NHS Swale 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 model to the Committee in March 2017.

1.2 Following three listening events held across Swale and DGS 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 Swale 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 two listening events held in Swale with the public in February 2017, as well as resource and financial considerations.

1.4 The Swale 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 model proposes that similar services remain at both Sittingbourne Memorial and Sheppey Community Hospitals, but that the ways in which services are integrated will deliver benefits to patients.

1.6 Ways in which urgent same day appointment capacity can be increased in future will be explored as part of the Primary Care Strategy discussions and this may include the provision of some or all urgent same day appointments from centralised 'hub' locations rather than from each individual GP practice.

1.7 The changes to the Swale urgent care model are not considered to be significant as proposals do not involve a change to the way in which patients access services, and no formal public consultation is currently planned. Swale CCG intends to carry out further engagement activities with a range of key stakeholders, and with the public, including co-design of the service specification, commencing in July 2017.

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), and Swale CCG made further progress by holding both a GP Engagement Event, and a Market Engagement Event. A summary is attached in ***Appendix A***.

2.3.2. **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.***

2.3.3. **February 2017: Swale Listening Events.** Listening events were held across Swale and DGS 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. Two such events were held in Swale, one in Queenborough and another in Sittingbourne, due to the very different issues facing residents of the localities of Sittingbourne and the Isle of Sheppey. 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, Swale CCG, in partnership with DGS 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 Swale and DGS CCGs, patient and clinician reference groups were held and a potential solution was identified which was based around a hub and spoke model. Swale CCG made further progress and held both a GP Engagement Event, and a Market Engagement Event.

3.4. 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.

3.5. 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.

3.6. In October 2015, the national programme pause was lifted.

3.7. 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:

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

3.7.2. 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.

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

3.7.4. System interoperability to enable greater integration.

3.8. 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:

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

3.8.2. 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.

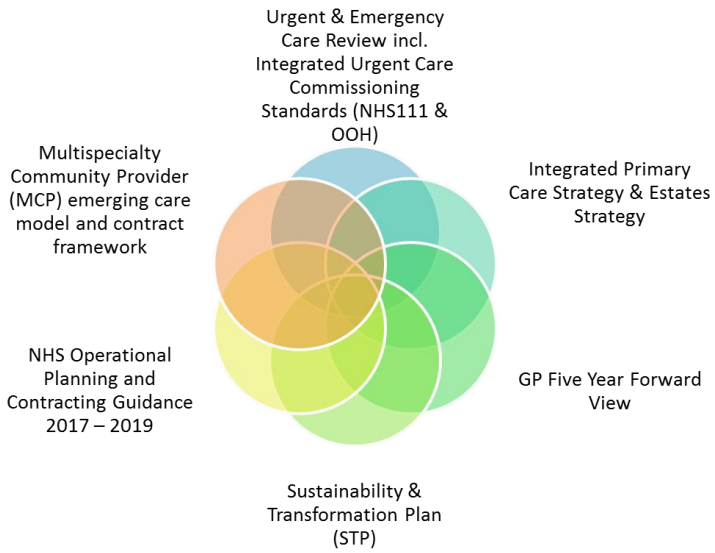
3.8.3. Workforce and workload issues.

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

3.8.5. 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.

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

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



3.10. 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 The flow of patients from Swale to Medway NHS Foundation Trust for urgent and emergency care services necessitates the need for Swale and Medway CCGs to work together to design urgent and emergency care services.

4.3.2 Medway NHS Foundation Trust – 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 largest age group growth is in people 85+ (bringing increased needs for health and social care).

4.7 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 over 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.

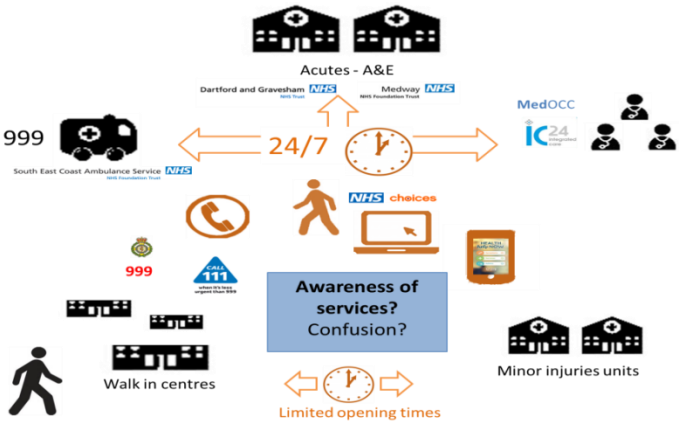
Other key facts about local emergency department (ED) November 2015 - October 2016**:**	**Swale**
ED rate per 1000 population	205
ED attendances discharged to GP / discharged with no follow-up	6 in 10
Average waiting time - emergency department	3.4hrs
Emergency department attendance growth	11%

4.8 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):	**Swale**
People living with LTC - Diabetes Register	6,367
People living with LTC - CKD Register	3,532
People living with LTC - Cancer Register	2,756
People living with LTC - Chronic Obstructive Pulmonary Disease (COPD)	2,493
People with Mental Health	725
People living with LTC - Palliative Care Register	158

4.9 Swale and DGS 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:

4.9.1 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:



4.9.2 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.

4.9.3 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.

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

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

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

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

4.9.8 There is an education gap for patients and clinicians.

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

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

4.9.11 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 outlined below.

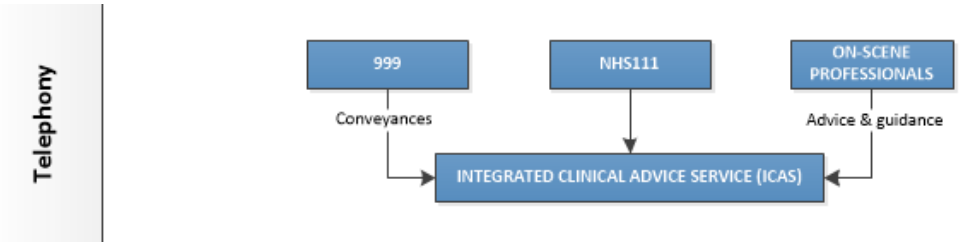
6. Potential Model and Critical Paths

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 clinician and patient reference groups, 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 'go live' is 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. The 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. Swale 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

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 April 2019 but this has yet to be explored fully.

6.4.1.4. The changes to the urgent care model are not considered to be significant and no formal public consultation is currently planned. Swale CCG intends to carry out further engagement activities with key stakeholders and the public, including some co-design elements specifically relating to the design of the service specification, commencing in August 2017.

6.4.2. Challenges

6.4.2.1. **Population Growth** – The population of Swale is 108,489 with a projected increase of 7.5% over the next 5 years. The population is split with 43,832 in Sheppey with a more defused population in rural areas and 64,657 in Sittingbourne and surrounding areas with a high percentage living in densely populated areas. Sheppey has the highest distribution of adults of working age and the highest distribution of over 65 year olds. There is an additional seasonal summer growth in the Sheppey population of between 30,000 and 40,000 holiday makers in the summer. The CCG's Local Plan has been subject to examination by the Inspector who has determined there is a need for an increased target to an additional 13,129 dwellings by 2031. Assuming 2.4 people per dwelling this gives a population increase of 31,661. The Swale Borough Council area includes Faversham which is not part of the CCG area so the likely population increase for our CCG is around 85% of the total i.e. circa 27,000.

6.4.2.2. **Health Inequalities** – Swale is the third most deprived district within Kent with Sheppey and Murston areas identified as being in the bottom quintile (lowest 20%) on the national deprivation scale. Swale has the lowest life expectancy in the region – 79.3 years compared to an average of 80.9 years in Kent and Medway. 28% of adults are classified as obese in Swale with the highest proportion on Sheppey. 73% of all deaths relate to cancer, circulatory and respiratory disease. The number of admissions to hospital due to alcohol specific conditions has been rising year on year since 2001

6.4.2.3. **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 and across organisational boundaries.

6.4.3. Key Elements of the Potential Clinical Model

6.4.3.1. **Same Services Improved through Integration** The potential model for Swale CCG represents an improvement to the current services offered, but does not represent a significant variation to current services due to the need to cater to the whole of the Swale population, including those on the Isle of Sheppey. Patients will be able to continue to access the same types of services in the same place as they currently do but there will be greater integration between services on each site, and between services across the two sites. Accessing available services will be less complicated and will be supported by centralised reception functions at each site and the possible use of Care Navigators. The potential model can begin to be worked on immediately in the form of procurement activities which are planned to commence after further public and stakeholder engagement.

6.4.3.2. **Walk-in Services –** The potential model addresses the feedback we have received from the public, and from the whole system event. The model therefore maintains urgent care walk-in services at both Sittingbourne Memorial and Sheppey Community Hospital. There was strong feeling from the public that there needed to be closer integration of Minor Injury and Walk-in Centre services on the Sheppey site and this will be addressed through the re-procurement exercise.

6.4.3.3. **GP Services In and Out-of-Hours** – Under the potential model practices would continue to operate as they currently do, including the offering of urgent same day appointments. There will be greater integration between in and out-of-hours GP services with the aim of creating a more seamless 24/7 GP function. The GP out-of-hours service will retain current services in terms of base sites and home visits, and may include the use of a multidisciplinary team to support the out-of-hours GP function (e.g. paramedic practitioners). This will represent a significant move towards the introduction of the GP as consultant model. Ways in which urgent same day appointment capacity can be increased in future will be explored as part of the Primary Care Strategy discussions and this may include the provision of some or all urgent same day appointments from centralised 'hub' locations rather than from each individual GP practice.

6.4.3.4. **ED Primary Care Streaming -** The flow of patients from Swale to Medway NHS Foundation Trust for urgent and emergency care services necessitates the need for Swale and Medway CCGs to work together to design urgent and emergency care services. This proposal is being led by Medway CCG. The proposal is for an Urgent Care Centre (UCC), operating 24 hours a day / 7 days per week, incorporating out-of-hours and walk-in provision, to be co-located with Medway Maritime Hospital ED. Patients will be streamed by a senior clinician into the most appropriate pathway and setting. These include the ED, Minor Injuries Unit, Frailty Pathway, and Paediatrics or directly to an acute assessment unit, hot clinic or ambulatory pathway. It will offer advice on self-care, pharmacy guidance and prescribing, access to primary care treatment including GPs and Nurse Practitioners, a Minor Injury Unit and home visits. The UCC will also include mental health services enabling swift access for patients as required and will be supported by diagnostics (X-Ray, USS, and Pathology). It will also be supported by social care with support from the Integrated Discharge Team and Discharge to Assess as required. Medway and Swale CCGs will collaborate to ensure the local population is appropriately consulted. The proposed changes mean that Medway Maritime Hospital will continue to provide services for Swale residents. Given the availability of a walk in centre, MIU and GP OOH services within Swale, Medway's proposed relocation of the Medway Walk-In Centre to the Medway Maritime Hospital site is expected to have minimal impact for the local Swale population. However, Medway and Swale CCGs are working together to ensure that Swale residents have the opportunity to comment on the proposed changes within

Medway, this will include a public event during the summer period. Medway CCG recently presented their consultation document before the HASC and it is included here for information – **Appendix D.**

7. Engagement Plans

7.1. The changes to the Swale urgent care model are not considered to be significant as proposals do not involve a change to the way in which patients access services, and no formal public consultation is currently planned. Swale CCG intends to carry out further engagement activities with a range of key stakeholders, and with the public, including co-design of the service specification, commencing in July 2017.

7.2. The engagement plan includes two events with local audiences. These events include:

7.2.1. 26 July 2017: Event in Sittingbourne with selected providers and key stakeholders to determine a draft specification for the services

7.2.2. 30 August 2017: Event for public and other stakeholders to examine and refine the draft specification for the services

7.3. In addition, there are plans to talk to local people about urgent care in the CCG roving roadshows which will be held in public areas such as supermarkets, Gateways, and health centres throughout the summer.

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 clinical model proposes that similar services remain at both Sittingbourne Memorial and Sheppey Community Hospitals, but that the ways in which services are integrated will deliver benefits to patients. The changes to the urgent care model are not considered to be significant as proposals do not involve a change to the way in which patients access services, and no formal public consultation is currently planned.

8.4. Swale CCG intends to carry out further engagement activities with a range of key stakeholders, and with the public, including co-design of the service specification, commencing in July 2017.