

## Urgent Primary Care Options for Formal Public Consultation

Primary Care Commissioning Committee meeting

**D**

25 September 2017

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<b>Purpose of Paper</b>	
<p>This paper sets out key information from the submission to NHS England's Strategic Sense Check Review 2. This information provides the assurance that the CCG has undertaken a thorough and detailed process to develop the options for a redesigned service pathway and model and should enable the Primary Care Commissioning Committee to approve the options to be taken out to formal public consultation and to approve the commencement of the consultation on 26 September.</p> <p><b>Please note that due to the size of the supporting appendices (as listed on page 25) only the supporting paper is included for consideration. The full version can be accessed at:</b></p> <p><a href="http://www.sheffieldccg.nhs.uk/Downloads/Primary%20Care%20Commissioning%20Committee/2017/September%202017/PAPER%20D%20SUPPORTING%20APPENDICES.pdf">http://www.sheffieldccg.nhs.uk/Downloads/Primary%20Care%20Commissioning%20Committee/2017/September%202017/PAPER%20D%20SUPPORTING%20APPENDICES.pdf</a></p>	
<b>Key Issues</b>	
<p>The key issues articulated in the paper include:</p> <ul style="list-style-type: none"> <li>• A clear justification of the need to redesign Urgent Primary Care in Sheffield because the current pathway and service configuration (the 'do nothing' option) is not feasible (section 3)</li> <li>• A description of the revised system pathway and the key differences from the current pathway (section 4)</li> <li>• An outline of the processes undertaken to identify the options for service reconfiguration to be included within the public consultation and of the activity, finance and workforce modelling underpinning this process (sections 5 and 8)</li> <li>• The options to be taken to public consultation and their benefits (section 6 and 7)</li> <li>• The future contracting and procurement issues that will need to be considered (section 9)</li> <li>• The biggest risks associated with the options to be consulted upon (section 10)</li> <li>• The formal public consultation plan (section 11)</li> </ul>	
<b>Is your report for Approval / Consideration / Noting</b>	
Approval	

<b>Recommendations / Action Required by the Primary Care Commissioning Committee</b>
<p>The Primary Care Commissioning Committee is asked to:</p> <ul style="list-style-type: none"> <li>• Approve the options to be taken out to formal public consultation</li> <li>• Note the consultation plan</li> <li>• Approve the commencement of the formal public consultation</li> </ul>
<b>Governing Body Assurance Framework</b>
<p><b><i>Which of the CCG's objectives does this paper support?</i></b></p> <p>Strategic objective – to ensure there is a sustainable, affordable healthcare system in Sheffield</p>
<b>Are there any Resource Implications (including Financial, Staffing etc)?</b>
No
<b>Have you carried out an Equality Impact Assessment and is it attached?</b>
<p>No. There are no specific issues with this report.</p> <p>An Equality Impact Assessment has been undertaken on each option included within the options appraisal process and is included within the pre-consultation business case (Appendix 3)</p>
<b><i>Have you involved patients, carers and the public in the preparation of the report?</i></b>
<p>Significant engagement with the public and other stakeholders has been undertaken as part of the review and redesign of the options to be taken out to public consultation as set out in section 3 of this report.</p>

# **Urgent Primary Care Options for Formal Public Consultation**

## **Primary Care Commissioning Committee meeting**

**25 September 2017**

### **1. Introduction**

- 1.1. This paper sets out key information from the submission to NHS England's Strategic Sense Check Review 2. This information provides the assurance that the CCG has undertaken a thorough and detailed process to develop the options for a redesigned service pathway and model and should enable the Primary Care Commissioning Committee to approve the options to be taken out to formal public consultation and to approve the commencement of the consultation on 26 September.
- 1.2. It should be noted that under the terms of the CCG's Constitution (in particular its Scheme of Reservation and Delegation) Governing Body would normally expect to take this kind of decision. However, once the options to be taken out to consultation were identified, it was clear that this would almost certainly create a significant conflict of interest for most Governing Body GP members (ie certainly all those who are partners in their practices). This is because any of the options if approved after consultation, are likely to result in additional investment in primary care, much of which may directly or indirectly benefit General Practices.
- 1.3. This means that Governing Body would no longer be quorate so following the terms of the Constitution (specifically the Standing Orders and Conflict of Interests Protocol), Governing Body agreed on 7<sup>th</sup> September to delegate the decision to the Primary Care Co-commissioning Committee (PCCC). Governing Body also agreed that assuming the options for public consultation are approved, it will delegate all other decisions relating to the Urgent Primary Care public consultation and any Final Business Case for implementation of the chosen option to PCCC.

### **2. Scope**

- 2.1. Urgent Primary Care refers to a health problem that the patient thinks needs to be looked at by a Health Care Professional within the next 24 hours. It includes both mental and physical health needs and minor injuries as well as minor illness. This includes all of the services listed below. It does not mean an illness/injury that is serious, life or sight threatening or needs an immediate response where you would call 999 or drive to A&E. This type of care is known as Emergency Care and is outside the scope of this reorganisation.

Figure 1 Services in scope for the review and redesign of Urgent Primary Care



2.2. It should be noted that only the urgent primary care activity seen within the adult and paediatric A&E Departments is included within scope, emergency activity is excluded. Dental care has also been excluded from the scope of the review. This is because NHS England (who commission all dental care) are currently undertaking a review of urgent dental care across South Yorkshire. The SCCG team are in dialogue with NHS England colleagues to make sure that each organisation is sighted on the potential impact and outcome of the other organisation's work.

2.3. The review of urgent primary care services fits within the 'Ensuring patients' needs are met within Primary Care' work stream of the CCG's Urgent Care Strategy (May 2016). In January 2017 Governing Body tasked the Urgent Care Portfolio with undertaking the review and developing options to redesign Urgent Primary Care within Sheffield. This work has been led by the Urgent Primary Care Working Group comprising GPs, Locality Manager representatives and members of the Urgent Care, Mental Health, Children and Young People, Active Support and Recovery and Engagement and Communications teams. This has been overseen by an Urgent Primary Care Programme Board (which includes Sheffield Providers and NHS England) and is accountable to the Urgent and Emergency Care Transformation Delivery Board (A&E Delivery Board as was).

### 3. Why is the redesign needed?

3.1. The Working Group reviewed a number of factors when considering why Urgent Primary Care should be redesigned and what issues the redesign needed to address. These included:

- The national and local context and strategic direction
- The national requirements and best practice for urgent care and how Sheffield measures against these
- The need and demand for Urgent Primary Care services in Sheffield
- The current configuration of services
- Feedback from the engagement with Patients, Public, Primary Care and providers

- 3.2. It is recognised both nationally and locally that in the face of increasing demand for services, changing expectations of patients, changing healthcare policy regarding seven day services, increased workforce challenges and increased financial pressures that commissioners must seek to develop innovative ways of delivering high quality and safe services that continue to meet patient need.
- 3.3. Nationally a review of urgent and emergency care has been led by Sir Bruce Keogh with the aim of ensuring that patients nationally have access to integrated 24/7 urgent care services. This review is now in its implementation phase and is supported by national guidance and expectations for the entire urgent and emergency care pathway.
- 3.4. Urgent care is highlighted as a priority within local STP plans with the overarching aim of simplifying urgent and emergency care and making it easier for patients to access the right services closer to home. This is supported by the local UECN and West Yorkshire Emergency Care Network Vanguard which are focussed on delivering the key elements of the national strategy at pace.
- 3.5. The CCG's Urgent Care Strategy (May 2016) interpreted the national strategy and outlined the local strategy needed to deliver the national requirements. This is structured around four key work streams, the first of which is to 'Ensure patients' needs are met within Primary Care'. This element of the strategy focuses on ensuring that patients only access acute care when needed and that wherever appropriate their care is provided in primary care.
- 3.6. Several national documents have been published recently which set out the standards and expectations for local Urgent and Emergency Care systems. These include the 'Stevens and Mackey letter 'Action to get A&E performance on track' (March 2017), the Urgent and Emergency Care Delivery Plan (April 2017), the 'Standards and Principles for Urgent Treatment Centres' (July 2017) and the 'Integrated Urgent Care Service Specification (August 2017).
- 3.7. Key areas highlighted in current guidance that are of most relevance to the services and pathways within the scope of this programme of work are:
- The need to standardise walk in centres, minor injury units and urgent care centres into Urgent Treatment Centres (UTC) centres. These must treat minor illness and injury together with an emphasis on the need to co-locate services where possible so that they offer a consistent high quality service and are less confusing for patients to access.
  - Simplify access to local services through a single entry point (NHS 111) with the integration of 111 and local Out of Hours GP services to deliver high quality clinical assessment, advice and treatment.
  - Deliver the requirements of the GP Forward View Next Steps (March 2017) with regard to rolling out pre-bookable and same day evening and weekend GP appointments, together with the provision of GP streaming in A&E departments by September 2017.
- 3.8. There are significant health inequalities and a significant gap in life expectancy between the most and least deprived communities. The causes of this include differential access to and unwarranted variation in healthcare. Sheffield's

disadvantaged and marginalised communities are more likely to have cancer, cardiovascular disease, respiratory disease and mental illness and they are more likely to be diagnosed late, to have more years of poor health and to die prematurely.

3.9. Over and above disease burden and morbidity, the principal factors of population need underpinning demand for urgent care in the city are likely to be related to age profile, ethnicity / migration and deprivation.

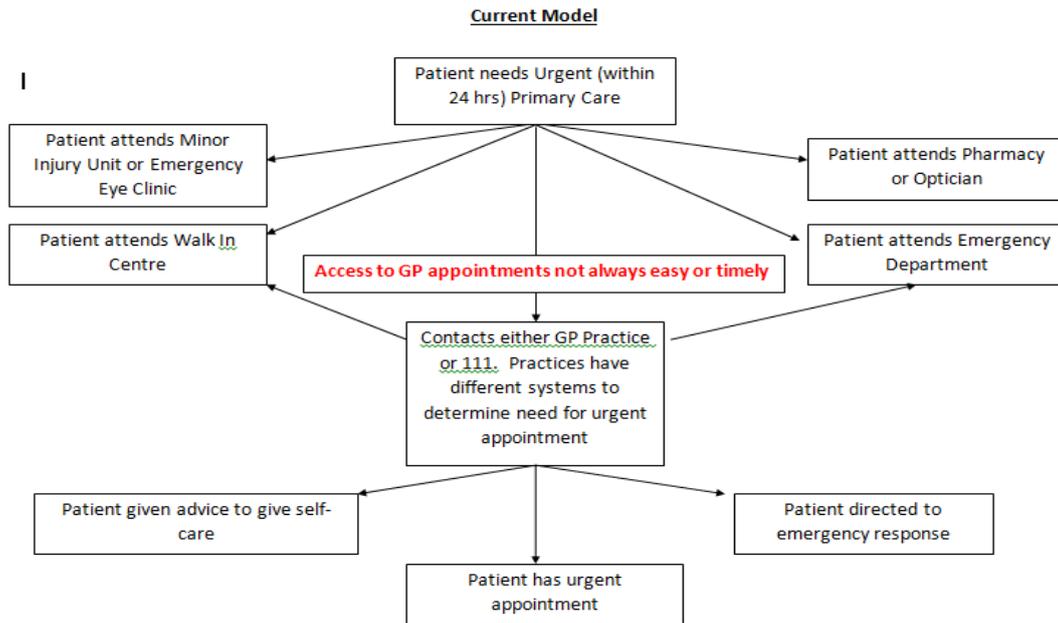
3.10. Sheffield has a strong young age bias in the population because of the 2 universities and this skews the need and demand profile. Being born outside the UK, non-English as first language and recent migrants are factors militating in the direction of unscheduled care use relative to primary care / planned care. Estimates of non-British nationals per 1,000 resident population is substantially higher than the region and of the eight English core cities, Sheffield is the 3rd highest for international inward migration. In deprivation terms, circa 35% of Sheffield LSOAs appear in the bottom 20% of LSOAs nationally, and the overall IMD2015 deprivation score is significantly higher than England (27.6 vs 21.8).

3.11. The Public Health team have analysed the level of need and current demand for urgent care within Sheffield. The key findings from this work are summarised below:

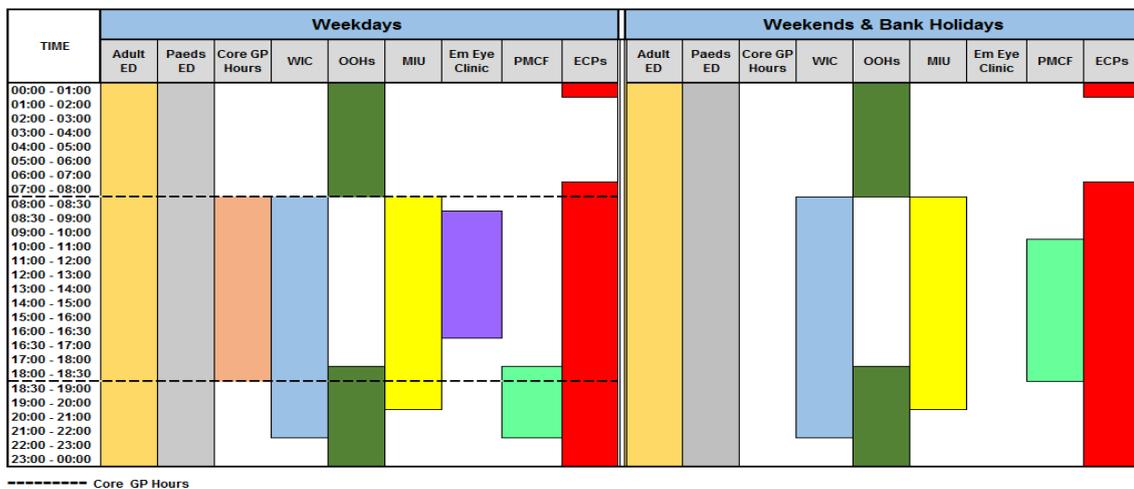
- The need for urgent care is hard to quantify, but when considering the number and age band of patients with multiple long term conditions, ambulatory sensitive care conditions and the risk of being admitted to hospital, it is clear that the older the population is, the greater the need for urgent care.
- Different services within the city are currently serving very different population constituencies and that there are inequalities of access based on levels of deprivation.
- The age profiles of the three unscheduled options are radically different. A&E has a very marked older age and elderly bias, whereas satellite and walk-in clinics have a marked young age bias
- There is only a weak association of satellite clinic rates of attendance (referral + self-referral) with deprivation, in contrast to the much stronger positive deprivation association shown by A&E attendees
- The mapped geospatial distribution of A&E, WIC and extended access attendees are very markedly different, reinforcing the assertion that these services are serving radically different populations
- Based on comparative age profiles it is estimated that a quarter of WIC attendees are university students

3.12. The current model of Urgent Primary Care has multiple, duplicating service offers and no clear pathway for patients to follow as set out in Figure 2. In addition, the availability of these services differs depending on the time or day of the week (see Figure 3) and there are gaps in access.

**Figure 2: Current model/pathway**



**Figure 3: Current access provision to first line urgent care services in and out of hours**



3.13. Social Care, PEARS optometrists, Social Prescribing, Self-Care and Pharmacies are excluded from this summary as provision is provided at scale across Sheffield, with different hours, etc.

3.14. Extensive engagement on Urgent Care has been carried out over the last two years (see Appendix 1 for full reports). This included work with Healthwatch Sheffield to understand the experiences of people who utilise urgent care services in the city. The main findings from the general engagement (approximately 14,500 contacts) are summarised below. Patients are:

- Unable to get a GP appointment when they need one or at a suitable time
- Confused about what services to use

- Experiencing urgent care services very differently across Sheffield
- Experiencing a complicated, fragmented system with a lack of communication between services and organisations

3.15 Further work was undertaken at the start of 2017 to ensure the CCG heard from groups that had not been well represented so far. The groups included:

- Homeless people
- People dependent on drugs and alcohol
- People living in deprived communities
- Vulnerable people (e.g. asylum seekers, people being trafficked, those with failed asylum, those who have fled domestic violence etc.)
- City Workers
- Students

3.16 In the most recent 289 community members shared their views and semi-structured interviews were conducted with staff from the health, social care and the charity sector, to enable exploration of ideas and themes that emerge from daily contact with community members. The key themes and trends are summarised below:

- Access to mobile phones was described as an issue by staff working in specialist health services with 13 out of 164 people (8%) not having access to a phone
- The cost of travel on public transport was described as a barrier particularly for people with no or low income
- Specialised support teams are pivotal in navigating the system with and on behalf of people.
- Based on the self-reported information, all communities reported that the service they had used most in the last year was pharmacy, other than the substance misuse community.

3.17 Opportunities for providers to engage with the review were advertised on NHS Contracts Finder via 2 Procurement Intention Notices and both current and potential providers attended 3 workshops on minor illness/injury and 1 meeting on urgent eye care. Providers confirmed that from their perspective:

- The level of urgent care demand is significantly impacting on some providers i.e. current KPI performance is not being achieved, with quality and long-term sustainability concerns
- The skills mix of the workforce is often inappropriate for patient's clinical need.
- Communication between providers is often fragmented.

3.18 Members of the Working Group have also attended a number of meetings with GPs and Localities, local representative committees and other stakeholders. Progress reports are being provided to the Healthier Communities & Adult Social Care Scrutiny & Policy Development Committee who are acting as a helpful 'critical friend'. All of the stakeholder meetings are listed in Appendix 2 for information.

3.19 These meetings and all of the feedback received and discussions have been used to:

- Identify the main reasons for redesigning Urgent Primary Care and the objectives to be achieved from the redesign (as per Table 1 below)
- Shape the new urgent care pathway
- Informed the development and refinement of the options to be taken out to consultation

3.20 The main reasons for redesigning Urgent Primary Care as articulated in Table 1 provide a clear justification as to why remaining with the current pathway and configuration of services (the 'do nothing' option) is not feasible. This discounting of the 'do nothing' option is further supported by the fact that specific aspects of the current configuration failed to pass the permutation test as outlined in section 5 and the fact that the current service configurations scored as higher than any of the redesigned options in the combined Equality Impact Assessments and Quality Impact Assessments (as outlined in section 5)

**Table 1: Reasons and objectives for Urgent Primary Care redesign**

Main reasons for redesigning Urgent Primary Care	Objectives of redesign
Patient feedback said the current system is confusing and hard to navigate and patients are not always treated in the most appropriate service. The range and location of services also creates confusion and duplication	Reduce duplication and simplify access
Patients are not accessing the current services based on levels of need. Some groups of patients are encountering barriers to access e.g. cost of public transport, access to a phone, and interpreter requirements.	Reduce inequalities
Access to urgent appointments within practices varies significantly across Sheffield, as does the length of wait for a planned appointment. This creates further inequalities across the city.	Improve access to urgent care provided by GP practices (without increasing waiting times for planned care)
The increase in demand for GP appointments is not sustainable from workforce and financial perspectives	Support a sustainably resourced primary care
Empowering patients to self-care where appropriate encourages them to take responsibility and positive action for their health and wellbeing and reduces unnecessary interactions with urgent care services.	Encourage and support self-care
The CCG has a duty to ensure that it buys services which provide value for money (spending less, spending well and spending wisely).	Provide value for money
Patient feedback had indicated that being able to access care locally is important but this has to be balanced to ensure that care is also appropriate for the	Deliver care locally and appropriately

population.	
Over the last year, STHFT have struggled to achieve the four hour A&E target. This is in part because of the volume of attendances, a proportion of which could have been managed within primary care.	Reduce pressure in Emergency Departments
The system has to incorporate a number of national requirements into the services provided within Sheffield; including the need to provide urgent treatment centres.	Contribute to or enable delivery of the national requirements

3.21 It should be noted that there is no requirement for the redesign to result in a significant recurrent cost saving to the system. The CCG does require the revised service model to provide value for money and it does expect that savings will be made from some services but these will need to be reinvested within other primary care services in order to ensure the whole model is sustainable.

3.22 The Health and Wellbeing Board confirmed that these objectives are in line with those of the Health and Wellbeing Board.

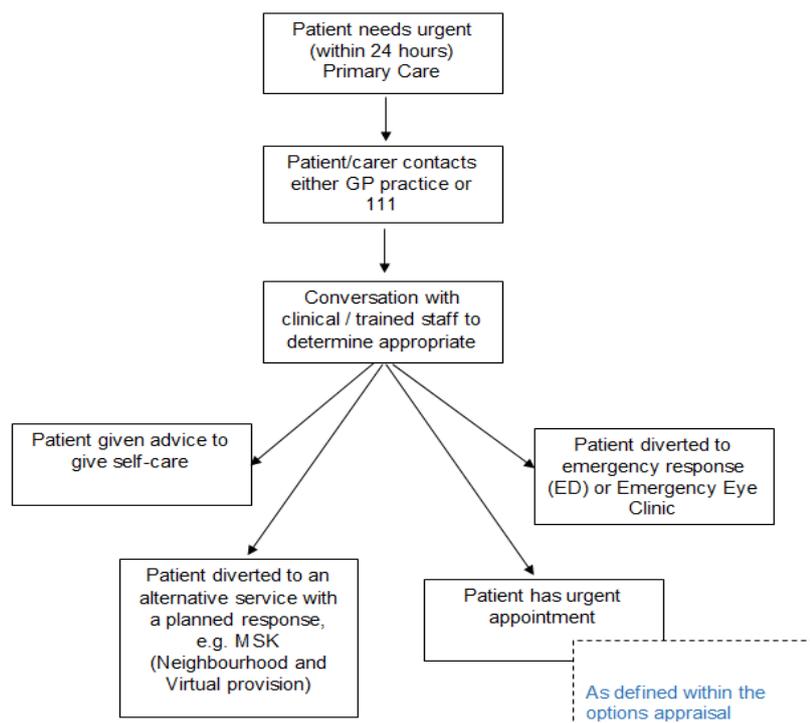
#### **4 System pathway**

4.1 As outlined in section 3 above, the current service configuration provides a duplicated service offer and is confusing for patients. The Working Group set out to address this in part by simplifying the pathway to access Urgent Primary Care. The revised pathway, set out in Figure 4, was developed, refined and tested as appropriate through the stakeholder engagement described above.

4.2 The pathway will be described in the public consultation documentation for information along with the three options for where services would be provided from.

4.3 Some patients will recognise this pathway as the one they currently follow when they need an urgent appointment but this will now become the consistent pathway that all patients will follow. Key aspects of this revised pathway are detailed below.

**Figure 4: Revised System Pathway**



4.4 When somebody thinks they need urgent primary care, the main route of access will be to contact either their GP practice (in working hours) or 111 (in or out of working hours). The patient or their carer will speak to a clinician (or trained advisor) who will determine the most appropriate response for the patient. The majority of this activity will be undertaken virtually by phone, skype etc, although some patients may require a face to face conversation. Currently, many Pharmacies provide a signposting (and sometimes treatment) service for minor ailments (in and out of hours) and this is expected to continue even though it is not referenced within the pathway above. Similarly, some patients will ask an Optician for advice or assessment of an eye condition and this will also continue to happen.

4.5 The main strength of this pathway is the impact of the conversation with the clinician or trained staff. The patients will not have to wait an extended length of time from requesting the conversation to actually having it, as is often the case now. The purpose of the discussion is to direct/signpost the patient to the most appropriate response for their health need. The clinician/trained staff will have access to the patient's full health record when they have the conversation (where the patient has given consent).

4.6 These factors will ensure that both planned and urgent care services are used more effectively within Sheffield and should reduce demand for urgent primary care across the system. The ability to consistently guarantee and book the patient an urgent face to face appointment within 24 hours when necessary as part of that conversation will be of significant benefit to patients.

4.7 The ability of pharmacists and opticians to book appointments across the system is not something that has been deemed to be a priority at this stage in the redesign because of the technical and financial challenges this would present and this is why they are not referenced in the second step of the pathway above.

4.8A key element of the new pathway is assessing whether patients require continuity of care (approximately 11% of the population) as part of the triage process. Those who do will continue to be seen at their own GP practice in hours with longer appointment lengths. Patients who don't need continuity of care for that episode will be directed to the reconfigured service as set out in the options within the consultation. Continuity of care should be provided when it will positively impact on the outcome of the consultation.

4.9A further associated aspect of the pathway will be the diversion of patients with urgent primary care needs away from emergency services (999 and A&E). Patients with urgent primary care needs who ring 999 will be diverted to 111 and those who present at the A&E departments will be diverted through the GP streaming process into an UTC. Both of these changes will be enacted through commissioning activities outside the direct sphere of the Urgent Primary Care review and redesign but they are clear interdependencies.

## 5 Process to identify options to take out to public consultation

5.1 The provider workshops considered, added to and refined a list of options for the service redesign. These were generated from the objectives and engagement work outlined above. This resulted in a 'long list' of options that could potentially be considered.

5.2 Each of these options were subjected to a permutation test. This test consisted of three questions which were refined at one of the Provider workshops. The answer to each question had to be yes in order for an option to progress to the next stage. The questions were:

- Are activity levels likely to sustain the services?
- Does the change enable the right thing to happen first time (reduce costs?)
- Is the permutation logically feasible, i.e. estates, capital, core contract, workforce, infrastructure, etc?

5.3 Attendees of the last provider workshop were invited to score each option against the three questions. These were then reviewed and considered by the Working Group who made the final decision on each of the tests/options. The final results are included below. The 'yes' outcome below indicates that the option progressed to the next stage of the process.

**Table 2: Results of the Permutation Test**

Options	Outcome
<b>Urgent (within 24 hours) GP offer for patients who don't feel they need continuity of care options</b>	<b>Option Remains?</b>
<b>8am – 6.30pm Week days</b>	
1 site within Sheffield for the whole city	No
3, 4 or 8 sites across Sheffield	No
16-19 sites (Neighbourhoods)	Yes
Do Nothing: 81 sites (GP Practices) + WIC	No
<b>6.30pm – 11pm &amp; all day weekends</b>	
1 site within Sheffield for the whole city	No

3, 4 or 8 sites across Sheffield	Yes but 3 sites does not meet extended access requirements and there is insufficient activity for 8 to be viable
16-19 sites (Neighbourhoods)	No
Do Nothing: WIC, Extended Access Hubs and Out of Hours services	Not considered as discounted within Case for Change
<b>11pm – 8am 7 days a week</b>	
1 site within Sheffield for the whole city	Yes
3, 4 or 8 sites across Sheffield	No
Do Nothing: Out of Hours services	Not considered as discounted within Case for Change
<b>Minor Injuries Options</b>	
Minor Injuries seen and treated within 2 existing EDs (1 adult and 1 paediatric)	Yes
Adult and paediatric minor injuries seen and treated within 1 stand-alone unit (located anywhere in Sheffield)	No
Minor injuries seen and treated on sites co-located with the 2 existing EDs (1 adult and 1 paediatric)	No
Minor injuries seen and treated at same locations as Urgent Same Day Primary Care offer - Patients who don't feel they need continuity of care	No
Adult Minor injuries seen and treated on NGH site co-located with ED and Paediatric minor injuries seen at SC(NHS)FT ED	Yes
Do Nothing: Adult Minor Injuries seen and treated within existing ED and at a stand alone unit, Paed Minor Injuries seen and treated within existing ED	No
<b>Urgent Eye Care Options</b>	
Urgent eye care undertaken at a number of community sites across the city with extended opening hours	Yes
Do Nothing: Emergency Eye Clinic	Not considered as discounted within Case for Change

5.4 At this point, the national requirements for Urgent Treatment Centres and GP streaming were considered and options for how these could be incorporated were developed. The Urgent Treatment Centre options were also subjected to the permutation test and 3 of these passed.

**Table 3: Permutation Test Outcomes for UTCs**

Options	Outcome Option Remains?
Option 1: At NGH and SCH - co-located with GP streaming	Yes
Option 2: Just at NGH co-located with GP streaming	Yes
Option 3: Co-located with existing MIU	No
Option 4: Existing WIC location	Yes
Option 5: A neighbourhood site	No

5.5 All of the options that passed the permutation test were then considered, **combined** and developed further by the Urgent Primary Care Working Group to generate 6 options for minor illness/injury and one option for urgent eye care. This process was underpinned by Equality Impact Assessments and Quality Impact Assessments and detailed activity, workforce and finance work as outlined below.

- 5.6 As well as simplifying the pathway, all options are based around establishing an Urgent Treatment Centre(s) located close to A&E. This will replace the current Walk-in Centre and Minor Injuries Unit and treat both minor illnesses and minor injuries. Patients will still be able to walk into UTC(s) if they choose to but will also be offered appointments booked at the point of conversation with the clinician/trained staff. The differences between the options predominantly relate to where children are treated.
- 5.7 The Neighbourhood service (for patients who don't need continuity of care) will be led by GPs, but will include a multidisciplinary team of professionals, including Pharmacists and Advanced Nurse Practitioners etc. The patients will be seen by the most appropriate member of the team and this will be determined during the conversation with the clinician/trained staff. The staff having the conversation will also have access to a swift response from a wider team; i.e. MSK, Children and Mental Health staff based in existing and co-located services with same day slots available plus offer of virtual support to the multidisciplinary team. The team will also actively support patients back to health via telephone check-up appointments when necessary.

**Table 4: The options included within the options appraisal process**

	Option 1	Option 2	Option 3	Option 4	Option 5	Option 6
	Patient / carer contact NHS111 or local GP surgery and are signposted to appropriate care					
<b>8am – 6.30pm Weekdays</b>	Patients who need continuity of care for that episode seen within own <b>practice</b>					
	Patients who do not need continuity of care seen within a <b>neighbourhood setting</b> (currently 16) or at					
	<u>Adults</u> <b>NGH UTC</b> (illness symptoms and minor injuries)	<u>Adults</u> <b>NGH UTC</b> (illness symptoms)  <b>NGH UTC</b> (minor injuries)	<u>Adults</u> <b>City Centre UTC</b> (illness symptoms)  <b>NGH UTC</b> (minor injuries)	<u>Adults</u> <b>NGH UTC</b> (illness symptoms)  <b>NGH ED</b> (minor injuries)	<u>Adults</u> <b>NGH UTC</b> (illness symptoms)  <b>NGH ED</b> (minor injuries)	<u>Adults</u> <b>City Centre UTC</b> (illness symptoms)  <b>NGH ED</b> (minor injuries)
<u>Children</u> <b>SC(NHS)FT UTC</b> (illness symptoms)	<u>Children</u> <b>NGH UTC</b> (illness symptoms)	<u>Children</u> <b>City Centre UTC</b> (illness symptoms)	<u>Children</u> <b>SC(NHS)FT UTC</b> (illness symptoms)	<u>Children</u> <b>NGH UTC</b> (illness symptoms)	<u>Children</u> <b>City Centre UTC</b> (illness symptoms)	
<b>SC(NHS)FT ED</b> (minor injuries)	<b>SC(NHS)FT ED</b> (minor injuries)	<b>SC(NHS)FT ED</b> (minor injuries)	<b>SC(NHS)FT ED</b> (minor injuries)	<b>SC(NHS)FT ED</b> (minor injuries)	<b>SC(NHS)FT ED</b> (minor injuries)	
<b>6.30pm – 11pm Weekdays Weekends (Saturday/ Sunday 8am – 11pm)</b>	Patients seen within a <b>locality setting</b> (4 sites location tbc, sites also provide planned care) or at					
	<u>Adults</u> <b>NGH UTC</b> (illness symptoms and minor injuries)	<u>Adults</u> <b>NGH UTC</b> (illness symptoms)  <b>NGH UTC</b> (minor injuries)	<u>Adults</u> <b>City Centre UTC</b> (illness symptoms)  <b>NGH UTC</b> (minor injuries)	<u>Adults</u> <b>NGH UTC</b> (illness symptoms)  <b>NGH ED</b> (minor injuries)	<u>Adults</u> <b>NGH UTC</b> (illness symptoms)  <b>NGH ED</b> (minor injuries)	<u>Adults</u> <b>City Centre UTC</b> (illness symptoms)  <b>NGH ED</b> (minor injuries)
	<u>Children</u> <b>SC(NHS)FT UTC</b> (illness symptoms)	<u>Children</u> <b>NGH UTC</b> (illness symptoms)	<u>Children</u> <b>City Centre UTC</b> (illness symptoms)	<u>Children</u> <b>SC(NHS)FT UTC</b> (illness symptoms)	<u>Children</u> <b>NGH UTC</b> (illness symptoms)	<u>Children</u> <b>City Centre UTC</b> (illness symptoms)
	<b>SC(NHS)FT ED</b> (minor injuries)	<b>SC(NHS)FT ED</b> (minor injuries)	<b>SC(NHS)FT ED</b> (minor injuries)	<b>SC(NHS)FT ED</b> (minor injuries)	<b>SC(NHS)FT ED</b> (minor injuries)	<b>SC(NHS)FT ED</b> (minor injuries)
<b>11pm – 8am (7 days a week)</b>	Adults and children attend <b>NGH UTC</b> (illness symptoms and booked appointments only)					

5.8 The Working Group developed options appraisal themes and indicators which were tested and refined with attendees of the third provider workshop and were signed off by the Urgent Primary Care Programme Board. The Group then applied a weighting to each indicator and developed assessment criteria for the scoring process. It was agreed that the options with the 3 highest total scores would be taken forward to the consultation phase.

**Table 5: Options Appraisal Criteria**

Theme to support evaluation	Indicator	Weighting
Criteria 1 – Public Feedback 1	Access to Urgent Primary Care is simplified	25
Criteria 2 – Public Feedback 2	Services are easy to access (close to home / public transport links)	15
Criteria 3 – Clinical and Quality 1	Care is delivered in the right place, first time	15
Criteria 4 – Clinical and Quality 2	The option ensures that the primary care workforce is sustainable	15
Criteria 5 – System and Commissioner Objectives 1	Inequalities are reduced	15
Criteria 6 - System and Commissioner Objectives 2	The options support the integration agenda	15
Criteria 7 – Value for Money	Is the system financially sustainable; i.e. the new model doesn't cost more than the current one	Yes / No No = Rejected

5.9 EIA and QIA were completed for each of the 6 minor illness/injury options, the eye care option and the current systems (do nothing option) for minor illness/injury and urgent eye care (Appendix 3) to show the qualitative impact of each option. In addition, a quantitative measure was also described for each EIA and QIA and these were aggregated to generate an overall score. These overall scores were used to score the option appraisal Criteria 5 (Inequalities are reduced).

5.10 For ease, the combined EIA/QIA scores for each of the options are detailed below:

Minor Illness/injury

- Option 1: Combined score of 7.4 (Moderate Risk)
- Option 2: Combined score of 9.1 (High Risk)
- Option 3: Combined score of 10.1 (High Risk)
- Option 4: Combined score of 7.2 (Moderate Risk)
- Option 5: Combined score of 9.1 (High Risk)
- Option 6: Combined score of 10.1 (High Risk)
- 'Do Nothing' Option: Combined score of 11.6 (High Risk).

Urgent Eye Care

- Option 1: Combined score of 6.0 (Moderate risk)
- Do Nothing' option: Combined score of 8.6 (High risk)

5.11 Analysis of travel times, both for cars and bus journeys has been undertaken to assess the impact of patients travelling from one practice to another and travelling from different parts of the city to the UTC(s). The journey times to the UTC were

factored into the options appraisal scoring process under criteria 2. The travel times between practices will help to inform the decision as to where to site the neighbourhood and locality sites as outlined in section 6.

5.12 The 'Do Nothing' option was not formally appraised because the case for change was felt to be strong enough to require a new model and key components of the current system failed to pass the permutation test. The Urgent Eye Care option was not formally appraised because only one option was considered.

5.13 The 6 options set out in Table 5 were then individually assessed by 10 members of the Urgent Care Working Group and an independent GP from outside Sheffield. For transparency, the scores of members of the Group with potential conflicts of interest were then excluded (although this did not change the ranking order of the options). This approach was designed to provide a comprehensive review and evaluation process to support recommendations to improve clinical outcomes and sustainability.

5.14 The results of the option appraisal are set out below:

**Table 6: The Presenting Options from the Options Appraisal**

Option	Score
Option 1 (First)	33
Option 2 (Second)	28.05
Option 3	21
Option 4 (Third)	25.5
Option 5	21
Option 6	19.5

## 6 Options to be taken out to formal consultation

6.1 The inclusion of a preferred option does not mean that this will necessarily be the option implemented at the end of the process. Due to the complex nature of the subject it was however considered helpful to highlight to the public and stakeholders which option the CCG believes offers the greatest benefits to patients and the health care system.

### 6.2 Preferred option for minor illness/injuries (Option 1).

#### 8am – 6.30pm Week Days

- Patients who need continuity of care seen within own practice
- Patients who do not need continuity of care seen within a neighbourhood setting (currently 16) or at
- Adults attend Northern General Hospital Urgent Treatment Centre (NGH) (illness symptoms and minor injuries)
- Children attend Sheffield Children's (NHS) Foundation Trust Urgent Treatment Centre (SCH(NHS)FT) (illness symptoms) or SC(NHS)FT ED (minor injuries)

### **6.30pm - 11pm weekdays and 8am – 11pm weekends**

- Patients seen within a locality setting (4 sites location tbc, sites also provide planned care) or
- Adults attend NGH Urgent Treatment Centre (illness symptoms and minor injuries)
- Children attend SC(NHS)FT Urgent Treatment Centre (illness symptoms) or SC(NHS)FT ED (minor injuries)

### **11pm – 8am 7 days a week**

- Adults and children attend NGH Urgent Treatment Centre (illness symptoms and booked appointments only)

### **6.3 Option 2**

Option 2 is the same as option 1 except that both Adults and Children are seen at the NGH Urgent Treatment Centre for illness symptoms (instead of Adults being seen at NGH and children being seen at SCH).

### **6.4 Option 4**

Option 4 is the same as option 1 except that Adult minor injuries are seen at NGH ED rather than the NGH UTC

### **6.5 Option for Adult Urgent Eye Care**

Care is undertaken in the community across a number of sites (maximum 25) with extended opening hours

6.6 It is important to note that the consultation will not include the location of the neighbourhood or the locality settings. The CCG will include information in the consultation which describes which General Practices sit within each neighbourhood.

6.7 The decision about where patients will be seen within in each neighbourhood/locality will be made after the consultation and will be based on a number of factors including:

- Accessibility –journey times by car and public transport from each practice
- Space available within the location
- How the practices wish to work from a workforce perspective
- The needs of the population in each neighbourhood

## **7 What does this mean for the people of Sheffield?**

7.1 The public will have an opportunity to engage with and further shape the redesign of Urgent Primary Care services within Sheffield through the 3 month public consultation.

7.2 Assuming the revised system pathway, one of the minor illness/injury proposed options and the proposed urgent eye care option are implemented, the public should see a number of improvements across the system. An initial benefits analysis has been undertaken, but from a patient perspective, the main outcomes

are summarised below. These will satisfy the objectives set out at the start of the process.

- Simplified services, making it as easy as possible for people to get the urgent care they need first time, whatever part of the city they are in
- More people (including children and people requiring eye care) cared for in primary care in a timely, more equitable manner – within 24 hours of initial request
- Patients who need continuity of care will be seen by their GP practice with longer length of appointments
- Reduced duplication of services and best use made of local taxpayers' money
- Increased service navigation for patients and booked urgent appointments, less need to 'turn up and wait' for urgent health care
- Patients can see the most appropriate clinician for their needs including Mental Health worker, Physiotherapist or Pharmacist
- Where necessary patients will be receive call back to assess change in condition and jointly agree next steps
- Patients who choose to call 999 or go to an Emergency Department with minor illness symptoms will be diverted to an urgent primary care service

7.3 In addition, implementation would result in

- Compliance with all national commissioning guidance
- Reduced demand for A&E, which will contribute to improved performance of the 4 hour A&E target for patients with life threatening urgent care needs
- A strong and sustainable Primary Care workforce

## **8 Activity and Finance and Workforce Modelling**

8.1 Detailed activity, finance and workforce modelling was undertaken to inform the options appraisal process.

8.2 The first step in this process was to establish the spend for Urgent Primary Care based on the current CCG investment in urgent care services within the scope of the urgent primary care model. In a number of areas an estimate has been made as to the proportion of total activity within the current contract which falls into the model. This is summarised in Table 7 below.

**Table 7: Current spend**

<b>Current Service</b>	<b>17/18 Contract Value</b>	<b>% of contract within the model</b>	<b>Spend for Urgent Primary Care</b>
	£'000	£'000	£'000
<b>Funded from CCG core allocation</b>			
Walk In Centre	2,659	100%	2,659
Minor Injuries Unit	1,090	97%	1,061
A&E Adults	13,804	9%	1,276
A&E Paediatrics	5,347	9%	471
Emergency Eye Centre	1,144	71%	812
GP Collaborative	3,742	100%	3,742
111	1,241	100%	1,241
<b>CCG spend</b>			<b>11,263</b>

<b>Additional funding received from NHS England</b>			
Extended Access - Primary Care Hubs	3,479	53%	1,844

8.3 The following notes should be considered when reviewing the table above:

- The cost of activity undertaken in General Practices has not been included because this is part of the GP core contract arrangements, which are assumed to continue.
- In 2017/18, building on the pilot work undertaken through the auspices of the Prime Minister's Challenge Fund in 2015/16 and 2016/17, Sheffield CCG is one of a few areas in the country which has been allocated funding by NHS England to support extended access in primary care and which is being used to support access through four primary care hubs. There is uncertainty whether or how this funding will flow post March 2019. Thus to be prudent the modelling assumes this funding is not available recurrently.
- The model excludes current A&E activity for minor illness, as this is the subject to separate discussions re GP streaming. It is acknowledged that any analysis of the impact of service reconfiguration on current providers would need to recognise the impact of both work streams.

8.4 As noted in section 3.9 above, there is no requirement for the redesign to result in a significant recurrent cost saving to the system. The CCG does require the revised service model to provide value for money and it does expect that savings will be made from some of the current services but these will need to be reinvested within other urgent primary care services in order to ensure the whole model is sustainable.

8.5 The activity included within the current model of care provided a baseline which was then adjusted to reflect the expected change in activity flows resulting from the changes to the current pathway. This involved an assessment of how activity may reduce/increase as a result of implementing clinical triage and then reflecting how the flow of activity would change with the new service configuration.

8.6 This work required the use of a number of activity, financial and workforce assumptions. Where possible, these were based on national evidence or best

practice, e.g. the Channel Shift Model and/or snap shot audits of the activity currently undertaken within the system. All of the assumptions made were agreed by the Working Group as being prudent and sensible at this stage. Further detailed work will be undertaken during the public consultation phase to test and refine all of the assumptions in preparation for the development of the Final Business Case.

- 8.7 The results of this analysis suggests that there would be a significant increase (242,000) in the volume of clinical triage contacts but that this would actually drive a reduction (103,000) in the number of face to face appointments required across the urgent care system. This is because the whole scale adoption of clinical triage across the city will enable approximately 40% of patients to be redirected to self care, planned or emergency care and because the navigation provided at the triage conversation will ensure that patients are directed to the correct service first time.
- 8.8 An assessment of the current workforce in general practices and the additional workforce required to deliver each of the proposed options has been undertaken. At this stage it is anticipated the workforce needed will be formed from a combination of existing staff working in current services and some additional, new staff across a range of clinical professions. The conclusion of the analysis undertaken to date and the current workforce strategy indicates that the workforce requirements of each option can be met. Further detailed work will be undertaken during Phase 2 to assess the current workforce across the whole of urgent primary care, to refine the skill mix split for each service and to understand what that would mean for the staff working within each of the current services.
- 8.9 Based on the modelling undertaken, the overall financial impact of the reconfiguration based on implementation of the preferred minor illness/injury option and the eye care option is broadly cost neutral against expected recurrent allocations This position excludes potential non recurrent set up costs.
- 8.10 If Option 2 were to be implemented, this cost increase would be expected to be negated through the reduced workforce and overhead costs associated with having 1 rather than 2 UTCs in the city.
- 8.11 Implementation of Option 4 would be unaffordable if the current tariff arrangements were retained. This option passed the options appraisal process on the basis that the CCG would seek to negotiate a revised tariff arrangement for the adult minor injury activity but this does pose a significant risk.
- 8.12 As stated above, the modelling is based upon many assumptions at each stage of the new pathway and this does create a significant level of risk as outlined further in section 9.
- 8.13 No capital costs and associated revenue consequences have been assumed to be required at this stage because it is anticipated that the services can be provided from within the existing estate. Further testing of this assumption will be undertaken during the next phase of the process.
- 8.14 There is expected to be an impact on the current urgent care providers within the city and this will range from the closure and replacement of some services (Walk In Centre, Minor Injuries Unit) to a re-location (Locality evening and weekend service) to an increase or reduction in activity (Urgent and Emergency Eye Care, A&E Departments, GPs, Opticians, Out of Hours services). The CCG is

cognisant of the impact that these changes and any associated procurements may have on individual providers when combined with other service developments. Further work will be undertaken with the potentially affected providers during the next phase of the process to test and refine the impact of implementation of each of the potential options.

## **9 Future Contracting and Procurement**

9.1 The resulting model will need to be commissioned using the NHS Standard Contract form. There are, however, several different contracting models that could be adopted. These include:

- Prime Provider / Lead Provider model whereby one provider is responsible for delivering the commissioned service across the area and will sub contract specific elements of the pathway/service to other providers.
- Alliance model whereby the CCG and Provider(s) enter into an agreement to work cooperatively and to share risks and rewards. Each provider has their own NHS Standard Contract with the commissioner but there is also an overarching alliance agreement in place which enables the commissioner and providers to work together.
- Status Quo whereby this service model is incorporated into each provider's existing NHS Standard Contracts with Sheffield CCG; dependent on procurement / market development as discussed below.

9.2 These options will be fully explored and developed fully within an options appraisal outlining contracting and procurements routes, during the public engagement period, following NHSE Stage 2 Approval process.

9.3 The route to sourcing provider(s) for delivery of the resulting model will be fully explored and developed fully within an options appraisal outlining contracting and procurements routes, during the public engagement period.

## **10 Risks**

10.1 The Working Group has a live risk register which captures all of the potential risks associated with both the process of the review and redesign and the implementation of the options agreed at the end of the process. The highest risks associated with the options to be consulted on are summarised below.

**Table 8: Highest risks associated with the review and redesign**

Risk Description	Impact Risk Score	Deliverable Risk Score	Mitigation Plan
CCG is unable to overcome one or more 'non-negotiable' issues required to work at scale (e.g. governance, medical indemnity) within programme timescales	16	16	Local task and finish group set up involving key stakeholders to develop and implement action plan. Access NHS E support and learning from around the country on how to resolve issues. To be monitored monthly by the Urgent Care In Primary Care working group.
Option 4 identified as option to be implemented but becomes unaffordable due to tariff negotiations	12	15	Explanation of the risk included within the public consultation documents. Further work undertaken during Phase 2
Assumptions used to inform the activity and financial modelling are incorrect or not managed/controlled	12	12	Significant further work planned during Phase 2 to test and refine assumptions, working with current providers. To be monitored monthly by the Urgent Care In Primary Care working group
Investment required in primary care to set up neighbourhoods cannot fund activity deemed to be part of the GP core contract	12	12	Work with NHS E to clarify what activity is considered to be part of core contract. Further define requirements of the neighbourhood aspect of the model and how this would be commissioned during phase 2
SCH & NGH are unable to or do not want to accommodate UTC facilities	12	12	To be explored in more detail during Phase 2 with relevant providers
Practices chose not to adopt neighbourhood working and/or redeploy staff from practices into neighbourhood service	12	12	Understand reservations and ensure that the benefits of working at scale are clearly communicated. Work with neighbourhoods to develop viable operational models. Consider phased implementation approach. To be monitored monthly by the Urgent Care In Primary Care working group.
Sheffield ACP does not mature sufficiently quickly to manage issues that may arise	12	12	Issues would need to be managed in accordance with ACP MOU and escalated as necessary

## 11 Consultation Plan

11.1 A comprehensive communications and engagement plan has been developed to support the 3 month formal consultation and it is attached as Appendix 4. It aims to raise awareness of the changes being proposed and give people a wide variety of opportunities to give their views on these. It includes a focus on ensuring we hear from people with protected characteristics and from vulnerable groups or those living in areas of deprivation and draws on the learning from the engagement and pre-consultation phases to ensure it is based on 'what works' for our stakeholders and responds to the needs and preferences they have expressed.

11.2 Assuming the options and consultation plan are approved by the Committee, the formal consultation will run from 26<sup>th</sup> September until 18<sup>th</sup> December 2017.

## **12 Next steps and timescales for implementation**

12.1 Approval of the options and consultation plan constitutes the end of Phase 1 of the Urgent Primary Care review and redesign programme. Phase 2 will run from 26<sup>th</sup> September until the end of March 2018. The key actions within this phase will focus on the public consultation and the significant amount of work required to progress and develop a Decision Making Business Case. It is anticipated that the Primary Care Commissioning Committee would consider that business case in March 2018.

12.2 Once the Decision Making Business Case is approved, the programme would move into Phase 3, mobilisation. It is anticipated that the full pathway and service configuration would be in place by April 2020, although elements of this will need to be phased in over the next 2 years.

## **13 Conclusion**

13.1 NHS England have recently scrutinised this work at a Stage 2 Assurance Checkpoint. The team were commended on the extensive development and appraisal process and Yorkshire and Humber assurance panel confirmed it had been provided with evidence that the proposals could be assured to a sufficient level against the four tests for service change:

- Strong public and patient engagement,
- Consistency with current and prospective needs for patient choice,
- A clear clinical evidence base; and
- Support for proposals from clinical commissioners

## **14 Recommendations**

The Primary Care Commissioning Committee is asked to:

- Approve the options to be taken out to formal public consultation
- Note the consultation plan
- Approve the commencement of the formal public consultation

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On behalf of: Peter Moore, Director of Strategy and Integration

11 September 2017