NHS
Sheffield
Clinical Commissioning Group

A

Primary Care Commissioning Committee
Unadopted minutes of the meeting held in public on 25 September 2017
Boardroom, 722 Prince of Wales Road

Present:	Ms Amanda Forrest, Lay Member (Chair)
(Voting Members)	Mrs Nicki Doherty, Interim Director of Delivery – Care Outside of Hospital Miss Julia Newton, Director of Finance Mrs Mandy Philbin, Acting Chief Nurse Mrs Maddy Ruff, Accountable Officer
(Non-Voting Members)	Mrs Katrina Cleary, Programme Director Primary Care Dr Trish Edney, Healthwatch Sheffield Representative Ms Victoria Lindon, Senior Primary Care Manager, NHS England Dr Zak McMurray, Medical Director
In Attendance:	Mrs Carol Henderson, Committee Secretary Mrs Kate Gleave, Deputy Director of Strategy and Integration (for item 78/17) Mr Peter Moore, Director of Strategy and Integration (for item 78/17) Mrs Rachel Pickering, Primary Care Co-Commissioning Manager

Members of the public:
There were five members of the public in attendance.
A list of members of the public who have attended CCG Primary Care Commissioning Committee meetings is held by the Director of Finance.

Minute		ACTION
71/17	**Welcome and Introductions** The Chair welcomed members of the Sheffield Clinical Commissioning Group (CCG) Primary Care Commissioning Committee and those in attendance to the meeting. The Committee and invited attendees individually introduced themselves to the members of the public.	
72/17	**Apologies for Absence** Apologies had been received from Mrs Penny Brooks, Chief Nurse, and Professor Mark Gamsu, Lay Member. Apologies for absence from those who were normally in attendance had been received from Dr Nikki Bates, CCG Governing Body GP, Dr Mark Durling, Chair, Sheffield Local Medical Committee (LMC), and Mr Greg Fell, Director of Public Health, Sheffield City Council. The Chair confirmed that the meeting was quorate.	

73/17 **Declarations of Interest**

The Chair reminded the committee members of their obligation to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of NHS Sheffield Clinical Commissioning Group (CCG), and that not only would any conflicts of interest need to be noted but there would also need to be a note of action taken to manage this. The Chair reminded members that they had been asked to declare any conflicts of interest in agenda items for discussion at today's meeting in advance of the meeting.

Declarations declared by members of the committee are listed in the CCG's Register of Interests. The Register is available either via the secretary to the Primary Care Commissioning Committee or the CCG website at the following link:
http://www.sheffieldccg.nhs.uk/about-us/declarations-of-interest.htm

There were no declarations of interest relating to agenda items from today's meeting.

74/17 **Questions from the Public**

One provider and two members of the public had submitted questions before the meeting. The CCG's responses to these are attached at Appendix A.

75/17 **Minutes of Previous Meeting**

The minutes of the meeting held on 27 July 2017 were agreed as a correct record, subject to the following amendments:

a) Welcome and Introductions (minute 59/17 refers)

Second sentence to read as follows:

The Chair and invited attendees individually introduced themselves to the members of the public.

b) Sheffield Primary Care Estates Strategy (minute 65/17 refers)

Second paragraph to read as follows:

… and consider which third sector organisations might also be engaged.

c) Update on Thursday Afternoon Opening (minute 67/17 refers)

Final sentence of third paragraph to read as follows:

… it is anticipated that a mixed economy of individual practices and 'at-scale' models is being developed.

d) Transformational Support (minute 68/17 refers)

First sentence of fourth paragraph to read as follows:

The Programme Director advised that the second paper relating to this item was the proposal that SCCG had submitted to NHSE about resilience in General Practice

76/17 Matters Arising

a) Transformational Support (minute 68/17 refers)

The Senior Primary Care Manager, NHS England reported that the Programme Director Primary Care had been advised that certain elements of the CCG's resilience plan bid had been successful, which she would confirm as part of her update to the next PCCC meeting. **KaC**

b) Interpreter Service (discussed at previous meetings)

The Healthwatch representative asked when an update on procurement of this service would be given. The Programme Director Primary Care responded that this contract had only just been agreed and would present an update to the committee in either November or December. **KaC**

77/17 Update on Thursday Afternoon Opening

The Programme Director Primary Care presented this report which provided members with an update on the Sheffield position in relation to access to GP services during core hours and extended hours, covering the extended access Directed Enhanced Service (DES). She reminded members that, as reported to the committee in July, NHS England was seeking assurance, by way of a plan, from the CCG, that access to core services would be delivered throughout the week, as 75% of our Member practices had not been fully open over the winter period in 2016/17.

The Programme Director Primary Care advised members that the position had been improving since June. She reported that the CCG's Task and Finish Group continued to understand the requirements of the new extended access DES guidelines which had raised a number of questions as to whether our opening at scale options would be acceptable. She reported that the position now was that 71% (58) of practices had indicated that they would open or were already open, with a small number (four) opening but not offering the extended access DES. The practices that had indicated that were not going to open would not be eligible to offer the DES. In summary, she reported that considerable progress had been made but we awaited the commissioner guidance regarding those practices that continued not to offer full week opening.

The Programme Director Primary Care explained that the CCG would

support the practices in their communications strategy that demonstrated the degree of opening and accessibility.

Members supported the direction of travel as it fitted our model of primary care, and asked that patients were kept totally up to date as to what was happening at their practice.

The Primary Care Commissioning Committee:

- Discussed and noted the content of the report.
- Noted the significant improvement made in a short period of time on increasing access to GP services during core hours from 1 October 2017.
- Supported the proposal to work with the practices on their communication to patients and their new E-Dec submission.
- Recognised that further work was anticipated, subject to the Commissioner Guidance expected from NHS England on the 'reasonableness test'.
- Supported the ongoing development of an at scale solution to deliver core general practice in the longer term in line with the proposed urgent primary care options.

78/17 **Urgent Primary Care Options for Formal Consultation**

Mrs Kate Gleave, Deputy Director of Strategy and Integration, and Mr Peter Moore, Director of Strategy and Integration, were in attendance for this item to present this report and give a presentation that updated members on the process that had been undertaken to develop options for formal public consultation for a redesigned service pathway and model for urgent primary care.

The Deputy Director of Strategy and Integration drew members' attention to the engagement that had been undertaken through a variety of methods from 2015 to 2017 and the work undertaken with providers. Three engagement workshops had also fed into this work, which had informed a long list of options that had been whittled down, with each one subject to a permutation test and an options appraisal process which had also included a travel times assessment between each practice. A case for change had then been presented to NHS England at a stage 2 assurance checkpoint, when they had taken a view as to whether sufficient work had been undertaken to provide them with a significant level of assurance against the four tests for service change (strong public and patient engagement, consistency with current and prospective needs for patient choice, clear clinical evidence base, and support for the proposals from clinical commissioners). She was pleased to be able to report that NHS England had concluded that all four tests had been met through the undertaking of a thorough process. She clarified that there would be no changes to services this coming winter, which had been made very clear in the public consultation document. With regard to timescales, it was proposed that the consultation would run from 26 September 2017 to 18 December 2017, with feedback from the public consultation to be presented to the PCCC in February 2018. Final

proposals would be presented to the committee for approval at the end of March 2018. The CCG's Strategic Communications Lead had been working with members of the public as a reader to give the CCG a view as to whether the consultation document was an 'easy to read and understand' document.

The Deputy Director of Strategy and Integration explained the proposed revised system pathway and the options included within the options appraisal process that were detailed at table 4 (page 15). The patient or their carer would contact either their practice or the NHS111 service, discuss the most appropriate option and be booked appointment. They were aiming for 60% of these discussions to be with a clinician although some discussions would be with a trained member of staff.

The Deputy Director of Strategy and Integration explained that, for patients / carers contacting the services within GP core hours, if they needed continuity of care for that episode, they would be seen within their own practice, but if they did not need continuity of care they would be seen within a neighbourhood setting. Patients or carers contacting the services between the hours of 6.30 pm to 11.00 pm and / or at weekends between the hours of 8.00 am – 11.00 pm would be seen within a locality setting, and those contacting the services between 1.00 pm to 8.00 am on any day of the week would be seen at the Northern General Hospital (NGH) Urgent Treatment Centre (UTC). However, for urgent eye care there would be an opportunity for the patient to be seen across a number of sites.

The Director of Finance advised members that she could reassure them that a substantial amount of modelling work had been undertaken, although some assumptions had had to be made. She also highlighted that proposals relating to possible procurement and contract models would follow the outcome of the consultation.

Members were advised that key messages fed back during work to date with hard to reach groups had included that there were a large number of patients without access to telephones, especially if they had no access to credit. They had also fed back that the cost of using public transport was very high

The CCG had been surprised by some of the information on patients who used the walk in centre facilities, with data showing there was almost 25% more people in the 18-25 student population compared to the profile for this age range in Sheffield. A high number of these students chose to access the walk in centre, whilst keeping their own GP and still being registered outside of the city, which meant that we, as a city, did not receive the funding we should to provide the treatment to those patients. Work needed to be undertaken to seek clarity as to why these patients did not register in the city. There were also a lot of anomalies of how patients access services and we needed to get bac to the position where core GP services were providing these services. We also had a developing neighbourhood

maturity index, a lot of which would be past paced, and had to make sure that they were all dovetailed.

Members discussed that there would be huge workforce implications whichever option was agreed. There was also a gap in our whole system approach in that the CCG had a lack of influence with the providers of public transport in the city, which had to meet the needs of passengers / patients, and it would be helpful if the Accountable Care Partnership (ACP) could get some influence in that.

The Healthwatch representative recognised the huge workload pressure on practices and that the idea of simplifying the process was welcome. Her thoughts were that a large number of students were advised by their patients not to register with another GP, but it would help if all practices made re-registering a less threatening process.

Finally, the Deputy Director of Strategy and Integration drew members' attention to section 5.8 that set out the rationale for selecting only the three highest total scoring options to be taken forward to the public consultation phase, and that they would stand by the decision they had made.

The Primary Care Commissioning Committee:

- Approved the options to be taken out to formal public consultation.
- Noted the consultation plan.
- Approved the commencement of the formal public consultation.

79/17 **Month 5 Financial Position**

The Director of Finance presented this report which provided information on the financial position for primary care budgets as at 31 August 2017 and asked the committee to consider the risks and challenges to be managed in-year. She drew members' attention to the key issues which included that there were some small year to date underspends on the delegated budgets and on the additional CCG commissioned budgets. She advised that if these continued to year end they would be needed to offset other CCG pressures. With regard to the provisional winter resilience reserve of £350k, she advised that proposals for expenditure were expected to be presented to the committee at the next meeting. **KaC**

The Primary Care Commissioning Committee:

- Noted the financial position at Month 5.
- Considered the potential risks and challenges to delivery of a balanced financial position against primary care budgets for 2017/18.

80/17 **Proposal for Amendment to Terms of Reference for the Primary Care Commissioning Committee (PCCC)**

The Director of Finance presented a proposed change to the PCCC's

Terms of Reference to include the CCG's Clinical Director for Care Outside of Hospital as a non voting member of the committee. She advised that this role would be a non voting member as this role was undertaken by a GP with likely conflicts of interests, as with GPs on the Governing Body., although it would depend on their particular circumstances.

The Primary Care Commissioning Committee recommended to Governing Body to approve the change to the committee's Terms of Reference to include the CCG's Clinical Director – Care Outside of Hospital as a non voting member.

81/17 **Any Other Business**

The Chair reported that she had not been advised of any items to be discussed under this item, therefore, there was no further business to discuss in public this month.

82/17 **Date and Time of Next Meeting**

The next meeting scheduled to take place on Thursday 26 October 2017 has now been CANCELLED.

The next meeting will take place on Thursday 23 November 2017, 2.00 pm – 3.30 pm, in the Boardroom, 722 Prince of Wales Road.

Appendix A

Responses to Questions raised at the
NHS Sheffield CCG Primary Care Commissioning Committee
25 September 2017 in relation to Urgent Primary Care

Question 1. Why are the options you propose to consult on so similar, all of them assuming the closure of existing facilities (Minor Injuries Unit, Eye Emergency Clinic and Walk-In Centre)?

CCG response: All three of the minor illness/injury options recommend closing the Minor Injuries Unit and the Walk-In Centre and replacing them with Urgent Treatment Centres in line with national requirements. While each option may seem very similar they have been arranged to ensure the CCG has been diligent in exploring in all combinations of service models to ensure the best value and quality for patients.

The Emergency Eye Clinic would not be closed and will continue to treat patients with emergency, sight-threatening eye conditions whilst urgent eye conditions are treated within locations across Sheffield.

Question 2. What evidence do you have of dissatisfaction with the quality and location of care provided at these facilities? They seem well-located for Broomhall and other neighbourhoods on direct bus routes housing disadvantaged and vulnerable people you identify as being confused by current systems. In contrast, the NGH site is further from the city centre and finding anything there is extremely difficult.

CCG response: The rationale behind the closure of these facilities is not based on any dissatisfaction with the quality of the service but instead as part of a wider look at the entire local Urgent Care system and what model delivers the most equitable and accessible quality care for patients whilst also meeting national mandates.

While the Northern General Hospital site may be further from the city centre it still has good public transport links. Basing the Urgent Treatment Centre at the NGH also has the benefit of allowing co-location with A&E and on-site access to X-ray and other diagnostics (a national requirement of the new Urgent Treatment Centres).

It should be noted that under the proposals, the majority of patients requiring diagnosis and treatment of minor illnesses will be seen within 24 hours of request by their own or a local GP practice, thus limiting the distance that patients have to travel. Only patients with an injury would have to travel to the Northern General Hospital or Sheffield Children's.

Question 3. What are the outcomes of any discussions you have had with staff and their unions?

CCG response: Discussions have been had with organisational representatives from providers across the city as part of the options development phase.

Discussions with staff and their unions about their views on the proposed options will occur as part of the consultation phase.

Question 4. Can the CCG give an assurance that the Public Consultation Document provides a clear and approved Plain English statement of what is actually being consulted on in relation to Urgent Care. When will it be available?

CCG response: The public consultation document provides a clear description of what is being consulted on and has been written for a public audience. It was not possible to go through the plain English Crystal Mark assessment in the time available but we did have it reviewed by a lay volunteer to check that it was easy to understand and used plain English.

It was made available on 26 September and can be found on our web site at http://www.sheffieldccg.nhs.uk/get-involved/urgent-care-consultation.htm

As well as the full document, there is a short summary version which is intended to be the main source of information for the public. This will be available online and printed copies are being sent out to venues across the city, including current urgent care services and GP practices.

Question 5. What analysis of patient flow and patient satisfaction has been undertaken for the Minor Injuries Unit? The main justifications given for its proposed closure are criteria such as proximity to A&E and, implicitly, cost. Patient confusion around A&E/MIU is subject to a variety of interpretations.

CCG response: A detailed analysis of patient flow (including time profiling) and acuity was undertaken to ensure that the service requirements have been fully identified. The analysis also included examining a patient's registered GP practice to best inform the equality of access for proposed service locations.

Question 6. Has the CCG evaluated how access to and use of new urgent care facilities will be affected if proposed national charges to migrants for community-based care other than GP or Emergency Care are implemented.

CCG response: The changes to "NHS (Charges to Overseas Visitors) regulations 2015" result in several changes to the charging rules, some of which formally come into effect from 21 August and some from 23 October 2017.

However, under the current model for Urgent Care in Primary Care, any new services put into place would generally be providing care which met the urgent service definition provided In the regulations ie. *a service that the treating clinician determines is not immediately necessary but which should not wait until the recipient can be reasonably expected to leave the UK.*

On this basis, the care would be provided immediately and where an Overseas Visitor is chargeable (defined by the detailed guidance – link below) the provider

would need to invoice the patient directly for their care. Where charge exempt, the CCG is responsible for payment (but the provider is required to gather evidence such as EHICs and there is a formal process which is also outlined in the guidance).
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/639277/Guidance_to_Charging_Regulations_post_21_August_final__Master_version_.pdf

Question 7. Will the CCG make its workforce modelling for the proposed new system publicly available?

CCG response: The CCG does not consider that the workforce modelling needs to form part of the public consultation.

Question 8

a. **Please provide a breakdown of the criteria used to evaluate each of the 6 options listed in Paper D. Please also list the actual scores of each Option.**

CCG response: The breakdown of the criteria used to evaluate each option and the scores for each option are included within the attached spreadsheet (Appendix 1)

b. **Further, can the PCCC confirm that the full analysis of each of these options will be included in the Consultation documents going out to the public?**

CCG response: The consultation documents will not include a full analysis of each of the options. The document is designed as a simple explanation of the issues and options for the general public and the full analysis is too detailed for such a document.

Question 9

a. **Please detail the consultation format used to speak to patient groups and stakeholders to collate the information referred to in Paper D and Paper D Supporting Appendices**

CCG response: Consultation has not yet happened but in the pre-consultation phase we used semi-structured interviews, questionnaires (online and off line), interviews with patients in waiting rooms (inc WIC), focus groups and peer to peer conversations with vulnerable communities.

b. **In particular, please can you clarify exactly when and how the Walk-In Centre local team was consulted on these options?**

CCG response: The conversations were about information gathering in the pre-consultation phase to help inform the development of options for consultation. They were not about consulting on options as they had not been developed at that stage. See below re who and when.

c. **No consultation has taken place with the onsite team during 2017 to their knowledge. They are therefore concerned that the Walk-In Centre is cited in Paper D as having been fully consulted with on the options and impact of no longer having a city centre urgent care location, when this is not the case. It is the view of the local team that no such consultation has taken place and we would wish for this to be taken into consideration when PCCC members are discussing the process for shortlisting the 6 options to the 3 being proposed as going to public consultation.**

CCG response: As explained above, no consultation has been carried out on the options yet. The consultation started on 26 September and runs until 18 December, and providers and their staff will have the opportunity to comment on the options as part of this process.

Representatives of One Medicare Ltd. engaged in the development of the options through the provider workshops process and a specific stakeholder meeting. As part of the engagement work with vulnerable groups, a meeting was held with Paul Higginbottom (the WIC General Manager) on 22 March 2017 at the WIC. Paul was relatively new in post so, following an internal CCG conversation, he agreed that a subsequent conversation with Luke Minshall (the previous manager at the WIC) would be helpful to double check the information supplied. This was undertaken on 29 March 2017 on the phone.

Question 10

a. **In Paper D Supporting Appendices, P8, a reference is made at bullet point 3 to "Data supplied by the Walk-In Centre showed that the majority of patients that attend are students and young professionals, that less than 3% of people revisit and most people arrive by car. This data is different to the assumption that the Walk-In Centre is providing support to large numbers of vulnerable people as an 'overspill' to commissioned primary care services in the city centre." Please can you confirm when this data was supplied and by whom as it is not data that the Walk-In Centre recognises as having been requested to supply. Nor does the data referenced correlate with the reports and analytics done by the Walk-In Centre itself which clearly shows substantial use of the service by vulnerable patients.**

CCG response: When the age profile of attendances at the Walk-In Centre is compared to that of the Sheffield age profile, the Walk-In Centre has an excess of attendees in the student/young professional age bracket relative to the general age range. This is supported by the demographic data provided by One Medicare and a review of patients' registered practices. It was also referenced in a discussion with the Walk-In Centre General Managers.

The Walk-In Centre General Manager provided the information regarding the statistic that less than 3% of people revisit.

The Walk-In Centre General Manager shared a copy of the patient survey undertaken by the Walk-In Centre in January 2017 which included a question on 'How did you get here'. This indicated that 38 out of the 60 people who attended arrived by car.

The assumption (made within the CCG) that the WIC was providing overspill to commissioned primary care services was not borne out in the semi-structured interviews with staff at The Mulberry Clinic, the Cathedral Archer Project or Devonshire Green practice nor the questionnaires from people who utilised the CAP.

b. On a related point, please could you confirm how the analysis of usage by vulnerable groups has been undertaken. It should be noted that vulnerability of patients is coded within patients records. Were read codes analysed to provide this data?

CCG response: The information on the usage of the WIC by vulnerable groups came from the data, interviews and questionnaires as outlined in question 10 a. Read codes were not analysed.

Question 11. Please can you confirm how the risks of this consultation have been evaluated and how the impact on the winter period of undergoing a consultation which is likely to cause uncertainty for staff and confusion for patients is to be mitigated?

CCG response: The risks associated with the programme were scored using the CCG's risk matrix which considers both impact and deliverability.

The consultation document and all consultation activities will make it clear that there will be no change to services this winter. The proposed options will take 2 years from the point of the decision being made to be fully mobilised, i.e. April 2020. Specific consultation activity is planned for groups of staff particularly affected by the changes and the CCG is working with providers to ensure that this is tailored appropriately to their needs.

Question 12

a. Can you please confirm how the timeframes for achievement of the March 2020 "go live" date for the new system have been reached and the steps taken to ensure those timeframes are met?

CCG response: The timeframes are based on a combination of the national requirements to implement particular requirements e.g. Urgent Treatment Centres (Dec 19) and a realistic judgement of timeframes to mobilise the local changes.

The steps being taken to ensure those timeframes are met will be planned/enacted during phases 2 and 3 of the programme plan.

b. **What back up plan is in place, should these dates not be achievable, to ensure patients are not put at risk by the "running down of services" and a subsequent lack of capacity and skilled staff during the redesign period?**

CCG response: The CCG will seek to work with providers to manage the risks.

c. **How have the costs of ceasing care delivery from 3 locations, Broad Lane and the 2 MIUs, been evaluated and factored into this consultation process?**

Our evaluation included a value for money criteria including consideration of contractual obligations.

d. **What consideration has been given to the substantial amount of NHS funds already invested in the Broad Lane location?**

CCG response: The establishment of a city centre primary care access centre 8 years ago was in response to a previous national government requirement. This service review is responding to the changing population needs and expectations and new government policy initiatives.

The OneMedicalGroup Board support a redesign of the urgent care system, however they are concerned that the initial 6 options proposed have been filtered down to a very narrow set of 3 options as set out in Paper D, which are all very similar and confusing for the public to understand. The Board would therefore ask the PCCC to consider all 6 options going out to consultation as a fairer way of fully evaluating the impact of such changes and giving the public a better opportunity to assess and feed into process. The Board would like it noted that they do not feel that all options have been fully considered and therefore the redesign that is needed to achieve long term sustainability and viability of the Sheffield health economy will be put at risk.

This request was noted at the meeting. PCCC felt that a robust process had been followed and that it was appropriate to proceed with the top 3 scoring options as had always been the intention.

Criteria 1 - Public feedback 1	Assessment	Translation
Access to Urgent Primary Care is simplified	5 – excellent	Patients have 4 choices of urgent care service
	3 – adequate	Patients have 5 choices of urgent care service
Weighted as 25	1 – very poor	Patients have 6 choices of urgent care service

Criteria 2 - Public feedback 2	Assessment	Translation
Services are easy to access (close to home/public transport links)	5 – excellent	The majority of patients can access the UTC(s)/SCH ED within a 15 minute drive
	3 – adequate	Most patients can access the UTC(s)/SCH ED within a 15 minute drive
Weighted as 15	1 – very poor	Some patients can access the UTC(S)/SCH ED within a 15 minute drive

Criteria 3 - Clinical and quality 1	Assessment	Translation
Care is delivered in the right place first time	5 – excellent	All patients who present at an UTC can be treated first time i.e. regardless of whether they have minor illness or minor injury or a more signifcant injury either because treatment can be provided by same or co-located service
	3 – adequate	Only adults or only children who present at an UTC can be treated first time i.e. one group would have to travel to a second site if they presented with a minor or more significant injury when service only sees illness)
Weighted as 15	1 – very poor	All patients who present at an UTC might have to travel to a second site to complete treatment (i.e. attended with a minor or major injury when service only sees illness)

Criteria 4 - Clinical and quality 2	Assessment	Translation
The option ensures that the primary care workforce is sustainable	5 – excellent	Option enables the most efficient use of skillmixed workforce thereby supporting sustainability
	3 – adequate	Option makes no significant impact on current sustainability of workforce
Weighted as 15	1 – very poor	Option generates an inefficient use of skillmixed workforce detrimentally impacting on workforce sustainability (either because workforce spread too thinly or duplicated unnecessarily across services)

Criteria 5 - System and Commissioner objectives 1	Assessment	Translation
Inequalities are reduced	5 – excellent	The risk of increasing inequalities is low
	3 – adequate	The risk of increasing inequalties is moderate
Weighted as 15	1 – very poor	The risk of increasing inequalties is high

Criteria 6 - System and Commissioner objectives 2	Assessment	Translation
The option supports the integration agenda	5 – excellent	Option enables significant potential for integration of services and staff across health and social care/primary and secondary care boundaries and time periods i.e. in and out of hours
	3 – adequate	Option presents no change from the status quo

Weighted as 15	1 – very poor	Option limits potential for integration of services and staff, either because of stand alone or isolated health and social care or primary/secondary care services, incompatability of different IT systems etc

Criteria 7 - Value for Money	**Assessment**	**Translation**
	Yes/No	Is the system financially sustainable - ie it doesn't cost more than the current system (excluding Non-Recurrent funding) including likely risks

	Adult UTC NGH, Paed UTC SCH, Minor Injuries UTC Option 1		Adult/Paed UTC NGH, Minor Injuries UTC Option 2		Adult/Paed UTC City, Minor Injuries UTC Option 3		Adult UTC NGH, Paed UTC SCH, Minor Injuries ED Option 4		Adult/Paed UTC NGH, Minor Injuries ED Option 5		Adult/Paed UTC City, Minor Injuries ED Option 6	
Criteria 1 - Public feedback 1 Access to Urgent Primary Care is simplified	27	6.75	45	11.25	27	6.75	9	2.25	27	6.75	27	6.75
Criteria 2 - Public feedback 2 Services are easier to access (closer to home/public transport links)	31	4.65	21	3.15	33	4.95	29	4.35	17	2.55	29	4.35
Criteria 3 - Clinical and quality 1 Care is delivered in the right place first time	43	6.45	25	3.75	11	1.65	41	6.15	25	3.75	9	1.35
Criteria 4 - Clinical and quality 2 The option ensures that the primary care workforce is sustainable	35	5.25	29	4.35	19	2.85	25	3.75	23	3.45	19	2.85
Criteria 5 - System and Commissioner objectives 1 Inequalities are reduced	27	4.05	9	1.35	9	1.35	27	4.05	9	1.35	9	1.35
Criteria 6 - System and Commissioner objectives 2 The option supports the integration agenda	39	5.85	28	4.2	23	3.45	33	4.95	21	3.15	19	2.85
Criteria 7 - Value for Money												
Total		33	0	28.05	0	21	0	25.5		21		19.5

Ranked in order	Option 1	33
	Option 2	28.05
	Option 4	25.5
	Option 5	21
	Option 3	21
	Option 6	19.5