improve patient experience. A summary of the feedback received is attached in ***Appendix B.***

2.3.4. **February 2017: DGS Listening Events.** Listening events were held across DGS and Swale CCG areas to hear how the public (including some community groups/organisations) felt about the potential model and to better understand the ways in which the model might affect people. One event was held in Shorne primarily for DGS residents. Attendees were asked to (i) share and discuss the review of urgent and local care conducted to date - including feedback from previous patient and public engagement, (ii) provide an overview of future proposals and the emerging urgent and local care models, and (iii) get patient and public feedback on the model to help inform the next stage of its development. A summary of the feedback received at these listening events is attached in ***Appendix C.***

3. National and Local Context

3.1. In November 2013, the Keogh Review - End of Phase One Report outlined the case for change and proposals for improving urgent and emergency care services in England. The report highlighted five areas for the future of urgent and emergency care;

3.1.1. Provide better support for people to self-care

3.1.2. Help people with urgent care needs to get the right advice in the right place, first time

3.1.3. Provide responsive urgent care services outside of hospital so people no longer choose to queue in the Accident and Emergency (ED) department

3.1.4. Ensure that those people with more serious or life threatening emergency care needs receive treatment in centres with the right facilities and expertise in order to maximise the chances of survival and a good recovery

3.1.5. Connect all urgent and emergency care service together so the overall system becomes more than just a sum of its parts

3.2. The findings of this report were further supported by the publication of the NHS Five Year Forward View in October 2014, which stated that urgent and emergency care services will be redesigned to improve integration between emergency departments (ED), GP out-of-hours services, urgent care centres, NHS 111 services and ambulance services.

3.3. Between February and May 2015, DGS CCG, in partnership with Swale CCG, and Medway Clinical Commissioning Group (Medway CCG), pursued a programme of activity across North Kent which began to look at urgent care. In both DGS and Swale CCGs, patient and clinician reference groups were held and a potential solution was identified which was based around a hub and spoke model.

3.4. In June 2015, DGS CCG took a local decision to pause the programme due to the recognition of the emerging impact of the Ebbsfleet development on the local health economy; an impact which required further analysis before the programme could be moved any further forward.

3.5. In July 2015, a national programme pause was applied. CCGs received a letter from Dame Barbara Hakin which focused on the need to ensure a functionally integrated 24/7 urgent care access, treatment and clinical advice service incorporating NHS 111 and out of hours. With NHS 111 previously out of scope of the urgent care redesign, programmes were paused pending publication of further guidance.

3.6. In September 2015, guidance was published within the Commissioning Standards Integrated Urgent Care, which focused urgent care redesign on the planned reconfiguration of urgent and emergency care services to enable 'commissioners to deliver a functionally integrated 24/7 urgent care service that is the 'front door' of the NHS and which provides the public with access to both treatment and clinical advice'. Central to this vision is the promotion of NHS111 as a single point of access for urgent care, supported by the introduction of a 'clinical hub' or Integrated Clinical Advice Service (ICAS) that will assess patient needs and advise on the most appropriate course of action (including enabling the patient to self-care where appropriate), and/or onward referral. This will provide access for the public to a wide range of clinicians whilst also providing advice to health professionals in the community so that no decision has to be made in isolation.

3.7. In October 2015, the national programme pause was lifted, and in May 2016, the DGS CCG local programme pause was lifted.

3.8. In June 2016, the urgent and emergency care programme was re-established in line with the Commissioning Standards - Integrated Urgent Care (September 2015) which focus on the following:

3.8.1. The commissioning of NHS111 as the telephony single point of access for urgent care providing a call handling, initial triage and signposting service.

3.8.2. The provision of an Integrated Clinical Advice Service (ICAS) to support NHS111 with telephony clinical triage, multi-disciplinary team advice, guidance and referral, ensuring no decision is made in isolation.

3.8.3. The GP out-of-hours service (including base sites and home visits).

3.8.4. System interoperability to enable greater integration.

3.9. Other face-to-face aspects of urgent and emergency care services, and the points at which urgent and emergency care overlaps with the requirements and proposals laid out for the General Practice Forward View, and the Kent and Medway Sustainability and Transformation Plans (STP), have also been reviewed, and although not all the requirements are addressed within the urgent and emergency care potential model, care has been taken to ensure the outcomes of different programmes are complementary. This has included consideration of the following:

3.9.1. Extended primary care access by March 2019 and the provision of urgent same day bookable appointments within primary care.

3.9.2. Primary care managed urgent care service to support the acute trust to avoid unnecessary ED attendance and/or hospital admission, deliver the 4 hour ED standard and meet ambulance handover times.

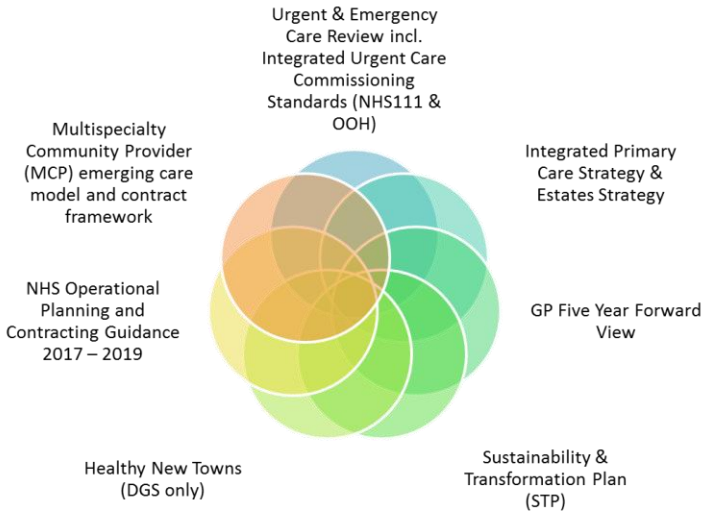
3.9.3. Workforce and workload issues.

3.9.4. Increased use of technology and improved interface between general practice and hospitals.

3.9.5. Preventative support services and the ways in which self-care can be encouraged from NHS111 and ICAS without the need for a face-to-face consultation, where clinically appropriate.

3.9.6. Increase efficiency and implement demand reduction measures whilst addressing predicted growth.

3.10. The full spectrum of national guidance that influences this case for change is as follows:



3.11. The Kent and Medway Sustainability and Transformation Plan (STP) is currently in development and aims to deliver an integrated health and social care model that focuses on delivering high quality, outcome focused, person centred, co-ordinated care that is easy to access, and enables people to stay well and live independently and for as long as possible in their home setting.

4. Why is Change Necessary?

4.1 The local NHS system is no longer designed to meet the needs of the local population and in some areas the CCG, and their respective GP membership, are struggling to deliver the quality of care to which they aspire, and that their patients want.

4.2 Changes need to be made to the ways in which local and urgent care are provided in order to ensure that general practice is sustainable now and in the future.

4.3 Local, urgent and emergency care services are struggling under the weight of demand.

4.3.1 Darent Valley Hospital – Performance against the 4 hour Emergency Department Constitutional Standard for 2015/16 and 2016/17 has fallen short of the target of 95%.

4.4 Funding for services is limited, and finding appropriately skilled and experienced staff is a challenge for all areas of health and social care. At times this can lead to different services competing for the same key clinicians.

4.5 There is therefore a duty to ensure public money is spent wisely on services that really address the needs of the local population.

4.6 The boroughs of Dartford, Gravesham and Swanley are planning for significant housing growth and economic development between now and 2030 with the most rapid increase between 2015 and 2025. Population growth is estimated to be in the region of 22% by 2035. This will undoubtedly have an impact on the healthcare requirements for the area.

4.7 The largest age group growth is in people 85+ (bringing increased needs for health and social care).

4.8 A high proportion of patients are attending the emergency department who do not have life threatening emergencies and this is evidenced by the fact that 50% of patients who attend emergency department are discharged to their GP or discharged with no follow-up care. Whilst some of these patients would have been most appropriately cared for within an emergency department, a high proportion of these patients may be more appropriately cared for by primary care clinicians.

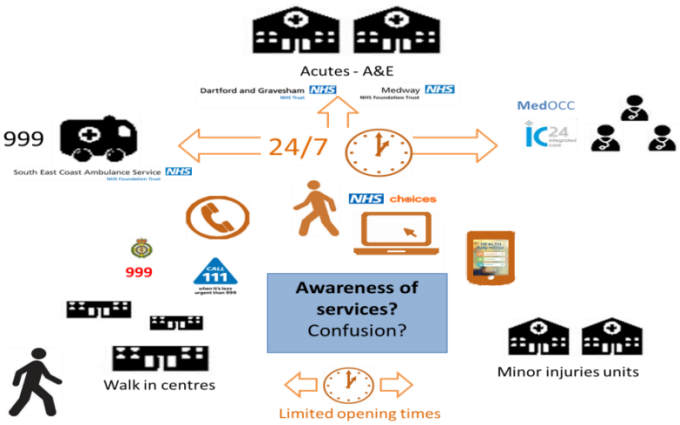
Other key facts about local emergency department (ED) November 2015 - October 2016**:**	**DGS**
ED rate per 1000 population	307
ED attendances discharged to GP / discharged with no follow-up	5 in 10
Average waiting time - emergency department	3.2 hrs
Emergency department attendance growth	7%

4.9 There are a large number of patients with long term conditions and mental health needs within the CCG area who may benefit from having more clarity regarding available support outside an acute Trust or emergency department.

Key facts about patients with long term conditions and mental health issues (2015/2016):	DGS
People living with LTC - Diabetes Register	13,004
People living with LTC - CKD Register	10,003
People living with LTC - Cancer Register	5,765
People living with LTC - Chronic Obstructive Pulmonary Disease (COPD)	4,419
People with Mental Health	1,818
People living with LTC - Palliative Care Register	827

4.10 DGS and Swale CCGs have asked patients, the public, and representatives from across health and social care in North Kent for their views about why change is necessary. Detailed feedback received from the engagement activities is included in ***Appendices A – C***. A high level summary of the key points and themes raised is outlined below:

4.10.1 The healthcare landscape is overly complex and it is often difficult for patients, the public, and sometimes even clinicians, to successfully navigate their way through the many services available as shown below:



4.10.2 Patients sometimes access services inappropriately because, for example, they may be worried about a healthcare problem but do not know where to go, or because it is not possible to access their GP immediately.

4.10.3 Brand strength influences public behaviour and the strongest brands (i.e. GP and emergency department) have the most significant demands placed upon them, and despite all previous efforts to change public behaviour, they continue to be the most accessed/used services.

4.10.4 The needs of patients have changed (increasingly elderly population, living longer with long term conditions).

4.10.5 Patients want more local, out-of-hospital care.

4.10.6 The current system supports competition rather than collaboration, and communication between services / providers needs to be improved.

4.10.7 There is a void in care/support for patients following urgent and emergency care attendance/treatment.

4.10.8 There is an education gap for patients and clinicians.

4.10.9 Patients need to take more responsibility for their health and local services should better support self-care.

4.10.10 Doctors may over-medicalise patients because they want to 'do something'.

4.10.11 The current system has resource problems in terms of funding and availability of appropriately trained staff.

5. What Sort of Change is Necessary?

5.1 The changes to the integrated urgent care system must address the eight key elements outlined by NHS England by 2020. These elements are as follows:

5.1.1 A patient can make an appointment out-of-hours in a single call

5.1.2 A patient can make an appointment in the in-hours period

5.1.3 Data can be transferred between providers

5.1.4 The Summary Care Record is available in the hub and elsewhere

5.1.5 Care plans and patient notes are shared

5.1.6 The number of patients speaking to a clinician increases above the current level of 22% by the implementation of a Clinical Hub (40-60% by 19/20)

5.1.7 The capacity for NHS111 and OOHs is jointly planned

5.1.8 There is joint governance across Urgent and Emergency Care Providers

5.2 In addition to this, over the course of many months, a structural clinical model that spanned local, urgent and emergency care has emerged and has been presented at each engagement event in order to encourage feedback and to better understand the needs of the public. Feedback received relating to urgent and emergency care has been considered when refining model options.

5.3 Detailed feedback received from the engagement activities is included in ***Appendices A – C***. A high level summary of the key points relating to the structural model are outlined below:

5.3.1 Simplify the health landscape and make services easier to access

5.3.1.1 Limit the number of entry points and avoid duplication

5.3.1.2 Standardise access times and link to contractual agreements

5.3.2 Ensure services are integrated

5.3.3 Cater to both urban and rural populations and address healthcare inequalities

5.3.4 Consider brand strength or GP, 999 and ED, and the influence on public behaviour/perception

5.3.5 Consider the creation of a seamless 24/7 GP service

5.3.6 Other clinicians should help support GPs. Introduce GP consultant model (specialist generalist)

5.3.7 Identify the patients who need to see a named GP, any GP, or another health professional or voluntary sector support (care navigators).

5.3.8 Limit access to the ED (Emergency Department) – requiring clinical referral.

5.3.9 Encourage and support prevention and self-care

5.3.10 Enable a patient to access virtual triage assessment by app or phone

5.3.11 Ensure services are affordable and sustainable both now and in the future

5.3.12 Specific feedback relating to each CCG area is given in **Appendices A – C**, and feature within the potential model below.

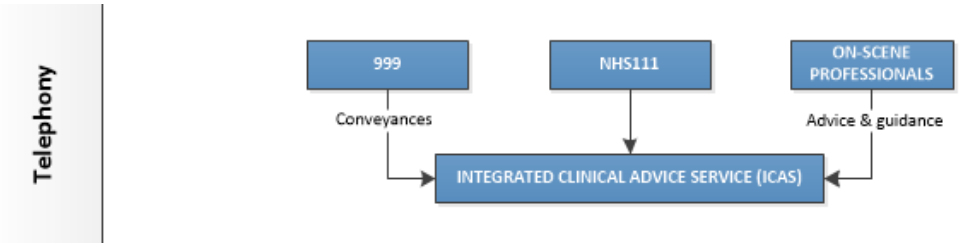
6. Potential Model and Critical Paths

6.1. Development of Potential Model

6.1.1. The potential model has been agreed, based on a review and consideration of national requirements, and feedback gained from engagement events held with GPs, the 'whole system' event that took place in November 2016 and listening events held in February 2017. Model options have been agreed by both the Executive Team and senior clinicians.

6.1.2. There are two key elements to the model (i) telephony services (requiring the re-procurement of NHS 111 and the design and procurement of an Integrated Clinical Advice Service (ICAS) which includes current 'GP Speak to' services), and (ii) face-to-face services (including all unscheduled, walk-in, urgent care services).

6.2. NHS111 and Integrated Clinical Advice Service (ICAS) Telephony Services



6.2.1. To provide economies of scale, and to ensure resilience for the NHS111 service, the North Kent CCGs (i.e. DGS, Swale and Medway), together with West Kent CCG, are pursuing re-procurement of a single NHS111 service to cover all areas. The intention is that the service would 'go live' in April 2019.

6.2.2. The ICAS builds on the team of clinicians already supporting the NHS111 service, and will be developed in line with both NHSE guidance and the Commissioning Standards for Integrated Urgent Care, and will be procured across the North Kent CCGs only. The intention is that the service would 'go live' in April 2019 in line with NHS111.

6.2.3. The Integrated Urgent Care Commissioning Guidance states that it anticipates that that up to 60% of all calls to NHS111 could be transferred to a clinical hub, or ICAS (this figure currently sits at approximately 26%), and that the ICAS will also provide clinical support to On-Scene Professionals.

6.2.4. The NHS111 number will remain free to call and will still be available 24 hours a day, 7 days a week to ensure patients have easy and swift access to urgent care. It will be the single point of access for urgent care, however patients and the public should be enabled to access integrated urgent care via alternatives routes to the telephone i.e. digital online platforms.

6.2.5. Patients dialling NHS111 will be triaged by a Health Care Advisor, and then be directed as appropriate to a range of multidisciplinary clinicians and services. Patients with complex problems requiring early assessment by a clinician will be identified quickly and transferred to speak to the appropriate clinician.

6.2.6. The current NHS111 service is supported by a team of clinicians, mainly paramedic and nursing staff, and the requirement is to enhance this clinical support service by procuring an ICAS. The ICAS has not yet been designed, but may include one or more of each of the following professionals; specialist or advanced paramedics, nurses with primary, community, paediatric and or urgent care experience, mental health professionals, prescribing pharmacists, dental professionals, senior doctors with

appropriate primary care competencies. Additional clinicians may also be included depending on local need.

6.2.7. A comprehensive electronic Directory of Services will support accurate and appropriate signposting and onward referral.

6.2.8. System interoperability will allow safeguarding alerts, special patient notes, including end of life care plans and recent contact history, to be available at the point of access to ensure appropriate assessment of patient need. In addition, as a minimum the Summary Care Record will be available to all clinicians in the ICAS.

6.2.9. NHS111 and the ICAS will help support patients to self-care where appropriate, or where a patient needs to have a face-to-face assessment/consultation, clinicians working in the ICAS will have the capability to make an electronic referral to the service that can best deal with the patient's needs, as close to the patient's location as possible.

6.2.10. The re-procurement of the existing NHS111 service and the enhancement of the existing clinical support (ICAS) are not thought to represent a significant variation. It is recognised however that there should be some communication activities undertaken with the public to promote the services.

6.3. Prevention and Self-Care

6.3.1. DGS CCG is committed to improving health prevention activities, and where clinically appropriate, encouraging and supporting patients to self-care.

6.3.2. The plans around prevention and self-care are based on our belief that more people can take greater responsibility for their own health and wellbeing through, for example, attending the sorts of clinics/services that may be available in Community Campuses/Health and Wellbeing Hubs in the future as part of the Primary Care Strategy Programme.

6.3.3. The urgent care model aims to increase the support people have when accessing urgent care, either through the telephony or face-to-face elements of the model, so that they can be supported, where clinically appropriate, to care for themselves more successfully, and to know when and how to seek support if they need it.

6.3.4. The CCG believes information, education and technology can help support people and patients to become more proactive about self-care and this has been explored with the public at the Listening Events.

6.4. Potential Model Options

6.4.1. Critical Path

6.4.1.1. The telephony elements of the model will 'go live' in April 2019.

6.4.1.2. The change to the face-to-face elements of the model (discussed below), once agreed, is intended to be operational from July 2019.

6.4.1.3. Piloting of services may be possible in existing estate before July 2019.

6.4.2. Challenges

6.4.2.1. **Population Growth** – Between 2016 and 2035 the DGS CCG population is set to grow by circa 22% with the most rapid growth by 2025. This growth varies by area e.g. in Dartford there is an expected 43% population increase by 2026. Developments identified in the adopted Local Plans will result in an additional population of 57,749 people assuming a minimum of 2.4 people per unit of accommodation and requiring an additional 32 GPs at a minimum. Additional resource must be secured in order to address this growth and improve health outcomes and continue to deliver critical targets.

6.4.2.2. **Staffing** – Workforce issues need to be addressed to ensure there are sufficient staff with the required level of skills and experience. This includes working with GP member practices, and other providers, to explore ways in which the multi-disciplinary team can help support each other, but also to identify ways in which recruitment and retention issues can best be addressed.

6.4.2.3. **Health Inequalities** - Dartford is ranked at 170 nationally, among the most deprived council areas, with Gravesham ranked at 124 and Sevenoaks ranked 272 out of the 326 local authorities. Areas of Dartford, Gravesham and Swanley are within the bottom quintile (lowest 20%) on the national deprivation scale.

6.4.2.4. **Health and Social Care** – To realise the benefits of the potential clinical model in terms of patient experience, quality of care and avoidance of unnecessary ED attendance / hospital admission it is important that health and social care providers work collaboratively across organisational boundaries to help support the urgent care proposals.

6.4.3. Key Elements of the Potential Clinical Model

6.4.3.1. **Planned Appointments** – Under the potential model practices would continue to operate as they currently do, including the offering of urgent same day appointments. Ways in which urgent same day appointment capacity can be increased will be explored as part of the Primary Care Strategy discussions.

6.4.3.2. **GP Out-of-Hours Services** – The potential model aims to deliver greater integration between in and out-of-hours GP services with the aim to create a more seamless 24/7 GP function, and there will be closer integration between the GP service, NHS111, ICAS and other urgent care services. The GP out-of-hours service would continue to offer home visits where clinically required, and offer out-of-hours face-to-face consultations at a base site. Both elements of the

service may include the use of a multidisciplinary team to support the out-of-hours GP function (e.g. paramedic or nurse practitioners). This will represent a significant move towards the introduction of the GP as consultant model.

6.4.3.3. **Centralisation of Walk-in Services and Re-Design of the Services based at Gravesham Community Hospital and Fleet Healthcare Campus.** Simon Stevens, Chief Executive Officer for NHS England, and Jim Mackey, Chief Executive Officer for NHS Improvement, have identified that the fragmented nature of out-of-hospital services made services unable to offer patients adequate alternatives to ED and this is impacting upon the ability of many NHS systems to provide ED services within the required standards. Based on feedback from engagement events, and guidance from NHS England and NHS Improvement, within the potential model non-ED urgent walk-in services would be centralised (this does not include same day or urgent GP appointments which would continue to be available at local practices). NHS111 will be the single point of access to urgent care, and after the service is re-procured , and supported by an enhanced clinical support service (Integrated Clinical Advice Service), it is anticipated that there will be a reduction in the need for face-to-face consultations in and out-of-hours. The reduced number of patients who still need to access walk-in urgent care services, such as those provided by the Walk-in Centre and Minor Injuries Unit, will be able to access these services at Gravesham Community Hospital. The Minor Injuries Unit services would remain on the Gravesham Community Hospital site, and the Walk-in Centre services would relocate from the Fleet Health Campus to the Gravesham Community Hospital site (approx. 1.3 miles away). These services would together form an Urgent Care Centre on that site. A re-design of the services at Fleet Healthcare Campus may then include increased general practice, and extended primary care access to 8pm Monday to Friday, and 8.30am to 1pm on Saturdays. As part of the re-design of both sites, other health and wellbeing services will be considered.

6.4.3.4. **Emergency Department (ED) Primary Care Streaming** – Attendances to Emergency Departments continue to increase, and a proportion of these patients have clinical concerns that could be dealt with by primary care services. Streaming these patients out of highly pressured EDs, to co-located GP led primary care services, ensures that patients receive the care that they need, whilst improving patient experience by ensuring that the standards around ED waits are more consistently achieved. There are several options for primary care streaming models. Primary care, GP led streaming within ED is a new NHS England development initiative, and will be in place at Darent Valley Hospital ED from October 2017. In line with best practice principles identified by NHS England, it will operate extended hours and will consist of an experienced and suitably qualified ED nurse who will work to agreed streaming criteria to determine if patients need to be seen by a primary care service, or by the ED. A

primary care, GP led service will be co-located with the ED and will see and treat appropriate patients within the four hour wait standard.

7. Intensive Stakeholder Engagement - Community Impact Assessment

7.1. The CCG sought advice from the Consultation Institute regarding whether the proposed centralisation of the Walk-in Centre and the Minor Injuries Unit at Gravesham Community Hospital would require a full public consultation.

7.2. On the advice of the Consultation Institute, and in order to ascertain the level of engagement or consultation that may be required, the CCG conducted a Community Impact Assessment by talking to a range of local stakeholders.

7.3. This intensive piece of stakeholder engagement was carried out in late June 2017 with the aim to determine whether local people considered the proposed changes to be substantial or controversial. In line with best practice, it was carried out in large part by an independent organisation and feedback documented. Feedback was sought regarding the key elements of the urgent care proposals, and particularly the proposed move of the Walk in Centre at the Whitehorse Surgery in Northfleet, to Gravesham Community Hospital which is 1.3 miles away.

7.4. This intensive engagement comprised:

7.4.1. Telephone interviews with local politicians and GP practice staff conducted independently by the Public Engagement Agency (PEA™)

7.4.2. Discussions with 85 local people and patients using the Walk-in Centre and neighbouring GP practices (conducted by CCG staff during one day, evening and weekend day)

7.5. **Telephone interviews** were conducted with councillors representing the five wards most directly impacted by the proposed changes: Coldharbour; Northfleet North; Northfleet South; Painters Ash; Pelham; and with a representative from each of the three GP practices in the same location as the Walk-In Centre (i.e. The Forge, Whitehorse Surgery, and The Gateway practices).

7.6. The full report on the community impact assessment is attached in ***Appendix D***.

7.7. In summary, the following key themes emerged from the telephone interviews:

7.7.1. Nearly all respondents agreed that urgent care services need to change although concern was voiced about how successful the change would be;

7.7.2. Most people said the proposal to move the Walk-in Centre was a good idea. Positive feedback included reducing waiting times; reducing the pressure on GPs; Gravesham hospital is more accessible; good public transport – buses and trains; better use of resources; one point of access; improved access to GPs

7.7.3. 4 people were less positive and their concerns included: need to decentralise, be more local; need to add not reduce services; could be seen as cost-saving; concern about privatisation; parking at the hospital is limited/always full; transport may be difficult at the starting point of the journey; potential for increasing waiting times

7.7.4. GP "superhubs" and extended GP hours were welcomed as a way of reducing waiting times and being more responsive to people who worked

7.7.5. Concerns were funding, clinical staffing, losing the personal touch, increased workload, staff retaining their jobs

7.7.6. People need to be educated on how to use the services more appropriately

7.7.7. People need ongoing information about the proposed changes

7.8. Participants were asked what else the CCG should do to gain people's views and feedback. A range of approaches were offered, including:

7.8.1. Giving people information about the changes: what and why

7.8.2. Using networks; speaking with resident associations

7.8.3. Using social media, such as website, twitter

7.8.4. Writing to people; putting information in newspapers

7.8.5. Conducting surveys; running focus groups and workshops

7.8.6. Providing information via the surgeries

7.9. One person said there should be a consultation if people were overwhelmingly against the proposals. Another said while consultation is a good thing it doesn't inspire the general public – the CCG needs to go out and talk to people and keep them informed.

7.10. The need to inform and communicate more effectively with people who might use services was an important theme. Ensuring people had confidence in the new services being provided (and how to access them), will be an important element of success.

7.11. Respondents were clear that any changes made must result in better patient experiences and outcomes but provided differing views, about whether a perceived centralisation of services would deliver the improvements required.

7.12. The patients who took part in the **face-to-face interviews** came from the following areas: Gravesend, Northfleet (including close proximity to the Walk-in Centre), Dartford, Greenhithe, Swanscombe, Chalk, Longfield, Meopham, and one patient from Rochester. This included a number of patients who lived very local to the Walk-in Centre. Ages ranged from teenage to 80+ and 35 males were interviewed compared with 50 females. The patients came from a variety of ethnic backgrounds.

7.13. In summary, the following key themes emerged from the face-to-face interviews:

7.13.1. 71% (60 people) thought it was a positive thing that it could move to the Gravesham Hospital site

7.13.2. Only eight people felt it was a negative thing, and the rest (12) gave neutral views

7.14. Positive feedback included:

7.14.1. Better accessibility for a wider population

7.14.2. Better public transport links

7.14.3. Easier to find

7.14.4. Co-location with the Minor Injuries Unit would make it easier to use services in the right way.

7.15. Negative feedback included:

7.15.1. Parking could be an issue as patients would need to pay

7.15.2. If the small number of parking spaces on site were taken, town centre parking could be costly.

7.16. The patients who were spoken to face-to-face on site were largely positive about the possible move of location to Gravesham Hospital and this included some people who lived very local to its current site. It should be stressed that many of those who felt it would be a positive move, mentioned the parking issues.

7.17. Of those who thought the potential move was positive, 31 stated that it would be more accessible for patients than the current Walk-in Centre.

7.18. Better transport links were also given as a plus side to the move with many people thinking of the benefits for others who live out of the town centre but who could benefit from the improved transport links.

7.19. Some of the patients who lived within a short walk of the current Walk-in Centre said they did not feel the proposed move was negative because they were likely to benefit from more GP appointments available at Fleet Healthcare. They also said they would be happy to travel a mile into town to the Walk-in Centre if needed and it would not be a problem.

7.20. Of the 60 patients who said it would be a positive move, 18 felt parking could possibly be an issue for some people; solutions they suggested included more parking on site, making parking free, creating a drop off point, and using nearby carparks for free parking.

7.21. Of the eight people who said it would be a negative move, three didn't want it to move at all, one felt hospitals were not a place for people to see a GP and felt there would be stigma involved, four felt having to travel further was an issue, and one suggested a Walk-in Centre should also be put at Darent Valley Hospital.

7.22. Some people felt locating the Walk-in Centre alongside the minor injuries unit was a positive move and that it would help people understand how to use services better.

7.23. This feedback has, in the opinion of the CCG, confirmed that local people do not see the plans to relocate the Walk-in Centre as controversial.

7.24. In terms of future stakeholder engagement, based on the findings of the Community Impact Assessment, the CCG proposes to act in line with the assessment findings. There appeared to be minimal appetite for a more formal consultation process, especially as most stakeholders broadly supported the proposals.

7.25. The CCG proposes to conduct a full range of engagement activities between August 2017 and October 2017, using the variety of channels and methods identified by the respondents and outlined above, to ensure the local people are fully informed and appropriately engaged. This will include a roving roadshow with CCG staff talking to local people in supermarkets, Gateways, health centres and hospitals, an online survey, focus groups with residents groups and audiences identified by an Equalities Impact Assessment, and at least three events – one for providers and key stakeholders to work up draft specifications for services, another with GPs (PLT) to build on the specification, and a third one with patients and public to test the specification and refine before going out to tender.

8. Conclusions and Recommendation

8.1. The Committee is requested to note the content of this case for change and proposed model of care and to determine if the Committee considers the proposals to be a substantial variation and if a period of formal consultation with the Committee is required.

8.2. The model options include the re-procurement of NHS111 services, supported by an enhanced Integrated Clinical Advice Service (ICAS) with improved system interoperability, and the re-procurement of GP out-of-hours services.

8.3. The model option includes the centralisation of non-ED urgent care walk-in services at the Gravesham Community Hospital site and the re-design of the services based at Fleet Healthcare Campus. The proposed model features the potential relocation of the Walk-in Centre service to Gravesham Community Hospital (1.3 miles away) in 2019, and a possible re-design of the service at Fleet Healthcare Campus to include increased general practice provision and extended primary care access.

8.4. On the advice of the Consultation Institute, and in order to ascertain the level of engagement or consultation required, the CCG conducted a Community Impact Assessment in June 2017. Based on the findings of the community impact assessment, the CCG proposes to conduct a full range of engagement activities between August 2017 and October 2017, using a variety of channels and methods to ensure the local people are fully informed and appropriately engaged.